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**MODEL JOB DESCRIPTIONS
AND COMPETENCIES
FOR MEDICAL ADVISERS
IN ADOPTION AND FOSTERING**

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MODEL JOB DESCRIPTIONS AND COMPETENCIES FOR MEDICAL ADVISERS IN ADOPTION AND FOSTERING

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INTRODUCTION

The following three job descriptions are designed to provide a flexible template for doctors working with adoption and fostering agencies and engaged in promoting the health and wellbeing of children in public care. The need for such templates has been clearly articulated by our membership to support their specialist role, as the nature of children in need of public care has become increasingly complex. They have been designed by a working group of the Health Group Advisory Committee of the British Association for Adoption and Fostering, all of whom have long experience as clinicians working in this area. Consultation feedback actively sought from a range of interested bodies, regional groups and individual members has helped shape their development.

The job descriptions have, as far as possible, been drafted to reflect the variations in nomenclature and regulations in the different countries and to encompass the different roles, both strategic and service delivery. We are aware that there is local variation in both the scope and scale of these posts, and individuals are encouraged to adapt the job descriptions to reflect local requirements. Importantly they are not prescriptive documents. The nature of this work is such that an individual clinical case can require considerable research and medical time. This is sometimes a puzzle to commissioners who measure output by numbers of children seen or 'episodes of care'. To reflect this we have provided guideline time allocations to individual clinical tasks: these items of work are based on the BAAF health assessment model, which was designed to reflect statutory requirements, and the Department of Health recommendations for health assessment (*Promoting the health of looked after children*, England, DH 2002). It is important to note that these were derived from prospective diary recording by the committee members and were endorsed on consultation. They are therefore believed to be realistic rather than aspirational.

To accompany the job descriptions we have developed competencies for practitioners working in this field. They are designed to be consistent with and build on Higher Specialist Training competencies in 'Child Protection and Children in Special Circumstances (social paediatrics)' issued by the Royal College of Paediatrics and Child Health (*A Framework of Competencies for Higher Specialist Training in Paediatrics*, October 2005). As well as informing the personal specification of new appointments they should provide a template to guide continued professional development for doctors in post.

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MODEL JOB DESCRIPTION ONE

DESIGNATED DOCTOR FOR LOOKED AFTER CHILDREN (England)

DESIGNATED DOCTOR FOR LOOKED AFTER CHILDREN (Northern Ireland) ¹

**LEAD CLINICIAN FOR LOOKED AFTER AND ACCOMMODATED CHILDREN
(Scotland)**

NAMED DOCTOR FOR LOOKED AFTER CHILDREN STRATEGIC ROLE (Wales) ²

Throughout this job description where the term “Designated Doctor” is used this applies to all the posts named above.

The 2002 Department of Health guidance *Promoting the health of looked after children* (due to be revised in 2008) and 2007 draft guidance for Wales *Looking after health* recommends that all provider trusts should have a doctor with strategic responsibility, who is fully registered with the GMC and has had an enhanced CRB check. Although there is no such specific guidance in Northern Ireland or Scotland, it would be good practice for providers to appoint such a doctor, who is fully registered with the GMC and has had an Enhanced Disclosure Check from Access NI, or an enhanced Disclosure Scotland check.

It is acknowledged that this job description is embedded within a multi-disciplinary system, the aim of which is to provide an integrated service for a very vulnerable group of children. Since there is considerable regional, geographic and local variability in arrangements across the UK, this job description will need to be tailored to the demands of the particular post.³

This job description should be jointly agreed by the relevant local commissioning and providing bodies. Throughout this job description where the term “looked after children” is used, this applies to children currently being looked after and accommodated by local authorities/Health and Social Care Trusts, including unaccompanied asylum seeking children and those for whom the care plan is adoption.

¹ Given the different structures and the changes evolving under the Review of Public Administration in Northern Ireland, this is an interim title for this role in Northern Ireland.

² In Wales, the Designated Doctor appointed by the National Public Health Services provides strategic professional advice to the Welsh Assembly Government and to the Local Health Boards as the commissioners of health services in Wales. They may not have any operational or clinical responsibilities with regard to looked after children. Job descriptions for these posts are locally agreed in Wales.

³ Given the different structures and the changes evolving under the Review of Public Administration in Northern Ireland, agencies may wish to modify the job description to meet local needs.

The key principles and relevant practices which form the foundation of this post are detailed in various statute, regulations and guidance for each country, which are listed in the Appendix, along with useful references.

A. PERSON SPECIFICATION

The designated doctor for looked after children should:

1. Be an advocate for all looked after children.
2. Hold consultant status or equivalent, in a health provider organisation (preferably but not necessarily a Consultant Community Paediatrician).
3. Have undergone higher professional training in paediatrics. Alternatively, by virtue of experience and practice, have demonstrated appropriate competencies.
4. Have relevant experience in the clinical management of children including those with neuro-developmental, emotional, behavioural and attachment difficulties, child protection, and adult health issues pertinent to parenting.
5. Have substantial clinical experience of the health needs of looked after children and ideally should have experience of working as a medical adviser to an adoption and/or fostering agency.
6. Have substantial knowledge of medico-legal issues relating to looked after children and the law applying to children in the court process.
7. Have good negotiating and leadership skills and experience of multi-agency working at local and regional level.
8. Have good verbal and written communication skills, with an ability to express complex medical issues in lay terms.

B. CLINICAL ROLE

The designated doctor should ideally be clinically active in the field of looked after children. If not clinically active they should have had considerable past clinical experience in paediatrics and have kept up to date with community paediatric issues. The clinical role should be separately encompassed within the job description.

C. DUTIES AND RESPONSIBILITIES

These should be appropriately agreed and allocated with other relevant health professionals (e.g. designated nurse for looked after children) in the locality.

