Health-promoting Care: A toolkit for improving the health of looked after children
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‘Health is created and lived by people within the settings of their everyday life, where they learn, work and play’.¹

**Introduction**

This report has been produced by NHS Health Scotland (NHSHS) on behalf of the Scottish Government’s Looked After Children Health Service Improvement Group.

NHSHS is a national Health Board working with public, private and third sector organisations to reduce health inequalities and improve health for all in Scotland. It is identified as a corporate parenting partner within the Children and Young People (Scotland) Act 2014.²

The report can be viewed as a practical toolkit which supports corporate parenting partners working in community, health and social care settings to improve the wellbeing of looked after children through enhancing health-promoting behaviours and encouraging healthy lifestyles.

It promotes a holistic approach to health and wellbeing and highlights evidence-informed actions that partners can undertake within their own role and remit to address the social and environmental factors that impact on the health of looked after children.

The approach has been titled ‘Health-promoting Care’ and this report has been produced to support its implementation in Scotland.

**Key issues**

Looked after children represent one of the most excluded and vulnerable groups in Scotland. They face additional challenges to their health and wellbeing compared with peers who have not experienced the care system.³

Children entering care can experience poorer mental health and behavioural problems than their peers,⁴ with particular concern focused around health-related behaviours such as sexual health, substance misuse and physical activity.⁵

Issues may be triggered and aggravated by the poor social and environmental conditions in which they have lived. These can include adverse family circumstances such as poverty, deprivation, domestic violence, trauma, abuse, isolation, neglect, poor adult role modelling, educational disruption and parental/carer substance misuse. These adverse experiences can increase the risk of adopting health-harming behaviours which transcend into adult life, leading to poorer health outcomes.⁶

Protective factors such as self-esteem, encouragement, positive relationships, and safe and nurturing environments have been associated with healthy behaviours. Other factors include access to opportunity, involvement in community activities and having access to health information and services.⁷ However, many looked after children have had limited engagement with these factors prior to entering care.

NHSHS’s Evidence Summary: Looked after Children³ highlights high-level evidence related to public health interventions designed to improve the health and wellbeing of looked after children.
The summary identified love and affection as having a significant impact on the emotional health and wellbeing of looked after children. It highlighted the desire of looked after children to experience a sense of permanence and belonging that can often be absent from their lives.

Looked after children reported a need to have someone in their life who can provide emotional support and encouragement and help them to achieve their goals and ambitions. Some reported a lack of encouragement to attend and do well at school. They identified issues that can impact negatively on their mental health and wellbeing, expressed a need to access suitable networks that can provide emotional support and practical help after leaving care and appreciated having someone to talk to about their concerns, particularly in confidence. They also expressed concern around stigma and prejudice within their community and reported a lack of information about local services and advice on how to access them.

Policy

The policy context for addressing these issues and improving health and wellbeing is represented within a number of documents in Scotland and stresses the need for looked after children to enjoy the same rights and opportunities as peers who have not experienced the care system. These policies include: Looked After Children and Young People: We Can and Must Do Better; These Are Our Bairns; The Early Years Framework; GIRFEC; Better Health, Better Care; Equally Well; The Commission on the Future Delivery of Public Services; National Parenting Strategy; Mental Health Strategy for Scotland: 2012-2015; Getting Our Priorities Right; Children and Young People (Scotland) Act 2014; Getting it Right for Looked After Children and Young People.

Guidance, recommendations and priorities within the different policies and strategies reflect the main health and wellbeing issues facing looked after children. They acknowledge that the health, wellbeing and developmental needs of looked after children can be varied and complex and can be met most effectively through a range of services working collaboratively across different sectors and settings.

The National Parenting Strategy acknowledges the wider issues that affect parents’ and carers’ abilities to provide a safe, health-promoting home environment. It supports parents and carers to improve their parenting skills, access high-quality health information, provide the best start in life for those in their care and access early learning, childcare and out-of-school care support.

The Early Years Framework addresses the needs of children whose lives, opportunities and ambitions are constrained by poverty, poor health, poor attainment and household unemployment. It adopts a prevention/early intervention approach and recognises the impact that living and learning environments, social relationships and access to universal services can have on health and wellbeing. It also recognises the contribution that adult services have on outcomes for children and young people, and identifying this as a priority within service planning and delivery – ensuring that parents, carers and children have integrated support from relevant services in order to meet their needs.

The Scottish Government’s strategy on looked after children, Getting it Right for Looked After Children and Young People, stresses the significance of stable placements on an individual’s ability to form positive, supportive relationships and become more familiar with community resources and services. It prioritises early intervention, partnership working,
empowerment, engagement and addressing the barriers to community resources and opportunities that looked after children can face.

The development of planned interventions designed to address issues relating to the health and wellbeing of looked after children should support and align with the implementation of these important documents.

Health inequalities

Different levels of exposure and interaction with the social determinants of health can lead to health inequalities, with marginalisation and discrimination compounding the effects. Health inequalities can therefore be seen as preventable and unfair differences in health status experienced by certain population groups.

Addressing health inequalities involves a blend of actions around equity, children’s rights and social justice, encompassing reduced exposure to health-harming environments and fair access to opportunities, services and community resources. Social work and social care practitioners work with some of the most disadvantaged groups in our society, and this presents opportunities to help address the social determinants of poor health for those most at risk.

The Health-promoting Care approach seeks to build the capacity of partners working in health and social care settings to address important areas relating to health improvement. It has been designed as a practical resource which supports the implementation of local and national policy and helps partners and stakeholders to achieve national outcomes linked to improving the health and wellbeing of looked after children.

Health-promoting Care

Drawing on its skills and experience in developing health-promoting schools and health-promoting hospitals, NHSHS worked with a wide range of partners within health and social care to further develop the concept of Health-promoting Care settings for looked after children.

A vision for Health-promoting Care

All looked after children in Scotland enjoy the highest possible standard of health and wellbeing. They access high-quality health and social care services that are responsive to their needs, and feel included, respected and responsible within safe and nurturing environments. They feel involved in the decisions that affect their health and wellbeing, have equitable access to community resources and enjoy positive opportunities to flourish and achieve their potential.

Aim

To promote and improve the health and wellbeing of looked after children.
Objectives

The objective are to:

- protect looked after children from existing threats to their health and wellbeing
- support looked after children to adopt healthier lifestyles and avoid risky health behaviours
- mitigate against factors that increase health inequalities and undermine health and wellbeing.

Definition of terms

‘Health-promoting Care’ refers to social care placements for looked after children that, in addition to the valuable care and service they provide, actively seek to improve health and wellbeing.

The term ‘looked after children’ used throughout the report includes looked after children, young people and care leavers in continuing care.

‘Placement’ refers to residencies where children or young people live once they enter the care system and are termed as ‘looked after’. This includes secure care, residential care units, special residential schools, foster and kinship care, living ‘at home’ and those exercising their rights to continuing care.

Health-promoting placements are therefore supportive living and learning environments where individuals work together to identify relevant issues, agree solutions and undertake changes to improve outcomes.

‘Wellbeing’ can be viewed as the realisation of children’s rights and the achievement of every child to flourish in light of their potential, skills and ability. It is identified within the Children and Young People (Scotland) Act 2014 as the attainment of eight indicators of wellbeing (safe, healthy, achieving, nurtured, active, respected, responsible, included), often referred to by the letters SHANARRI.

The relationship between health and wellbeing is seen as a two-way process in which health influences wellbeing and wellbeing influences health. Encouraging looked after children to be ‘active’ through promoting physical activity can benefit their health but it can also benefit their mental health and wellbeing, for example by reducing anxiety and depression, improving mood and increasing the ability to cope with psychosocial stressors. Similarly, participation in physical activity can assist in the development of children and young people by providing opportunities for social interaction and integration, encouraging communication and self-expression, developing positive relationships and building self-confidence. It has also been suggested that physically active children and young people more readily adopt other health-related behaviours such as the avoidance of tobacco, alcohol and drugs.

Approach

The Health-promoting Care approach is influenced by the World Health Organization’s (WHO) definition of health as: ‘a state of complete physical, mental and social wellbeing and
not merely the absence of disease or infirmity.' This recognises the wide range of factors that interact to influence the health and wellbeing of children and young people. These factors include family circumstances, life experiences, lifestyles, individual characteristics, attitudes, behaviours, educational attainment, relationships, social networks, social and physical environments, and access to health-related services and community resources.

The WHO’s ‘Health for All’ strategy and the Ottawa Charter for Health Promotion acknowledges the influence of settings on health and wellbeing. The charter identifies settings for health as: ‘the place or social context where environmental, organisational and personal factors interact to affect health and wellbeing.’ Examples of settings have included: schools, community centres, youth clubs, universities and colleges, care homes, hospitals and prisons.

The settings approach has been applied within different contexts across Scotland, and NHSHS has provided a short briefing paper which draws on high-level evidence regarding its adoption in health-promoting schools and hospitals.

A health-promoting school is defined in the WHO Global School Initiative as: ‘a school that is constantly strengthening its capacity as a healthy setting for living, learning and working’. Health-promoting hospitals seek to become ‘healthy organisations’ by ‘improving the health of patients and staff, developing healthy physical environments and linking with the wider community’.

Health-promoting Care therefore seeks to improve the health and wellbeing of those living, working and interacting with a care placement setting for looked after children. It seeks to coordinate health improvement activity and can be applied to support parents and carers (including corporate parents) to address the social and environmental determinants of poor health and wellbeing.

Values and principles

Health-promoting Care is built on the values and principles of equity, empowerment, partnership working and sustainability, along with the Common Core of Skills, Knowledge & Understanding and Values for The ‘Children’s Workforce’ in Scotland, GIRFEC and the United Nations Convention on the Rights of the Child (UNCRC).

Equity

The approach takes action to ensure that looked after children are not treated unfairly on any basis, particularly with reference to age, sex, ethnicity, disability, culture or sexual orientation. It values diversity and reflects on the risks to equity and discrimination as a result of adverse family circumstances, outdated organisational practice and service design and delivery. It seeks to address barriers that restrict or prevent looked after children from accessing support, community services and opportunities.

Empowerment

Health promotion seeks to empower individuals to have more control over the wide range of factors that influence their health and wellbeing. The WHO’s most widely accepted definition of health promotion adheres to this aim, identifying it as ‘the process of enabling people to
increase control over, and to improve, their health’. This also informs the principles of person-centred practice and coproduction.

Person-centred practice

GIRFEC is built on the principles of child-centred practice, which places children and families at the centre and encourages practitioners to think creatively about involving them to develop effective practice.

A person- or child-centred approach to health improvement ensures appropriate consideration is given around issues identified by looked after children themselves and the actions they feel would work best for them. It allows for a flexible approach in which health improvement interventions start from where a child is at the time and makes small, manageable steps towards agreed or achievable goals.

Coproduction

Person-centred practice can help lay the foundations for the principles and practice of coproduction, which focuses on positive dialogue and engagement between people who use services and those who provide them. It ensures service users are ‘active partners’ in their care, with a view to achieving better health and wellbeing outcomes. Health issues are identified jointly by staff, parents or carers, and looked after children, with solutions and actions taken together.

Partnership working

Action to improve the health and wellbeing of looked after children can be complex, requiring the support of a wide range of partners working together. Factors that determine health and health inequalities can often lie outside the immediate sphere of NHS healthcare services. It is only through engaging local planning frameworks and structures such as Community Planning Partnerships, Health and Social Care Partnerships and Integrated Joint Boards to work more closely with local authorities, voluntary and community organisations, and parents, carers and families that factors influencing the health and wellbeing of looked after children can be adequately addressed.

Sustainability

The Health-promoting Care approach does not rely solely on health professionals and/or health promotion specialists to deliver health improvement interventions within the care setting. Instead, health promotion is integrated into the day-to-day activity of parents and carers. It is often initiated and supported by health professionals but ownership should rest ultimately with parents, carers and services themselves.

National care standards

The approach is designed to align with the values and principles that underpin the national care standards, such as rights, equity, quality and consistency and includes evidence-based actions to support partners around delivery.
Inspections

The outcomes and actions identified within the logic model are designed to reflect key issues within health and social care, which are inspected on by partner organisations such as Healthcare Improvement Scotland and the Care Inspectorate.

GIRFEC

Health-promoting Care recognises health as one of the eight indicators of wellbeing within GIRFEC. The indicators relate to the quality of a child’s or young person’s life and essentially outline what it means when things are going well.

UNCRC

Health-promoting Care adopts a rights-based approach and aligns with the UNCRC. Child rights embedded within the approach include:

- the right to be protected from violence, abuse, mistreatment and neglect
- to have opinions taken into account
- to access the best health care possible
- to receive information that helps looked after children to stay healthy
- to respect the rights, freedoms and reputations of others
- to live full, inclusive and independent lives
- to meet together and join in a wide range of cultural and recreational activities.

Corporate parenting

Corporate parenting has been described as ‘the formal and local partnerships between services responsible for working together to meet the needs of looked after children, young people and care leavers.’

The Children and Young People (Scotland) Act 2014 identifies corporate parenting duties as:

- be alert to matters that may adversely affect wellbeing
- promote the interests of looked after children
- provide opportunities to participate in activities that promote wellbeing
- take appropriate action to help looked after children make use of the services and support provided
- take appropriate action to improve the way organisations exercise their corporate functions in relation to looked after children.
The Act places a statutory duty on corporate parents to cooperate and collaborate with each other when exercising their responsibilities around promoting wellbeing.

