NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Children Looked After & Young People

GP and Practice Staff Resource Pack

Bath and North East Somerset (BaNES), Swindon and Wiltshire Integrated Care Board (BSWICB)

Designated Nurses for Children Looked After

October 2022.

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1. Background

What is a Child Looked After?

Children Looked After (CLA) are also referred to as Looked After Children (LAC) or Children in Care (CIC). All three terms refer to the same cohort of children but the terminology is used by different parts of the system. So, for all legislative and statutory guidance they are referred to as LAC, Local Authorities refer to them a CLA and children themselves often refer to themselves as CIC. Nationally Children and Young People (CYP) dislike the acronym "LAC" as they say it sounds like they "lack something" as highlighted in the quote below:

> A fostered child asked: "Why do I have to go to 'LAC' review – what's 'lacking' with me?" 2019

Bath and North East Somerset (BaNES), Swindon and Wiltshire Clinical Integrated Care Board (BSWICB) have adopted the use of CLA as opposed to LAC in all of their communications to reflect CYP views.

A child is looked after by a local authority if they are in the care of the local authority by reason of a Care Order issued by the courts (where the local authority shares parental responsibility with the parent) or if they are being provided with accommodation under the Section 20 of the 1989 Children Act (i.e., voluntary care, where the local authority does not have parental responsibility for the child). See "Categories of Children Looked After" for more details.

The most common reason for children and young people coming into local authority care is abuse or neglect while in the care of their own family. However, Children Looked After (CLA) also include all children where the local authority has the authority to place the child for adoption, unaccompanied asylum-seeking children (UASC), and some young people involved in the Youth Justice System. It does not include those children who have been adopted or subject to a Special Guardianship Order (SGO), nor does it include those children and young people who are in Private Fostering arrangements (see 'Children Who Do Not Have Looked After Status' for more detail).

There were, 80,850 CLA in England as of 31st March 2021 including adoptions, for the reporting Year 2021 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk) an increase of 1% compared to 31 March 2020.

The majority of these children and young people will be placed with foster carers (including family members who have been approved as 'kinship' or 'family and friends' foster carers), whilst others may be placed in residential or secure children's homes, other specialist residential care homes,

independent, ‘semi-independent’ or supported accommodation for older young people or remain living with their parents while subject to a Care Order.

In January 2022, 385 CLA were placed outside of local authority boundaries from the BSW ICB footprint which can produce challenges to effective interagency communication.

At 31 March 2022 in BSW ICB there were 953 CLA who are children from the ICB. The numbers of CLA have generally been static across the BSW footprint over the last two years, whilst nationally the numbers have increased.

Why is Statutory Guidance needed for the care of Children Looked After in General Practice?

CLA share the same health risks and problems as their peers, but often to a greater degree, and in the context of greater challenges such as discord within their own families, frequent changes of home or school, and lack of access to the support and advice of trusted adults.

Children often enter the care system with a worse level of health than their peers, in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect.

We know that almost half of all children looked after have a diagnosable mental health disorder. Data collected by the Children’s Commissioner in 2015 suggests that while fewer than 0.1% of children in England are in care, 4% of children referred to specialist CAMHS services are in care. We also know that 52 per cent of children in care have low subjective wellbeing compared to around 10 per cent of children in the general population. Additionally, there is an increased risk of developmental disorders such as attention deficit hyperactivity disorder and autistic spectrum condition (ASC). In addition they are significantly more likely to be diagnosed with Conduct Disorder, Anxiety and Depression. Given that the best predictor of psychiatric disorders in adulthood is a psychiatric disorder or disturbance in childhood or adolescence, there is very strong obligation for early intervention with this high-risk group for their present needs and future wellbeing. (2017) improving-mental-health-support-for-our-children-and-young-people-full-report.pdf (scie.org.uk)

Other research and surveys found that two thirds of all children looked after had at least one physical health complaint. The most frequently reported were eye and / or sight problems, speech or language problems, bed-wetting (including among older children), difficulty with coordination, and asthma. Apart from asthma and eczema, these were all more common among children looked after than among children in the general population.

The fact that longer-term outcomes for Children Looked After remain far worse than those of their peers, is evidence of an important health inequality.

Primary Care Services have an important role to play in the identification of the individual health care needs of children and young people who are looked after. They often have prior knowledge of the child or young person looked after, of the birth parents and of carers, helping them to take a holistic and child-centred approach to health care decisions and may also have continuing responsibility for the child or young person when they return home.