1. Advisory Role

- a) Provide advice to local health providers on questions of planning, strategy, performance monitoring and audit in relation to health services for looked after children.
- b) Ensure that expert health advice on looked after children, including on issues of medical confidentiality, consent and information sharing, is available to colleagues in health and social services.
- c) Advise and assist local commissioning bodies in fulfilling their responsibilities to improve the health of looked after children. In Wales this role is primarily fulfilled by the Designated Doctor.
- d) Advise the Strategic Health Authority (and the Designated Doctor in Wales) by whichever system is in place on deficiencies, priorities and areas of risk across the locality
- e) Ensure that appropriate policy on training is in place locally for all health personnel in relevant areas concerning looked after children.

2. Policy and procedure

- a) Ensure robust clinical governance of local NHS services for looked after children.
- b) Develop and review policies and procedures relevant to the health care of looked after children, including implementation of new government recommendations, and ensure those providing healthcare to looked after children are aware of and implement local policies and procedures.
- c) Contribute to local children's plans, and attend relevant strategic meetings.

3. Liaison

- a) Liaise with, advise and support local Named Doctors and health professionals working with looked after children.
- b) Advise and work collaboratively with statutory and non- statutory agencies on health policy relevant to looked after children.
- c) Liaise with children's services and other health providers on policy for health care provision for children placed out of area.
- d) Liaise with relevant specialist health services (e.g. mental health, sexual health) concerning planning and strategic issues.

4. Monitoring and information management

- a) Ensure that health assessments are carried out and health care plans implemented to the appropriate standard.

- b) Provide an analysis of the health inequalities and health needs for local looked after children.
- c) Ensure an effective system of audit is in place.
- d) Ensure that the views of looked after children and young people are informing the design and delivery of their local health services.

5. Annual report

- a) Ensure that an annual report on the effectiveness of health services for looked after children is produced. This report should be made available, for monitoring purposes, to health providers and commissioners, the Director of Children's Services, or the Director of Social Work Services or Chief Social Work Officer and to the Strategic Health Authority and NPHS Wales.

6. Training and supervision

- a) Ensure that health professionals working with looked after children are appropriately trained.
- b) Participate as appropriate in local undergraduate and postgraduate paediatric training, to ensure that the health of looked after children is promoted.
- c) Ensure appropriate clinical supervision is available for all health professionals working with looked after children.

D. PERSONAL DEVELOPMENT

- 1. The designated doctor will attend relevant regional and national Continuing Professional Development (CPD) activities, equivalent to at least 10 CPD hours per year, in order to maintain up-to-date skills in the area. It is the responsibility of the employer to support specialist training, which is likely to be external.
- 2. The designated doctor will have a responsibility to maintain up to date knowledge in areas specific to looked after children e.g. mental health issues, blood borne viruses, substance misuse.
- 3. The designated doctor should be part of a regional network of doctors working with looked after children, child protection and safeguarding.

E. APPRAISAL

- 1. The designated doctor should have a professional appraisal on an annual basis. Ideally reference should be made to someone with specialist knowledge of looked after children.

2. Designated professionals will be performance managed in relation to their designated functions by the relevant local commissioning body.

F. ACCOUNTABILITY

1. The Designated Doctor is responsible to, and accountable within, the managerial framework of their employing body, and should also report within a local safeguarding framework.
2. The Designated Doctor is accountable to the Chief Executive of the employing body,
i.e. England and Wales: Chief Executive of the employing Trust
i.e. Northern Ireland: this will need to be determined following the Review of Public Administration
i.e. Scotland: Chief Executive of the NHS Health Board.

G. AUTHORITY

The Designated Doctor should have the authority to carry out all the above duties on behalf of the employing trusts, and be supported in so doing by others (e.g. doctors, nurses, administration).

H. RESOURCES REQUIRED FOR POST

The post holder will need to negotiate the following with the employing body:

1. A sessional time commitment for the post. The number of sessions will depend on local factors including the size and number of local authorities and health providers, the size of the local health team and the number of looked after children. *Health for all children* (Hall 4) estimates that for a population of 100,000 where a local authority and health provider are co-terminus, one designated session per week is recommended as a guide.
2. Adequate and appropriate administrative support for the designated doctor.
3. Adequate resources to deliver training, and at times of additional work e.g. new Regulations.
4. Appropriate support and supervision for the individual. This is an acknowledgement of the stressful nature of this work.

These recommendations have been derived by consensus from consultation with the BAAF Health Group Advisory Committee and regional health groups.

Appointment as Designated Doctor does not in itself signify responsibility for providing all clinical care for looked after children, which should be the subject of separate negotiated agreements with relevant trusts.

MODEL JOB DESCRIPTION TWO

MEDICAL ADVISER TO ADOPTION AGENCY

All Adoption Agencies must have a Medical Adviser (Adoption Agency Regulations 2005 for England; Adoption Agencies (NI) Regulations 1989 for Northern Ireland; Adoption Agencies (Scotland) Regulations 1996; Adoption Agencies (Wales) Regulations 2005) who is fully registered with the GMC and has had an enhanced CRB, an Enhanced Disclosure Check from Access NI or an Enhanced Disclosure Scotland check.

It is acknowledged that this job description is embedded within a multi-disciplinary system, the aim of which is to provide an integrated service for a very vulnerable group of children. Since there is considerable regional, geographic and local variability in arrangements across the UK, this job description will need to be tailored to the demands of the particular post.⁴

This job description should be jointly agreed by the relevant Health Trust(s) / Health Boards / Children's Trust(s) / Adoption Agency(ies) covered by the post. It is important that the job plan reflects the workload, as this is frequently underestimated. Throughout this job description where the term "looked after children" is used this applies to children with a care plan for adoption.

The key principles and relevant practices which form the foundation of this post are detailed in various statute, regulations and guidance for each country, which are listed in the Appendix, along with useful references.