This collaboration can include:

- sharing information
- sharing responsibility for action
- coordinating activities
- funding activities.

The Health-promoting Care approach is designed to support collaboration and joint working.

**Health promotion: areas of focus**

Health-promoting Care incorporates the 'key areas of focus' for health promotion which are listed within the Ottawa Charter. They include:

- creating supportive, healthy environments
- developing individual skills, knowledge and competencies
- encouraging the adoption of healthier lifestyles and avoiding risky behaviours
- fully involving (looked after children) in decisions that affect their health and wellbeing
- supporting better access to high-quality healthcare services
- ensuring equitable access to community resources and positive opportunities
- supporting (looked after children) to be valued and accepted members of their communities.

Partnership working plays a crucial role in the success of the Health-promoting Care approach as it requires children, young people, staff, parents, carers, health professionals and their partners, including third sector and voluntary organisations, to support each other and work together to improve outcomes possibly by taking an active lead in at least one of the above actions.

**Quality statements**

Inspired by the Ottawa Charter’s 'key areas of focus', a series of context-relevant quality statements have been developed in partnership. The statements effectively outline the primary purpose of the Health-promoting Care approach. They summarise the priority areas of focus and identify the standards which the approach will strive to achieve. They are designed to help address the negative health behaviours and social determinants of health outlined within the key issues section which, in turn, are reflected within relevant policy relating to improving the health and wellbeing of children and young people.
Health-promoting Care (of looked after children) will seek to:

- improve the life chances of looked after children
- provide safe, stable and nurturing care environments free from abuse, neglect and harm
- identify and address the immediate and on-going health and wellbeing needs of looked after children
- support access to health services such as GPs, health centres, dentists and specialist services
- provide access to high-quality health information on topics such as mental health, sexual health substance misuse and physical activity
- encourage carers to act as positive role models and advocate for improved health and wellbeing
- involve looked after children in all appropriate decisions and issues that affect their health and wellbeing
- promote healthy lifestyles and encourage looked after children to avoid risky health behaviours
- build skills and knowledge to support positive lifestyle choices in preparation for leaving care
- mitigate the effects of emotional trauma, mistreatment, loss and bereavement on positive mental health and wellbeing
- promote inclusion and participation in school and community activities (including educational, cultural, and sport and leisure opportunities)
- provide positive learning environments that actively encourage and support the interests, goals and ambitions of looked after children
- develop the confidence, self-esteem, resilience, communication skills and capacity of looked after children to cope with adverse experiences and life circumstances
- promote positive values such as a respect for the rights of others, equality, diversity and respect
- support looked after children to achieve their potential and play a full role within their communities.

Logic model

The above quality statements were used in the development of a logic model for improving health outcomes for looked after children (see Appendix 1). A logic model is simply a planning tool outlining what needs to happen in order to achieve desired goals. There are many different types of logic models but most are simply graphic diagrams that help to illustrate the relationship between evidence-informed actions and planned outcomes. They are sometimes referred to as ‘theories of change’.42

The logic model in Appendix 1 was developed in partnership by NHSHS and was applied, in turn, to develop the Health-promoting Care approach. It includes a full set of medium- and
short-term outcomes linked to the National Performance Framework and a series of evidence-informed actions.

Logic model development

The views of looked after children

The national organisation ‘Who Cares? Scotland’ ran a workshop for children and young people with experience of the care system in Scotland. This was to gauge their views on the outcomes and actions outlined in an advanced version of the Health-promoting Care logic model.

Participants identified a number of factors that could enhance a care placement’s capacity to support development and provide positive learning opportunities to improve health. These included care placement environments which are ‘clean, nicely decorated, and safe’. They should have ‘quiet areas, personal space, clear rules and regulations, and provide lessons relating to living skills’.

Attributes of staff and carers working to promote health and wellbeing were identified as being: ‘patient; a good listener; non-judgemental; trustworthy; approachable; kind; discreet; consistent and caring’. Participants felt confident that staff and carers demonstrating these attributes ‘understand how to create these health-promoting environments’.

Barriers to accessing relevant health services included the issue of permanence, with participants expressing the difficulties of having to continually develop new relationships with health professionals and register with different health services.

Time to build positive relationships with health professionals was a factor impacting on their willingness to communicate sensitive, health-related issues during consultations and health assessments.

Workshop participants also identified barriers which hamper interaction with services and resources within their own community. These barriers included: stigma; transport; confidence; and money. The young people preferred staff and carers not to treat health-related issues such as self-harm and eating disorders in a punitive way. They expressed the importance of positive relationships with staff and carers with knowledge of relevant sources of information and support.

The views of partner organisations

A national workshop provided an opportunity for our main partners and stakeholders to discuss a later draft of the logic model in detail. A key issue identified during the workshop included the function of universal services such as health, education and leisure with regard to improving the health and wellbeing of looked after children. It focused on their potential role around early intervention to help prevent vulnerable children and young people from entering the care system in the first place.

Other key issues and comments offered within the workshop included: a need to identify a lead for each of the proposed actions; further detail on how actions can be undertaken; how the outcomes are measured; identifying the evidence base behind the actions; more attention on staff and carer health; and a request to change the name of the logic model to the ‘achieving outcomes’ model. Workshop participants also wanted clearer links made to other
existing policies, strategies and approaches designed to help improve the health and wellbeing of children and young people.

Outcomes

The outcomes within the Health-promoting Care logic model can be viewed as the changes or factors that are expected to support the implementation of the current policy context and make the most positive impact on the health and wellbeing of looked after children. They are balanced across health and social care and focus primarily on enhancing the physical, social and emotional environments within which looked after children live their lives.

The outcomes focus primarily on assessing and addressing health and wellbeing needs, promoting healthy behaviours and lifestyles, fostering involvement in school and community activities, encouraging access to opportunities and ensuring looked after children achieve their potential.

Outcome indicators

The following table (Table 1) aligns with the outcomes highlighted within the logic model and lists a number of outcome indicators to help measure success. These are simply aspects that help gauge whether or not an outcome has been achieved. Some outcomes are seen as ‘hard’ and can be measured numerically, using fairly straightforward direct indicators, while others are viewed as ‘soft’ and require indirect proxy indicators.

Table 1: Logic model/outcome indicators

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator</th>
<th>Data collection method</th>
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<tbody>
<tr>
<td>SO1*</td>
<td>% eating breakfast every morning on school days</td>
<td>Discussion and observation</td>
</tr>
<tr>
<td>SO1</td>
<td>% not misusing harmful substances such as alcohol, nicotine or drugs</td>
<td>Discussion and interviews</td>
</tr>
<tr>
<td>SO1</td>
<td>% meeting current physical activity guidelines (one hour of moderate to vigorous physical activity every day)</td>
<td>Data from needs assessments</td>
</tr>
<tr>
<td>SO1</td>
<td>% brushing their teeth at least twice a day</td>
<td>Discussion, interviews and data from needs assessments</td>
</tr>
<tr>
<td>SO2**</td>
<td>% who have received a physical and mental health needs assessments</td>
<td>Data from needs assessments</td>
</tr>
<tr>
<td>SO2</td>
<td>% who are registered with a dentist and are attending regular check-ups</td>
<td>Data from needs assessments</td>
</tr>
<tr>
<td>SO2</td>
<td>% who have completed immunisations by relevant ages</td>
<td>Data from needs assessments</td>
</tr>
<tr>
<td>Outcome</td>
<td>Indicator</td>
<td>Data collection method</td>
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<tr>
<td>SO2</td>
<td>% with wider health and wellbeing needs noted within their child care plan</td>
<td>Data from the child plan</td>
</tr>
<tr>
<td>SO3***</td>
<td>% whose hobbies, interests, ambitions and goals are identified and recorded</td>
<td>Discussion, interviews or data from the child’s plan</td>
</tr>
<tr>
<td>SO3</td>
<td>% meeting appropriate levels of educational attainment across the curriculum</td>
<td>Education report cards</td>
</tr>
<tr>
<td>SO3</td>
<td>% who aspire to move on to further or higher education and/or skilled employment</td>
<td>Discussion and interviews</td>
</tr>
<tr>
<td>SO3</td>
<td>% who feel they are supported to fulfil their potential</td>
<td>Discussion and interviews</td>
</tr>
<tr>
<td>SO4****</td>
<td>% who enjoy good relationships with carers, family and friends</td>
<td>Discussion and interviews</td>
</tr>
<tr>
<td>SO4</td>
<td>% who do not experience bullying, labelling or discrimination at school or in the community on the grounds of issues such as life circumstances, age, gender, ethnicity, religion, culture, disabilities or learning difficulties</td>
<td>Discussion and interviews</td>
</tr>
<tr>
<td>SO4</td>
<td>% who take part in sporting, cultural or recreational activities that increase social contact and enhances community participation</td>
<td>Discussion and interviews</td>
</tr>
<tr>
<td>SO4</td>
<td>% who are generally optimistic and realistic about what they can achieve in life</td>
<td>Discussion and interviews</td>
</tr>
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SO, short-term outcome.

*SO1: The physical, social and emotional environment of care placements promote healthy lifestyles and encourage positive health behaviours.
**SO2: The health and wellbeing needs of looked after children, including mental health, are assessed and steps to address those needs are undertaken.
***SO3: The interests, ambitions and personal goals of looked after children are known and encouraged, with barriers that may prevent access to opportunities identified and addressed.
****SO4: Looked after children enjoy positive relationships and live inclusive and independent lives within their community regardless of additional needs, disadvantage or disabilities.
The outcome indicators were developed from the HBSC, the SALSUS and GIRFEC to maximise the possibility of collecting comparable data. The outcome indicators may be revised in the future to reflect changes within the national survey(s).

**Data collection**

The outcome indicators were circulated to partners across Scotland for comment. Feedback highlighted that some of the data may be collected from comprehensive health needs assessments and local data sets, with the remaining data collected at the local level as part of the routine evaluation process (for example via a short survey undertaken by staff/carers). Realistic processes and protocols should be adopted in partnership to ensure that the data collection method remains realistic, achievable and timely.

The logic model should be viewed as a tool to support partners who wish to improve the health and wellbeing of looked after children. As such, the outcome indicators have been drafted to support the evaluation of the approach and should not be interpreted as national or local performance indicators.

**Actions**

The actions listed within the logic model can be viewed as the outputs of the approach. They are what the approach will actually do in order to meet the outcomes. Some of these actions may already be delivered as part of a carer’s parental-style responsibilities or a health professional’s core practice. However, they are included within the model because of their potential impact on health and wellbeing.

The actions are balanced across health and social care and seek to:

- enhance the physical and social environments in which looked after children live their lives
- promote healthy behaviours and lifestyles
- foster involvement in school and community activities
- engage local health-related services
- facilitate access to positive opportunities
- encourage individuals to achieve their full potential.

Other actions with a more individual focus include: develop self-esteem, resilience and assertiveness; and develop life skills that will help looked after children feel confident enough to engage with local services to help address issues relating to inclusion, stereotyping, stigma and discrimination.

The action description boxes (see Appendix 2) have been included to expand on the limited information that can be provided within the limitations of a logic model. They take the opportunity to define terms, where possible, and offer a greater degree of guidance to partners who wish to incorporate the action within their overall approach. However, partners are advised to further expand and develop these actions to ensure they are suitable and appropriate within a specific context or placement setting.
Actions evidence base

NHSHS has undertaken a review of the literature relating to improving the health and wellbeing of looked after children, linking it to the actions outlined within the logic model. This was to ensure that, from the best available evidence, the actions proposed as part of the Health-promoting Care approach can be viewed as relevant, appropriate and effective interventions that will help to achieve the outcomes.

The literature highlighted evidence and policy directives relating to a wide range of health-related issues reflected in the logic model’s actions. These included: providing healthy living environments; physical and mental health; health behaviours; educational attainment and home learning environments; employment; sports, activities and hobbies; accessing services; encouraging positive attachment; addressing trauma; foster and kinship care; positive parenting; partnership working; permanency; access to opportunities; independent living; expanding social networks; and community involvement. As a result, the literature review highlighted existing evidence that can be used to underpin the majority of the actions outlined within the logic model.

However, gaps and limitations do exist within the evidence identified, which restricts the end goal of adopting a purely evidence-based approach to improving health and reducing the health inequalities of looked after children. For example, the review uncovered limited evidence relating to acting as a positive role model, advocating on behalf of looked after children for positive health outcomes, and developing links with local organisations and resources to help identify opportunities for looked after children within their community. However, this may be uncovered with a more extensive review of the evidence base. Interventions that lack a strong evidence base may still have important contributions to make around overall impact as part of a package of interacting actions. In judging whether or not to include certain actions, partners can be pragmatic and draw on plausible theory and ethical principles in order to develop and implement certain actions, i.e. based on past experience, it is reasonably expected that the intervention will help achieve the intended outcome.

In addition, there is little specific evidence relating to the effectiveness of applying a healthy settings approach within health and social care placements for looked after children. The rationale informing the Health-promoting Care approach is derived mainly from Scottish Government policy and high-level evidence reviews, although some primary studies were also included. Although the evidence base suggests that the actions within the accompanying logic model are appropriate and effective, they are presented with a caveat of caution. However, developing and implementing such an approach within care placements for looked after children and findings from local evaluation studies may further advance the evidence base.

