

**IMPROVING THE HEALTH OF CHILDREN IN CARE AND
CARE LEAVERS
IN
LONDON 2008/9**

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1. Introduction

The health of children and young people in care (CiC) is substantially worse than the health of their peers living with their birth families. This is an important health inequality, but not usually seen as a public health priority. Nationally there were 44,200 children looked after for at least one year in September 2006 and 8,200 in London during that period.

It is not surprising that the health of CiC is often bad at the time of their entry to the care system, since it may reflect the impacts of poverty, poor parenting, physical / sexual abuse and neglect. Common problems include the effects of poor preventative care (such as lower rates of immunisation and worse dental health), delayed development, inadequate care of disability, undiagnosed health disorders, the direct effects of abuse or neglect and significant behavioural and mental health problems.^{1,2}

The mobility of CiC makes continuity of care difficult. In the year 2004-2005, 13% of looked after children moved through three or more different placements.³ Slow and unreliable transfer of health records and health information is another factor that contributes to poorly co-ordinated health care.

As corporate parents of CiC, local authorities have a statutory obligation to ensure that their health is regularly assessed and addressed, and to monitor the implementation of health care plans. The objective should be that when they leave care, CiC should have longer-term health and other outcomes similar to those of their peers who have not had to be taken into care.

However, the evidence shows that longer-term outcomes of young people who have left care remain strikingly worse than their peers. Nearly two thirds will have mental health problems, a quarter having a major depressive illness.² Three-quarters will have no academic qualification and between 50 - 80% of 16 to 24yr olds will be unemployed.² As many as 44% of substance and alcohol abusers will have been in care⁴ as will 23% of the adult prison population. In fact any experience of being in care is associated with lower levels of life satisfaction as an adult, but this can be improved if young people can gain a qualification, find

¹ Action Plan Health of Looked After Children Islington 2007-2010

² Prevalence of psychiatric disorders in young people in the care system. McCann et al (1996) BMJ313, 1529.

³ Department of Health (1999) *Me Survive Out There? New Arrangements for Young People Living in and Leaving Care*, Department of Health.

⁴ House of Commons Health Committee (1998) Second Report, *Children Looked after by Local Authorities*, The Stationery Office.

employment, reduce their drinking and smoking and develop successful partnerships.^{1,2,5}

Young people leaving care not only have high levels of a wide range of mental health problems with a particularly high incidence of depressive illness,⁶ but also may not know how to obtain mental health services, or get advice about healthy living, safe sex and emotional development.⁷

It is likely that the health issues for London's CiC are not substantially different from CiC outside the capital. A recent review of outcomes of London's CiC⁸ showed that most measures, including processes such as the percentage of CiC receiving their annual health assessments, had values similar to, or slightly better than, the average for England as a whole. However, there are substantial variations between individual boroughs, some of which show values much worse than nationally, while others are better.

An important issue for London is its large volume of refugee and asylum seeking children. London had 63% of all unaccompanied asylum seeking children in England in 2006.

Reducing the striking health inequalities of CiC is an issue for all local authorities, with their NHS partners and others. And action to reduce the variations in performance between local authorities is a further issue needing to be addressed.

3. Policy Context

Current guidance

Currently local authorities are obliged to ensure that the health status of each CiC entering care is fully assessed through a medical examination. Thereafter a review health assessment should be performed annually (six monthly for children under the age of 5 yrs). This process of annual health assessment goes back to the days when it was required to issue an annual Certificate of Freedom from Infection. It has encouraged a very narrow view of what health is and who is responsible for improving it.

⁵ Buchanan A. Are Care Leavers significantly dissatisfied and depressed in adult life? *Adoption and Fostering*. 1999. vol. 23 no4.35 – 40.

⁶ Broad B. Improving the health of children and young people leaving care. *Adoption and Fostering*. 1999 23(1): 40- 48.

⁷ Department of Health (Social Services Inspectorate) *When leaving home is also leaving care: an inspection of services for young people leaving care*. Department of Health 1997.(C1(97)4)

⁸ *Children in Care: the London picture – 2006*. Young London Matters, Oct 2007.

The body accountable for assessing the health of children entering care and for taking appropriate action to improve it is the local authority. However, the organisation responsible for the standard of health assessment and for providing health care interventions is the NHS. Currently the NHS is only indirectly accountable for how well it assesses health care need or how well it provides health care to CiC.