This guidance is based on the following key documents: Insert links for RCGP toolkit and NICE guidance 2020

Statutory Guidance: Promoting the Health and Welfare of Looked After Children 2015

Intercollegiate Roles and Competencies for Health Care Staff 2020

Additional advice and practice guidance on promoting the health and wellbeing of Looked After Children can be found in RCGP toolkit:

https://elearning.rcgp.org.uk/mod/book/view.php?id=12531&chapterid=372

and in the RCPCH Resource:
https://childprotection.rcpch.ac.uk/resources/looked-after-children/

and

NICE Guidance on Looked after Children and Young People: (NG 205) Oct 2021

www.nice.org.uk/guidance/ng205

2. What are the Primary Care Services Statutory Responsibilities to Children Looked After

- To act as advocates for the health of each child or young person who is is in care.

- To ensure timely, sensitive access to a General Practitioner or other appropriate Health Professional when a child or young person who is in care requires a consultation.

- To make sure that referrals made to specialist services are timely, taking into account the needs and high mobility of many children and young people who are in care.

- To provide, when needed, summaries of the health history of a child or young person who is in care, including their family history where relevant and appropriate, and ensure that this information is passed promptly to health professionals undertaking health assessments, subject to appropriate consents.

- To maintain a record of the health assessment and contribute to any necessary action within the health plan.

- To make sure that the clinical records, *including referrals*, make the "Child Looked After" status of the child or young person clear, so that their particular needs can be acknowledged.

- To regularly review the clinical records of CLA and young people who are registered with them. In particular they should gather relevant information and make it available for each statutory review of the health plan.

- To make sure the general practitioner-held clinical record is maintained and updated. It is a unique health record and can integrate all known information about health and health events during the life of any child or young person. This enables GPs, nurses, health visitors and others in primary care to have an overview of health priorities, and to know whether health care decisions have been planned and implemented.

- To deliver the best possible medical care to the child or young person, General Practice needs to have the best possible access to the relevant medical records. Registering these CYP as permanent patients and having full registration is essential. This ensures that the child's medical record hold accurate and contemporaneous information. This is particularly relevant due to the frequent placement moves some of these children and young people experience during their time in care.

3. Guidelines for the Care of Children Looked After in General Practice

At Registration

A child may be identified as being in care through the Young Persons Registration form, information volunteered by a Carer or Social Worker, on receipt of Statutory Health Review report or following enquiry by the practice when a child (other than a new born baby) is registered within an existing household.

Once Looked After Status is confirmed the practice should:

- Accept the child / young person as a fully registered patient
- Ensure that the following essential information is gathered and recorded in an easily retrievable manner:

    - Name of Carer/s
    - Name and contact details for their allocated Social Worker and Local Authority responsible for the child
    - Who has Parental Responsibility (in order to clarify any consent issues)
    - Other agencies involved

- Highlight the medical record in such a way as to ensure that all team members are aware of the child/young person's "CLA status" and adding the Child Looked After READ code / SNOMED code to the summary screen

- **Request previous records urgently and summarise them as a priority ensuring that all relevant health and social information is added to the summary screen.**

- Identify a lead professional within the practice who will be responsible for reviewing the record on a quarterly basis to ensure all identified health needs are being addressed and for providing reports for statutory reviews when requested.

- Invite the child/young person to a new patient medical with an appropriate professional. For all children this will serve to open communication with them and their carer including ascertaining whether they have delegated authority to consent and is an opportunity to identify any unmet need while awaiting previous records. For older children it will also provide a valuable health promotion opportunity including contraceptive and sexual health advice as appropriate. Professionals from the locality CLA Health Team maybe able to support the child/young person at these if known to them.

Accessing Healthcare

Continuity of care is particularly pertinent to this group of children and wherever possible they should be seen by the same GP/Practice Nurse and should not be seen by locum staff.

Record Keeping

The practice will maintain a contemporaneous and effective summary for the child/young person, collating information from consultations and correspondence, in order to build an accurate picture of their situation, ensure appropriate support is being provided and to identify any escalating concern (see below).

The lead health record for the child looked after or young person should be the GP-held record. A copy of the health assessment and multi-agency care plan should be scanned or retained in the record .

Information Sharing

The lead professional will ensure that the relevant information is provided in a timely manner when requested for statutory review of the health multi-agency care plan.

As central record holder it is imperative that all relevant information is passed on to facilitate holistic care and effective risk assessment and this should include information from secondary care, casualty departments etc as well as consultations at the practice.