A full report linking the logic model actions to the evidence highlighted within the existing literature is available at the end of this document (see Appendix 4).

Implementation

The following figure (Figure 1) is adapted and expanded from Healthy Settings: An Operational Process by Doherty and Dooris. It illustrates key steps around implementing the health settings approach at the local level.
1. Lead agency

An early stage of the implementation process includes identifying a lead agency with an understanding of the values, principles and approach of the intervention. The same values and principles outlined in the Ottawa Charter\(^1\) and applied within health-promoting schools and hospitals can be used to underpin the work.

2. Buy-in from stakeholders

Owing to the holistic nature of the approach, the successful achievement of its outcomes requires the support and involvement of partners from different sectors with different roles and responsibilities. It is recommended that buy-in is secured from all involved parties before the approach is developed at the local level. Partners should be clear regarding their roles and responsibilities within the approach and the actions they are expected to support or deliver in order to achieve specific outcomes within realistic timescales.

3. Local champions and coordinators

Identifying a lead/local champion can help to facilitate delivery at the local level. This should be someone with a strategic remit at the local level who can then coordinate progress and liaise with external partners.

4. Consultation and identifying needs

Once the key stakeholders and partners are involved, it is important that their views, thoughts and opinions are taken on board and embedded within the model. This can help to ensure that the approach remains context relevant, addresses local health issues and priorities are
developed in line with available resources and capacity and that stakeholder partners feel ownership of the approach.

5. Establishing local, multi-sectoral steering and working groups

These can help bring partners together, gauge commitment, share information, provide a platform for discussion, enable partners to influence the agenda and identify those best placed to influence change. It can also be placed in subgroups within current structures, or incorporated fully into established groups.

6. Action planning

An action plan can be a useful tool to help clarify the current state of play within the local area, also known as the ‘starting point’. It can be used to identify an end goal and outline the strategy to be adopted to achieve it, in this case, the development of Health-promoting Care placements. These are specific, measurable, achievable and realistic objectives that can be delivered within a set timescale, which help to break down tasks and track progress. It is recommended that the action plan is developed in partnership, with all partners, including looked after children, having an opportunity to influence the final draft. The action plan can help detail the required resources and promote joint ownership of a shared agenda, thereby supporting sustainability.

The action plan and implementation may therefore be slightly different within each locale. Partners may bring in different thoughts, views and experiences; address different issues; identify different priorities; and adopt slightly different ways of approaching actions. However, it is expected that each approach at the local level will share fundamental aspects such as values, principles and quality statements and will evaluate and review their approach against the outcomes identified within the logic model.

7. Delivery and implementation

This stage links to undertaking the actions identified within the logic model. These should be agreed with partners, set within available capacity and resources and ultimately support the implementation of local strategic delivery plans.

8. Reflective learning and evaluation

This involves either external evaluation of the interventions or applying a continual learning cycle to ensure reflective learning takes place, lessons are learned and changes implemented where and when required. The outcome indicators identified in Table 1 can be used to facilitate local evaluation of the approach. Partners may choose from a range of tools and processes to facilitate evaluation and learning.

Learning, Evaluation and Planning (LEAP) is an approach to planning and evaluation that is outcome-focused, participatory and learning-based. It supports partners in reviewing any actions undertaken, learning from their experiences and implementing any required changes to successfully achieve stated outcomes. It was developed by the Scottish Community Development Centre and can be used in different contexts and by partners working in different sectors and settings.
Partner roles and responsibilities

The logic model attempts to identify partners who may be most suitable to lead on particular actions; for example ensuring looked after children live in positive learning environments that encourage homework and develop supportive home–school links may be a role undertaken by parents or carers. Alternatively, assessing the health needs of those children may be identified as a role for health professionals.

The codes listed at the bottom right-hand corner of each of the logic model’s action boxes suggests a partner which might be best placed to lead, or coordinate the action (see Appendix 1).

Actions that focus on building self-esteem and confidence, developing positive attachment and encouraging children to be active and involved in school and community life may be led by staff, parents, carers, families and/or foster and kinship carers. Other activities such as supporting recovery from trauma or bereavement may be led through community-based therapeutic organisations while assessing health needs and undertaking screenings and immunisations will fall within the responsibility of health professionals.

The following partner profiles have been selected to briefly help illustrate the different roles each partner can develop and the range of unique skills and experience they can offer.

Partner profile 1: Health professionals

Health professionals clearly have an important role to play around supporting and delivering Health-promoting Care placements (looked after children). The Royal Colleges’ intercollegiate framework Looked After Children: Knowledge, Skills and Competence of Health Care Staff outlines their core skills, knowledge and competencies, which include:

- undertaking comprehensive health needs assessments
- contributing to healthcare planning
- clinical governance
- coordinating care and treatment activities.

This responsibility also extends to health promotion and health education activity.

NHS Education for Scotland’s A Capability Framework for Nurses who Care for Children and Young People who are Looked After Away from Home outlines key areas of responsibility for nurses working with looked after children. It highlights nurses working as members of interagency teams who maintain and improve the health and wellbeing of looked after children in their care, enable children and young people to identify and address factors that affect their health, and empower individuals, groups and communities to promote the health and wellbeing of looked after children. This responsibility also includes actively participating in the production of child care plans.

Partner profile 2: Parents and carers

Parents and carers have a unique and crucial role to play in improving health outcomes for looked after children for whom they have a responsibility. The roles and responsibilities of
parents and carers are outlined within key national documents and guidance such as the National Parenting Strategy. This strives to make it easier for parents and carers to better appreciate the positive difference they can make to a child's development, building their confidence and ability to care for children, helping them access support when needed and ultimately making the parenting/care-giving role a rewarding experience.

Specific actions for parents and carers that provide the greatest impact on health and wellbeing within the Health-promoting Care placements approach include:

- developing self-esteem, assertiveness, confidence and resilience
- nurturing learning, praising, encouraging and listening to children
- supporting their involvement in school and community activities
- helping them to achieve their personal goals and ambitions.

Delivery within different placement settings

Looked after children as a population can appear relatively heterogeneous, for example in terms of age, characteristics, reasons for being in care and the placements they are in. However, the actions within the logic model have not been drafted with a specific set of characteristics or placement setting in mind. Although the logic model attempts to identify a partner who may be best placed to lead on a particular action, this responsibility may depend on the type of placement and the issues being addressed at the time.

The following diagram (Figure 2) attempts to make a relatively straightforward point. It moves left to right from secure care to more community-based care and helps to illustrate the balance of support that can be offered by different partners across the different settings.

The bottom grey-shaded area represents social care services while the top green-shaded area represents families, parents, carers and other partners (such as schools, youth work and community and voluntary organisations).

Figure 2: A model for working in partnership
As illustrated, children within community-based placements (such as ‘kinship care’ or ‘at home’) may experience less day-to-day contact with social care services than children living in ‘residential care’ or ‘secure care’. In this context parents, carers, families and relatives, health professionals, schools, youth work and community and voluntary organisations may play a more direct role as ‘agents of change’ for health improvement and may have greater opportunity to deliver the proposed actions and achieve the logic model’s outcomes. This can help ensure that the health and wellbeing needs of looked after children can be addressed by the different partners, regardless of the context or setting.

Protocols, processes and systems

Health-promoting Care recognises the need for all partners to have reliable and robust systems, processes and protocols in place that can help to clarify and facilitate their role, enabling them to carry out their functions and responsibilities around improving health and wellbeing. These systems and processes can be reviewed and revised when developing the approach at the local level to ensure the support and effective contribution of relevant partners across health and social care.

NHSHS produced a short report in 2010 highlighting the systems, processes and protocols across Scotland by which looked after children in Scotland were identified to NHS Boards, the mechanisms by which health needs were assessed, recorded and communicated, and the interagency links set up to help improve their health and wellbeing. The study confined itself to an overview of children’s planning and assessment systems, rather than a detailed review of complex care pathways between health and social care services.50

For NHS partners, these protocols can include the need to have in place:

- systematic and formal communication between local authorities and NHS Boards to ensure Health Boards are aware of all looked after children in their area
- systematic and formal communication within local authorities to ensure schools and school nurse services are aware of pupils who may be ‘looked after’ and require additional support
- clarity around involving health professionals earlier in the placement or commissioning process to ensure decisions are informed by the health and wellbeing needs of the child
- clarity to identify which health professionals have responsibility for undertaking a comprehensive needs assessment with all children, especially those looked after ‘at home’.

For social care partners, these can include the need to have in place:

- positive and productive working relationships with healthcare professionals so that health issues identified informally by carers – or communicated to them by a young person – are discussed with relevant partners, while respecting the individual’s confidentiality
- clarity around appropriate referral processes to Children’s Adolescent Mental Health Services (CAMHS), particularly where issues linked to mental health and wellbeing have a social cause which may not require medical ‘treatment’.
Improvement methodology

Carrying out the actions within the logic model may involve initiating ‘small steps of change’ relating to policy, practice, systems, procedures and protocols linked to how an organisation and/or service is designed and delivered. It may involve looking closely at the current state of play and exploring what needs to happen or what might need to change in order to undertake the action and achieve a stated outcome.

NHS Scotland’s Quality Improvement Hub (QI Hub) ([www.qihub.scot.nhs.uk](http://www.qihub.scot.nhs.uk)) aims to support health and social care practitioner staff such as doctors, nurses and social workers to use quality improvement approaches as a core part of their work. The website includes tools and resources to help partners with their quality improvement journey.

*The Improvement Guide: A Practical Approach to Enhancing Organisational Performance* involves an improvement methodology framework for developing, testing and implementing changes to the way that things are carried out that will lead to improvement. This includes the planning cycle – Plan, Do, Study, Act (PDSA) – a useful tool to test whether or not the suggested change will bring about the desired improvement. It can help identify suitable methods and improvements that can be measured.

This approach has been adopted by the Scottish Government’s Education Directorate, which provides a model through which organisations can improve structures, procedures and practice. The Centre for Excellence for Looked After Children in Scotland has been working with a number of local authorities throughout Scotland using ‘improvement methodology’ to improve educational outcomes for looked after children.

Driver diagrams

A driver diagram can be a useful tool to identify the parts of a system, process or practice that need to be improved for an ‘action’ to be implemented successfully. They are particularly useful within improvement methodologies. While logic models help demonstrate links between outcomes and actions, driver diagrams can demonstrate the links between the actions and any improvements required.

Further information on using driver diagrams within improvement methodology can be accessed via NHS’s website. The Scottish Government website includes PDSA and driver diagram templates.

Partners wishing to implement the Health-promoting Care approach are encouraged to engage and link with local, regional and national organisations to ensure development is undertaken within a ‘knowledge into action’ approach and full use is made of available capacity, resources and expertise. NHS Scotland’s QI Hub includes details on developing a community of improvement advisors who work closely with practitioners in Community Planning Partnerships across NHS Scotland and there may well be an improvement advisor in your area who can offer direct support and guidance.

Summary

This report has been produced to support partners, parents and carers who wish to promote and improve the health of looked after children. It recognises the wide range of social and environmental factors that influence the health and wellbeing of children and young people. It
identifies practical, evidence-based actions that are designed to encourage healthy lifestyles and enhance the protective factors associated with healthy behaviours such as self-esteem, positive relationships and connectedness to school and community life.