A. PERSON SPECIFICATION

The Medical Adviser (MA) for Adoption must:

1. Be an advocate for children for whom the care plan is adoption.
2. Have undergone higher professional training in paediatrics. Alternatively, by virtue of experience and practice, have demonstrated appropriate competencies as advised by the Designated Doctor for looked after children (England and Northern Ireland) / Lead Clinician for looked after and accommodated children (Scotland) / Named Doctor for looked after children strategic role (Wales) (see relevant job description).
3. Have relevant experience in the clinical management of children including those with neuro-developmental, emotional, behavioural and attachment difficulties, child protection, and adult health issues pertinent to parenting.⁵

⁴ Given the different structures and the changes evolving under the Review of Public Administration in Northern Ireland, agencies may wish to modify the job description to meet local needs.

⁵ The role of Medical Adviser for **Voluntary Adoption Agencies**, who largely recruit adult carers, may be undertaken by a GP with expertise or other registered medical practitioner who has relevant specialist training. However, they should have knowledge and experience of children with very complex needs as these agencies are likely to be recruiting carers for such children.

4. The MA should ideally be involved in clinical work with looked after children. For MAs whose sole role is as medical adviser to panel it is important that they keep up to date with community paediatric practice.
5. Have the ability to achieve other competencies as appropriate to the role. (See section on competencies in this document.)
6. Have experience of, and the ability to work in, a multi-agency setting.
7. Have relevant knowledge of health and developmental issues of children adopted from abroad, if providing intercountry adoption services.
8. Have good verbal and written communication skills, with an ability to express complex medical issues in lay terms.

B. DUTIES AND RESPONSIBILITIES

1. Clinical Role

- a) It is preferred practice, but not obligatory, that the MA should undertake statutory health assessments of looked after children.
- b) The MA should provide a written health report on each child being considered for adoption. This report should include comments on birth history, family history, past medical history, current physical and mental health and behaviour and, if age appropriate, a developmental assessment. This report should assess the future implications for the child of their health history, and previous family and social situation, including their experiences in the care system. (See relevant Regulations for each country in the Appendix.)
- c) The MA should provide a written report to the agency on the health of prospective adopters, which will include interpretation of health and lifestyle information provided by the applicant and their GP. It may be necessary to liaise, with consent, with specialists about details of health problems identified.
- d) It is good practice for the MA to share all appropriate information with prospective adopters and to meet with them to discuss the needs of the child/ren with whom they are matched. It is also good practice to provide a written report of this meeting.
- e) The MA should be available to advise prospective adopters on health matters of children being considered for adoption from abroad, and ideally undertake health assessment of the child.

2. Panel Responsibilities

- a) The MA to the Adoption Panel is a full panel member. She/he has a responsibility to take part in panel consideration of cases and to contribute to the panel recommendation. Responsibilities of all panel members include attending a locally agreed percentage of all

panels, attending panel training and having an annual appraisal as a panel member. The minimum attendance which is usually required at panels is 75% (Effective Panels, BAAF 2005).

- b) As specified in the Adoption Agency Regulations for England and Wales, and the National Minimum Standards, the MA should work in partnership with the adoption agency to ensure that the written summary health report on the child and adult will be available to the agency in time to allow circulation to panel members in advance (e.g. for child, Part C of Form IHA - C/YP).
- c) The MA will be available at panel to discuss their written report and to answer questions on health issues at the request of other panel members.
- d) The MA should contribute to the identification of adoption support needs.
- e) The MA will need to contribute to court reports on children in placement order/freeing order and adoption order applications, and on prospective adopters in adoption applications.

3. Other Professional Responsibilities

The MA for adoption:

- a) Should be available to advise on particular health matters that arise in connection with the adoption process.
- b) Should support and advise other health professionals and relevant managers on health issues relevant to adoption, for example, consent issues for children placed for adoption, and adoption support including post placement.
- c) Should work closely with the local safeguarding and health professionals working with all looked after and accommodated children to ensure delivery of high quality clinical services through monitoring and audit.
- d) Should maintain contact and work closely with local paediatricians, local child and adolescent mental health services, primary care, and other relevant health professionals and specialists.
- e) Should work closely with partner agencies to address the health needs of children who have a care plan for adoption.
- f) May offer training on adoption matters to health personnel, prospective adopters and partner agencies.
- g) Should ensure that personal practice conforms to policies and procedures relevant to adoption, as outlined in statute and professional practice guidelines.

C. TRAINING AND PERSONAL DEVELOPMENT

1. This is a specialist post, and the post holder is likely to be unique within their provider service. Therefore it is essential to maintain contact with other MAs regionally and nationally. Membership of the BAAF Health Group is recommended as it offers professional support, notification of training opportunities, updates on policy and practice and access to national and regional meetings.
2. The MA should attend Continuing Professional Development (CPD) activities in order to maintain competencies in the area, equivalent to at least 10 hours per year, in topics relevant to substitute care. The MA should also attend general panel training to maintain awareness of adoption practice and legislation, including intercountry adoption where dealt with by the agency. It is the responsibility of the employer to support specialist training which is likely to be external.

D. APPRAISAL

1. The MA should have a professional appraisal on an annual basis. Ideally reference should be made to someone with specialist knowledge of adoption, particularly if there are areas of concern, in order to ensure that appraisal of the adoption role is appropriate.
2. MAs to panel in England and Wales will require an annual appraisal as a panel member, as required in statutory Guidance for England (Adoption and Children Act 2002 Guidance Department of Health) and Regulations for Wales (Adoption Agency (Wales) Regulations 2005).

E. ACCOUNTABILITY

Clear lines of accountability must be established within each job description.