Until recently, central guidance on improving the health of CiC was just that – guidance: most recently issued in 2002.⁹ The new White Paper *Care Matters* will change matters substantially; especially as revised health guidance (a draft for consultation to be published later in 2008) will have statutory impact on both local authorities and primary care trusts.

The White Paper “Care Matters: Time for Change”

Too often local authorities have seen health as something provided by the NHS. *Care Matters* makes it clear that a broader definition is needed, to include wider wellbeing, and that there are many areas impacting on it that are the responsibility of local authorities. These include access to play, sport and leisure, the quality of Sex and Relationships Education in local schools, involvement in youth work activity and in volunteering schemes, and access to healthy food.

The White Paper describes a large agenda across which work with CiC needs to be prioritised by both local authorities and by PCTs, requiring detailed and coordinated partnership work and making healthcare bodies more accountable.

The recently published *Care Matters: Time to Deliver* and the *Care Matters Action Log* confirm this direction and also outline some specific actions to be taken at national, regional and local level in relation to the health of children in care.

The London context

The Young London Matters programme has one particular workstream relating to CiC: *Strand 3: Improving the attainment of vulnerable groups: black African and Caribbean boys, and looked after children*. This strand was originally only concerned with educational attainment. It has now been agreed that it will also include work to improve health and wellbeing.

The Young London Mobility project is a linked, pan-London initiative which is looking at the impact children and young people of mobility between London boroughs. One strand of this programme has also chosen to focus specifically on the health of children in care who are placed outside their home borough, and

⁹ *Promoting The Health of Looked After Children*. London, Dept of Health, 2002.

more specifically to focus on improving access to CAMHS for this group of children, with the aim of providing equality of access and improving placement stability. Work is underway with Croydon, Lambeth, Lewisham and Southwark boroughs, which all have dedicated CiC CAMHS provided by the South London and Maudsley Trust. A draft protocol has been developed including standards for all CiC and for foster carer training across these four boroughs. This is currently being piloted within the four boroughs and learning will be disseminated across London later this year.

As part of the pan-London work in response to the White paper, several consultation events with young people in care have taken place, to consider what might be included in a pan-London 'pledge' to all CiC. Health issues were raised at these events and agreement has been reached to include a health element in the pledge relating to access to appropriate health services for all CiC.

There is an opportunity to add value to the impact of the White Paper in London, by championing the need to address health inequalities experienced by London's CiC, and by taking positive steps to share good practice and innovation across the capital.

4. Performance Indicators

It is not yet clear whether the White Paper will lead to any alteration to the performance indicators by which the health of CiC within each borough will be measured. However from April 2008, all local authorities will be expected to use the 'Strengths and Difficulties Questionnaire' to provide baseline information on the mental health of their CiC.¹⁰

Most of the current performance indicators for CiC concern educational attainment, placement stability and adoption rates. All of these are important areas in their own right, and all of them have an impact on health and wellbeing, but they do not address health status of each child or young person in care.

Currently there are only three CiC performance indicators that relate specifically to health: the proportion with immunisations up to date, the proportion who have received a dental check, and proportion receiving their annual health assessment – all over the previous 12 months.

The reported performance of London's boroughs in 2006 is shown in the Table in **Appendix 1**.

¹⁰ Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38, 581-586.

5. What is currently expected of health organisations and local authorities

At present, the expectations placed on health organisations and local authorities are described in the 2002 DH Guidance: “*Improving the health of looked after children*”.⁹ This guidance was accompanied by changes in regulations to enable review health assessments to be performed by a nurse. The guidance emphasised the need for assessments to be linked to a health care plan, whose implementation should be reviewed within future social services review meetings for each child or young person concerned. The guidance also stated that all PCTs should appoint a designated doctor and designated nurse for CiC. These professionals are often responsible at a strategic level for ensuring that health assessments and reviews are completed to an acceptable standard.

Anecdotally, the changes in regulations have led to the appointment of many more nurses (often jointly funded by PCTs and local authorities) to undertake review assessments and to work in close partnership with social workers – an important development.

The guidance advised that all health professionals doing health assessments should be trained to do them (including the doctors) and that ideally a local dedicated service should be commissioned to provide a service, which should be subject to clinical governance arrangements, including the use of clinical audit to assess coverage, impact and outcomes. None of the guidance is enforceable, and there has been no way of knowing centrally how well it has been followed.