The approach is underpinned by a logic model which provides an ideal mechanism to illustrate the links between current policy, suggested outcomes and proposed actions. In addition, the review of the literature around improving the health and wellbeing of looked after children has proved a useful exercise to build the evidence base for the recommended areas of action. Together with the case studies, kindly supplied by NHS Lothian and NHS Ayrshire and Arran, the report attempts to outline the why and how a settings-based approach to health and wellbeing can be implemented at the local level in Scotland. This will help partners to focus action on addressing the underlying causes of poor health outcomes of looked after children with a view to improving their overall health and wellbeing.
## Appendix 1: Logic model: health-promoting care for looked after children – achieving outcomes

<table>
<thead>
<tr>
<th>Actions</th>
<th>Short-term outcomes</th>
<th>Medium-term outcomes</th>
<th>High-level outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 – Act as positive role models for LAC, be alert to matters that affect their health and wellbeing and advocate on their behalf for positive outcomes.</td>
<td></td>
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<td>C&amp;P/ALL</td>
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<tr>
<td>A2 – Create healthy living environments with LAC which promote permanence, stability, connectedness, security and a strong sense of belonging.</td>
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<td>SO1</td>
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<tr>
<td>C&amp;P</td>
<td></td>
<td></td>
<td>MO1</td>
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<tr>
<td>A3 – Mitigate against the risk factors that have a negative impact on health and wellbeing such as substance misuse, emotional trauma, loss, separation, isolation, conflict, stress, anxiety, abuse and bullying.</td>
<td></td>
<td></td>
<td>C&amp;P/HP</td>
</tr>
<tr>
<td>A4 – Enhance the protective factors associated with positive health and wellbeing such as good nutrition, physical activity, emotional competency and good social networks.</td>
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<td>C&amp;P/ALL</td>
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<tr>
<td>A5 – Provide high-quality health information to LAC (such as sexual health, mental health and substance misuse), support the uptake of health promotion advice and encourage positive health behaviours.</td>
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<tr>
<td>C&amp;P/HP/HPS/SCH</td>
<td></td>
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<tr>
<td>A6 – Promote and improve the health and wellbeing of staff, parents, carers, and families to ensure they have the skills, knowledge, motivation and capacity to improve their own health and wellbeing as well as that of LAC.</td>
<td></td>
<td></td>
<td>HPS/HP</td>
</tr>
<tr>
<td>A7 – Nurture appropriate attachment behaviour by providing responsive, accepting, sensitive, discrete, authoritative and consistent parenting approaches and care routines as part of the caregiver role.</td>
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<tr>
<td>C&amp;P</td>
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<tr>
<td>A8 – Involve LAC and parent/carers to identify health issues through active dialogue, and encourage solutions agreed together and all parties can influence decisions which impact on their health and wellbeing.</td>
<td></td>
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<td>C&amp;P/ALL</td>
</tr>
<tr>
<td>A9 – Encourage educational attainment by developing safe and supportive home-learning environments which encourage homework, develop strong home–school links and fosters achievement.</td>
<td></td>
<td></td>
<td>C&amp;P/SCH</td>
</tr>
<tr>
<td>A10 – Assess the health and wellbeing needs of LAC using formal and informal processes and ensure all relevant information is kept up to date and is incorporated into the child’s care plan.</td>
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<tr>
<td>HP/C&amp;P/SCS/SW</td>
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<tr>
<td>A11 – Ensure LAC access scheduled screenings and immunisations, have regular health and dental checks, are registered with a GP/Dentist and access universal/specialist health services when required.</td>
<td></td>
<td></td>
<td>HP</td>
</tr>
<tr>
<td>A12 – All actions within the healthcare plan are coordinated by the lead professional and tracked, with all relevant information kept up to date and is incorporated into the child’s care plan.</td>
<td></td>
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<td>HP/ALL</td>
</tr>
<tr>
<td>A13 – Ensure suitable systems, processes and protocols are in place which enable health and social care staff to support delivery and work in partnership to improve the health and wellbeing of LAC.</td>
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<tr>
<td>ALL</td>
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<tr>
<td>A14 – Promote mental health and wellbeing by providing support to LAC (CAMHS tier 1), link with specialist support where required (CAMHS tier 2 and 3) and align with integrated care pathways.</td>
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<tr>
<td>A15 – Engage statutory corporate parenting duties by maintaining positive links with the named person and reviewing the health and wellbeing needs of LAC against any support and/or service(s) provided.</td>
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<tr>
<td>A16 – Assess the ambitions of LAC through active dialogue, and encourage the pursuit of activities, hobbies, interests and personal goals.</td>
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<tr>
<td>C&amp;P</td>
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<tr>
<td>A17 – Develop strong links with community organisations and services to ensure parents and carers are aware of opportunities and resources in their area and signpost/make these known to LAC.</td>
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<tr>
<td>C&amp;P/CP/VO</td>
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<tr>
<td>A18 – Identify and address any barriers which may discourage or prevent LAC from accessing community resources such as opportunities to play, participate in sport and leisure, cultural and/or school and community activities.</td>
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<td>C&amp;P/ALL</td>
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<tr>
<td>A19 – Develop assets such as self-esteem, confidence, resilience, coherence and positive coping strategies that enable children to achieve their goals.</td>
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<tr>
<td>C&amp;P/CP/VO</td>
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<tr>
<td>A20 – Promote assertiveness by encouraging LAC to adopt a positive self-image, an increased sense of personal control and support them to resist negative peer pressure linked to risky healthy behaviours.</td>
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<tr>
<td>A21 – Ensure LAC value diversity and respect their own rights as well as the rights, freedoms, ethnicity, culture, opinions and reputations of others.</td>
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<td></td>
<td>C&amp;P/CP/VO</td>
</tr>
<tr>
<td>A22 – Support LAC to develop and maintain positive relationships, ensure they have the opportunity to expand their social networks and enjoy full participation in home, school and community life.</td>
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<tr>
<td>C&amp;P/CP/VO</td>
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<tr>
<td>A23 – Ensure strong links with the wider community are in place to help address issues relating to inclusion, stereotyping and stigma, particularly those associated with disability, discrimination and/or disadvantage.</td>
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<td>C&amp;P/CP/VO</td>
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<tr>
<td>A24 – Staff, parents and carers know their obligation relating to children’s rights and can practically apply a rights-based approach within their own role and remit.</td>
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<td>C&amp;P</td>
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<tr>
<td>A25 – Help LAC to develop and maintain positive relationships, ensure they have the opportunity to expand their social networks and enjoy full participation in home, school and community life.</td>
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<tr>
<td>C&amp;P/CP/VO</td>
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<tr>
<td>A26 – Ensure strong links with the wider community are in place to help address issues relating to inclusion, stereotyping and stigma, particularly those associated with disability, discrimination and/or disadvantage.</td>
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<tr>
<td>C&amp;P/CP/VO</td>
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<tr>
<td>A27 – Staff, parents and carers know their obligation relating to children’s rights and can practically apply a rights-based approach within their own role and remit.</td>
<td></td>
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<td>C&amp;P</td>
</tr>
</tbody>
</table>

### National Performance Framework

**A** Live in safe, stable and nurturing care environments free from abuse, neglect and harm. **B** Enjoy the highest attainable standard of physical, social and emotional/mental health and wellbeing. **C** Experience improved life chances.

LAC, looked after children; SCS, social care staff; SCH, school; SW, social work; VO, voluntary organisations; A, action; SO, short-term outcome.
Appendix 2: Action descriptors

Section one

Action (A) descriptors relating to short-term outcome 1 – The physical, social and emotional environments of care placements promote healthy lifestyles and encourage positive health behaviours

A1 (i): Act as a positive role model* to encourage healthy behaviours

A role model can be defined as a person whose attitudes and behaviours are an example for others to follow. Staff, parents and carers may already model a range of positive behaviours to children and young people such as honesty, empathy, patience, tolerance, kindness and respect. The same approach can be applied to encourage children and young people to adopt healthy lifestyles and positive health behaviours.

This can be achieved by setting a positive example. Staff, parents and carers can do this by thinking about their own attitudes, behaviours and actions relating to health and wellbeing and how these can positively influence children and young people. This may involve eating healthy, undertaking regular physical activity, dealing with stress, not smoking and reducing their alcohol intake. Thoughts, views and actions around these health topics can help influence the behaviour and lifestyles of children and young people.

*The action is linked with improving the health and wellbeing of staff, parents and carers.

A1 (ii): Be alert to matters that affect their health and wellbeing

This action links to one of the six corporate parenting duties outlined under Section 58 of the Children and Young People (Scotland) Act 2014. Staff, parents and carers may become more alert to the issues that affect the health and wellbeing of children and young people through observation, by noticing changes in a young person’s health-related behaviour. They may develop positive relationships in which children and young people feel comfortable communicating health-related issues within a safe culture which is discrete and respects their opinions, rights and confidentiality. They may also access more formal systems and protocols designed to identify health and wellbeing needs, such as needs assessments, as well as key issues detailed within child plans. Staff and carers may build links with health professionals to keep updated with health-related research, trends and local health priorities.

A1 (iii): Advocate on their behalf for positive health outcomes

Advocacy is about supporting children to express their own needs and views and to make informed decisions on matters that affect their lives. Article 12 of the UNCRC ensures that every child in Scotland has the right to have their say in matters that affect them and to have their views taken seriously. The action can be linked with a responsibility to promote the interests of looked after children, as outlined within the Children and Young People (Scotland) Act 2014.
### A1 (iii): Advocate on their behalf for positive health outcomes

Staff, carers, social workers, youth workers and teachers can all promote the interests of children and young people and advocate on their behalf for positive health outcomes. They may become more aware of the rights of children and young people; know their interests, thoughts, views and opinions on health-related issues; speak on their behalf when engaging with universal and specialist health services; and respect confidentiality whenever possible.

### A2 (i): Create healthy living environments

Care placements can be viewed as ‘settings’ for health improvement. They have been defined as ‘the place or social context in which environmental, organisational and personal factors interact to affect health and wellbeing’.\(^1\) The term ‘healthy living environment’ refers to the social and physical home environment of looked after children.

Focusing on the physical home environment may involve ensuring children are safe from harm (including reducing accidents); live in smoke-free homes that are warm, dry and comfortable; minimise disruptive noise levels; involve young people around decorating; and furniture and has private and personal space.

Healthy social home environments can be safe, welcoming, inclusive, encouraging and non-threatening. They promote tolerance, promote respect for others and address bullying.

A secure home environment along with responsive carers are crucial factors in a child’s healthy physical and emotional development.\(^56\)

### A2 (ii): Promote stability, permanence, connectedness and a sense of belonging

This action is linked closely with developing healthy physical and social living environments. It promotes the concept of permanence through placement stability.\(^57\) This can help to build protective factors against poor health and wellbeing and allows more time to: foster continuity, security and a strong sense of belonging; develop secure attachments and long-term relationships; expand social networks; and increase awareness of community resources and healthcare services.\(^58\) Placement stability has been identified as a protective factor against emotional and behavioural issues, and fewer and more stable placements are recommended as means of promoting the health and wellbeing of looked after children.\(^3\)

### A3: Mitigate against risk factors impacting negatively on health and wellbeing

Looked after children can face a number of adverse life circumstances prior to entering the care system, including poverty, abuse, family trauma, loss, separation, isolation, conflict, stress, anxiety, poor adult role modelling and neglect. These can all be seen as underlying ‘risk factors’ for poor health and wellbeing. They can also be viewed as ‘social determinants of health’ and actions to address these factors as part of the care giver/positive parenting role can contribute significantly to improving health and wellbeing.
A4: Enhance the protective factors associated with positive health and wellbeing

Protective factors for health and wellbeing are factors that, when present, can help reduce the likelihood of poor health and wellbeing. These can include aspects such as skills, knowledge, coping strategies, competencies and resilience in either individuals, families, placements or communities. More tangibly, modifiable protective factors that can help mitigate against poor health outcomes include aspects such as placement stability (see A2, above), life skills, self-esteem, positive relationships, assertiveness, good education attainment, access to health services, parent or carer support, encouragement and living in safe environments.

A5 (i): Provide high-quality health information

Increased risk factors and the absence of protective factors can compound negative health behaviours such as sexual health, alcohol, tobacco, drug misuse, nutrition, physical activity and mental and emotional wellbeing. Processes outlined in A1 (ii) (being alert to matters that affect their health and wellbeing) can be used to identify relevant health topics and information which young people need to access.

Different partners can play a role in providing high-quality health-related information to looked after children. Parents and carers may raise awareness of particular health-related topics such as alcohol, healthy eating, physical activity and substance misuse. They may identify areas of interest for young people through active dialogue and take steps to fill potential knowledge gaps.

Children and young people access information through schools, youth clubs, social media or friends and peers. The delivery of any intervention would take into account the sensitivity required when undertaking health promotion within the home of children and young people.59

A5 (ii): Support the use of health promotion advice and information

There are a number of activities that can help looked after children to use health promotion advice and information given by health professionals. For example, highlighting the benefits of undertaking recommended levels of physical activity may not be enough in itself to encourage a change in behaviour. There may be practical barriers that serve to prevent behaviour change, such as motivation or low self-esteem. They may consider cycling to school for example but don’t have a padlock, reflective clothing or lights to use when it’s dark. They may prefer other forms of physical activity such as dancing, swimming or weight training but lack the proper equipment, entrance money, bus fares or friends to go with.

A6: Improve the health and wellbeing of staff, parents, carers and families*

It involves supporting and improving the health and wellbeing of staff, parents and carers. It extends beyond health and safety and seeks to increase the involvement of staff carers and
### A6: Improve the health and wellbeing of staff, parents, carers and families*

Parents in health-promoting activities such as eating healthy, physical activity and good emotional health and wellbeing.

*This action is linked with A1 (i) and A2 (i)*

### A7 (i): Nurture positive attachment behaviour

Secure attachment can be a main source of resilience in children and young people. When they feel safe to play and learn, they achieve better outcomes across health and wellbeing, learning, social and emotional development, behaviour and relationships with peers.\(^{60}\)

### A7 (ii): Provide consistent, authoritative parenting approaches and care routines

A consistent and authoritative parent and carer style can lead to better health outcomes for children and young people. It aligns well with child-centred principles and encourages a sensitive and flexible approach which involves children and young people and ensures parents and carers remain alert and responsive to their health and wellbeing needs.

Research on parenting styles shows that when parents are authoritative and engaged, children develop secure attachments and emotional bonds, which encourage them to thrive in their environment, safe in the knowledge that their physical and emotional needs will be met.

### A8: Involve looked after children and identify health issues through active dialogue

This action relates to involving children and young people in activities and decisions that affect them. It can include identifying health-related issues of importance to them, identifying solutions and agreeing actions.

