Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant a Phobl Ifanc
The Children and Young People

Dydd Mawrth, 9 Mehefin 2009
Tuesday, 9 June 2009

Cynnwys
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Procedural Motion

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg. Mae hon yn fersiwn ddrafft o'r cofnod. Cyhoeddir fersiwn derfynol ymhen pum diwrnod gwaith.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included. This is a draft version of the record. The final version will be published within five working days.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Eleanor Burnham	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Angela Burns	Ceidwadwyr Cymreig Welsh Conservatives
Christine Chapman	Llafur Labour
Ann Jones	Llafur (yn dirprwyo ar ran Lynne Neagle) Labour (substitute for Lynne Neagle)
Helen Mary Jones	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)

Eraill yn bresennol
Others in attendance

Dr Heather Payne	Deon Cyswllt, Prifysgol Caerdydd Associate Dean, University of Cardiff

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

Steve Boyce	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Tom Jackson	Clerc Clerk
Rita Phillips	Dirprwy Glerc Deputy Clerk
Helen Roberts	Cynghorydd Cyfreithiol Legal Adviser

Dechreuodd y cyfarfod am 9.16 a.m.
The meeting began at 9.16 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Helen Mary Jones:** Bore da a chroeso cynnes i gyfarfod y Pwyllgor Plant a Phobl Ifanc.

Helen Mary Jones: Good morning and welcome to the Children and Young People Committee.

[2] Atgoffaf bawb fod croeso i chi ddefnyddio'r Gymraeg neu'r Saesneg yn y cyfarfod. Mae offer cyfieithu ar gael a all fod o gymorth i glywed yn well yn ogystal ag i glywed y cyfieithiad. Atgoffaf bawb hefyd i ddiffodd unrhyw ffonau symudol, eu 'Mwyar Duon' neu unrhyw beth tebyg. Nid yw'n ddigon da i'w rhoi ar 'tawel' gan eu bod yn amharu ar yr offer cyfieithu a darlledu. Os clywch larwm tân, gofynnaf i bawb ddilyn y tywyswyr.

I remind everyone that you are welcome to speak in Welsh or English in the meeting. Simultaneous translation equipment is available, through which you can amplify the proceedings as well as receive the translation. I also remind everyone to switch off any mobile phones, BlackBerrys and so on. It is not sufficient to switch them to 'silent' as they interfere with the interpretation and broadcasting equipment. If you hear a fire alarm, I ask you to follow the ushers.

[3] Gofynnaf i Aelodau ddatgan unrhyw fuddiant o dan Reol Sefydlog Rhif 31. Gwelaf nad oes buddiannau i'w datgan.

I ask Members to make any declarations of interest under Standing Order No. 31. I see that there are none.

[4] Croesawaf Eleanor Burnham yn ôl i'r pwyllgor. Hoffwn gofnodi'n ffurfiol ddiolchiadau'r pwyllgor am holl waith Kirsty Williams yn ystod ei chyfnod ar y pwyllgor. Croeso cynnes hefyd i Ann Jones sy'n mynychu'r pwyllgor unwaith eto yn lle Lynne Neagle. Deallaf fod Lynne yn ôl yn swyddogol ar ôl ei chyfnod mamolaeth, ond bod ganddi gyfarfod arall y bore yma. Felly, yr ydym yn hynod ddiolchgar i Ann am fynychu'r cyfarfod.

I welcome Eleanor Burnham back to the committee. I would like to place formally on record the committee's thanks for Kirsty Williams' work during her time on the committee. I also warmly welcome Ann Jones who is attending the committee once again instead of Lynne Neagle. I understand that Lynne has officially returned from maternity leave, but that she has another meeting this morning. Therefore, we are extremely grateful to Ann for attending the meeting.

