Milton Keynes Annual Report on the Health of Children in Care

1 April 2016 – 31 March 2017

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Annual Report 2016/17
CIC Health Service (Milton-Keynes)

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Section 1 Executive Summary

I am pleased to present the Eighth Annual Health Report; an overview of the statutory health services provided to Milton Keynes Children in Care (CIC) from April 2016 to March 2017. The report provides assurance to our stakeholders including Milton Keynes Clinical Commissioning Group and Milton Keynes Council that Central and North West London Milton Keynes NHS Trust (CNWL-MK) are compliant with National Guidance; the Statutory Guidance on Promoting the Health and Well-being of Children In Care (DCSF&DH 2015) and NICE guidance: Promoting the quality of life of Children In Care and young people (2010).

On 31st March 2017, there were 395 children in care under the responsibility of Milton Keynes Council. The vulnerability of children and young people in the care system is widely recognised both locally and nationally. Abuse and neglect remain the main reason why children come into the care of the local authority. Developmental issues particularly speech and language delay remain the most common health related problem in children under the age of five years and emotional health and behavioural difficulties in the older age group.

The Saturday clinics continue to be run successfully. However due to the significant increase in the number of health assessments week day clinics have been introduced. The service continues to strive to retain flexibility in clinic appointments within the challenge of ensuring compliance with statutory timescales. The increase in both the numbers of children and young person’s coming into care and complexity of cases continue to put pressure on service delivery. Despite the challenges our performance indicators continue to compare favourably with national figures and our statistical neighbours.

During the year we had both CQC and Ofsted inspections. The inspection highlighted many aspects of very good practice as well as some areas where health services could make improvements. A joint action plan is being progressed with all our partners.

It has been a very busy but rewarding year. There is still more to do and we are proud of the joint working culture between all our partner agencies. We plan to strengthen existing partnerships, and develop new relationship all to ensure the health needs of Children In Care are met. We look forward to the coming year. We will continue to do our best to deliver high quality health service, achieve our performance indicators, promote the ‘voice of the child’ and be strong advocates for children and young people in care.

Dr Adeola Vaughan

Consultant Community Paediatrician
Designated Doctor for Children In Care

Of Note: The term ‘Children In Care’ (CIC), ‘Children Looked After’ (CLA) and ‘Children in Care’ (CIC) are all used to refer to children who are placed into the care system. The term ‘Children In Care’ is currently used within statutory and government documents. However, all terms may be used interchangeably. Within this annual report for Milton Keynes we use the term Children In Care.
Section 2

2.1 Milton Keynes Demographic Information: (Statistics provided by MK Planning and Transport Service Group June 2017)


Graph 1: Cumulative Population Change since 2013 in Milton Keynes

Key Points from the Population Projections:

The Milton Keynes population is growing in size and diversity. It was one of the fastest growing UK cities between 2005 and 2015, expanding by 17.1 per cent (Office for National Statistics, Mid-year population estimates, 2005 and 2015 data).

In 2017, the estimated population of Milton Keynes Borough will be 268,029. The population is expected to rise by around 15.1% from 268,029 to 308,498 by 2026.

School Age Population 5-16 year olds: Milton Keynes is more ethnically diverse than the England average and within the school population the percentage of children from black or minority ethnic heritage is 39.3%. (MK School Census 2016). The school age population is projected to be around 45,116 in 2017. The population is projected to rise by around 16.5% from 45,116 to 52,550 by 2026.

It has a relatively youthful population with 2017 figures showing the under 16 age group estimated at 24.2%. The average age of population is 34.5 years, compared to an average age of 50 years in England. (Milton Keynes Population Bulletin 2016-17).
MK Age range (2017-2026):

Early Year’s – 0 to 4 Year olds - projected to remain at a consistent level of around 20,000.

School Age Population - 5 to 16 year olds - projected to rise by 16.5% from 45,116 to 52,550 by 2026.

Young Adults - 17 to 24 year olds – projected to rise from 21,475 in 2017 to 23,795 in 2026.

With the population growing within Milton Keynes the above projections are key for Milton Keynes Children’s Social care (MK-CSC) in terms of future planning and provision of services.

2.2 National Children In Care data: (Department of Education National Statistics 2016)

As of 31st March 2016 there were 70,440 children in the care of local authorities in England compared to a figure of 69,480 in 2015. Looking at figures over the last 5 years there has been an increase of 4,940 (7.5%).