### A9 (i): Promote supportive home learning environments

The home learning environment is defined as measures taken in the home to encourage children’s learning. This includes actions encouraging play, talking and reading. This involves ensuring that there is quiet, physical space available to undertake home study or homework, which is free from distractions such as television with access to paper and writing materials. It may involve reminders to complete home study or homework at a reasonable time or taking an interest in school work and assigned tasks.
Section two

Action descriptors relating to short-term outcome 2 – Ensure the health and wellbeing needs of looked after children, including mental health, are assessed and steps to address those needs are undertaken

A10 (i): Assess the health and wellbeing needs of looked after children

Scottish Health Boards are required by the Scottish Government\(^6\) to provide all children who become looked after children with a health assessment within four weeks of notification. Guidance has been developed to assist NHS Boards and local authorities with the discharge of that obligation.\(^6\) It sets out the process that should be followed, and provides a template for the health assessment itself.

A10 (ii): All relevant information is up to date and incorporated into the child’s care plan

Information and data from the health assessment should be fully integrated into the child’s care plan. This multiagency plan reflects the views of the child and family and is made up of contributions from different services and agencies that identify wellbeing needs using the GIRFEC national practice model.\(^6\) A lead professional will ensure that health needs within the care plan are addressed.

Children’s plans should fully reflect their healthcare needs and should include health promotion, healthy lifestyles and general surveillance and assessment of developmental progress, as well as treatment for illness and accidents.\(^6\)

A11 (i): Looked after children have access to scheduled screenings and immunisations

Screening and immunisation rates are lower among children living in deprivation and some other groups experiencing inequalities, including looked after children.\(^6\)

Looked after children may miss some or all of their immunisations for different reasons. If so, this should be identified as part of the health assessment and steps taken to ensure that screenings and age-appropriate immunisations are completed and up to date as part of the child’s care plan.

Immunisation Scotland\(^6\) is a comprehensive online guide to immunisation and vaccines. It identifies why immunisation is important, when to immunise, what vaccines are available and how they protect against serious diseases such as diphtheria, tetanus, polio, measles, whooping cough and human papilloma.
A11 (ii): Looked after children are registered with a GP and dentist and have access to universal or specialist health services when required

NHS Boards have a responsibility to ensure that looked after children are registered with a GP and dentist, that their services are accessible to looked after children and that those children benefit from access to a range of appropriate services designed to meet their emotional, mental and physical needs.

Action to address these issues can range from individual focus (a person’s awareness of health services and their location, trust, self-esteem and confidence) to service orientation (flexible opening times, central locations, ensuring confidentiality and awareness of youth issues).

The WHO’s *Making Health Services Adolescent Friendly* identifies actions that NHS Boards can undertake to ensure their health services are youth friendly and accessible for looked after children.

Childsmile is a national programme designed to improve the oral health of children in Scotland and reduce inequalities both in dental health and access to dental services. Looked after children may not attend a planned dental check for reasons relating to unplanned placement moves, fear, phobias or confidence issues. Missed appointments result in some dental practices deregistering them. Parents, carers and staff can play a supporting role in dental health improvement by educating looked after children around the importance of good oral health care and attending regular dental appointments, advising on good tooth brushing and cleaning techniques and encouraging them take responsibility for their own health.

A12 (i): All actions within the care plan are coordinated by the lead professional, with partners supporting and responding to health improvement issues as required

Health professionals undertaking health needs assessments ensure that all relevant information is incorporated into the healthcare plan. These plans should fully reflect comprehensive health needs, including health promotion, health behaviours and lifestyles, developmental aspects, and healthcare treatment for illness, disease and accidents. Partners from health, social care and third sector organisations may have a role to play in meeting those wider health-related needs. However, the responsibility to coordinate and ensure that these actions are undertaken remain with the lead professional.

A13: Ensure that systems, processes and protocols are in place to support health improvement

Partners may require adequate processes, protocols and local practice agreements that allow them to carry out their role or primary function in addressing health and wellbeing, for example:

- formal channels of communication that ensure NHS Boards are aware of all looked after children in their area so that they can undertake health assessments in a timely fashion
### A13: Ensure that systems, processes and protocols are in place to support health improvement

- agreeing which health professionals have responsibility for undertaking health needs assessments with children looked after ‘at home’ or in kinship care
- agreement between relevant partners around storing and sharing sensitive health-related information
- positive working relationships with healthcare professionals so that health and wellbeing issues identified by carers are discussed with relevant partners while respecting confidentiality
- systematic and formal communication within local authorities to ensure schools and school nurse services are aware of pupils who may be ‘looked after’ and require additional support.

### A14: Link with CAMHS (CAMHS tier 1), specialist support where required (CAMHS tier 2 and 3) and align with integrated care pathways

Further clarity may be required to ensure that parents and carers can liaise with healthcare professionals to make appropriate referrals to CAMHS and identify where an issue relating to mental health and wellbeing may have an underlying social-related cause that does not require clinical treatment.

### A15: Maintain positive links with the named person service and review the health and wellbeing needs of looked after children against any support and/or service(s) provided

Building on the recommendation from For Scotland’s Children,73 and Protecting Children: Framework for Standards,74 the Scottish Government has introduced the concept of a ‘named person’ to act as the first point of contact for children and families. This ensures children, families, parents and carers have one point of contact to access help and support. Once a concern has been brought to the attention of the named person, it is the named person’s responsibility to take action to provide help or arrange for the right help to be provided to promote the child’s development and wellbeing.75 The named person may be a health visitor, or (after the age of five years where responsibility moves to education) a teacher, head teacher or other member of staff.
## Section three

Action descriptors relating to short-term outcome 3 – The interests, ambitions and personal goals of looked after children are known and encouraged, with barriers that may prevent access to opportunities identified and addressed

<table>
<thead>
<tr>
<th>A16: Assess the ambitions of looked after children and encourage the pursuit of activities, hobbies, interests, and personal goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>The document <em>Wellbeing: Printable Guide to Measuring Meaningful Outcomes</em> identifies a number of action areas which can impact on the health and wellbeing of children and young people. This includes supporting and encouraging a child or young person’s interest in one or more hobby, sport, volunteering opportunity or recreational activity within the school or community setting. This is designed to expand social networks, develop responsibility, leadership and decision-making skills and increase involvement in school or community life (identified as protective factors for positive health and wellbeing). By applying a person-centred approach to this action, parents, carers and staff can engage in positive dialogue with children and young people to discover which particular sports, activities and/or hobbies they are interested in, actively encourage the pursuit and development of these interests and address any barriers that might prevent or discourage a child or young person from accessing available opportunities.</td>
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<table>
<thead>
<tr>
<th>A17: Identify community resources, organisations and services, and signpost to looked after children</th>
</tr>
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<tbody>
<tr>
<td>This action involves parents, carers and staff carrying out background work to explore what resources are available within the school or community in which looked after children interact. A child or young person may be unsure which, if any, activities or hobbies they might like to pursue. The intervention may therefore involve exploring different resources and activities within the local community and using this knowledge to initiate or prompt interest in finding out more about it. Children and young people may know the kind of activities that they would like to undertake and communicate them through positive dialogue. Therefore, the action may consist of finding out where those activities are delivered, how they can be accessed and who provides them, and then supporting the child or young person to access them.</td>
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<table>
<thead>
<tr>
<th>A18: Identify and address barriers which prevent looked after children accessing community resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and young people may be aware of which sport, leisure or recreational activities within their community they would like to pursue and have the required knowledge regarding where those opportunities are delivered. However, they may fail to pursue those interests for a number of reasons including: sociocultural reasons, poverty and deprivation, cost, lack of</td>
</tr>
</tbody>
</table>
A18: Identify and address barriers which prevent looked after children accessing community resources

transport, accessibility, time, poor motivation and inspiration, fear of the unknown, and/or a lack of support.

A useful intervention may consist of exploring any barriers with children and young people and addressing issues and identifying solutions together.

A19: Develop assets such as self-esteem, confidence, resilience, coherence and positive coping strategies and develop the life skills necessary for leaving care and/or moving to independent living

Ensuring our young people are ‘successful learners, confident individuals, effective contributors and responsible citizens’ is embedded within Scotland’s National Outcomes.78 Confidence and self-esteem are particularly important for children and young people and can impact significantly on behaviour, motivation, relationships, social networks, learning, activities, ambitions and achievements.79 Confidence and self-esteem can be a solid foundation for empowerment and the building blocks of resilience.

Recommendations from the National Institute for Health and Care Excellence (NICE)77 relating to looked after children identify having access to creative arts, physical activities and other hobbies and interests within their community as effective ways to build confidence and self-esteem. It also identifies assertiveness training (appropriate to age) as a way to promote self-esteem and safety, combat bullying and enhance wellbeing.20 One of the most effective ways to foster self-esteem and confidence in children and young people is for staff carers, parents and professionals to demonstrate it themselves and offer constructive and positive praise and encouragement to children and young people whenever possible.71

A20: Promote assertiveness

The guidelines Promoting the Quality of Life of Looked after children and Young People published jointly by the Social Care Institute for Excellence (SCIE) and the NICE calls for age-appropriate assertiveness training for all children and young people.61 This action is designed to promote self-esteem and safety, enhance communication skills and help address issues around bullying, aggression, violence, stigma and discrimination as well as promoting youth engagement, involvement and inclusion.

A21 and 24: Looked after children value diversity and respect their own rights as well as the rights, freedoms, ethnicity, culture, opinions and reputations of others

The Scottish Government is committed to recognising, respecting and promoting children’s rights as part of its wider commitment to improving life chances for all children and young
people. The UNCRC lies at the heart of the Scottish Government’s policy and practice, such as GIRFEC.

The GIRFEC values and principles stress the promotion of children’s wellbeing by keeping them safe, promoting their development and respecting their views. Ensuring that children have the best possible chances requires a whole-child approach, building on strengths and promoting resilience, alongside encouraging opportunities, reaching their full potential and valuing diversity.

Action to support this agenda therefore supports national policy implementation at the local level.

Article 42 of UNCRC requires that children and families should know about children’s rights, and that practitioners are clearly instrumental in making sure this happens. For example, the named person service in Scotland provides the opportunity to minimise discrimination by picking up issues that likely to affect children’s wellbeing as soon as possible.

The ongoing work by the Scottish Government to develop Common Core of Skills, Knowledge & Values for all those working in children’s services is being heavily informed by both the GIRFEC approach and UNCRC.

The Scottish Government paper UN CRC: The Foundation of Getting it Right for Every Child on which this information is based, has been produced to help understand how the application of GIRFEC will progress respect for the rights of each individual child and young person across Scotland.

Section four

Action descriptors linked to short-term outcome 4 – Looked after children enjoy positive relationships and live inclusive and independent lives within their community regardless of additional needs, disadvantage or disabilities

A22: Support looked after children to develop and maintain positive relationships, ensure they have the opportunity to expand their social networks and enjoy full participation in home, school and community life

Children want and need positive, loving relationships with the people closest to them. Overall, the strongest driver of low subjective wellbeing is when children experience weak and uncaring relationships with their family or carer. Children also need positive, stable, relationships with their friends to help address issues relating to social isolation which can undermine the goal of social connectedness.

Social connectedness is important to looked after children because it can give them a sense of belonging. It can also support their access to opportunities, services and community resources. Research from different fields point to the damaging effects of isolation and shows why social connectedness is so important to health and wellbeing.
Stigma is often identified as a major barrier to improving the health and wellbeing of looked after children. A recent survey and evidence review on stigma by Young Minds\textsuperscript{84} highlighted the detrimental effect that stigma has on young people in talking about how they feel and accessing support services if they need them.

The paper recommends that discussions around equality and diversity should include conversations about where young people may live. Normalising the idea of care so that all children understand that young people grow up in a variety of different settings, including foster care and residential care, may help to address some of the stigma attached to looked after children and will improve their overall wellbeing and mental health.
Appendix 3: Case studies

Case study 1: NHS Lothian – health-promoting units

Health-promoting units (HPU) are residential care placements for looked after children that continuously seek to strengthen their capacity as healthy settings for living, learning and working. The HPU programme has been running in Lothian since 2008 and has been applied in partnership in Edinburgh and Midlothian councils.

Rationale

The programme supports the outcomes for young people outlined in the 2007 GIRFEC publication,85 *Better Health, Better Care*12 and *Equally Well*.13 It draws on earlier Government initiatives such as health-promoting schools and Healthy Working Lives, as well as the 1986 WHO Ottawa Charter for Health Promotion.1 Error! Bookmark not defined. It also supports *These are our Bairns*,9 he national care standards38 and the UNCRC.33

Approach, principles and ethos

The approach illustrated a way of thinking where learning, care, health and wellbeing are viewed holistically and interact to improve the quality of care and the young person’s experience of it.

Aims and objectives

The aims of the HPU programme are to:

- promote a strategic, whole-setting approach to improving health and wellbeing
- reduce health inequalities and promote social inclusion
- improve and support the physical, social and emotional health and wellbeing of children, young people and adults through the unit setting
- promote healthy lifestyles within the unit
- enhance children and young people’s involvement in unit life
- celebrate success, including the sharing of good practice between units and partner agencies.

Key partners and stakeholders

Each unit has a HPU coordinator with the responsibility for coordinating their unit progress towards becoming a health-promoting establishment. This work is overseen by a HPU steering group comprising the City of Edinburgh Council Residential Care, Workforce Learning and Development, Health Improvement Team, Througcare and Aftercare, NHS Lothian Looked After Nursing Service, Healthy Respect, Health Promotion Service, CAMHS, Edinburgh Leisure and Edinburgh Connect – a dedicated Mental Health Team which provides support to residential staff and looked after children. This steering group links to the Health Link Workers group, which is
made up of residential care workers with a specific role around health and wellbeing and HPU. This allows a two-way flow of information sharing and support.