[5] Er gwybodaeth, bu inni ofyn i blant a phobl ifanc yn Eisteddfod yr Urdd, yr wythnos diwethaf, nodi beth yr hoffent ei drafod. Bu bron i 300 o blant bleidleisio. Felly, yn amlwg, yr oedd yn ymarfer gwerth chweil. Byddwn yn gwneud yr un ymarfer yn Sioe Frenhinol Cymru ac ystyriwn sut i'w ymestyn drwy ddefnyddio cynghorau ysgol, o bosibl. Mae gwasanaeth addysg y Cynulliad hefyd yn rhoi cyfle i'r plant sy'n ymweld â'r Cynulliad bleidleisio. Felly, diolchaf i'r staff am drefnu'r digwyddiad yn yr Eisteddfod a diolchaf yn arbennig i Tom yn ei rôl fel y ddraig ac am wisgo'r siwt benodol honno. [*Chwerthin.*] Mae lluniau ar gael.

For your information, we asked children and young people at last week's Urdd Eisteddfod to note what they would like us to discuss. Almost 300 children voted. Therefore, clearly it was a worthwhile exercise. We will undertake the same exercise at the Royal Welsh Show and we will consider how to extend it by possibly using school councils. The Assembly's education service also gives children who visit the Assembly the opportunity to vote. Therefore, I thank staff for organising the event in the Eisteddfod and I especially thank Tom for his role as the dragon and for wearing that particular costume. [*Laughter.*] Photographs are available.

[6] They will be suppressed for a small fee. [*Laughter.*]

[7] **Helen Mary Jones:** Diolchaf i Aelodau am eu parodrwydd i gwrdd yn gynt nag arfer heddiw er mwyn sicrhau bod Dr Payne yn gallu ymuno â ni.

Helen Mary Jones: I thank Members for their willingness to meet earlier than usual today to ensure that Dr Payne could join us.

9.19 a.m.

Ymchwiliad i'r Trefniadau ar gyfer Rhoi Plant a Phobl Ifanc mewn Gofal yng Nghymru
Inquiry into Arrangements for the Placement of Children and Young People into Care in Wales

[8] **Helen Mary Jones:** Diolchaf i Dr Payne am ymuno â ni. Dyma ein sesiwn dystiolaeth gyntaf ar gyfer yr ymchwiliad hwn. Bu inni ofyn eisoes am dystiolaeth ysgrifenedig a disgwyliwn dderbyn y cyflwyniadau hynny erbyn mis Medi.

Helen Mary Jones: I thank Dr Payne for joining us. This is our first evidence session for this inquiry. We have already asked for written evidence and we expect to receive those submissions by September.

[9] Diolch am fynychu'r cyfarfod hwn ac am eich papur defnyddiol, Dr Payne. Diolch hefyd am aildrefnu eich meddygfa er mwyn gallu bod gyda ni. Yr ydym yn ddiolchgar iawn. Trown at y cwestiynau.	Thank you for attending this meeting and for your useful paper, Dr Payne. I also thank you for rearranging your surgery to be able to be with us. We are very grateful. We will now turn to the questions.

9.20 a.m.

[10] I will begin, Dr Payne, by looking at the points that you raised about health and wellbeing needs. To start with a fairly broad question, how do the health and wellbeing needs of looked-after children differ from those of most children?

[11] **Dr Payne:** They are considerably worse off in practically all measures of health outcomes: access to healthcare, the outcomes relating to their general health, and their educational wellbeing. Mental and physical health will have an impact on educational success and attainment. We know that care leavers are much more deprived than other children, and much more likely to have a teenage pregnancy, to be unemployed, and to be imprisoned. So, there is a range of measures that tell us that looked-after children, on the whole, do far worse than other children. They have been described on numerous occasions in the past as 'uniquely deprived' in our society, and we have the evidence to bear that out.

[12] **Helen Mary Jones:** Thank you. That is a grim picture, but it comes as no surprise to any of us. Christine, you have the next question.

[13] **Christine Chapman:** What is the value of specialist health services for looked-after children and what are the particular benefits of specialist nurses for looked-after children?

[14] **Dr Payne:** I am afraid that you are asking someone who will not give you an unbiased opinion. I am totally committed to having specialist nurses as the primary focus of healthcare for looked-after children. Twenty or so years ago, when I started doing this work, I was doing medical examinations for looked-after children. They did not turn up, were not brought, were not interested, and did not want to have their clothes taken off to be examined. If you are a doctor, that is what you do.