Ages and male/female ratio of children in care:

Of the 70,440 figure, 39,670 (56%) were males and 30,780 (44%) were females.

5% of children were under 1 year old, 13% were between 1 and 4 years old, 20% were between 5 and 9 years old, 39% were between 10 and 15 years old and 23% were aged 16 and over.

The reasons why children start to be looked after have remained very stable; Absent Parenting has increased from 8% to 12%, this is due to an increase in Unaccompanied Asylum Seeking Children who fall into this Category. The majority of Children In Care in 2016 started to be looked after due to abuse or neglect (54%)

Commencing Children in Care status:

A total of 32,050 children became children in care during the year ending 31st March 2016. This is an increase of 2.3% from the previous year’s figure of 31,340 and an increase of 12.9 from 2012. In 2016 there was a small decrease in the number of children aged 9 and under.

The percentage of children aged 10 to 15 decreased from 31% in 2011 to 29% in 2016.

The number aged 16 and over has increased steadily each year since 2011.

In 2015, 18% were aged 16 and over, compared with 12% in 2011.
**Ceasing Child in Care status:**

The number of children ceasing ‘child in care’ status has increased over the past five years; however the increase from 2015 to 2016 was very small.

31,710 children ceased ‘child in care’ status during the year ending 31st March 2016, an increase of 1% from the previous year’s figure of 31,320 and an increase of 17% from 2011.

In 2015, 7,830 children aged 1-4 years ceased to be ‘child in care’ status. The percentage of 1-4 year olds dropped from 27% in 2015 to 25%.

The percentage of children who ceased ‘child in care’ status when they were 18 years old has remained fairly stable since 2011. In 2015 there were 7,970 children who ceased ‘child in care’ status when they were 18 years old. This represents 25% of all children ceasing to be a ‘child in care’.

**Unaccompanied Asylum Seeking Children:**

Of the 70,440 children in care, 4,210 (6%) were unaccompanied asylum seeking children. The number of unaccompanied asylum seeking children increased by 34% between 2014 and 2015 and 54% between 2015 and 2016. A higher percentage was boys (90%) with 74% reported to be aged 16 and over.

2.3 **Milton-Keynes Children In Care Statistics: (Statistics supplied by Performance Management Team Children's Social Care)**

There were 540 children in the care of Milton Keynes Local Authority at some point in the period in comparison to last year’s figure of 523. This indicates an increase of 17 cases (3.2%) and an increase of 69 cases (13.6%) since 2015. This figure fluctuates month by month as children and young people come into care but then may leave depending on individual need and circumstance.

**The number of children continuously looked after by Milton Keynes Children’s Social Care for 12 months or on 31/3/17:**

**Total: 255.** Data indicates a significant rise of 35 cases (16%) when compared to last year’s figure of 220.

**The number of children in the care of Milton Keynes Local Authority as on 31st March 2017:**

**Total: 395.** Data indicates a significant rise of 50 cases (14.5%) when compared to last year’s figure of 345. There have been several large siblings groups that have been brought into care and this has had a level of impact on total figures of children needing CIC status.
Rates of Children In Care:

Graph 2: Numbers and Rates of Children In Care Captured (2015-2017)

This indicates the rate per 10,000 children and young people in the care of Milton Keynes Local Authority (age 0-17) has reached the current recorded rate (2015/2016) for our Statistical Neighbours and England.

Compared to national data and our statistical neighbours, the number of children in care is below average although slightly higher than the average in the south East.

NB: The statistics for England, South East and our Statistical Neighbours have yet to be reported on for 2016/2017 so they may have experienced a similar increase.

Age and Gender:

Age:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>22 (5.5%)</td>
</tr>
<tr>
<td>1-4 year's</td>
<td>56 (14%)</td>
</tr>
<tr>
<td>5-9 year's</td>
<td>73 (18.5%)</td>
</tr>
<tr>
<td>10-15 year's</td>
<td>153 (39%)</td>
</tr>
<tr>
<td>16/17 year's</td>
<td>91 (23%)</td>
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Gender split:

<table>
<thead>
<tr>
<th>Males/Females ratio:</th>
</tr>
</thead>
<tbody>
<tr>
<td>233/162</td>
</tr>
</tbody>
</table>

The age distribution of Milton Keynes Children In Care (MK-CSC) is comparable to national data.