**Development stages/process**

The Lothian HPU guidance was adapted from Healthyschools+ (the Edinburgh and Lothians health-promoting schools programme), which was developed by NHS Lothian Health Promotion Service and its partners in 2004.

**Activities**

Involvement of children, young people and families is at the heart of the HPU programme. The whole unit community undertakes an information gathering exercise to identify development tasks in six key areas (see *Figure 3* below), a proportion of which must be identified by residents, who are then involved in the tasks themselves and the monitoring and evaluation of impact. Unit staff, young people and partners collectively produce a portfolio of evidence at each of the three tiers of the programme. Tier 1 – engaging with; tier 2 – embedding; and tier 3 – sustaining health promotion. By tier 3, health promotion is part and parcel of everyday life, and effectively built into the fabric of the unit.

*Figure 3: The Lothian HPU model*

![The Lothian HPU model](image)

(HPU Steering Group, Healthy Respect, NHS Lothian)

**Achievements**

The HPU programme is now embedded within the Integrated Children’s Services Plans for both Edinburgh and Midlothian Community Planning Partnerships. The University of Edinburgh was commissioned in 2013 to undertake an evaluation of the early stages of implementation of the HPU programme (tier 1) in Edinburgh. The aim of this was to examine how effective the scheme had been in developing a whole-unit approach to the health and wellbeing of looked after children in residential care.
The report concluded that the HPU was an important initiative and one that staff and young people in units throughout Edinburgh have engaged with and contributed to.

**Implementation**

**Southhouse Close Support Unit (CSU), Edinburgh**

Southhouse CSU has been awarded tier 1 and 2 accredited HPU status. At the time of writing, it had recently submitted a portfolio of evidence to the HPU steering group for accreditation at tier 3. All its processes have focused on:

- the involvement, consultation, participation and inclusion of the young people themselves, their families, the whole staff team, other professionals and the wider community
- an ongoing strengthening of the unit’s capacity as a health setting for living, learning and working
- enabling a way of thinking and working where health and wellbeing are valued by everyone at the unit and in the wider Southhouse community.

The young people at Southhouse are 12 years old and upwards. The service aims to offer a place for residents up to their late teens and work on an outreach basis with several ex-residents. All of the young people function at various levels of development in different settings and situations, not always consistent with their chronological age, owing to early experiences, poor attachments and trauma. Close support offers extra care, firm boundaries, specialist input and close attachment experiences to assist residents with dealing with the effects of traumatic early experiences, emotional and behavioural issues and in reaching their potential in life.

Communication levels and methods must reflect this and lots of creativity is used within the HPU process to ascertain needs, wishes and to encourage full inclusion and participation. The HPU process takes place mainly within the unit itself, but also out in the wider community. Southhouse, to ensure the HPU directives, takes account of all of these issues – the unit bases its approach on the developing mutuality of the staff and young people’s relationships, as these are key to achieving the positive outcomes wished for within each of the three HPU tiers.

Staff utilise a large range of activities to involve young people in residence, ex-residents, outreach young people, staff at the unit, families, neighbours, other professionals, various other agencies and specialist services [e.g. Edinburgh Connect, Looked After and Accommodated (LAAC) nursing team, Hospital and Outreach Teaching Service, Crew (substance use support), smoking cessation services, community dentist, local nominated pharmacy, CAMHS, Young People’s Service, Woodland Trust, Scottish Water, Trades Maiden Fund, Valley Park Community Centre and Edinburgh Leisure, among others].

At every stage of the HPU process the young people are at the heart of all activities. They are consulted, involved and encouraged to participate and have their views and decisions respected and valued. They are included in planning and progress
meetings, and are very much involved with the work in action planning and the evaluation process. Fun and exciting launch events and celebrations of achievements are a large part of the process.

Each of the three HPU tiers has provided Southhouse with:

- improvements and developments in the health focus within the unit
- improvements in access to and the nature of the health services offered to young people
- relevant and effective local policies regarding health within the unit (e.g. food and smoking policy)
- refurbishment and repair of the building and garden
- increased individual and group activities and events with a holistic health theme
- greater involvement and links in the local community, better links with families and closer working relationships with other agencies
- support and closer working relationships with other units.

Other positive impacts are outlined in the three HPU portfolios Southhouse CSU has produced to date.

Southhouse CSU has been provided with very positive feedback and incentive to continue on its journey to ensure that the holistic health and wellbeing of all the unit’s stakeholders remains a prime directive within the support and care we provide to each other.

(Southhouse CSU, City of Edinburgh Council)

**Midlothian Residential Services (MRS)**

MRS has been committed to the process of HPUs since 2011. It has achieved both HPU tiers 1 and 2 and at the time of writing was working on tier 3.

MRS currently comprises three four-bedroom houses and one two-bedroom flat, all situated in Midlothian. One of the houses is specifically aimed at older young people and work is currently ongoing in relation to the authority’s commitment to the ‘staying put’ agenda. The house is a residential home for young adults over the age of 16 years, where the emphasis is on supporting them to develop their independence.

MRS also includes an early intervention outreach service alongside the residential provision which undertakes programmed and specific pieces of work with children, young people and their families with the aim of reducing the necessity to accommodate them away from home. Midlothian Council prides itself on ensuring that all children and young people can remain living in their own community.
At tier 1, the units at that time submitted portfolios separately, but with the creation of the new three houses and one flat service, MRS decided to submit evidence for tier 2 in an integrated portfolio which showcased achievements across the whole service.

MRS’s achievements to date are the result of clear aims and objectives being set out, which the entire team have focused on. For each tier MRS gathered information from all the young people in its care, their families/carers, other stakeholders and the staff team. On each occasion information was gathered and analysed. The team looked specifically at any gaps identified in the service and worked with the young people to identify what improvements could be made. This then informed what the development tasks and subsequent action plans would be.

Over the course of gaining both tiers 1 and 2, the development tasks, activities and achievements were diverse and varied, and included some of the following:

- holding a summer BBQ which included family, friends, neighbours and community policing to name a few
- creation of a ‘snug’ room which was designed by the young people to give them a space to unwind and relax
- review of all young people’s care plans to make them child-friendly and easier for the young people to understand
- support for staff from the Scottish Institute for Human Relations to manage change in relation to the decommission of the existing young people’s home in preparation for the new buildings being built and subsequent move
- the recruitment of ‘cook to manage’ menu planning and encouragement of young people’s participation in the growing and purchase of food
- encouraging young people to feel confident about accessing amenities in the local community including the leisure centre, skate parks and libraries
- creation of a ‘chill out room’ which doubled as an information point for all young people.
- development of a new ethos for the service in offering a therapeutic approach to young people bringing together the staff team.

(Midlothian Residential Services, Midlothian)
Case study 2: NHS Ayrshire and Arran – Health Improving Care Establishment (HICE)

The HICE framework is designed to support increased health improvement activity within residential care settings for children and young people. It takes a holistic, inclusive approach to health and wellbeing and focuses on five key areas: ethos; partnership working; environment, resources and facilities; promoting healthy attachments; and staff health and wellbeing.

Aims and objectives

- provides a structure from which health promotion activity can be directed
- supports services to develop and build on good practice in areas relating to health improvement
- highlights successful health promotion activity and shares learning with other service providers
- encourages consideration of health in its widest context.

The HICE framework has three main strengths:

1. It is a pan-Ayrshire model, allowing for greater opportunity to share practice and to increase consistency in relation to the prioritisation of health and wellbeing.
2. It is closely aligned to GIRFEC.
3. It places the individual at the centre.

Rationale

By incorporating a holistic, settings-based approach to health improvement, there is potential within the care system to address some of the challenges faced by children and young people looked after and accommodated.

Approach/principles/ethos

A HICE has an inclusive ethos which takes care of individuals, is fair and promotes respect for self, others, the wider community and the environment. It promotes and fosters a sense of responsibility in individuals for their own actions, health-related behaviour and lifestyles. Achievements of children and young people and staff are celebrated.

NHS Ayrshire and Arran, East Ayrshire, North Ayrshire and South Ayrshire Councils all support the development and implementation of the framework. However, it is recognised that a wider partnership approach is essential to its success. Consequently, children’s homes are actively encouraged to forge links with other
statutory and third sector organisations to support them achieve a health-promoting establishment.

An Ayrshire-wide steering group has been formed with representatives from NHS Ayrshire and Arran and its partners with responsibility for the overall development and progress of the framework. Local arrangements for implementation, monitoring and evaluation are being established.

**Key partners/stakeholders**

The framework was developed in partnership between NHS Ayrshire and Arran and the three co-terminus local authorities of East, North and South Ayrshire Councils.

**Development stages/process**

The framework utilised learning from other settings-based health improvement frameworks such as health-promoting schools. Stakeholder events were held to identify the key areas and outcomes of the framework. Consultation with young people who were looked after and accommodated within local authority units took place.

**Implementation/types of placements**

The overall responsibility for the implementation of HICEs within each unit was delegated to an identified member of staff or a HICE coordinator. In some cases, this was the unit manager, but the majority of coordinators were residential workers. To ensure that the coordinators did not have sole responsibility for the framework, units were encouraged to form groups with other staff members and young people.

Implementation followed a standard format. All units evidenced how the range of outcomes were being met and, from this, identified any areas for improvement. The units were then asked to develop a one-year action plan to work on these identified areas for improvement. This process was then repeated on an annual basis.

**Activities**

Healthy attachments are known to be a key component in the health and wellbeing of looked after children and young people. Young people have access to opportunities to develop their social and emotional wellbeing and are supported to build their confidence, self-esteem and resilience. Processes are in place that promote and encourage healthy attachments with peers and responsible adults.

The importance of the health and wellbeing of staff working with looked after and accommodated children and young people is one of the priorities of a HICE. Staff have access to appropriate training and development opportunities to support improvements in health and wellbeing and enjoy access to information and support regarding appropriate occupational health and wellbeing services. The wider community offers many opportunities to enhance the health and wellbeing of all children and young people, staff and families. The units develop and maintain these links to the benefit of all involved.
Partnership working

Each unit has a strong commitment to partnership working and collective responsibility that actively involves and reflects the views of the children and young people, staff, families and key agencies. Appropriate involvement from specialist services is an integral part of a HICE’s policy.

Achievements

The flexibility of the HICE approach encourages and helps to facilitate collaborative working between residential units in each locality while allowing each local authority area to implement it in accordance with their own service needs. It has improved partnership working with some health services, including CAMHS, resulting in more positive outcomes for young people.

The approach has encouraged residential units to consider health in its widest sense and avoid viewing health purely in term of medical intervention and access to health services. It has provided additional evidence for the Care Inspectorate in terms of health and wellbeing, allowed staff to consider their own health and how this can impact on children and young people.

A number of challenges presented themselves in the development and delivery of the approach. These included: sustaining the involvement of children and young people in the framework’s implementation; ensuring the approach and accompanying framework are fully integrated within existing planning and performance cycles; the challenge of having a regional framework recognised by national bodies, such as the Care Inspectorate; placing greater emphasis on a social model of health; and supporting and encouraging all residential care staff to be involved in HICE.

Next steps

Local authority units will continue to be supported to implement the HICE approach. A pan-Ayrshire HICE network for residential staff will be formed and will be used to share practice and discuss emerging issues and areas for development.

For further information please contact: the Health Promotion Team, Afton House, NHS Ayrshire and Arran.
Appendix 4: NHSHS evidence review: health improvement and looked after children

Introduction

This briefing outlines the evidence on looked after children and explores how it relates to the logic model on looked after children, in particular the 24 actions outlined in the model. The links to the actions are outlined within boxes in this briefing. Some of the links between the evidence and the actions can be seen as tenuous, and subjective judgements have been made in some cases regarding the links.

Some of the actions within the logic model may not be underpinned by reliable, high-level evidence but this does not necessarily rule them out as effective interventions within the logic model, particularly if plausible theory suggests that these are the most suitable and appropriate actions to be taken. The briefing includes mainly high-level evidence, although a few primary studies and Scottish Government strategies and policies have also been included.

The looked after children population can be seen as relatively heterogeneous, particularly in terms of age, reason for being in care and types of care placements they are in. For example, looked after children could be in foster care, residential care, kinship care or looked after at home. Much of the literature focuses on one or two of these subgroups within this population and might compare one or another of these groups. This means that any evidence found may not be applicable to the whole of the population of looked after children.

Scottish Public Health Network (ScotPHN) review

ScotPHN undertook a review of the health needs of looked after children in 2013. No literature was found on interventions to improve physical health outcomes for looked after children. The review found that most of the literature on interventions to improve outcomes for looked after children focused on mental health.