[15] I did quite a lot of work with Professor Ian Butler at the time. I was also working in Cardiff with my local fostering team, which comprised foster carers and children and young people who were in the care system. We asked them what they wanted to get healthier. They said that they would like to talk about their health and talk to someone who could give them the right information. So, we shifted to a health-promotion model, which monitored the obvious things like growth, the special senses, the things that need to be checked with dentists, and all those sorts of things, but it was also about plugging children and young people into accessing health services. It was informing them of how to go to their GP and how to get signed up with a dentist. So, having been aware of the problem and concerned that people did not seem to worry that looked-after children did not turn up for their medicals, over the past 20 years or so, I have managed to be successful in shifting it to a system that is now universally accepted. As proof that this works—apart from the fact that the children like it, value it and like being able to talk about their health—the looked-after children in our area now have more protection against measles than other children. So, in relation to the immunisation rate as an outcome measure, we can see that it has been very successful.

[16] **Christine Chapman:** In your paper, you identify funding problems for specialist healthcare services for looked-after children. What would you say is the case for funding such services, and approximately how much staff time is required to provide the service in your area?

[17] **Dr Payne:** Caerphilly has a population of 180,000 with a child population of 40,000, and we need two full-time LAC nurses there, working 37 hours per week. It is not just the direct care; there is a huge amount of co-ordination and liaison involved, as well as providing support for foster carers. The nurses who work with me, Jane Dove and Maraline Jones, are terrific. They are health visitors by profession and are now clinical nurse specialists. They have been trained in brief cognitive behavioural therapy, so that they can give brief interventions. They have a tremendous range of skills and provide a very holistic service. That means that they are very efficient. Whereas I used to spend appreciable periods of time doing that work, they now do it and I am just there to consult. So, if there is a particular problem, I will see a child for something specific, but it means that, instead of seeing all the children, I see probably about 10 per cent who have a specific medical issue. If they do not have a medical problem, they do not need to see a doctor, but they do need to see a health professional.

[18] However, it is wider than just the number of appointments. One reason why they have such a high success rate in getting young people to take up the service is that they are flexible. They do not just do what I have to do, which is to send an appointment notice for six weeks' time. Owing to the constraints of my service, I cannot do anything else. The nurses negotiate a time and a place where the young person will be comfortable, so it plugs them back into the system. It is personal advocacy. It is about the children understanding that they are worth it and helping them to understand how to ask for and how to access services. That is a life skill that is very important for them. It is about the importance of replacing their lack of parenting. I know that that point about corporate parenting has been taken on board, very widely—namely that we have to be in the place of parents—but this is at the sharp end, and you really have to put your money where your mouth is and make sure that you are standing up for these children. Sorry, but there are no votes in this, and these children do not write letters to their AMs.

[19] **Helen Mary Jones:** Before I bring Christine in with her next question, I just want to ask a question, Dr Payne. Roughly how many children are covered by the two full-time nurses?

[20] **Dr Payne:** That is 40,000 children, including about 1,200 looked-after children. That is not forgetting that about 50 per cent more children will go into and come out of care during the year than the point prevalence of looked-after children—in other words, the snapshot that is taken at 31 March every year. So, there is the point prevalence of who is there now but, during the year, the workload is 50 per cent more than that number.

[21] **Helen Mary Jones:** Thank you; that is helpful.

[22] **Christine Chapman:** I think that you have touched on the answer to my next question, Dr Payne, but perhaps there is more to it. You stated that looked-after children nurses promote the empowerment of children and their participation in their healthcare. You have said that the children enjoy the involvement of this service. In what other ways does that happen, as far as their participation is concerned? Are there any other things? Are there any other issues there?

[23] **Dr Payne:** Do you mean on healthcare?

[24] **Christine Chapman:** Yes.