For example, if the assessments are not provided by a dedicated service and the doctors performing health assessments have received no training in the health problems experienced by CiC, that is likely to remain the status quo. Many local authorities still use GPs to do assessments, most of whom have had no training in the special needs and difficulties experienced by children in care.

And the fundamental problem remains, that while the local authority is accountable for performance of the three “health” indicators, it is the NHS which is the body responsible for health assessment and provision. The guidance does not yet have statutory impact, and PCTs have usually prioritised not CiC as a health inequality priority.

6. Children’s mental health and psychological well-being

The Department of Health commissioned the Office of National Statistics to carry out a survey on the ‘Mental health of young people looked after by local authorities in England.’ This was published in 2002 and confirmed findings of earlier research about the high level of mental health need amongst CiC, particularly those in residential care: 45% were assessed as having a

mental health disorder (compared with around 10% of the general population); 37% had conduct disorders, 12% emotional disorders & 7% as hyperactive; 75% of children in residential care were assessed as having a mental health disorder.¹¹

Further analysis carried out by Tamsin Ford et al.¹² found that even when CiC were compared to children in a community sample from the most deprived socio-economic groups, they still showed significantly higher rates of mental health disorders. The authors suggest that this is largely due to adverse factors impacting on children prior to entry into care. They also identified significantly higher rates of developmental disorders, such as autism and ADHD, which may have gone previously undiagnosed. Other studies also indicate that behaviour and mental health problems in children, along with a number of other factors in the child and carer, are linked to increased risk of placement breakdown.

In recognition of this high level of mental health need amongst CiC, there has been an expansion of dedicated CAMHS provision for CiC over the past few years both at national, regional and local level. Within London there are a number of teams with national expertise, such as the National Treatment Foster Care team at the South London and Maudsley Trust and the national team for fostering and adoption at the Tavistock Clinic in North London.

Of equal importance has been the development of dedicated CAMHS teams or posts working with CiC and their carers. These now exist in the majority of London boroughs, although there is great variation in terms of the range of services offered and which children and young people have easy access to the service, with particular inconsistency existing for children placed out of borough. The current work being undertaken by the London Mobility project goes some way to addressing this issue within one sector of London. Access to appropriate services for Care Leavers, particularly those aged 18 plus and the development of protocols around transition of young people between child and adult services remains a challenge.

The White paper will require the development of targeted/dedicated CAMHS in all authorities but guidance has not yet been written outlining how these services should operate. However, both research and policy guidance point to the need for improved training and support for foster carers, residential workers and social workers in understanding children's mental health and in practical strategies for dealing with children's behaviour, alongside interventions with children and young

¹¹ Meltzer M., Gatward R., Corbin T., et al (2003) *The Mental Health of Young People Looked After by Local Authorities in England*. England. TSO (The Stationery Office).

¹² Ford, T. et al. (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *British Journal of Psychiatry*, **190**; 319-325.

people themselves. At a regional or sub-regional level, there is potential for cooperation between boroughs and their health partners in developing training and support packages for foster carers, such as the Fostering Changes programme developed by the South London and Maudsley Trust.

7. Young People Leaving Care

Providing support for young people leaving care, through their transition to full independence, is full of challenges. Young people need advice on a range of health issues, from guidance on safer drinking and drug taking, to sexual health advice, how to deal with stress – which is a major issue for young people leaving care¹³ - and a need to ensure continuity of decision making about their health. As the requirement for health assessments to be completed ends at aged 18, this can leave young people particularly vulnerable after that time. Therefore local and regional strategies addressing the health of children in care also need to include the health of care leavers.

It is essential for young people to be able to continue to obtain health advice at what is a very stressful time for them, and that personal advisors should work closely with doctors and nurses involved in earlier health assessments to ensure that the most important health priorities for these young people are properly and sensitively addressed. Primary care services, in particular those of GPs are often insensitive and understand little of what it is like to be in care. Research shows that often young people find GPs moralistic and judgmental, not approving of young people's lifestyle and making that opinion quite open and explicit.¹³

For some young people with complex health or mental health needs, transition planning is needed to ensure that they access appropriate specialist healthcare into adulthood. This may be particularly important for young people with disabilities or serious mental health problems. However for all care leavers, health promotion is key to improving their outcomes, both in terms of healthy lifestyles for young people and access to appropriate primary care services.

