**Protocol on sharing medical information in early permanence planning.**

*Further guidance is contained in The Role of Fostering For Adoption In Achieving Early Permanence for Children (2017) from Coram/BAAF.*

Early Permanence Carers should have been recruited, assessed and well prepared through specific training to take on the task of caring for a child in an early permanence (concurrent planning/FfA) placement. They will be especially resilient and able to cope well with uncertainty and loss. Whilst they will be motivated by wishing to create a family through adoption, they must also have been able to demonstrate that they are able to put the best interests of the child above their own and actively support the local authority’s work with and assessment of the birth parents and reunification if this is what is decided. In the initial stages of a placement the child is placed with the early permanence carers under Fostering Regulations and their task is to work alongside the local authority. Whether there are still active plans to help the parents achieve reunification (with adoption as a back-up plan – this is concurrency) or at this stage a single plan of adoption for the child (fostering for adoption) we know that things can change significantly during proceedings and therefore all EP carers are prepared for uncertainty from the onset. However, in order for any EP placement to fulfil its potentially longer-term role of adoption (if this is in the best interests of the child) the planning, linking and initial matching (this is different to the formal matching that can only take place if the courts grant a Placement Order) need to be robust enough to prove suitable to fulfil both roles. Thus, this protocol stresses the importance of sharing any medical information pertinent to this at the pre-placement stage.

**Medical advisers in some areas of the country, have expressed concern that sharing relevant important parental and birth family health history late in the placement (by which time EP carers have become attached to the child) really doesn’t allow carers to proceed with informed consent. It is important that as much medical information about the child’s family is shared as possible with consent from their parents.** **If consent is refused or is unobtainable a decision should be made by the medical advisor based on the best interests of the child, proportionality and relevance of the information to long term care and planning.**

The following guidance aims to help medical advisors decide what medical information is appropriate to share at what stages of EP planning.

**Guidance**

1. Any information that is known to the child’s social work team that relates to the health of the child can and should be shared with the EP carers and their supervising social worker prior to the placement being agreed. As EP carers take on both a commitment to foster the child initially a*nd* adopt the child if they cannot return to live with their family they must be in a position to make an informed decision in regard to whether or not they can meet the needs of the child in both the short and long term.
2. Every effort should be made by the child’s social worker to obtain the parents’ consent to share any of their health history that is relevant to their child with EP carers. It is important to help the parents to understand that it is in the child’s best interests for the carers to have a comprehensive picture of the child’s health history and needs in order to provide the best current care and also for the placement to potentially fulfil its dual role.
3. It will be important for the child to have as much information about their family health history as possible, to inform their long-term health and wellbeing.
4. At the Early Permanence Placement Planning Meeting all the available medical information about the child (as collated by the medical advisor) that the EP carers need in order to be able to care for the child at placement should be shared with the adoption social worker.
5. Medical Advisors should meet (this can be virtual) or have a telephone call with EP carers to share relevant and available health information. Where possible information about what is shared during this meeting/discussion should be documented in the child’s notes. A key aspect of this discussion would be to help the carers understand the uncertainties of future prognosis and to present a balanced picture of the risks which are known and what is unknown at this stage.
6. It is in the child’s best interests, for both immediate care and possible long-term care for the relevant family health and medical history to be shared with the EP carers. It is the child’s social worker’s role to gain signed, informed consent from the birth parents to enable this to happen. (This could include documenting any questions that the parents have).

For example, if the child was born with drug withdrawal symptoms the carer will need to know about that as it is fact about the child’s health that is relevant to them.  But the carer does not necessarily need to know in detail the history of the mother’s drug use – proportionality is key – it becomes a professional judgement and if we are promoting transparency in practice, parents need to know what will be shared with the child’s carers.