[25] **Dr Payne:** They are encouraged to take up leisure activities and are given health promotion materials. They are asked about smoking, which we know is an effective intervention; in fact, not many of our looked-after children smoke. They are asked about

substance misuse and safe sex. So, again, in a sensitive way, they are offered the health services that they are likely to need. We have quite a number of very vulnerable children and young people who are sexually active, but it is about helping to protect them while also helping them to make positive choices. On their participation in decisions about themselves, the social services department in Caerphilly runs a very good forum that involves young people in the care system: it sends out a newsletter and has a number of systems in place. We in health are not directly involved with those systems, but I know that it has a very active system and, of course, it uses the individual advocacy scheme for young people in care.

[26] **Eleanor Burnham:** You have suggested that every health trust should have a named doctor for looked-after children—and I hate using that expression because I feel that it stigmatises people, but I suppose that we have to use certain expressions.

[27] **Dr Payne:** They are children.

[28] **Eleanor Burnham:** Absolutely. How many such doctors are you aware of at present, and does the named person need to be a doctor or could it be another health professional? May I also ask a further question that is related to this? Along the way, do doctors and nurses have extra training, because a lot of what you have said is common sense, is it not? Although none of us is a perfect parent, it is quite shocking to think that you are talking about very basic care and the very basic needs of youngsters.

9.30 a.m.

[29] **Dr Payne:** You are, but part of the issue is to do with professionals understanding what the problem is. Doctors usually operate when someone comes to them asking for something. Most doctors are not particularly tuned in to health promotion. Public health specialists are, and community paediatricians tend to be as well, but hospital-based acute care doctors are totally external. People come to them and say 'I am ill; save me', so the proactive approach to health promotion and health protection is not seen as—

[30] **Eleanor Burnham:** Forgive me for asking, but we are also talking about primary care. Surely, a GP should—

[31] **Dr Payne:** That was the principle that I worked on when I first tried to set up this service, namely that a GP would be in the ideal position to provide this service. However, GPs did not feel comfortable doing it, and I could not get them to take it up. It is quite a specialised role, because you need to have a broad range of skills in child protection. Quite a lot of the children who come into care have been abused, but no-one has realised that. They have a lot of acting-out behaviour, but so would any of us have if we were separated from our primary care givers. I often say to people that it is as though I had taken them and put them down in China: they do not know what people are saying, nothing is familiar, you do not like the food. Is it any wonder that you will stamp your foot a little?

[32] So, although a lot of it is common sense, the specialist skill is in knowing which bits are just common sense and which bits need something else to happen.

[33] **Eleanor Burnham:** Or maybe having someone with a keen interest in it, rather than someone who is only interested in adults.

[34] **Dr Payne:** That goes almost without saying. It is vital to have someone whose focus it is, and not just an interest. However, it needs to be someone's job, because, if it is everyone's job, no-one does it. That was my experience of trying to mainstream this work over the past 20 years. You cannot get people to take a sufficient interest in it to develop the sufficient skills to be good enough to feel comfortable enough to do it. So, I abandoned that

and went for the specialist approach. It is essential to have a lead nurse, but is also essential to have a lead doctor, because we do different things. What we need to do is to work together with social services and education, because the child's experience of health is not determined just by doctors or nurses.

[35] **Eleanor Burnham:** Are you therefore suggesting that, in primary care, there should be someone at every practice who has some type of specialism or an inclination towards not just children, but vulnerable children?

[36] **Dr Payne:** There ought to be expertise in children in every primary care team. If you have expertise in children, you must have expertise in the fact that some children are vulnerable and in need. It is a core skill. Children make up 25 per cent of the population and we will be missing a trick if we let people get away with saying, 'I do not deal with children'.

[37] **Eleanor Burnham:** Absolutely. Thank you. How effectively, in your experience, do social workers monitor the progress and wellbeing of looked-after children, particularly after a placement has been made?

[38] **Dr Payne:** It varies tremendously. In my experience, social work teams are susceptible to the vagaries of employment pressures and many other pressures. Sometimes, the teams are really good; sometimes they are really poor. We see some social services departments subjected to special measures, and it has happened in local authorities that have traditionally been extremely good, so it can happen to any social services. The key is to work together with social workers, so that there is time for me and my clinical nurse specialists to pick up the phone to liaise with social workers. Our job is to explain health information and make sure that it is properly understood. Again, that is inter-agency working and it requires time and a shared goal.

