Children and Young People Committee

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Committee Inquiry into arrangements for the placement of children into care on Wales

Submission from Dr Carolyn Sampeys

Background

I am the Named Doctor for Adoption, Fostering and Looked After Children for Cardiff and Vale University Health Board. I have been a Community Paediatrician for 21 years and in my current post for 13 years. My role includes the responsibility for managing the health provision for Looked after Children in Cardiff and the Vale of Glamorgan, those placed out of county and children placed within our area from other counties.

I have developed two specialist teams which provide nurse-led health assessments and support to Looked after children, their carers and social workers (Children First Teams). Our specialist nurses are able to work very flexibly, arranging to see the children wherever and whenever is most convenient for them. They work as part of a Community Paediatric team managed by myself. The Cardiff team has been in operation for 8 years, the Vale team for 7 years. The Welsh Assembly Government Children First Programme was the catalyst for developing these teams in close partnership with Cardiff and the Vale of Glamorgan local authorities.

Unfortunately there have been inter-agency funding issues which have led to a reduction in service in the Vale and the inability to further develop the Cardiff CF team to ensure every Looked after child has a named nurse.

Our teams have remained constant, with only one change in personnel in the last 8 years. This means that there has been continuity for young people, many of whom have experienced changes of carer, social worker and school. The nurses are a committed and highly valued resource by local authorities, carers and most importantly the children and young people with whom they work.

Following a base-line audit, we have demonstrated, in yearly reports, a sustained increase in uptake of health assessments for our Looked after children (over 90%) which in turn means an increased interface with health and an expectation of improved health outcomes for these children and young people. Immunisation rates and registration with GP and Dentist are all better than in the general population. Our ultimate aim is for care leavers to be confident in accessing health care with an increased awareness of the importance of being healthy.

Disappointingly there are not enough specialist nurses across Wales to adequately provide health input to all the Looked after children and young people who need it. I remain convinced that there should be a Community Paediatrician with responsibility for Looked after Children in each Trust area which may cover one or more local authorities. This needs to be adequately resourced. The Named Community Paediatrician should manage a multi- disciplinary team which includes specialist nurses. It is important that the youngest Looked after children (under 5 years) are seen by a Community Paediatrician who can carry out a developmental assessment and that a Community Paediatrician is available to see any other children the Specialist nurse feels require their input.

Children who are placed out of county fare the worst as a result of the lack of specialist nurse provision across Wales as they are likely to receive a second rate service such as an appointment with a GP or a Paediatrician in a clinic setting.

On a National level I chair the BAAF (British Association of Adoption and Fostering) Welsh Medical Group for Paediatricians/Medical Advisers across Wales who have a special interest in Adoption, Fostering and Looked after children. We liaise closely with Specialist nurses for Looked after children across Wales who meet independently of the medical group which serves their needs at present.

I chair the all-Wales Looked After Children's Health Exchange (LACHE) which was initially set up to advise WAG on the health needs of Looked after children. The LACHE were tasked with developing statutory guidance on promoting the health and well-being of Looked after children (similar to the guidance issued by DFES in England). The WAG debate which led to "Towards a Stable Life and a Brighter Future" halted work on this guidance as the LACHE advised WAG on the amendments to the Regulations. The role of Specialist nurses for Looked after children was recognised in the amended Regulations. The LACHE , hosted by Children in Wales, still feels statutory guidance would be helpful to practitioners within health and partner agencies and it remains on our agenda as a piece of work "in waiting".

I am vice-chair of BAAF UK's Health Group which ensures I keep abreast of developments across the UK and promote Wales at every opportunity.

The views expressed below in response to the consultation questions have been collated from colleagues locally and across Wales where possible.

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" Response to Consultation Questions

1. In determining whether and where to place a child into care, a social worker will need an accurate picture of a child's needs and circumstances, which may require them to have information from a range of local services- health services, social services, etc. who may also have to consider their responsibilities towards confidentiality. To what extent is information about a child's needs effectively shared with decision makers, and do you have any examples of good practice in such inter-agency communications? Is there a clear understanding of who is ultimately accountable for decisions about a child's care?

In practice, the majority of children are placed into or moved within care in Wales without true inter-agency consultation or communication. Ideally there should have been a core assessment prior to a child entering care. Some, but not all, local authorities offer a multi-agency Placement Panel to decide whether or not a proposed placement out of area meets the child's social, educational and health needs. In practice most cases are discussed retrospectively. Child and Adolescent Mental Health Services (CAMHS) are not uniform across Wales and it is vitally important if a child is in need of CAMHS input that their foster placement is in an area where this is available.

Social workers don't always share information about a child's pre-care experiences in any referral to health which may impact on health staff being able to address their needs appropriately.