All leaving care services need to ensure that health and access to positive activities are included as part of young people's pathway planning and to consider using their premises to offer health services. Best practice in this area includes designated nurses and voluntary sector organisations offering counselling, providing sessions within the Leaving Care Service and all personal advisors being offered training in promotion of both physical and mental health.

¹³ Bob Broad. *Improving the health and wellbeing of young people leaving care*. Russell House Publishing, 2005.

8. Future expectations from *Care Matters: Time for Change & Time for Action*

The White Paper *Care Matters: Time for Change* recognises the need to sharpen the focus at local level on the health and wellbeing of CiC. It proposes achieving this through a number of means:

- Inclusion of the health needs of CiC in the new joint strategic needs assessment in each authority, which will include health partners
- Issuing of new statutory guidance to both local authorities and health partners, setting out their statutory responsibilities in this area
- Provision of named health professionals for CiC
- Improved sex and relationships education for CiC and increased support for pregnant young women and young mothers in care or who are care leavers
- Addressing substance misuse issues for CiC and care leavers
- Improving access to leisure activities and other positive activities, including play and music for CiC and their carers.

The White Paper recognises that the health and wellbeing of children in care is the responsibility of everyone who works with children, from teachers to foster carers and residential workers, as well as of the local authority itself and all health agencies.

Care Matters requires that authorities and PCTs start with improved strategic planning for CiC, including the needs of CiC being included in the Joint Strategic Needs Assessment from April 2008. This should also inform the development of local targets through Local Area Agreements; the challenge being to ensure that CiC remain a priority despite competing demands placed on both local authorities and PCTs. Elected members will also have powers to require PCTs, NHS Trusts and NHS Foundation Trusts to co-operate with overview and scrutiny committees in the provision of information regarding the health of CiC.

The new statutory health guidance will be published for consultation in late 2008 and this will include guidance on the role of the named health professional for CiC and ensure that CAMHS provide targeted or dedicated provision for CiC. It will also set out expectations in relation to health assessments for CiC and

subsequent health plans and include specific reference to substance misuse and sex and relationships education issues.

To successfully implement Care Matters, health and wellbeing issues need to be considered within **all** strands of work at both regional and local level, rather than being considered as something which sits separately and is chiefly the concern of health professionals. The engagement required to bring about real change in outcomes for children lies between local authorities and their health partners at both strategic and operational level. The statutory nature of the new health guidance should ensure that there is sufficient leverage to make this engagement possible.

The named health professional may be responsible for:

- ensuring that the child's health assessments and reviews are undertaken;
- co-ordinating the child's health care plan on actions falling to the NHS to ensure they are undertaken and tracked and any blockages are sorted;
- acting as a contact point for the child, carer and other health practitioners about the child's health needs;
- acting as a key health contact for the child's social worker;
- holding the health chronology for the child;
- interpreting health needs to social services and education;
- ensuring that when a child is moved out of the PCT area, records are swiftly transferred and critical information about the child is made available to health professionals in the child's new area of residence;
- ensuring the particular needs of disabled children, including those with complex healthcare needs, are taken into account; and
- acting as a local point of contact for the responsible commissioner for children placed out of the original PCT area.

9. Current baseline across London

Alongside the performance data outlined earlier there are a number of sources of self –reported data which contribute to the picture of provision, although not necessarily outcomes for children, across London.

In the self assessment exercise completed by all CAMHS partnerships across London, the majority of boroughs rated themselves green (24) on CAMHS provision for LAC with a small number reporting amber (8) and none reporting red scores. This gives London a higher overall rating than other regions within England.

Some boroughs and PCTs, for example Islington, have developed local health strategies for CiC, which cover all health issues, including both physical and mental health issues, in a holistic way. This strategy has used the National Healthy Care Standard¹⁴ as a framework for analysing progress to date and to help identify future actions.

Additional baseline data is also available from both the CAMHS and the child health mapping exercises. These are annual service mapping exercises which are completed by each PCT and their local authority partners.

In addition to the existing data, we decided that a short questionnaire should be sent out to all boroughs/PCTs to provide a broader range of qualitative data.

Questionnaire Methodology:

A questionnaire was sent via the chairs of the CAMHS partnerships asking them to provide baseline information about CAMHS provision for children in care in their area and also information about the current strategic planning for children in care and provision of health assessments (**Appendix 2**)

Findings

Results of the questionnaire have now been collated and are currently being analysed.