[39] **Eleanor Burnham:** You have mentioned specialist training for the doctors; would you say that that is also needed by social workers, who may not have had it yet?

[40] **Dr Payne:** I know that we have a piece of work that is ongoing on the core skills for working with children, but it is terrifically important that we stand back and make a statement such as, 'If you work with children, you've got to know how to do it; these are the skills and these are the learning outcomes'. Let us ensure that we have a training strategy so that our whole workforce, whether they are doctors, nurses, teachers or social workers, understands how children communicate, how they say what they have to say to us—

[41] **Eleanor Burnham:** We live in a changing world, due to the technology that is around us, and people are communicating in various innovative ways, with some of us Twittering and so on. I listened to Baroness Greenwood talking about neurological links, and her view—I do not know whether you agree with it—was that we have several different issues going on now that some of us have never had to encounter.

[42] **Dr Payne:** It is important that we learn to listen to what children are telling us, because they are telling us the same things, but they are telling us in a different way. Twitter and iPods will come and go, but children still want to talk to us and be heard.

[43] **Eleanor Burnham:** But there is—

[44] **Helen Mary Jones:** I am sorry, Eleanor, we will have to move on or we will not get through everything. We are not working to a tight timetable, but our witness is.

[45] **Dr Payne:** It is because of my patients; otherwise, I would stay here all day.

[46] **Helen Mary Jones:** Ann, will you come in with question 7?

[47] **Ann Jones:** In your written evidence, you stated that:

[48] 'foster carers should routinely be given the full health assessment documentation on the child, subject to the appropriate parent and child consent'.

[49] Why is that not happening at present, and what are the barriers to achieving that across the piece?

[50] **Dr Payne:** In terms of health information, in Caerphilly we have this inter-agency protocol, which is quite unusual, and we dealt with all these problems in a systemic way, asking, 'What do people need to know?'. We asked foster carers what they wanted to know as part of our working group, which we set up 10 or 12 years ago, so we dealt with those issues by saying, 'Okay, in that case, we'll ask the child at the beginning of the consultation if they're happy to share this information'. So, routinely, when the health assessment is done, a copy of that information is passed on to the foster carer and the GP. I cannot speak for social-services-gathered information, which goes through a different route, directly from the social worker to the foster carer. All I know is that, when I see children and young people, regarding whatever I am consulting with them for, and I ask the foster carer what they know about that young person's history, they frequently say, 'I have no idea about anything'. I can only conclude that there are no great systems to give them all the information, but, as I said, we have a system to give them what we have control over, namely the health information, which works well. As with any system, confidential information is confidential, but if you get consent and involve the young person in the process and say, 'It will help you if we can share this, but it will be kept confidential by the foster carer', they hardly ever disagree.

[51] **Ann Jones:** Do you have any experience of issues with information transfer regarding children in care homes? Do staff get it all or just what people think that they should have?

[52] **Dr Payne:** We have hardly any care homes now—there are very few and they are mostly specialised placements. They get a large amount of information, because they are jolly expensive; if that is what a child needs, that is what they need, but the expense tends to be a big driver for people to be very clear about why they want to spend that amount of money.

[53] **Helen Mary Jones:** Will you move on to question 9, Ann?

[54] **Ann Jones:** I am sorry; I did not look down the list. You have highlighted a number of barriers to the exchange of information between health and social services, and you mentioned that you do not know what information they are getting. Is this a widespread problem and are you aware of any good practice that would help us to address these issues?

9.40 a.m.

[55] **Dr Payne:** I did take the opportunity to consult with some of my colleagues. The British Association for Adoption and Fostering health group contains all the lead doctors in fostering and adoption, and also quite a number of the nurses, in Wales. I took the opportunity to ask my colleagues. The general feeling is that most people do not have an inter-agency agreement between health and social services, and the feedback was that they have dreadful problems, with children placed without health information. Do not forget that some counties are net importers of looked-after children. Many children are placed from English counties, particularly, into very pleasant parts of Wales where it is felt that they will have a better quality of life. It means that Pembrokeshire and some parts of north Wales have vast numbers of looked-after children who are not their own, and this dislocation of accountability is a

dreadful problem.