Health issues

Physical health

The ScotPHN review found that obesity, dental caries and vision problems are consistently observed among looked after children and rates of dental, visual and hearing problems may be higher than those of the general population. However, the association may be due to deprivation rather than the fact that they are looked after children. The Scottish Government’s Strategy on looked after children also highlighted that Health Boards should ‘provide ready and responsive access to a GP, dentist, looked after child nurse, mental health and sexual health services as required’.
Linking evidence to actions

These issues mean that it is essential that looked after children are given ‘access to scheduled screenings and immunisations, have regular health and dental checks, are registered with a GP/dentist, and can access universal/specialist health services when required’ (action 11 in the logic model). These issues also relate to action 4, ‘enhance the protective factors associated with positive health and wellbeing such as good nutrition and physical activity’. Obesity is related to both diet and physical activity and dental caries are also related to healthy eating and diet.

Mental health and wellbeing

The ScotPHN review found high levels of psychiatric morbidity in this population, with prevalence rates highest for behavioural problems. It is not clear in the literature whether or not much of the mental illness is a result of the causes and/or consequences of care. However, there is a difference in rates observed between the care placements. Leve et al.\(^8\) reported that children in care are vulnerable to problems with emotional and behavioural development, brain and neurobiological development and social relationships.

Health behaviours

The ScotPHN review also found that rates of tobacco and illicit drug use may be higher among looked after children than among the general population. There may also be increased rates of sexual risk-taking behaviours among this population, which may be due to deprivation rather than being looked after.

Linking evidence to actions

It is important, therefore, to mitigate against these behavioural risk factors, such as substance misuse, and this links with action 3.

Other studies

Research shows that looked after children in developed countries, including the UK, have poorer mental health, behavioural problems and poorer health behaviours around sexual health, alcohol and drug use and smoking.\(^5\)

A cross-sectional study was undertaken investigating physical illness in looked after children.\(^8\) They found that looked after children have an increased prevalence of some physical illnesses. For example, epilepsy, cystic fibrosis and cerebral palsy were more commonly reported in looked after children. There were limitations with this study, so the results should be treated with caution.
Education and employment outcomes

The ScotPHN review found that education and employment outcomes at nine months post school are poorer for looked after children than those of the general population of school leavers in Scotland. Children who are looked after at home have the poorest educational outcomes.

One of the studies that ScotPHN reviewed was Tideman et al. In their study on looked after children in foster care they found that intensive educational support improved age-appropriate IQ and educational attainment at a two-year follow-up.

The Scottish Government found that looked after children tend to leave school at an earlier age than other young people. This means that they tend to have lower levels of educational qualifications and are less likely to go on to positive destinations after school compared to other young people.

The booklet, Looked After and Learning, produced by the Centre for Excellence for Looked After Children in Scotland (CELCIS) also mentions that educational outcomes are lower for looked after children. This booklet also suggests things that schools and teachers can do to help a looked after child reach their full potential. This booklet also suggests that looked after children typically have lower attendance rates at school than the general population. It recommends that schools should try to encourage attendance, for example by engaging with primary carers.

Linking evidence to actions

Anything to help improve educational attainment, including encouraging attendance, is therefore of relevance. This is highlighted in action 9 in the logic model.

Offending behaviour

The research and evidence linking looked after children and offending behaviour is limited; however, it has been recognised that this group of children can be at greater risk of offending behaviour. The possible reasons for the link are cited as: lack of placement stability, poor educational attainment and negative social or family relationships. The ScotPHN review found that looked after children may be at increased risk of imprisonment compared to the general population; however, it is not clear how much this difference can be affected by deprivation.

Sports and other activities

Within the ScotPHN review, one of the studies they investigated was Karadag and Ozcebe. They found that exposure to sports activities was associated with decreased rates of daily tobacco use, and weekly alcohol and illicit drug use. They focused on adolescents living in orphanages in Ankara in Turkey, but because the data were cross-sectional, they could show only an ‘association’ rather a ‘cause’ between sporting activities inducing a reduction in rates of tobacco use.
Linking evidence to actions

This relates to action 18 in the logic model, ‘identify and address any barriers that may discourage or prevent looked after children or care leavers from accessing community resources’ such as opportunities to play, participate in sport and leisure, cultural and/or school and community activities.

To a certain extent, this also relates to part of action 4: ‘enhance the protective factors associated with positive health and wellbeing’ such as physical activity.

This study also relates to action 3. This actions is about mitigating against the risk factors, which have a negative impact on good health and wellbeing.

The booklet produced by CELCIS suggests that schools should be encouraging out-of-school interests and hobbies to looked after children. This will help to increase their social skills and bring them into contact with a wider range of people. Teachers can do this by engaging with the pupils and communicating with them, allowing them to build up a relationship and trust with them. The booklet discussed providing high levels of encouragement for looked after children.

Linking evidence to actions

This relates to action 22 in the logic model, which suggests to ‘develop and maintain positive relationships to ensure that they have the opportunity to expand their social networks and enjoy full participation in home, school and community life.’ It also relates to action 16, which discusses assessing the ambitions of looked after children through active dialogue, and encouraging the pursuit of activities, hobbies, interests and personal goals.

NHSHS evidence review

NHSHS undertook an evidence review of looked after children in 2012 in which high-level evidence on looked after children was reviewed. The work analysed five reviews of effectiveness and outcomes: evidence informing the development of NICE public health guidance (PHG); three systematic reviews/reviews of reviews; and one review of cost-effectiveness.

This paper acts as a refresh of the original review. NICE has recently reviewed guidance PHG 28, but did not review the evidence that supports this guidance. The evidence contained within NHSHS’s 2012 review has changed very little; however, there are some notable developments of note, such as new/updated strategies and policies with some studies published since 2012.

The following section will summarise some of the main evidence which came out of NHSHS’s 2012 and review it against the actions and outcomes detailed within the looked after children’s logic model in Appendix 1.
Outcomes for looked after children

There were a few reviews\textsuperscript{93,94,95} that investigated the factors associated with outcomes for looked after children. Two of these reviews\textsuperscript{93,95} investigated outcomes that mattered to these children and young people. The key themes, which were identified as mattering to looked after children, by one of the reviews\textsuperscript{95} were:

- an environment in which they feel cared for and supported
- a sense of belonging
- emotional and practical support
- an opportunity to retain contact with birth parents and families
- support to manage emotional impact of contact with parents
- continued support of professionals
- reliable and accessible professionals.

The review authors\textsuperscript{95} argue that these aspects are important and may have an indirect effect on the emotional and behavioural health of the looked after children. However, they could not prove any causal link with emotional and behavioural health.

Their findings were very similar to the findings of the other review.\textsuperscript{93} This review also found that looked after children felt that being given love was important to them and significantly impacted on their emotional wellbeing, in particular their self-esteem. Self-esteem can have a profound lasting impact on future outcomes. Looked after children also felt that their sense of identity is compromised by a reduced sense of belonging.

Linking evidence to actions

The evidence from both these reviews relate to a number of actions in the logic model including action 2 (create healthy living environments with LAC, which promote permanence, stability, connectedness, security and a strong sense of belonging), action 3, (mitigate against risk factors which have a negative impact on good health and wellbeing such as emotional trauma, separation, isolation, conflict, stress, anxiety, abuse and bullying), action 4 (enhance the protective factors associated with positive health and wellbeing such as emotional competency and good social networks), action 7, (nurture positive attachment behaviour by providing responsive, accepting, sensitive, discrete, authoritative and consistent parenting approaches and care routines as part of the caregiver role), action 16, (assess the ambitions of looked after children through active dialogue) and action 19 (develop assets such as self-esteem).
Self-esteem is also discussed in the booklet by CELCIS,\textsuperscript{91} which suggests that self-esteem can be improved in the school environment by teaching new skills to looked after children.

**Carers and families**

The review by Dickson \textit{et al.}\textsuperscript{95} also looked at the contribution of the attitudes, skills and abilities of birth families and foster, residential and kinship carers to improve the emotional and behavioural health of looked after children. The review highlighted that the following issues were important to carers and families:

- a relationship with looked after children
- a relationship with a social worker
- payment
- peer support
- training
- accessibility of mental health services.

**Treatment foster care**

NHSHS’s evidence review looked at factors associated with outcomes for looked after children. This review found that there was good-quality evidence indicating a positive association between treatment or therapeutic foster care and placement stability and a reduced level of behavioural problems.\textsuperscript{94}

Good-quality evidence suggests that there is an association between the training of foster carers and the permanent placement of the looked after child. This could potentially impact on the emotional and behavioural problems of looked after children.

For example, evidence of mixed quality suggests that the increased number of placements is a risk factor associated with the reduced likelihood of positive outcomes and that placement stability can be viewed as a protective factor for health and wellbeing, being associated with fewer emotional and behavioural problems. As the majority of the studies reviewed were undertaken in the USA, differences between policies and systems of care between countries may limit the extent to which the findings are generalisable to the UK context.
Linking evidence to actions

Stable living environments are discussed in A2 (see Appendix 2). This review also partly links with action 6, which is related to promoting and improving the health and wellbeing of staff, parents, carers, and families to ensure they have the skills, knowledge, motivation and capacity to improve their own health and wellbeing. It relates to the fact that the training of foster carers can help to improve their health and wellbeing. Training could make them feel more skilled and knowledgeable and, in turn, could help with their wellbeing.

A Cochrane review undertaken in 2008 investigated if treatment foster care improved outcomes in children and young people.96 This review was not included in NHSHS’s evidence review. Treatment foster care is a foster family-based intervention, which aims to provide young people (and, where appropriate, their families) with a tailored programme designed to affect positive changes in their lives.

Previous data suggest that treatment foster care may be a useful intervention for children and young people with complex emotional, psychological and behavioural needs, who require placements in non-family settings. It may also be a useful intervention to help integrate usually hard-to-place children and young people in family-based settings.

This review investigated five studies involving 390 participants. The results indicated some clinically meaningful decreases in: antisocial behaviour, the number of days children and young people ran away from placements; the number of criminal referrals and the time spent in secure settings. There was some evidence that young people in treatment foster care spent more time in treatment over the long term and more time at home. Examination of educational and employment outcomes showed improvements in school attendance, homework completion and finding work.

However, the generalisability of findings is limited. All the studies were conducted in the USA, the total number of included studies was small and the profile of participants was quite mixed. Also, it was not possible to make statements about treatment foster care effectiveness compared with other composite interventions.

Training and support

One of the reviews which NHSHS analysed was the effectiveness of training and support for carers, professionals and volunteers on looked after children’s health outcomes.97 It was found that there was a lack of evidence regarding the impact of additional training on professionals working with looked after children.
Linking evidence to actions

Although the evidence was lacking in this review, training and support could potentially link to action 6, which is about the promotion and improvement of the health and wellbeing of carers, staff and parents. Training and support can help to improve the skills and knowledge of all the people that work with looked after children. This can then help to enhance the health and wellbeing of people that work with the looked after children as well as improve the outcomes for the children and young people.

Kinship care and foster care

Another review included in NHSHS’s evidence review, investigated the impact of kinship care compared with foster care on outcomes for looked after children.98 It found that looked after children in kinship care (compared with those in non-kinship foster care) experienced better outcomes in relation to behaviour (i.e. lower levels of behaviour problems, higher levels of adaptive behaviour), mental health (i.e. significantly less mental illness and improved positive emotional health) and increased placement stability.

However, children in foster care are more likely to be adopted and to use mental health services than those in kinship care. There were methodological weakness to the studies, which this review investigated. This review was undertaken in 2009 while the evidence refresh identified another one very similar to it undertaken in 2014 with very similar results.98

The 2014 review99 compared the impact of kinship care (compared to non-kinship foster care) on the safety, permanent placement and wellbeing of children removed from the home because of maltreatment. It looked at 102 studies and found that children in kinship care experience better outcomes with regard to behavioural problems, adaptive behaviours, psychiatric disorders, wellbeing and placement stability (placement settings, number of placements and placement disruption).

There were no detectable differences between the groups on reunification, length of stay (in placement or out-of-home care), educational attainment or family relations. Children in foster care are more likely to be adopted and to use mental health services than those in kinship care. There were a number of methodological weaknesses (e.g. risk of bias and lack of comparability between the kinship and non-kinship groups of participants), which limit the acceptability of these findings.

Access to services

Another review,100 which was included in NHSHS’s evidence review, covered the effectiveness of interventions to improve access to specialist or universal health services by looked after children and the impact of access to services on their physical and emotional wellbeing (compared with usual care). The review considered evidence which was of mixed quality. These studies were different in relation to the range of services included, the nature of the interventions and outcomes assessed
and, therefore, had mixed views on what was effective. It was also difficult to make valid comparisons. The evidence was limited and inconclusive, partly because the review explored only five studies.

### Linking evidence to actions

Although the evidence was limited and inconclusive, this review could link to action 14, around providing support and linking with specialist services such as CAMHS.

### Support services for transition to leaving care

One review included in NHSHS’s evidence review included the effect of support services for transition to adulthood or leaving care on all the adult outcomes of looked after young people. The review was primarily about synthesising the evidence on the effectiveness of transition support services (TSSs) on adult outcomes compared with usual or no care. They found that looked after young people who receive TSSs are more likely to complete school with qualifications.

Overall, TSSs have a positive effect on the current employment of looked after young people, and those who received TSSs were likely to have a place to live and be living independently. The review also considered other outcomes such as parenthood, and health and mental health, but the evidence was often inconclusive or there were mixed views on if and how TSSs impacted on these outcomes. For all the outcomes investigated the evidence was of mixed quality. In comparison with no TSSs, TSSs are cost-effective if they focus on skills to assist in employment.