The smallest number of children continues to be within the under 5 age group.

The clear majority remains within the 10-15 year age group. The overall picture of causes for why children become looked after remains fairly consistent.
Causes for children becoming looked after by Milton Keynes Local Authority:

<table>
<thead>
<tr>
<th>CATEGORY OF NEED FOR CHILDREN LOOKED AFTER AT 31 MARCH 2017</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or neglect</td>
<td>163</td>
</tr>
<tr>
<td>Disability</td>
<td>42</td>
</tr>
<tr>
<td>Parental illness or disability</td>
<td>30</td>
</tr>
<tr>
<td>Family in acute stress</td>
<td>58</td>
</tr>
<tr>
<td>Family dysfunction</td>
<td>53</td>
</tr>
<tr>
<td>Socially unacceptable behaviour</td>
<td>7</td>
</tr>
<tr>
<td>Low income</td>
<td>2</td>
</tr>
<tr>
<td>(Includes UASC) Absent parenting</td>
<td>40</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>395</td>
</tr>
</tbody>
</table>

It must also be recognised that most cases have more than one cause for being in care.

Ethnicity breakdown for CIC as of March 31st 2017

<table>
<thead>
<tr>
<th>CYP Group</th>
<th>A - White Background</th>
<th>B - Mixed Background</th>
<th>C - Asian Background</th>
<th>D - Black Background</th>
<th>E - Other / Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>MKC 0-19*</td>
<td>67.0%</td>
<td>8.0%</td>
<td>12.0%</td>
<td>12.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>CIC</td>
<td>65.4%</td>
<td>10.3%</td>
<td>6.9%</td>
<td>10.1%</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

There is a clear dip in CIC from an Asian background when looking at the MKC population as a whole. The increase in ‘Other’ Ethnicities in CIC is in the main due to Unaccompanied Asylum Seekers who continue to be supported as CIC.

Distance of Geographical Placements:

Children in Care Placement figures for in and out of Milton Keynes (April 2016-April 2017).

Graph 3:

This shows children and young people in the care of MK-CSC are predominantly placed in and around the Milton Keynes area within a 20 mile radius. A small proportion of children are placed between...
21-50 miles and 51-100 miles out with Milton Keynes. The smallest number placed 101 miles and over. When comparing to other local authorities, Milton Keynes does not have a significantly greater number of distant placement. Many of these placements are for positive reasons such as an adoption or being with a family member. There may be safeguarding and risk management issues identified indicating an out of area placement is needed or a child/young person may need to access specialist provision to meet a complex need.

**Children and young people with disabilities:**

There are currently 18 children/young people who are CIC and who are cared for within a specialist team- The ‘Children With Disabilities Team’ (CWD). This team works exclusively with children who have profound and significant learning and/or physical disabilities or life threatening illnesses and their families. They offer advice, guidance, signposting and support working in partnership with families and other professionals to safeguard all children and promote their well-being. If a child/young person with complex disabilities becomes a CIC, they will require their health needs to be assessed in an Initial Health Assessment and thereafter to have a RHA in accordance with statutory guidance.

The health team and the CWD are acutely aware this is a highly vulnerable group. Placements for these children may include highly specialist units, residential schools and foster care. On-going parental involvement may be central to the child’s world and that of their family, depending on individual circumstance and as such they may be involved in the health assessment process. These children will also have a range of named professionals involved in their health care on an ongoing basis. The CIC Nurses are acutely aware of the importance of effective assessment avoiding duplication and over assessment for the child. Information and medical reports are gathered to assist the assessment and also ensuring the voice of the child is central to that process.

**Number of CIC for 12 months or more and type of placement:** (As of March 31\textsuperscript{st} 2017)

Total children/young people placed with foster carers: 195. This is an increase of 29 from last year’s total of 166.

Total children/young people requiring support placed in residential children’s home: 28. This is an increase of 7 from last year’s total of 21.

Total children/young people placed with a parent: 9. This is a decrease of 2 from last year’s figure of 11.

Total children/young people placed for adoption: 2. This is a decrease of 4 from last year’s figure of 6.

Total children/young people placed in residential school/residential setting: 18. This is an increase of 8 from last year’s figure of 10.