F. RESOURCES REQUIRED FOR THE POST

- a) Programmed Activities for the post should be agreed and a corresponding adjustment made to the MA's other clinical duties within the job plan (see Table 1).
- b) Appropriate administrative support for the MA should be agreed, competent to manage the sensitive and specialised nature of the work.
- c) There should be support and supervision for the individual. This is an acknowledgement of the sometimes stressful nature of this work.

TABLE 1**ESTIMATE OF TIME REQUIRED TO CARRY OUT THE DUTIES AND RESPONSIBILITIES OF THE MA FOR ADOPTION**

These recommendations have been derived by consensus from consultation with the BAAF Health Group Advisory Committee and regional health groups, and prospective audit of services. These recommendations reflect the actual time required to undertake specific tasks and should be used as a guide to long term planning for delivery of high quality services.

ACTIVITY	TIME (hours)	Per annum
Scrutiny/review of prospective adopters health assessments (including all research needed, providing advice as required, provision of report)	½ hour per applicant	
Carrying out comprehensive paediatric health and developmental assessments, e.g. Completing Part B of BAAF Form IHA-C or YP	1.5 hours per child	
Collating health information and preparing a report on a child being considered for adoption (including all research needed and answering queries as required) ⁶ e.g. Completing Part C of BAAF Form IHA-C or YP	4 hours per child (not including seeing child – see above)	
Carrying out an adoption review health assessment, e.g. Completing Part B of BAAF Form RHA-C or YP	1 hour per child	
Preparing a report for an adoption review health assessment. e.g. Completing Part C of BAAF Form RHA-C or YP	1 hour per child (not including seeing child – see above)	
Scrutiny of health assessment of child to be adopted from abroad, and counselling of prospective adoptive parents, including provision of written report.	3 hours per child	
Preparation and reading papers for Panel	4 hours per half day panel	
Attending Panel ⁶ (one session)	4 hours per half day panel & travel	
Counselling prospective adopters about individual children, including provision of written report	2 hours per child	

⁶ Arrangements for assessment of children whose care plan is for Special Guardianship or long term fostering, and prospective carers for them, may need to be negotiated.

Training of health professionals and prospective adopters, including preparation	As required	
Miscellaneous additional demands as required, e.g. threatened adoption disruption due to health issues, advising social workers, liaison with designated health professionals	Approximately 2 hours per month	
Monitoring and audit of services, and attendance at team and inter-agency meetings	4 hours per month	
Attendance at regional and national meetings		8 hours per year minimum
Clinical CPD specific to adoption		10 hours per year minimum
Panel training		8 hours per year

N.B.

There may from time to time be other committees and sub-groups that will need attention.

MODEL JOB DESCRIPTION THREE

MEDICAL ADVISER / NAMED DOCTOR FOR LOOKED AFTER CHILDREN

The 2002 Department of Health guidance *Promoting the health of looked after children* (due to be revised in 2008) and 2007 draft guidance for Wales *Looking after health* recommend that all provider trusts should have a Medical Adviser / Named Doctor for Looked After Children, who is fully registered with the GMC and has had an enhanced CRB check. Although there is no such specific guidance in Northern Ireland or Scotland, it would be good practice for providers to appoint such a doctor, who is fully registered with the GMC and has had an Enhanced Disclosure Check from Access NI, or an enhanced Disclosure Scotland check.

It is acknowledged that this job description is embedded within a multi-disciplinary system, the aim of which is to provide an integrated service for a very vulnerable group of children. Since there is considerable regional, geographic and local variability in arrangements across the UK, this job description will need to be tailored to the demands of the particular post.⁷

This job description should be jointly agreed by the relevant Health Trust(s) / Health Boards / Children's Trust(s) / Independent Fostering Providers that will be covered by the post. It is important that the job plan reflects the appropriate workload, as this is frequently underestimated. Throughout this job description where the term "looked after children" is used, this applies to children currently being looked after and accommodated by local authorities, including unaccompanied asylum seeking children and those for whom the care plan is adoption.

The key principles and relevant practices which form the foundation of this post are detailed in various statute, regulations and guidance for each country, which are listed in the Appendix, along with useful references.

A. PERSON SPECIFICATION

The Medical Adviser / Named Doctor (MA / ND) for looked after children must:

1. Be an advocate for looked after children.
2. Have undergone higher professional training in paediatrics. Alternatively, by virtue of experience and practice, have demonstrated appropriate competencies as advised by the Designated Doctor for looked after children (England and Northern Ireland) / Lead Clinician for looked after and accommodated children (Scotland) / Named

⁷ Given the different structures and the changes evolving under the Review of Public Administration in Northern Ireland, agencies may wish to modify the job description to meet local needs.

Doctor for looked after children strategic role (Wales). This role may be undertaken by a GP with expertise or other registered medical practitioner who has had relevant specialist training, and who ideally is working as part of a looked after children team.

3. Have relevant experience in the clinical management of children including those with neuro-developmental, emotional, behavioural and attachment difficulties, child protection, and adult health issues pertinent to parenting.⁸
4. Have the ability to achieve other competencies as appropriate to the role. (See section on competencies in this document.)
5. Have experience of, and the ability to work in, a multi-agency setting.
6. Have good verbal and written communication skills, with an ability to express complex medical issues in lay terms.

B. DUTIES AND RESPONSIBILITIES

1. Clinical Role

The MA / ND for LAC:

- a) Will take an active role, together with relevant colleagues, in assessing and promoting the health and well-being of looked after children. The MA / ND alone may not see all looked after children, but be part of a team of health professionals who do.
- b) Should ensure the provision of a written health report on each child becoming looked after. This report should include comments on birth history, family history, past medical history, current physical and mental health and behaviour and a developmental assessment. The report should address the future implications for the child of their health history, and previous family and social situation, including their experiences in the care system.
- c) Should provide a written report to the agency on the health of prospective carers, which will include interpretation of health and lifestyle information provided by the applicant and their GP. It may be necessary to liaise, with consent, with specialists about details of health problems identified.