[56] **Helen Mary Jones:** We will now go back to Eleanor.

[57] **Eleanor Burnham:** Beyond all of this, to what extent is there a shared understanding among professionals and carers around confidentiality, particularly where personal information is concerned?

[58] **Dr Payne:** There is room for quite a lot of improvement about a shared understanding of what confidentiality means, and you can only arrive at that by working together and using live situations to explore possibilities. This is why I keep coming back to the point of inter-agency working. When I do this health work, I am not just working as a health professional; I work as part of a team for the child. That is what takes time. You need structures by which you come into contact with social workers, either by meeting them or speaking to them, to tease out the problems that we are trying to solve.

[59] **Eleanor Burnham:** So, there is a variation, obviously, but is there not a protocol? You have alluded to your good practice in Caerphilly. Are you the only part of Wales that works like that? If you are, how can it be rolled out, and who should roll it out?

[60] **Dr Payne:** As far as I am aware, we are the only area that has an inter-agency agreed protocol. I think that Cardiff may also have developed one, but its problem was that it lost funding for the nurses; so, I am not quite sure what happens in Cardiff now.

[61] **Eleanor Burnham:** You must talk to these people.

[62] **Helen Mary Jones:** Eleanor, could you try to be focused with the supplementary questions?

[63] **Dr Payne:** The point about accountability is tremendously important. When I was looking through this, I thought, 'We know exactly what should happen; it is just that it has not happened'.

[64] **Helen Mary Jones:** You recommend that every local health board and local authority should have a protocol in place for work on health assessments and the sharing of personal information for the purposes of 'discharging joint responsibilities'. In your view, would the model used in Caerphilly meet those requirements, or are there things that you would like to do to strengthen that model? There may be some issues about recommendations that this committee may wish to make to the Government about what should be done elsewhere.

[65] **Dr Payne:** Sure. I would suggest that the model is very effective. Again, it is not just me saying that; it is social services. It is an agreed inter-agency model, which is key. Supporting it with information systems that actually allow the sharing of information, rather than putting the same data into lots of different databases, is important. It would be nice if the integrated system was actually integrated with us in health. There are cross-service boundaries that need to be dealt with, but that could happen. We do it by making clear what we do with the data and getting consent to that sharing of data. Therefore, it needs to be supported by a quality assurance mechanism, which uses the right data, collected it in the right way. There should also be some sanction or benefit if you get it wrong or right. Therefore, the answer is 'yes' to the system, but we should also have a quality assurance mechanism to go with it, and it should be someone's job to do it.

[66] **Helen Mary Jones:** Do you have a view as to how effective the children's commissioning support resource database is at facilitating the appropriate placement of children?

[67] **Dr Payne:** I do not think that it is about appropriate placement; it is about whether there is a placement. We would need a fairly major foster care recruitment strategy in order to provide anything resembling a choice of foster placement. If we had a choice, there would be lots of areas where we could have an input—temperamental factors, and so on, which we know affect matching. This would only apply to longer-term matching, but we are not at the stage where we could realistically offer a choice.

[68] **Helen Mary Jones:** Thank you—that is interesting. Ann, we are back to you for the next question. You have been busy today.

[69] **Ann Jones:** I have enjoyed it, though.

[70] Dr Payne, you mentioned children who are placed out of county, and highlighted a number of problems in meeting their healthcare needs. Could those problems be resolved by changes to funding and practice, or is a more fundamental change required on how we deal with out-of-county placements?