Referrals

The practice will ensure that all referrals highlight the “CLA Status” of the child/young person to allow any mechanisms in place in the receiving organisation to respond to this fact (some departments have the ability to prioritise these referrals to reflect the propensity for these children who fail to access care as a result of relocation).

Advocacy

The practice (most likely in the form of the lead professional) will at all times act as advocate for the child/young person and liaise with appropriate professionals to ensure all their needs are identified and addressed.

Training

All training for staff on CLA and care leavers should be underpinned by the required level of safeguarding children and adults' intercollegiate documents framework. In addition level of skill, knowledge and competencies identified in the Intercollegiate document for looked after children 2020 must also be applied.

The competencies encompassed in the CLA framework are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare, health and wellbeing of Children Looked After and young people, as well as care leavers. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice. Promoting the health of Children Looked After refers to this specific intercollegiate framework (2020) stating 'health professionals contributing to the care planning cycle for looked after children should have the appropriate skills and competences and receive continuing professional development'. Different staff groups require different levels of competence depending on their role and degree of contact with looked after children, young people and care leavers, the nature of their work, and their level of responsibility.

The framework identifies five levels of competence and gives examples of staff groups that fall within each of these. Those identified with a Primary Care focus are listed below.

Level 1: all staff including non-clinical managers and staff working in healthcare settings.
Staff Groups- All staff working in Health Care settings

Level 2: minimum level for all non-clinical and clinical staff who, within their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children.
Staff Groups-. These include- GP practice safeguarding administrators, GP reception managers, GP practice managers, clinic reception managers and receptionists, phlebotomists and pharmacists.

Level 3: all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the health needs of a looked after child/young person or care leaver
Staff Groups- GPs, practice nurses (including nurse practitioners within primary care) and Paramedics. It is expected that doctors in training (including foundation level doctors) who have posts in these level 3-affiliated specialties/with significant children/young person contact, will also require level 3 training.

Level 1
GP brief training Videos on CLA and Care Leavers.

CLA video:

https://www.powtoon.com/c/eXUqshyeiFJ/1/m

Care Leavers video

https://www.powtoon.com/c/gliMNL5lAYm/1/m

Level 2 Training is underdevelopment and is hoped to be available in Jan 2023.

Level 3

e-LfH Safeguarding Children and Young People (SGC)>Safeguarding Children-Level 3. Module Looked After Children
In addition:

Hierarchy: Part 1 and Part 2

Healthy Child Programme (HCP) > HCP 04 - Safeguarding > 04_03 Looked After Children Part 1 Challenges and Principles

Healthy Child Programme (HCP) > HCP 04 - Safeguarding > 04_04 Looked After Children Part 2 Influencing Factors and Outcomes of Care Journeys

Hierarchy: Mental Health

MindEd Education > Anna Freud Centre - Link Programme > Section 2: Clinical management of mental health > Managing the Mental Health of Children and Young People with Heightened Vulnerability > Looked After Children

4. Consent and Parental Responsibility

Each and every healthcare intervention requires the health practitioner to discuss the risks and benefits of the prescribed treatment and seek the patients consent to that treatment.
Health professionals must always consider the Gillick/Fraser advice in any consultation with a child or Young Person which equally applies to CLA in all consultations. Consideration should be given and with the young person's permission, that the explanation about the intervention should be shared with the identified responsible adult (carer or SW) to ensure they support the young person in making their choice.

Where a child is not considered able to give consent for a planned procedure or intervention, the practice must ensure that they have consent from an individual holding Parental Responsibility (PR) and should ensure that this is recorded clearly in the notes.

Definition of PR: "All the rights, powers and duties of parents in relation to a child and his property"

According to Section 3, Children Act 1989:

- PR is 'shared' between parents and the local authority if the child is cared for under an order imposed by the courts, i.e. Section 31 Full Care Order or Section 38 Interim Care Order, or a Section 44 Emergency Protection Order.

- Birth parents retain full PR if child is cared for under a Section 20 of the 1989 Children Act, Voluntary Agreement.

Clarification of PR for the child should have been gathered at the time of registration (see pg.7), but where there is any doubt the procedure should be deferred and the child's allocated Social Worker contacted for clarification.

As described above, consent in relation to a child can only be given by the person who holds Parental Responsibility (PR) for the child as set out in the Adoption & Children Act 2002 except in a situation where:

The child's life is threatened and emergency treatment is needed - in an emergency situation health professionals are allowed to act in the child / young person's best interest.