⁸ The role of Medical Adviser for **Independent Fostering Providers**, who mainly recruit adult carers, may be undertaken by a GP with expertise or other registered medical practitioner who has relevant specialist training. However, they should have knowledge and experience of children with very complex needs as these agencies are likely to be recruiting carers for such children.

- d) Should be available to advise on particular health matters that arise in connection with looked after children and the permanence process.

2. Other Professional Responsibilities

The MA / ND for LAC:

- a) Should support and advise other health professionals and relevant managers on issues relevant to looked after children, for example, consent, confidentiality and information sharing.
- b) Should work closely with the local safeguarding and looked after children health professionals to ensure delivery of high quality clinical services through monitoring and audit.
- c) Should maintain contact and work closely with local paediatricians, local child and adolescent mental health services, primary care, and other relevant health professionals and specialists.
- d) Should work closely with partner agencies to address the additional specific health needs of looked after children e.g. dental and sexual health.
- e) May offer training on looked after children to health personnel, prospective carers and partner agencies.
- f) Should ensure that personal practice conforms to policies and procedures relevant to looked after children, as outlined in statute and professional practice guidelines.
- g) While this is not obligatory in Regulations, many fostering panels benefit from a health adviser attending panel. This role can be negotiated with the local authority as required.

C. TRAINING AND PERSONAL DEVELOPMENT

- 1. This is a specialist post, and the post holder is likely to be unique within their provider service. Therefore it is essential to maintain contact with other MAs / NDs for looked after children regionally and nationally. Membership of the BAAF Health Group is recommended as it offers professional support, notification of training opportunities, updates on policy and practice, and access to national and regional meetings.
- 2. The MA / ND should attend Continuing Professional Development (CPD) activities in order to maintain competencies in the area, equivalent to at least 10 hours per year, in topics relevant to LAC. It is the responsibility of the employer to support specialist training which is likely to be external.

D. APPRAISAL

1. The MA / ND should have a professional appraisal on an annual basis. Ideally reference should be made to someone with specialist knowledge of looked after children.
2. Although not required by regulation, it may be beneficial for the MA / ND who sits on a fostering panel to undergo an annual appraisal as a panel member.

E. ACCOUNTABILITY

Clear lines of accountability must be established.

F. RESOURCES REQUIRED FOR THE POST

1. Programmed Activities for the post should be agreed and a corresponding adjustment made to the MA / ND's other clinical duties within the job plan (see Table 2).
2. Appropriate administrative support for the MA / ND should be agreed, competent to manage the sensitive and specialised nature of the work.
3. There should be support and supervision for the individual. This is an acknowledgement of the sometimes stressful nature of this work.

TABLE 2**ESTIMATE OF TIME REQUIRED TO CARRY OUT THE DUTIES AND RESPONSIBILITIES OF THE MA / ND FOR LAC**

These recommendations have been derived by consensus from consultation with the BAAF Health Group Advisory Committee and regional health groups, and prospective audit of services. These recommendations reflect the actual time required to undertake specific tasks, and should be used as a guide to long term planning for delivery of high quality services.

ACTIVITY	TIME	Per annum
Scrutiny/review of prospective carer's health assessment (including all research needed, providing advice as required, provision of report)	½ hour per applicant	
Carrying out comprehensive paediatric health and developmental assessments ^{9 10} e.g. Completing Part B of BAAF Form IHA-C or YP	1.5 hours per child	
Collating health information and preparing a report on a child being considered for permanence ¹¹ (including all research needed and answering queries as required) e.g. Completing Part C of BAAF Form IHA-C or YP	4 hours per child (not including seeing child – see above)	
Carrying out a review health assessment, e.g. Completing Part B of BAAF Form RHA-C or YP	1 hour per child	
Preparing a report for a review health assessment. e.g. Completing Part C of BAAF Form RHA-C or YP	1 hour per child (not including seeing child – see above)	
Preparation and reading papers for Panel	4 hours per half day panel	
Attending Panel ¹¹ (one session)	4 hours per half	

⁹ In England, *Promoting the health of looked after children* recommends that initial health assessments should be completed by a physician. In Wales, *Looking after children* allows for initial health assessments to be completed by a physician or specialist nurse for LAC.

¹⁰ Where the post encompasses clinical responsibility for unaccompanied asylum seeking children, additional time will be required to deal with language, culture and specialised health needs, and resources should reflect this.

¹¹ Arrangements for assessment of children whose care plan is for Special Guardianship or long term fostering, and prospective carers for them, may need to be negotiated.

	day panel & travel	
Training of health professionals and prospective carers, including preparation	As required	
Miscellaneous additional demands as required, e.g. threatened placement disruption due to health issues, attending selected statutory reviews, liaison with designated health professionals	2 hours per month (average for LA with 200 CLA)	
Monitoring and audit of services, and attendance at team and inter-agency meetings	4 hours per month	
Attendance at regional and national meetings		8 hours per year minimum
Clinical CPD (specific to LAC) (this may incorporate panel training if relevant)		10 hours per year minimum

N.B.

There may from time to time be other committees and sub-groups that will need attention.

The remaining clinical time should be allocated according to the Trust's responsibility in meeting the needs of children as well as the specific interests and expertise of the individual.

COMPETENCIES

COMPETENCIES FOR PAEDIATRICIANS / PHYSICIANS WORKING IN THE FIELD OF ADOPTION, FOSTERING AND LOOKED AFTER CHILDREN

These competencies build on knowledge, skills and attitudes detailed within the RCPCH document 'A Framework of Competencies for Core Higher Specialist Training in Paediatrics' (October 2005), and in particular the following points:

- have a sound knowledge of consent and parental responsibility in relation to child protection examinations and the health needs of looked after children, and understand the relevance of the child's care status.
- understand the immediate and long-term impact of parental factors on outcomes for children in child protection and children looked after e.g. substance misuse, domestic violence, mental health problems, chronic physical illness.
- understand the long-term implications of becoming looked after e.g. separation, loss, multiple moves, risk of subsequent abuse in care, disrupted education and routine health care.
- understand the health and lifestyle factors of carers/birth parents which may impair the current and future health and well-being of children e.g. smoking, mental health problems, learning difficulties.