For a child already in care, the best opportunity to discuss a proposed placement move with various professionals and the child or young person is at a statutory Review chaired by an Independent Reviewing Officer (IRO).

2. To what extent does the Children's Commissioning Support Resource Database provide sufficient information about child placements, and to what extent is the database currently utilised? How could the database be better utilised?

I am aware that local authorities need to satisfy themselves that an identified placement is able to provide all the services advertised. Perhaps there should be independent inspection of the available placements when listed on the CCSR.

3. Information about a child's needs and circumstances will be needed by fostering agencies and foster carers in order to appropriately conduct risk assessments, provide for a child's needs, etc. To what extent is appropriate information normally provided to fostering agencies and foster carers, and how could such communication be improved? Does the commissioning system enable or inhibit the provision of information to prospective fostering agencies and carers, and do you have any examples of good practice in the provision of information to fostering agencies and/or foster carers?

It is always advisable for information to be shared with foster carers so that they may appropriately care for the children placed with them. However, I am aware that carers sometimes inform my colleagues that they have been given no information about a child's health or pre-care experiences (such as sexual abuse) by the social worker prior to placement.

4. To what extent are placements planned out? Is there clarity over whether placements will be for a short period of time, whether it may eventually lead to adoption, etc.? Can you provide any examples of good practice in the planning of foster placements?

Unfortunately, across Wales, there is little evidence that placements are routinely "planned". Children are usually placed where there is a vacancy, which can lead to a further placement breakdown and harm to the Looked after child involved. There are frequently emergency short term placements provided. How long is "short term"? Some Looked after children move into a short term placement and remain there for months or years. Change of General Practitioner or school may not therefore happen appropriately. Children and their carers are often unclear as to where the placement may lead, which can be very unsettling. In Adoption the plan is usually clearer, although some children may move to a family placement or long term foster care as further information becomes available.

5. To what extent are the risks of foster placements explained to foster carers?

This is done to a limited extent which makes it very difficult for carers to care appropriately.

6. To what extent do children and young people participate in their own placements' process?

If a child has a significant need or behaviour this is sometimes taken in to account. For a child who has more subtle requests or needs - such as being in a placement with a family who enjoy sport or art or with similarly aged children- this may not be given sufficient weight. The Independent Review system should be able to ensure the child's voice is heard in all decisions affecting them. In some areas in Wales, advocates fro Looked after children and young people are not routinely provided.

7. To what extent do you consider that a child's social worker remain engaged in their care, once they have gone into a foster placement? For example, who is responsible for initially liaising with schools? Are foster carers given sufficient flexibility and autonomy to care for their children, without bureaucratic impediment?

If there are no problems with a placement, social workers may not have a great deal of involvement. The same is true if it is a placement with relatives. Flexibility and autonomy for foster carers varies widely. Foster carers need clarity about those things they can or cannot consent to with pre- arranged consent. There can be issues about consent for school trips which causes difficulties for the child or young person involved. Often carers are left to liaise with school initially, but the responsibility for developing a Personal Education Plan with the school remains with the social worker. Basic consent for immunisations, health assessments and emergency health care will have been obtained from birth family and it is important that this is disseminated appropriately

8. To what extent are placements of children into care qualitatively reviewed? Can you provide any examples of placements being given a cost-benefit analysis for example?

I have not been made aware of any qualitative reviewing of placements.

9. Are there any further comments you'd like to make about the placement of children into care? Are there any specific recommendations you would suggest the Committee makes to the Welsh Assembly Government.

Specialist nurses **for Looked after children have made an enormous contribution to the health and well-being of Looked after children and young people in Wales and have contributed to placement stability. It is vital that all Looked after children should have access to a named nurse to help meet their health needs, provide statutory health assessments, support and health promotion and to advise their carers and social workers. They can appropriately advocate for individual children and young people and should be involved in any placement decision. Guidance (and resources) from WAG on the importance of appointing sufficient specialist nurses for Looked after children would greatly help the development of Wales- wide coverage.**

Foster carers **are a wonderful resource and they care for our most vulnerable children. They need appropriate and adequate training to be firmly part of the multi-agency team. This important role needs to be valued and enhanced to encourage recruitment and retention of foster carers in Wales. There should be a range of quality placements available for Looked after children and young people.**

Multi-agency working **is essential to improve the outcomes for children placed in care in Wales. Although locally we developed a multi-agency Team with Children First funding initially, when ring-fenced funding was discontinued the multi-agency element was lost despite evidence of its success. Information sharing across agencies can be problematic with different databases and IT systems and differing views on confidentiality. A more seamless service for Looked after children could be provided if a shared database was developed. WAG guidance on promoting the development of shared or communicative IT systems would be helpful.**