The health professional considers that the child has the cognition to understand the risks and benefits of the treatment and has the capacity to make the decision (see GMC 0-18: guidance for all doctors).
Practitioners must pay due regard to a CLA rights as with any other Child/Young person.

In addition, prescribing health practitioners may decline to provide treatment if they consider that the person who holds PR, or the child if aged 16 or 17 years, does not have capacity (Mental Capacity Act 2005). Under these circumstances, other routes to obtaining consent may be taken, such as seeking the decision of a court of law.

Delegated Authority

Carers (foster carers, residential children's home staff etc.) do not automatically have PR for a Child Looked After and therefore cannot be presumed to be able to provide consent.

However, in a bid to ensure that CLA receive as 'normal' a childhood as possible, **delegated authority** is used by the local authority to give carers as much responsibility as possible for day to day decision making for children in their care. So, for example, foster carers no longer have to request permission from the child's Social worker for the child to be allowed to stay over at a friend's house, or to leave the child with a trusted babysitter, when they go out for the evening etc. When children are placed 'permanently' with a foster carer it is expected that the foster carer will take more responsibility for decision making. So, for example, they may be given the responsibility for deciding what school the child attends.

The birth family share parental responsibility with the local authority when the child is looked after under any care order, therefore the extent of authority 'delegated' to a foster carer will need to be negotiated with the birth family and may differ for different children. There should be a clear agreement in place clarifying who is able to make decisions regarding the child's care.

In relation to the child's health, delegated authority for carers will usually cover routine developmental, dental, hearing and optician checks and the provision of simple over the counter medications where appropriate and safe for the individual child.

Carers are also able to give consent for emergency medical treatment if the child's life is threatened.

However, Delegated Authority does not cover routine medical treatment; informed consent for this should always be obtained by the health practitioner with adult who holds PR, either birth parent or SW.

In cases where need arises for planned treatment including surgical interventions or anaesthetic the child's Social Worker will seek consent from the birth family and/or social care service manager.

5. Children Looked After Statutory Health Reviews

Initial Health Assessments

An Initial Health Assessment (IHA) should be undertaken within 20 working days of the child becoming looked after. It is undertaken by the Community Paediatric Team.

Review Health Assessments and Care Leaver Health Assessments

Specialist Nurses from the BSW ICB commissioned health services for CLA undertake all subsequent Annual (or bi-Annual for 0-5's) Review Health Assessments (RHA)for Children Looked After.

This should include recording when last child had a dental check, or an oral check for 0-5's. All completed statutory health assessment for CLA will be shared with the registered GP Practice for actions to be followed up and retained on the child health record.

Children Looked After Emotional and Mental Health

When children have experienced significant adverse childhood experiences, it can result in excess activation of their stress responses, which can have long term effects on their brain development and their physical health. This can impact a child's emotional development and ability to form secure relationships, and can also impact on physical development including co-ordination, language development, concentration, memory and processing skills.

These effects can be helped by children developing responsive relationships with their caregivers, and being helped to learn and develop core life skills, which can buffer the long term effects of their early experiences.

CLA who have experienced stressful environments including domestic violence lead to an increase in the circulating hormone cortisol. This in pregnancy is known to cross the placenta and affect the development of the foetal brain such that the baby and later the child's own stress responses are altered. The response can be unpredictable with babies and children either being hyper vigilant, where their stress responses are exaggerated, or down-regulated and withdrawn "quiet babies". This stress response becomes the default response for that child although new responses can be learnt. It can impact on their social functioning both in the short and the long term.

As part of their initial health assessment, CLA may be referred into a CAMHS service for advice and support but subsequently they may attend Primary Care with developing issues. The first point of call will be referral to CAMHS to determination of any mental health intervention or onward signposting to the most appropriate service to support.

A copy of the referral should be sent to the childs SW to be retained on the social care record. Ensure that any referral highlights this is a CLA.

6. Categories of Children Looked After

A child or young person is 'Looked After' under the **Children Act, 1989** if he/she is accommodated by the local authority:

- Under a **Section 20 Voluntary Agreement** with parental consent or own consent if aged 16 or 17
- Subject to a care order imposed by the courts (**Section 31 Full Care Order** or **Section 38 Interim Care Order**)
- Subject to a **Section 44 Emergency Protection Order** while a **Section 47 Child Protection Investigation** take place
- Is remanded through the criminal court
- Subject to a Secure Order (**Section 25**) and placed in secure accommodation. Home Office approval is required for children under 12 years of age
- Unaccompanied Asylum Seeking Children (UASC) if determined by formal age assessment and are under 18 years of age

Any young person who has been in care at any time during their childhood is considered to be vulnerable and at greater need until at least their 21st birthday (24 if in education or disabled).