A good working knowledge of child protection as outlined in 'A Framework of Competencies for Core Higher Specialist Training in Paediatrics' (October 2005) is essential for this work. Practitioners will require additional skills as outlined in 'Safeguarding Children and Young People: Roles and Competences for Health Care Staff', Intercollegiate Document (April 2006).

These competencies relate to the clinical elements of the designated and named roles and the medical adviser to adoption panels. For any strategic role, additional competencies will be required.

It is acknowledged that a doctor may not have all the following competencies at appointment. Employing Trusts will need to ensure that the appointed doctor receives appropriate training and supervision within their Personal Development Plan (PDP) towards developing these competencies, skills and knowledge. Trusts should ensure that competencies can be met within the team of named and designated professionals. All doctors working in this field should have an annual appraisal specific to this role. Employing trusts should ensure that CPD requirements are resourced.

A. GENERAL COMPETENCIES

Knowledge

1. Understand in detail the factors that promote child health and development.
2. Be aware of how one's own beliefs, experiences and attitudes might influence professional involvement in adoption and fostering work.
3. Understand the complexity of health care provision for looked after children and the resources required to provide a high quality comprehensive health service.

Skills

4. Be able to communicate with traumatised children and to understand the child's or young person's viewpoint. It is important to recognise that this may be a challenging process.
5. Be able to understand the unique needs of the child in the care system and be able to advocate for these needs.
6. Be able to act as a full participating local authority panel member being aware of the ways one's own beliefs, experiences and attitudes might influence decision making.
7. Be able to advise the employing provider organisation and the service commissioners of the complexity of the work, and specifically of the time & resources necessary for coordinating a high quality comprehensive assessment and subsequent report writing.

Criteria for assessment

Be able to demonstrate:

- an in depth knowledge of the factors that promote child health and development.
- sensitive and effective communication with traumatised children.
- understanding of the child's or young person's viewpoint.
- understanding of the unique needs of the child in the care system, and advocate for these needs.
- awareness of the potential impact of one's own beliefs, experiences and attitudes on professional involvement in adoption and fostering work.
- effective participation as a panel member where applicable.
- effective advisory role to the employing provider organisation and service commissioners concerning the resources required to deliver a high quality service.

B. THE CHILD

Knowledge

1. Understand the long term consequences of early trauma and loss, including the impact on the child of:
 - Disrupted health care including failure to access routine health promotion and immunisations
 - adverse factors in the antenatal period and in early childhood
 - poor parenting
 - separation from birth family including siblings
 - multiple carers
 - disrupted attachment
 - contact with birth family
 - disrupted education
2. Understand the importance of safeguarding children who frequently come from a background of abuse and neglect, and might be more vulnerable to abuse because of separation from the birth family.
3. Understand the needs of specific groups of looked after children, for example children with a disability, refugee and asylum seekers, minority ethnic groups and adolescents, as well as inter country adoptees.
4. Understand the importance to a child of their personal and family health history to their future emotional well-being.

Skills

5. Be able to undertake a comprehensive health assessment of a looked after child, including physical, emotional and social development, sexual health and lifestyle issues, in light of the above factors.
6. Be able to formulate a comprehensive individual health care plan.
7. Be able to provide a written health report on each child being considered for adoption. This report should include comments on birth history, family history, past medical history, current physical and mental health and behaviour and, if age appropriate, a developmental assessment. This report should assess the future implications for the child of their health history and previous family and social situation, including their experiences in the care system.
8. Be able to effectively communicate with social workers, prospective adopters and foster carers, providing clear written advice about the impact and meaning of all of the above factors.

9. Be able to provide advice to local authority adoption and fostering panels.
10. Be able to provide post placement support and advice with regard to the health needs of children placed locally and out of area.
11. Be able to interpret new health information in the birth family, which comes to light after placement, e.g. genetic information, and advise on management of this new information.
12. Be able to work with and support other professionals, working alongside the agency, to ensure appropriate review and implementation of the Health Care Plan.

Criteria for assessment

Be able to demonstrate:

- in depth awareness of the long term consequences of early trauma and loss.
- ways of safeguarding children within the care system.
- awareness of the needs of specific groups of looked after children.
- a comprehensive health assessment of a looked after child, appropriate to their background and situation.
- preparation of a written health report which meets statutory requirements, on each child being considered for adoption.
- effective communication with social workers, prospective adopters and foster carers.
- awareness of provision for post placement support.
- Giving advice on the health needs of children placed locally and out of area.
- identification and management of new health information in the birth family.
- effective consultation with health care and other professionals and participation in interdisciplinary discussions.

C. BIRTH FAMILY

Knowledge

1. Understand the implications of genetic disorders in the birth family and their impact on child health and development.
2. Understand the implications for a child of adverse factors in the antenatal period including poor diet, failure to access antenatal care, exposure to tobacco, drugs, alcohol and blood-borne infections, etc.
3. Understand the implications of parental mental and physical ill health and learning disability for a child.

4. Understand the short and long term impact of parental lifestyle, including domestic violence and substance misuse, on child health and development.

Skills

5. Be able to engage with birth parents in the best interests of the child.

Criteria for assessment

Be able to demonstrate:

- effective engagement with birth parents in the best interests of the child.
- advanced knowledge of the implications for the child of genetic conditions, parental mental and physical ill health and learning disability, adverse factors in the antenatal period, and birth family lifestyle issues.