[71] **Dr Payne:** Funding would help, but accountability is the key. When children from Caerphilly, for example, are placed in Pembrokeshire—and there might be perfectly good reasons for that—they will go from my area's waiting list for speech therapy and occupational therapy to the bottom of the new area's waiting list. There is no mechanism to stop that, because that is how the system works. If they need psychiatric or psychological input, then it may be that children and adult mental health services are configured differently in the new location, so the service that they were getting may not be handed over. There is no obligation to liaise with service providers in the new location, and that work would not be funded from my job plan. Often, I do not even know that a client has moved, because there is not necessarily any consultation in planning the healthcare. So, there is a certain disconnect there as well. The same happens in reverse, and that is worse, because, although there is an obligation for local authorities to consult with the receiving area before they place a child, I have never known it to happen—and if it does not happen, nothing follows.

[72] **Ann Jones:** You mentioned someone moving from your local authority area to Pembrokeshire, which is obviously within Wales, but I was going to ask you about cross-border placements, whereby someone could go from here to England, or vice versa, with different policies being in place. There are obviously enough problems within Wales, but is that an issue? Do we need to look at that differently, or under the same protocol?

[73] **Dr Payne:** My solution to that particular issue would be to say that, wherever a child lives, that is where their health services should come from. That would be the easiest solution. We would have to be careful that some areas were not taking a hit from having children placed there and left without any planning or preparation. There would have to be some financial exchange, but if the accountability was fair and square, we could hand it all over to a nominated person who could ensure that the child gets the right services. Again, the up and over structure needs to be in place.

[74] **Helen Mary Jones:** How do the current commissioning arrangements in Wales affect the quality of placements for looked-after children, in your view?

[75] **Dr Payne:** Do you mean the commissioning of placements or services?

[76] **Helen Mary Jones:** Both—the commissioning of placements, and then health services.

[77] **Dr Payne:** Specifically on health services, we do not have a real strategic view on

health services for looked-after children. I think that they have been tucked in with child protection and bolted on to the national public health service duties. They have designated doctors for child protection, and then looked-after children were kind of stuck on to the end of the title; they are mentioned in the terms of reference and the job role, but there is no clinical commitment. Many of my colleagues are very vocal about the things that we want to see, but in terms of taking forward a strategy and making it happen, and ensuring that you have the right outcome measures, that you are collecting the right data and that the quality control and quality assurance mechanisms are in place. We do not see that. So, as I say, we know what might help but I do not think that it is happening.

9.50 a.m.

[78] **Helen Mary Jones:** That is helpful. My final question might be a bit difficult to answer. You make some very constructive suggestions in your paper, but could you single out one key recommendation that you would like this committee to make to the Assembly Government on ensuring that the health outcomes for looked-after children are improved, particularly with regard to the information that is needed when they are placed?

[79] **Dr Payne:** It has to be about staff—giving people the job of being designated doctors and nurses who deliver the service and are accountable all the way down the chain, so that they understand that they have to look a looked-after child in the face and explain to them what speech therapy they are going to get in a particular week.

[80] **Helen Mary Jones:** That is helpful. Do Members have any additional questions for Dr Payne? I see that they do not. Thank you for disrupting your schedule to be here, Dr Payne.

[81] **Dr Payne:** Not at all. I am most grateful to you for being so flexible. My clinic is on a Tuesday morning and that is my first commitment, but it was great to have an opportunity to get this down and off my chest. This is still very dear to my heart and I would really like to see this work.

[82] **Helen Mary Jones:** I think that we can all see how committed you are, and it was well worth our clocking in 15 minutes early to get the evidence that we have received. Thank you very much indeed.

9.51 a.m.

Cynnig Trefniadol
Procedural Motion

[83] **Helen Mary Jones:** Yr ydym yn symud i drafod materion sydd yn dod i'r amlwg yn y papur ar gyllidebu ar gyfer plant. Yr ydym wedi cytuno ymlaen llaw y dylem wneud hyn mewn sesiwn gaeedig.

Helen Mary Jones: We will now discuss emerging matters in the paper on children's budgeting. We have decided that we should do this in closed session.

[84] Cynigiaf fod

I propose that

y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog Rhif 10.37(vi).

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[85] Gwelaf fod y pwyllgor yn gytûn.

I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 9.52 a.m.
The public part of the meeting ended at 9.52 a.m.