7. Care Leavers

A Care Order can last until the child is aged 18. When Looked After Children reach the age of 16, they begin preparing to leave the care system as young adults. As they transition YP are provided with a Personal Advisor to help support them from childhood to adulthood until they are 25 years old.

During this crucial period of transition from 'care' to independence, services aim to prevent or reduce the long-term negative impact of a traumatic transition, providing support with:

- finding a suitable place to live

- securing and sustaining constructive education, training or employment
- establishing and maintaining supportive relationships

Without support, care leavers are at increased risk of homelessness, mental health problems, substance misuse and entering the criminal justice system.

There is a SNOMED CT code for care leaver that can be added to the young person notes but this MUST be done with their consent and professional to YP discussion.

SNOMED CT term: Care leaver (finding)
SNOMED CT code: 1064671000000107

8. Children who do not have "Looked After" Status

Children and young people are **not** Looked After if:

- They are living with their parents or a close family member (unless they are subject to a care order and/or it's a kinship or 'family and friends' placement under Section 20)

- They are subject to Team Around the Child Plan, Child Protection Plan or are receiving Section 17 Child in Need Services from the local authority. This includes if they are receiving **Respite Care** (a series of short-term breaks), unless the child receives substantial packages of short breaks, sometimes in more than one setting, and belongs to a family who may have difficulties providing support to their child while they are away from home or monitoring the quality of care received, in which case the child will be accommodated under Section 20 of the 1989 Children Act.

- They have been **adopted** (see 'Adoption'), or the person whom they live with has been granted one of the following Court Orders:

- A **Child Arrangement Order (CAO)** replaces Residence and Contact Orders (Children and Families Act 2014). It is a private law order that regulates arrangements relating to with whom a child is to live, spend time or otherwise have contact, usually following divorce or separation of the parents.

- A **Special Guardianship Order (SGO)** is a private law order appointing one or more individuals to be a child's 'Special Guardian', often a grandparent, aunt or uncle. It is made under the Children Act 1989 and is intended for those children who cannot live with their birth parents and who would benefit from a legally secure arrangement with another family member. An SGO enable a child to remain in his or her family as, unlike adoption, it does

not end the legal relationship between the child and his or her birth parents. **Any child who was previously Looked After will cease to be looked after when a SGO is made**.

Adoption

According to the **Adoption and Children Act 2002**, children may be placed for permanent adoption with either:

- The consent of their birth parents. Placement by consent is the free unconditional agreement of the parent or guardian of a child to that child's adoption. The consent can be withdrawn at any time up and until an adoption order is made.
- The agreement of a court under a **Placement Order**.
- Prospective adoptive parents initially gain shared Parental Responsibility with the local authority and the birth parents and the child remains CLA until the **Adoption Order** is made final.

The **Adoption Order** severs all legal ties with the birth family and confers parental rights and responsibilities on the new adoptive family. The birth parents no longer have any legal rights over the child and they are not entitled to claim the child back.

When a child is adopted a new NHS number is created; this goes to Child Health and Practices are informed. The GP will not have access to the child's old notes but will have access to the Adoption Medical Report.

Private Fostering

Private fostering is when a child or young person under 16 years old (or under 18 if disabled) goes to live with someone for 28 days or more by private arrangement (without the involvement of a local authority) with someone who is **not** their parent, guardian or close relative (a close relative may be a brother, sister, half-sibling, aunt, uncle, grandparent or step parent).

The following are examples of typical Private Fostering arrangements:

- A child from overseas staying with a host family while attending a language school or overseas students at boarding school who stay with a host family during the holidays.
- A teenager living with a friend's family because they don't get on with their own family.
- Children living with a friend's family because their parents' study or work involves unsociable hours, which make it difficult to use ordinary day care or after-school care.

- Children staying with another family because their parents have separated or divorced.

If a family is caring for a child through private fostering, or has made private fostering arrangement for their own child, The Children Act 1989 sets out their duty to notify the local authority so that the arrangement can be assessed to ensure it provides a safe environment for the child and all care needs are met.

Families who have an established private fostering arrangement but were unaware of their duty to let the local authority know should not worry about any legal action if they have acted in good faith.