- 28 of a possible 32 questionnaires were returned (87%)
- 13 out of 28 had a recent health needs analysis for children in care (46%)
- 22 out of 28 (78%) had a health strategy for children in care but only 3 areas had an action plan to accompany their strategy
- 27 out of 28 areas had designated or targeted CAMHS provision for children in care, although this varied as to which age range they served and also whether this provision was for all children in care living in the borough or only those who were in care to that authority (**Appendix 3**).

Gaps

Further work is needed to look at the rich qualitative data as well as the quantitative data received through the questionnaires. However the key issues identified so far are:

¹⁴ www.ncb.org.uk 2006

Strategic planning: whilst most areas had health strategies, less than half were linked to a local needs assessment and only three had accompanying action plans.

Capacity: the qualitative feedback often highlighted the lack of capacity in local areas amongst designated doctors and nurses and some vacancies in key posts. This impacted on their ability to deliver effective health assessment and review services.

Children out of borough: the approach to both CAMHS and health assessment provision for children out of borough was not consistent and these children were often seen to be receiving a less effective service. Concern was also raised about how to effectively implement the Responsible Commissioner Guidance.

Care Leavers: health provision for care leavers (including mental health) was also variable, with some services only working with children up to the age of 16 and others continuing until they are 25.

10. Commissioning for better health of CiC

Care Matters – Time for Change & Time for Action sets an agenda for commissioners of both health and social care services for CiC, and commissioners need to familiar with it. Within this agenda, however, there are a number of specific priorities that deserve coordinated action.

Public health issues

- Commissioners should promote children's access to leisure facilities across London, with the development of the London wide leisure card. Support and training should also be provided to carers on promoting positive activities, for example through the Healthy Care programme
- Children, young people and carers should have access to broad health promotion advice, with opportunities to increase physical activity, healthier eating, to address obesity and promote emotional well-being
- The specific needs of CiC and their carers should be included in local plans in relation to substance misuse and sexual health.

Ensuring views of CiC are taken into account

- The views of CiC for whom the borough and PCT are responsible should be sought to provide feedback to commissioners, so that their experiences

of health assessment and of the health care system can be used to develop service quality, accessibility and responsiveness.

Health assessment and care planning system

Systems to assess health care needs (and ensure that they are met) are of variable quality across London. The commissioning process is crucial to reducing avoidable variations. The important issues that should be covered include these:

- Commissioning of health assessment services for children in care needs to be done jointly between local authorities and PCTs. This will help achieve better joint accountability
- Nurses and doctors performing health assessments should ideally be employed by NHS organisations, and thereby subject to their clinical governance arrangements. This should include both training and annual appraisal. No nurse or doctor should assess the health of a child or young person in care without having undergone the necessary training
- Commissioners should ensure that time allocated for designated doctors and nurses is sufficient for the needs of their population of children in care; benchmarking on this issue could be undertaken across London
- The local health assessment service should have a consultant clinical head (ideally an experienced paediatrician) who will exercise clinical leadership and be responsible for clinical governance and audit of standards of the service
- The service contracted to run the health assessment system should also ensure that health care plans of individual CiC are implemented properly – which means both clinical effectiveness and appropriate promptness of response
- Independent Reviewing Officers should also review health care plans, as part of children’s statutory reviews.
- The performance of the service should be reported annually to both the PCT and the local authority, at a senior level. This report should include information about the health assessments of the borough’s CiC resident outside the borough.

Mental health & emotional well-being

- Joint commissioning should be in place for CAMHS for CiC and this should be linked to local CAMHS strategies and Children and Young People's plans.
- Commissioners need to commission training and support for professionals across health, social care and education and for foster carers and residential workers in promoting emotional well-being.
- Specific services for care leavers should form part of commissioning plans, including commissioning services from the voluntary sector where appropriate, and protocols relating to transition to adult services.

11. Recommendations

Initial recommendations from this work have been taken to the Young London Matters Strand 3(b) group. This group was initially focused on improving educational outcomes for children in care but has now included improving health outcomes within its remit for 2008/9. This draft paper has also been discussed with the London regional group for nurses working with children in care and the project group for the CAMHS Mobility project.

We are asking this Board to endorse our approach and agree actions to be taken forward at both a regional and local level, in line with *Care Matters*.