D. PROSPECTIVE ADULT CARERS (ADOPTION, FOSTERING AND KINSHIP CARE)

Knowledge

1. Understand the impact of adult health (physical, mental and emotional) and lifestyle on parenting.
2. Understand equal opportunities and the diverse nature of carers needed to provide parenting for children in the care system, and appreciate the challenging and complex nature of the task undertaken.

Skills

3. Be able to work with GPs and specialists in the interpretation of health reports on prospective carers prior to approval and for subsequent reviews. This may involve obtaining comprehensive and detailed information on particular aspects of an applicant's health. This will require specific consent.
4. Be able to analyse and evaluate information and evidence to give social workers and panels clear advice about any health or life styles issues relating to prospective carers that may impair their parenting skills now or in the future.
5. Be able to provide a written summary of the state of health of prospective adopters (depending on national Regulations). This report should include comments on family health , infertility or obstetric history as appropriate, past and current health, any concerns re use of alcohol, tobacco or habit-forming drugs, and assess any implications for parenting a looked after child.
6. Be able to teach and train non-health professionals in preparation groups.

Criteria for assessment

Be able to demonstrate:

- awareness of the impact of adult health and lifestyle issues on parenting.
- awareness of equal opportunities, the diverse nature of carers required, and the complex and challenging parenting task undertaken by carers.
- effective communication and consultation with GPs and specialists / other health professionals.
- appropriate analysis and evaluation of health and lifestyle information which may impact on parenting ability.
- preparation of a written health report, which meets statutory requirements, on prospective adopters.
- effective communication as an adviser to agencies and panels.
- effective training of non-health professionals in preparation groups.

E. MULTI-AGENCY WORKING

Knowledge

1. Understand each agency's role and responsibilities within local policies and procedures, and the importance of working in partnership.
2. Have a sound knowledge of local health services and where to obtain additional services for looked after children, including those placed out of area.

Skills

3. Be able to provide clear advice to adoption and/or fostering panel members on the health needs of the child.
4. Be able to provide clear advice to adoption/fostering panel members of any life-style and health issues in prospective carers relevant to parenting
5. Be able to work directly with children's social workers, foster carers, adopters and birth parents.

Criteria for assessment

Be able to demonstrate:

- in depth knowledge of each agency's role and responsibilities within local policies and procedures.
- effective communication and a good working relationship with health and social care professionals, panels, birth families and prospective carers.

- taking an advisory role concerning health needs of the child, and any life-style and health issues in prospective carers relevant to parenting.

F. CONSENT, CONFIDENTIALITY AND LEGAL

Knowledge

1. Understand parental responsibility/ies, consent, confidentiality and information sharing issues specific to adoption and fostering.
2. Understand the legal framework and court processes which underpin adoption and fostering in the UK.

Criteria for assessment

Be able to demonstrate:

- in depth knowledge of parental responsibility/ies, consent, confidentiality and information sharing issues specific to adoption and fostering.
- awareness of the legal framework and court processes which underpin adoption and fostering in the UK.

G. PROFESSIONAL DEVELOPMENT / TRAINING

Knowledge

1. Understanding of the importance of avoiding professional isolation by networking with other medical advisers and joining appropriate professional organisations and regional support groups.

Criteria for assessment

Be able to demonstrate:

- evidence of adequate and appropriate CPD.

APPENDIX

A. ENGLAND

Primary Legislation

Children Act 1989
Data Protection Act 1998
Human Rights Act 1998
Adoption and Children Act 2002
Care Standards Act 2000

Secondary Legislation

The Arrangements for Placement of Children (General) Regulations 1991 (SI 1991/890)
The Review of Children's Cases Regulations 1991 (SI 1991/895)
Children's Homes Regulations 2001 (SI 2001/3067)
Fostering Services Regulations 2002 (SI2002/57)
Adoption Agencies Regulations 2005 (SI 2005/389)
Special Guardianship Regulations 2005 (SI 2005/1109)
Family Procedure (Adoption Rules) 2005 (SI 2005/2795) (in particular, Practice Direction, Reports by adoption agency or local authority, supplement to rule 29(3))

Minimum Standards

National Minimum Standards for Fostering Services, March 2002
National Minimum Standards for Adoption, 2003
National Minimum Standards for Children's Homes, 2002

Government Policy

Care Matters: Transforming the lives of children and young people in care, DfES 2006

Guidance

The general principles of the Framework for the Assessment of Children in Need, National Service Framework for Children and Every Child Matters Working Together, HM Government 2006
Adoption and Children Act 2002 Guidance, DH 2005
Promoting the health of looked after children, DH 2002

Useful reference books, relevant policy and procedure documents

Effective Fostering Panels: Guidance on regulations, process and good practice in fostering panels in England, Borthwick and Lord, BAAF 2007

Effective Panels: Guidance on regulations, process and good practice in adoption and permanence panels, Lord and Cullen, BAAF 2005

BAAF Practice Note 23: *Consent to Medical Treatment for Children*, BAAF 1991

B. NORTHERN IRELAND

Primary Legislation

Data Protection Act 1998

Human Rights Act 1998

Children (NI) Order 1995

Adoption (NI) Order 1987

Adoption Intercountry Aspects Act (NI) 2001

Secondary Legislation

Adoption Agencies (NI) Regulations 1989

The Arrangement for Placement of Children (General) Regulations (NI) 1996

The Foster Placement (Children) Regulations (NI) 1996

Adoption of Children from Overseas Regulations (NI) 2002

Family Proceedings (Amendment) Rules (NI) 2003

Children's Homes (NI) Regulations 2005

Guidance

Children Order Regulations and Guidance

- Volume 3 – Family Placements and Private Fostering
- Volume 4 – Residential Care

DHSSPS Guidance – Co-operating to Safeguard Children, May 2003

UK National Standards for Foster Care

Useful reference books, relevant policy and procedure documents

Adoption Regional Policy & Procedures, June 2006

Area Child Protection Committees' Regional Policy & Procedures, April 2005

C. SCOTLAND

Primary Legislation

Adoption (Scotland) Act 1978
Data Protection Act 1998
Human Rights Act 1998
Children (Scotland) Act 1995
Regulation of Care (Scotland) Act 2001
Adoption and Children (Scotland) Act 2007

N.B. When the 2007 Act comes into force in 2009, the 1978 Act will be repealed. There will also be replacement regulations for the four sets of 1996 ones listed below and new Guidance from the Scottish Government for adoption and for Looked After Children and Fostering. The National Care Standards for Adoption and for Fostering will need to be amended.