Total young people placed in supported living: 18. This is an increase of 12 young people from last year’s figure of 6.

**Service Summary**

3.1 **Staffing**

The Children In Care Health Team is made up as follows:

**Designated Doctor**

The Designated Doctor is a Consultant Community Paediatrician employed by Central and North West London- Milton Keynes (CNWL-MK) and commissioned by Milton Keynes Clinical
Commissioning Group (MK-CCG) to deliver the role and function of the Designated Doctor. This role combines operational and strategic responsibility for children in the care of Milton Keynes local authority allowing both CNWL- MK and MK-CCG to deliver on its responsibilities to children in care in Milton Keynes. The post holder is also the Medical Advisor for Adoption and Fostering, managing these roles along with other responsibilities within a full time paediatric neurodisability post. All the doctors in the team are involved in the provision of clinical services for children in care. Regular training is provided to ensure consistency in service provision.

**Designated Nurse**

The Designated Nurse is employed by MK-CCG and also undertakes the role of Designated Nurse for Safeguarding Children. The Designated Nurse for CIC works alongside the Designated Doctor to assist MK-CCG in effectively fulfilling its role as a commissioner of services to improve and monitor the health of all children in the care of Milton Keynes Local Authority.

**Named Nurse for Children In Care**

The Named Nurse CIC post is jointly funded by CNWL-MK and MK-CSC as a full time position. This is predominantly a strategic role, working to develop, implement and monitor local policy within CNWL-MK and MK-CSC, in line with national policy and guidelines. This post is based within MK-CSC.

**Specialist Nurse for Children In Care**

The Specialist CIC Nurse is employed by CNWL-MK and is a full time position. This is her 7th year working in and developing this role. The Specialist CIC Nurse completes review health assessments for children in the care of Milton Keynes Authority above the age of 5 year’s. One significant advantage of this role is that review health assessments are completed by the same nurse promoting consistency for the child/young person and their carer and instilling a sense of security with the health assessment process. For children placed a significant distance from Milton Keynes, an ‘Out of Area’ request for a local CIC Team to complete the assessment, is made. The Specialist CIC Nurse will travel a distance of up to 2 hours to assess a MK child placed out of area. This post is based within MK-CSC.

**Administration**

It is a complex task to track the volume of children entering and leaving the care system and ensuring assessments take place within statutory guidelines. Administration for the CIC team has been jointly reviewed this reporting year by CNWL-MK and MK-CSC.

Business Support CIC has been increased by MK-CSC and the post is now full time. The complexity of working across CNWL Health systems, Out of Area health systems and CSC systems has been further recognised. Ensuring paperwork is co-ordinated across services and various electronic systems adhering to statutory timescales and ensuring confidentiality is recognised as a complex and fragmented task. In addition, Out of Area Assessment requests to and from other health authorities, is extremely time consuming.

Administration for the Community Paediatric Clinic is funded by CNWL-MK for 12 hours per week. This post is based at CNWL-MK Trust Head Quarters. In light of the increase in children coming into care and as such requiring a health assessment, this does affect the pressure not just on health but also on administrative staff.
3.2 Supervision Arrangements:

Health Team Supervision Meetings

The Named CIC Nurse is managed and supervised by the CNWL-MK Named Nurse for Child Protection. The Named Nurse and Specialist Nurse meet regularly for individual supervision providing an opportunity to consider individual cases, management of case-loads and practice issues. The Designated Nurse for CIC also meets regularly with the Named Nurse providing the opportunity to consider service provision and wider issues relating to the CIC service.

Once a month there is a whole team meeting with Designated Professionals, Named and Specialist Nurse to consider system wide partnership developments and to monitor quality assurance.

Effective liaison between services and enhancing good practice spanning all areas of health for children in care is paramount. The relationship and communication process between CIC Nurses and the Community Paediatricians in Milton Keynes is very well established.

Weekly meetings are held between the CIC Nurses with the Designated Doctor to review and discuss assessments which have taken place at the Community Paediatric Clinics and as part of overall quality assurance for health assessments within the team. These meetings also offer a supervision forum to discuss individual cases, practice issues and service development. Cases discussed are documented and scanned to Systm1 and LCS. The Designated Doctor is member of the BAAF health group and the forum allows for valuable peer support and discussion.