### Independent living

The majority of looked after children move to independent living between the ages of 16 and 18 years. Their journey to adulthood is much earlier than their peers, who tend to remain at home into their 20s. Young people who have been in care are at higher risk of social exclusion than their peers who have not been in care. They are also at risk of low educational attainment, unemployment, poverty, mental health problems, social isolation, homelessness and involvement in crime.

In recent years there has been a drive in policy and practice for care leavers, with the aim of delaying their transitions and ensuring that they are provided with personal support to help them achieve their potential as they move from care towards independence. In Scotland, the 2014 Children and Young People (Scotland) Act introduced substantive reforms around continuing care and aftercare that support the aims of Scottish Government’s Staying Put Scotland guidance.

The Staying Put Scotland guidance was produced for local authorities and other corporate parents to support looked after children to remain in care, as part of a staged transition towards adulthood and greater independence. It is about providing care leavers with connectedness and belonging. The Act introduced the term ‘continuing care,’ which gives looked after young people the entitlement to remain in their care placement until reaching the age of 21 years, enabling them to make a
successful transition to independent living at a time and pace that suits their individual needs. This will allow young people to maintain their relationships with their carers into adulthood. Continuing care was introduced in April 2015, initially for 16-year-old care leavers in kinship, foster and residential care.

As corporate parents, local authorities continue to have responsibilities for their looked after children beyond the point they leave care. The 2014 Act (part 10) extends access to ‘aftercare’ from those aged up to 21–26 years old. From April 2015, any young person who ceases to be looked after by a local authority on or after their 16th birthday will be eligible for aftercare services up until their 26th birthday.

There are a number of benefits to young people being able to stay with their foster carer after the age of 18 years old. It gives them greater control of the timing of their transition from care to independent living, they are offered the chance to experience transition that are akin to their peers and it offers continuity and stability in a nurturing family environment.102 These are all important factors for the health and wellbeing of looked after children.

**Linking evidence to actions**

These all relate to action 19, which discusses providing the life skills necessary for leaving care and/or moving to independent living.

**NICE**

Some of the evidence contained within the NHSHS’s evidence review came from work that NICE undertook on looked after children. This work culminated in the production of NICE guidance PHG2819 and NICE quality standard 31.102 NICE guidance PHG28 was reviewed in 2015, however, the evidence supporting PHG28 was not reviewed. NICE PHG28 contains 52 recommendations and the quality standard contains eight quality statements. The eight quality statements include: providing warm, nurturing care (quality statement 1); and providing stable and quality placements (quality statement 3).

**Warm, nurturing care**

The booklet, produced by CELCIS, *Looked After and Learning,*91 discusses having a stable and secure school environment, with nurturing staff, which are protective factors for looked after children. They suggest looked after children should have a good attachment with a significant other such as a teacher.
Linking evidence to actions

Warm, nurturing care and environments has some relevance to actions 2, 4 and 7 in the logic model. Action 2 is about living environments, which promote stability, connectedness and security and action 4 is about enhancing the protective factors associated with positive health and wellbeing such as emotional competency. Action 7 discusses nurturing positive attachment behaviour.

Specialist services

NICE also recommends having support from specialist and dedicated services such as CAMHS. NICE quality statement five suggests that 'looked after children should receive specialist and dedicated services within agreed timescales'.

Linking evidence to actions

This relates to action 14 in the logic model which says to promote mental health and wellbeing by providing support to looked after children and care leavers (CAMHS tier 1), link with specialist support where required (CAMHS tier 2 and 3).

When the Scottish Government were engaging on their latest strategy for looked after children they found that it could be difficult for looked after children to access services such as CAMHS.¹⁸

The NICE quality statements also include support to fulfil potential of looked after children (quality statement 7) and support to move to independence for looked after young people (quality statement 8).

Linking evidence to actions

The first part of the statement is about supporting looked after children to fulfil their potential, which relates to several actions in the logic model, namely actions 16, 19, 20 and 22. The second part of the statement discusses supporting the move to independence, and part of the action 22 relates to developing the life skills necessary for leaving care and/or moving to independent living.

One of the other quality statements (quality statement 2) recommends collaborative working between services and professionals and having a care plan for every child or young person. Looked After and Learning⁹¹ suggest that local authorities, schools and their partners should work together to create a positive learning experience for looked after children. This collaborative working also includes engagement and communication between the school and a child’s primary care giver.
This very much reflects what action 13 recommends, in particular to ‘work in partnership to improve the health and wellbeing of looked after children’. Action 10 in the logic model discusses a child’s care plan.

Other evidence

Attachment

One study reviewed the literature on attachment patterns in institutionalised children and then performed a meta-analysis on data from 10 attachment studies involving 399 children in institutional settings. The review found that children living in an institution were found to be at greater risk for insecure and disorganised attachment compared to their family-reared peers.103

Linking evidence to actions

It is therefore very important to nurture positive attachment in looked after children and this relates to action 7 in the logic model.

Stable placements

Many previous studies highlight the negative psychological, social and academic consequences of placement breakdown for foster children.104 Having a stable placement appears to be important for the health and wellbeing of looked after children, and this is reiterated in the NICE guidance statements and the Scottish Government’s strategy for looked after children.

In their strategy for looked after children, the Scottish Government highlighted that children who have a number of different placements tend to have poorer health, greater social and behavioural difficulties and poorer educational participation and progress compared to those who are adopted or are in long-term stable foster care.18 A sense of permanence is important for children’s health and wellbeing. They need to be able to develop strong and trusted relationships with their carer.

‘The Scottish Government defines “permanence” as providing children with a stable, secure, nurturing relationship and home, where possible within a family setting that continues into adulthood.’

Getting It Right For Looked After Children, 2015.18

The booklet by CELCIS indicates that placement instability is linked with poor educational attainment. The research suggests schools can help by providing stability and support.91

One review looked at how services can effectively promote placement stability.105 They reviewed quantitative and qualitative evidence and found that key protective factors included placements with siblings, placements with older foster carers, more experienced foster carers with strong parenting skills and placements where foster carers provide opportunities for children to develop intellectually. However, the
primary studies that they investigated were of variable quality and used heterogeneous measures for independent and dependent variables, which makes comparison between studies difficult to undertake. Some of the factors seem to positively influence placement stability.

Pritchett et al.\textsuperscript{104} found that older children or those with mental health problems or disabilities can be particularly vulnerable to disrupted placements or multiple placements. The review by Pritchett et al. aimed to summarise studies that examined how child characteristics influenced placement outcomes. This review found that numerous studies had investigated this subject area; however, the authors suggest that these findings need to be treated with caution because most of the studies were based on results from administrative data, i.e. quantitative studies, rather than from studies that had contact with the children or carers themselves.

<table>
<thead>
<tr>
<th>Linking evidence to actions</th>
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<tr>
<td>Action 2 in the logic model highlights having a stable healthy living environment. Some of the factors which influence placement stability seem to be around strong parenting skills and consistent parenting approaches are indicated in action 7. One of the factors is around carers providing opportunities for children to develop intellectually and this very much fits with action 9 in the logic model to encourage educational attainment by developing safe and supportive home-learning environments which encourage homework, develop strong home–school links and fosters achievement.</td>
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<tr>
<th>Interventions and services for foster and kinship care</th>
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<td>A systematic review was undertaken on interventions for foster and kinship care.\textsuperscript{106} The authors found that there was good support for wraparound services and relational interventions, but little support for the widely used carer training programme. The outcomes and interventions were relatively varied, focusing on carers, looked after children and service delivery. A systematic review was undertaken of thirteen studies, which evaluated services and programmes for kinship carers and children).\textsuperscript{107} The review investigated studies evaluating the effectiveness of the Kinship Navigator Program in USA,\textsuperscript{108} covering financial assistance, support services, and training and educational programmes. The findings indicated that positive results are shown for enhanced wellbeing and permanency outcomes for children and kinship carers. However, the rigour of the research designs appear poor, which makes it difficult to draw any firm conclusions about the effectiveness of these programmes.</td>
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</table>
Linking evidence to actions

Although the evidence is limited and somewhat inconclusive for both of these reviews, they could potentially link to action 6 (improve health and wellbeing of carers, parents, family and staff) in the logic model. If the carers are provided with training, financial assistance and support, then this could possibly help with the health and wellbeing of these carers as well as improve the outcomes for the looked after children.

Looked after children in school

A systematic review of interventions to support looked after children in school was undertaken. The review included interventions that improved attainment, or prevented drop-out or exclusions, and those that aimed to reduce absenteeism in looked after children. Studies were critically appraised and their results were considered, but no study was found robust enough to provide evidence on effectiveness. However, some promising interventions were identified. For example, popular interventions were tutoring, creating writing support and free books. The review did find that the looked after children's home environment did not support their learning in many cases. Therefore, the authors felt that home environment needs to be changed to facilitate leisure reading and home work.

Linking evidence to actions

This relates to part of action 9 in the logic model, which is to encourage educational attainment by developing safe and supporting home-learning environments that encourage homework.

Health behaviour change

There was a recent study to improve the health of looked after young people by using a tailored intervention with behaviour change techniques to improve their health behaviours. The intervention involved a small number of young people in care in Fife. The intervention was successful in terms of encouraging vulnerable young people in care to discuss health-related behaviours in a space that enabled them to explore the issues that were relevant to them. There were significant results for most health behaviours and wellbeing, which shows that individuals have been supported to adopt a healthier lifestyle.

Providing information on sexual health and relationships was one of the most common behaviour change techniques. The flexibility offered in delivery of the intervention was a key strength of the study, particularly because of the mobile nature of many looked after young people. However, this also made it difficult to capture the data on the different places and methods used for delivering the intervention. The limitations to this study include: the high attrition of the study sample and therefore subsequent small sample available for analyses; unusable
follow-up data; and a lack of a control group. For example, it is not known whether or not those not included in the evaluation had changed their behaviour.

**Linking evidence to actions**

This may relate to action 5 on the logic model, which discusses providing high-quality information to looked after children, support the uptake of health promotion advice and encourage positive health behaviours. It could also potentially relate to one part of action 20, which discusses supporting looked after young people to resist negative peer pressures linked to risky healthy behaviours.

**Scottish Government strategy**

The Scottish Government introduced their most recent strategy for looked after children in 2015, *Getting it Right for Looked after Children.* They identified three priority areas of work: early engagement, early permanence and improving the quality of care. Children who are looked after at home have been identified as a particular priority for the Scottish Government because they tend to have the worst outcomes of all looked after children and have a complex range of needs.

The strategy discusses corporate parenting and the named person, which were introduced in the Children and Young People (Scotland) Act 2014.

**Linking evidence to actions**

This is in line with action 15, which is about engaging statutory corporate parenting duties by maintaining positive links with the named person.

The Scottish Government realise that a care system is required which will ensure that children are looked after by people they trust, people who can meet their needs and want to build a caring relationship with the child or young person. This is partly about making sure that carers have the necessary skills, experience and support to meet the increasingly complex needs of children and young people they care for.

The Scottish Government strategy mentions that looked after children should be involved in what happens to them, including their health and wellbeing and their education, learning and welfare. Research by Who Cares? Scotland found that looked after young people wanted to be meaningfully included in planning how corporate parents will operate. Who Cares? Scotland is a voluntary agency providing support to looked after children in Scotland.

**Linking evidence to actions**

This fits with what is discussed in the action 8, which is to involve looked after children to identify health issues.
Scottish Health Boards are required by the Scottish Government to provide all children who become looked after children with a health assessment. The Scottish Government produced guidance to help NHS Boards to undertake this duty.62

**Linking evidence to actions**

This coincides with action 15 in the logic model, which says that corporate parents should review the health and wellbeing needs of looked after children against any support and/or service(s) provided. Health Boards are regarded as corporate parents and the guidance on health assessments produced by the Scottish Government discusses reviewing the health and wellbeing needs of looked after children.

**Conclusions**

The evidence links most clearly to action 2, which is around stable, secure healthy living environments, and action 9, which is about safe and supportive home-learning environments. The other actions include action 4, which is about enhancing positive health and wellbeing, such as promoting physical activity, and action 7, which is about nurturing positive attachments and consistent parenting approaches. The two other actions, actions 16 and 19, that the evidence links to are about encouraging the pursuit of activities and hobbies among looked after children and developing assets such as self-esteem and confidence.

There were six actions that did not really link to the high-level evidence. These were as follows:

Action 1: Act as positive role models for looked after children, be alert to matters that affect their health and wellbeing and advocate on their behalf for positive outcomes.

Action 12: All actions within the healthcare plan are coordinated by the lead professional and tracked, with partners being aware of their role around supporting wider issues relating to health promotion, prevention and protection.

Action 17: Develop strong links with community organisations and services to ensure that parents and carers are aware of opportunities and resources in their area and signpost or make these known to looked after children.

Action 21: Ensure that looked after children value diversity and respect their own rights as well as the rights, freedoms, ethnicity, culture, opinions and reputations of others.

Action 23: Ensure that strong links with the wider community are in place to help address issues relating to inclusion, stereotyping and stigma, particularly those associated with disability, discrimination and/or disadvantage.
Action 24: Staff, parents and carers know their obligation relating to children’s rights and can practically apply a rights-based approach within their own role and remit.

However, there might be other evidence, which was not investigated that links to these six actions.
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