Secondary Legislation, Statutory Instruments

Arrangements to Look After Children (Scotland) Regulations 1996, S.I. 1996/3262
Fostering of Children (Scotland) Regulations 1996, S.I. 1996/3263
Adoption Agencies (Scotland) Regulations 1996, S.I. 1996/3266
Residential Establishments – Child Care (Scotland) Regulations 1996, S.I.1996/3256
Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, S.S.I.2002/114
Regulation of Care (Requirements as to Care Services) (Scotland) Amendment Regulations 2003, S.S.I. 2003/149

Guidance

The Scottish Office, *Scotland's Children: The Children (Scotland) Act 1995, Regulations and Guidance:*

- Volume 1: *Support and Protection for Children and their Families*
- Volume 2: *Children Looked After by Local Authorities*
- Volume 3: *Adoption and Parental Responsibilities Orders*

all Edinburgh, HMSO 1997. These are available on the Scottish Government's website, www.scotland.gov.uk under Publications, Care and Social Work, 12 October 2004.

National Care Standards

Foster Care and Family Placement Services, revised March 2005
Adoption Agencies, revised March 2005
Care Homes for Children and Young People, revised September 2005
Short Breaks and Respite Care Services, revised September 2005
These are available on the Care Commission's website: www.carecommission.com and on the Scottish Government's website

Useful reference books, relevant policy and procedure documents

A Guide for Medical Advisers: Advocating, promoting and protecting the health of looked after children in Scotland, Millar with Fursland, BAAF 2006

BAAF Practice Note 38: Consent to Medical Treatment for Children in Scotland, BAAF 1998. This will be revised in 2009 in the light of the implementation of the Adoption and Children (Scotland) Act 2007.

D. WALES

Primary Legislation

Children Act 1989
Data Protection Act 1998
The Human Rights Act 1998
Adoption and Children Act 2002
Children Act 2004

Secondary Legislation

The Fostering Services (Wales) Regs 2003
Adoption Agencies (Wales) Regulations 2005
Special Guardianship (Wales) Regulations 2005
Access to Information (Post-Commencement Adoption) (Wales) Regs 2005
Adoption Support Services (Local Authorities) (Wales) Regulations 2005
The Family Procedure (Adoption) Rules 2005 (including practice directions)
Placement of Children (Wales) Regulations 2007
Review of Children's Cases (Wales) Regulations 2007
Children's Homes (Wales) (Miscellaneous Amendments) Regulations (2007)
The Local Authority Adoption Service (Wales) Regs 2007
Local Health Boards (Functions) (Wales) (Amendment) Regs 2007
The Local Authority (Non-Agency Adoptions) (Wales) Regs 2005
The Adoptions with a Foreign Element Regs 2005

Minimum Standards

National Minimum Standards for Local Authority Adoption Services for Wales 2003
National Minimum Standards for fostering services – Wales 2003

Guidance – Statutory

Guidance to Access to Information (Post-Commencement Adoptions) Wales Regs 2005
Adoption Support Services Guidance Wales 2006
Adoption Agencies (Wales) 2006
Special Guardianship (Wales) 2006
Towards a stable and brighter future 2007
Practice guidance on assessing the support needs of adoptive families 2005

Children Act 1989 Guidance Volume One Court Orders (2008)
Inter-Country Adoption Guidance and Information on Processes (2006)

Guidance – Non-Statutory

Preparing and assessing prospective adopters practice guidance 2007
Practice Guidance on Assessing the Support Needs of Adoptive Families (Wales) 2005

Looking after health, draft guidance Welsh Assembly 2007

Useful reference books, relevant policy and procedure documents

BAAF Practice Note 23: *Consent to Medical Treatment for Children*, BAAF 1991

Effective Panels: Guidance on regulations, process and good practice in adoption and permanence panels, Lord and Cullen, BAAF 2005

Effective Panels: Guidance on regulations, process and good practice in adoption and permanence panels in Wales (2008).

Health Information and Medical Reports when Children are being Adopted – Practice Guidance for SW and MA in Wales, Romaine and Sampeys, Carrick Design & Print Ltd 2006

E. UK WIDE: USEFUL REFERENCE BOOKS, RELEVANT POLICY AND PROCEDURE DOCUMENTS

Data Protection Act 1998
Human Rights Act 1998

BAAF Practice Note 46: *Health screening of children adopted from abroad*, BAAF 2004

BAAF Practice Note 47: *Using the BAAF health assessment forms: Setting standards of health practice across all agencies*, BAAF 2004

BAAF Practice Note 50: *Genetic testing and adoption*, BAAF 2006

BAAF Practice Note 51: *Reducing the risks of environmental tobacco smoke for looked after children and their carers*, BAAF 2007

BAAF Practice Note 53: *Guidelines for the testing of looked after children who are at risk of a blood-borne infection*, BAAF 2008

Doctors for Children in Public Care, Mather and Batty, BAAF 2000

A Framework of Competencies for Core Higher Specialist Training in Paediatrics,
RCPCH 2005

Safeguarding Children and Young People: Roles and Competences for Health Care
Staff, Intercollegiate Document 2006