- (i) Regional work plans for Care Services Improvement Partnership (CSIP), Regional Public Health Group and Government Office for London (GOL) should prioritise improving health outcomes for children in care for 2008/9, including developing the Healthy Care programme on a regional basis.
- (ii) All London PCTs to be asked to identify a health champion for CiC within the next 12 months.
- (iii) All local authorities and PCTs to assess the quality of their health assessments and health plans during 2008/9, including those for children placed out of borough.
- (iv) Local authorities and their health partners, alongside GOL and CSIP, should develop regional and local plans for training of professionals, foster carers and residential workers in health and mental promotion for children in care and care leavers, and a training programme for GPs in relation to work with CiC. Plans to be in place by March 2009.

- (v) All London boroughs and PCTs ensure that dedicated/targeted CAMHS are in place for CiC by April 2009 and protocols to ensure access to appropriate services for children placed out of borough and for care leavers are developed.
- (vi) A London regional approach to the implementation of the Responsible Commissioner Guidance to be agreed across PCTs and local authorities, to improve outcomes for children placed out of borough.
- (vii) An event to be held for London local authorities and their health partners, focusing on good practice in improving the health of CiC and preparing for implementation of the new health guidance.

John Hayward and Cathy James
April 2008

Appendix 1

Health care of looked after children, twelve months ending 30 September 2006

Local Authority	number				percentages			PAF Indicator C19 ¹ (average percentage)
	number looked after for at least one year	children whose immunisations were up to date	children who had their teeth checked by a dentist	children who had their annual health assessment	children whose immunisations were up to date	children who had their teeth checked by a dentist	children who had their annual health assessment	
ENGLAND	44,200	35,200	37,600	36,800	79.5	85.1	83.2	84.1
LONDON	8,200	6,310	7,150	7,240	77	87	88	88
INNER LONDON								
Camden	255	215	220	215	85	87	85	86
City of London	10	10	10	10	83	100	83	92
Hackney	350	300	315	270	86	90	78	84
Hammersmith and Fulham	270	190	240	250	71	90	93	91
Haringey	345	255	320	310	74	94	90	92
Islington	295	260	285	290	88	96	98	97
Kensington and Chelsea	155	150	135	140	97	85	88	87
Lambeth	455	175	430	390	38	94	86	90
Lewisham	345	245	240	265	71	70	77	74
Newham	500	420	425	455	84	85	91	88

Southwark	460	440	395	400	95	85	86	86
Tower Hamlets	250	100	220	225	41	87	89	88
Wandsworth	215	190	195	205	88	91	96	94
Westminster	215	170	180	170	80	85	80	82
OUTER LONDON								
Barking & Dagenham	235	170	230	235	73	98	98	98
Barnet	270	220	260	245	82	96	90	93
Bexley	155	125	145	140	82	92	92	92
Brent	285	190	250	255	67	87	89	88
Bromley	210	145	180	165	70	85	79	82
Croydon	520	410	405	445	79	79	86	82
Ealing	295	170	245	260	57	83	87	85
Enfield	220	190	170	200	86	76	90	83
Greenwich	340	245	305	270	72	89	79	84
Harrow	125	80	100	115	66	82	94	88
Havering	140	135	135	130	97	95	93	94
Hillingdon	380	340	345	350	90	90	91	91
Hounslow	235	190	215	205	81	92	88	90
Kingston Upon Thames	50	50	45	50	94	90	94	92
Merton	80	60	75	80	72	94	96	95
Redbridge	105	100	95	95	94	91	90	91
Richmond Upon Thames	70	70	60	70	99	89	97	93
Sutton	110	95	95	110	85	87	99	93
Waltham Forest	255	200	185	235	79	72	93	83

Source: DCSF 2008

Appendix 2

IMPROVING HEALTH OF CHILDREN AND YOUNG PEOPLE IN CARE (CiC) IN LONDON

1. Who are the leads for the health of children and young people in care (CiC)?
 - a) in your local authority (name and e-mail)

 - b) in your PCT

2. Has a health needs analysis for CiC been performed? **YES/NO**
If yes when? Date:

3. Do you have a health strategy for CiC in your borough? **YES/NO**

4. Who is the lead clinician for your local health assessment service for CiC?

5. How do you report and monitor your health assessment service for CiC?

6. Is there dedicated CAMHS provision for CiC in your borough? **YES/NO**
 - i. what age range does it serve?

 - ii. does it cover all children who are looked after by your borough and are living within the borough?

 - iii. does it cover children who are in care to other local authorities but who are resident in your borough?

 - iv. does it cover children who are your borough's responsibility, but who are resident outside your borough?

John Hayward and Cathy James

Appendix 3