Families can call their local Children's Services to make a notification or ask for advice if they are unsure whether or not what they are doing is private fostering.

It is all professional's duty to inform Children Services (CS) if they are made aware of a private fostering arrangement and advice to adult carer that it is also their duty to inform CS too.

9. Key Contacts

BSW ICB Commissioned CLA Health Teams:
BaNES- vcl.bathneslachealthteam@nhs.net
Swindon-The CLA Health Team - 01793464334
Wiltshire-The LAC Admin Team on 01225 618834 or Looked after Children's Nursing Team on 01225 618753.

The BSW ICB Designated Doctors and Nurses to support Primary Care with CLA
BaNES, Swindon and Wiltshire
bswicb.clahealthteamdes@nhs.net

Children's Social Care
BaNES Tel: 01225 396 312/13
Swindon Tel: 01793 466903
Wiltshire Tel: 0300 456 0108

CAMHS
Website- Oxford Health CAMHS | Child and Adolescent Mental Health ServiceOxford Health CAMHS

BaNES CAMHS- contact details are 01865 903889
Wiltshire CAMHS- contact Wiltshire Single Point of Access 01865 903330
Swindon CAMHS- contact point would be TaMHS 01793 463177

10. Full Web Links

Department of Education / Department of Health, Promoting the health and wellbeing of looked-after children: statutory guidance for local authorities, clinical commissioning groups and NHS England (2015). Accessed at:
Promoting the health and wellbeing of looked-after children - GOV.UK (www.gov.uk)

NICE Guidance: Looked After Children and Young People PH 28
Accessed at:
http://www.nice.org.uk/guidance/PH28

Overview | Looked-after children and young people | Guidance | NICE 2020

RCGP / NSPCC Safeguarding Children & Young People Toolkit for General Practice
Accessed at https://www.childhelplineinternational.org/wp-content/uploads/2017/11/RCGP-NSPCC-Safeguarding-Children-Toolkit.pdf

RCPCH / RCN Looked After Children: Knowledge, Skills and Competencies of Healthcare Staff Intercollegiate Guidance (2020.
Accessed at:
https://www.rcn.org.uk/professional-development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486

The author wishes to acknowledge the Ipswich and East Suffolk and West Suffolk Clinical Commissioning Groups for the use of their original document from 2015 in the development of this resource pack.

11. Appendices:

Quiz: Who can give Consent?
This quiz **alongside reading this document** can be considered as part of CPD in the CLA requirements as outlined by the intercollegiate document 2020

Answer these 10 questions:

1. Joanne takes her son Peter, aged 8 weeks to her GP for his first immunisations. Joanne is aged 15 years is Looked After under S20, Children Act 1989. Joanne and Peter are accompanied by Joanne's foster carer.

Answer:
_____

2. Michael is aged 16 years; he lives in a residential school for young people who have severe learning difficulties. He has been Looked After under S20 since he was 12 years old. He requires dental extractions under anaesthetic.

Answer:
_____

3. Tracy has had several sore throats and earaches and has been put on the waiting list for adeno-tonsillectomy and grommets. She is 7 years old and has been under a Care Order since she was 3 years old.

Answer:
_____

4. Philippa has brought Sian to the surgery for her pre-school immunisations. Philippa is planning to adopt Sian who is placed with her and her husband under a Placement Order.

Answer:
_____

5. Chantelle's grandmother takes her to the dentist as she is complaining of toothache. The dentist says Chantelle needs to have antibiotics and then a filling. Chantelle is cared for by her grandmother who has obtained a Special Guardianship Order.

Answer:

_____

6. Jack is brought to Accident and Emergency having been in a rough scrum during a rugby game at school where he lost consciousness briefly. X-rays indicate he has a broken arm and needs internal fixation. He is aged 14 years and is Looked After under an Interim Care Order.

Answer:

_____

7. Julia attends her local sexual health clinic for emergency contraception. She is aged 15 years and is Looked After under S20.

Answer:

_____

8. Matthew, foster carer, takes David to the opticians for an eye test. David is 5 years old and is subject to an Emergency Protection Order.

Answer:

_____

9. Tony, aged 10 years receives respite care as he has physical disabilities. He needs surgery to correct a spinal problem.

Answer:

_____

10. Denise is 17 years old and about to start an animal husbandry course at agricultural college. She missed out on her school leaver immunisations and now needs them before she can start the course. Denise has been in care most of her life under a Care Order.

Answer:

_____