Social workers have direct access to medical advice from the CIC Health Team. The nurses also have the advantage of being able to discuss individual cases with the child’s social worker as they are based within their team and can attend strategy meetings when required.

Close joint working between the Health Team and the Head of Delivery of Corporate Parenting is well embedded promoting joint discussion and liaison through the Health and Social Care Forum to promote the health needs of children in the care of Milton Keynes Local Authority. The Milton-Keynes Safeguarding Team including Milton-Keynes Children’s Social Care (MK-CSC), the Police Child Abuse Unit, Schools and all other partnership agencies work closely together assessing risk and quickly noticing warning signs relating to safeguarding and identifying children at risk.

3.3 Governance and Reporting Arrangements:

CNWL-MK is a member of the Milton Keynes Children and Family Partnership and the Milton Keynes Safeguarding Board. There is a strong and consistent leadership commitment to ensure the health needs of children in care are being met. The Associate Director of Children's Health Services is the lead for safeguarding and for Children In Care. This promotes consistency and joint working across fundamental key areas within children’s health services.

CNWL Divisional Safeguarding Governance sub-group:

The governance arrangements consist of a joint adult and children Divisional Safeguarding Governance sub-group which meets on a quarterly basis and is chaired by CNWL-MK Divisional Nursing Director. The group reports to the CNWL Board via the Divisional Quality Forum and provides assurance to the Trust Quarterly Safeguarding Group Meeting. The purpose of the sub group is to monitor safeguarding activity in the division, approve and ratify relevant documents and papers, share lessons learnt and assess, review and monitor safeguarding risks for the division. This remit includes ensuring that the division complies with the CIC agenda. The performance of IHAs and RHAs is also reported monthly on a Milton Keynes CCG Safeguarding Dashboard which is reviewed by the
sub group and submitted to the MK-CCG on a quarterly basis. This process ensures practice is monitored, statutory timeframes are being achieved and any potential difficulties hindering this highlighted.

**Corporate Parenting Panel**

The Corporate Parenting Panel (CPP) is an all-party council members panel whose purpose is to act as parent to all the children and young people who are in the care of Milton Keynes Council and to ensure that the Council’s and its partner agencies deliver on its pledge to children in care. The CPP raises awareness of the needs of children in care across the council and its partners and seeks to encourage the development of local resources to meet the needs of children in care.

The CPP panel meets 5 times a year and will call on officers and partners to provide information and reports on progress, in accord with its annual work plan in including those relating to meeting the Health needs. The CPP itself report on an annual basis to the CYP Select Committee, Full Council and Children and Family partnership.

**4 Performance Indicators**

**4.1 National Targets/Statutory requirements:**

Milton Keynes Local Authority sends statutory statistics to the department of health and education (DfE). DfE will publish their first national statistical release in September 2017. Statistics compiled and reported on for children in care are:

- The number of Initial Health Assessments completed within 28 days of the child/young person coming into care.
- The number of Review Health Assessments completed every 6 months for children below 5 years of age.
- The number of Review Health Assessments completed on an annual basis for all children/young people 5 year’s up to 18 years of age.
- The number of children below the age of 5 years with developmental check completed on a 6 monthly basis.
- The number of children registered with a dentist.
- The number of children/young people fully immunised in line with the national immunisation schedule.
- The number of children /young people between the ages of 4 years and 17 years with an SDQ completed.

**5 CIC Team Clinical Activity Relating to Health Assessments for CIC:**

The Local Authority (LA) is responsible for ensuring that arrangements are in place to carry out all health assessments within the statutory timescales. The CIC health team is responsible for the completion of statutory health assessments. Both agencies work closely together to ensure every child has a timely and up to date assessment. Milton Keynes is a unitary authority with one hospital and one community health provider CNWL-MK. This has the advantage of the community paediatric team using the same medical records system as the hospital, therefore not experiencing the frustration experienced by health providers in other local authorities where there are multiple medical record systems leading to gaps in medical information.

The CIC Nurses input health assessment data onto the council electronic recording system LCS- Liquid Logic. Specific data is recorded to monitor health assessment performance and ensure children’s
health needs are effectively outcomed. Close and timely communication with all health and relevant professionals is crucial and as such a full copy of the health assessment is also scanned onto the hospital electronic record system (EDM) if a child is under the care of any specialist health provision. The full assessment is also scanned to the community health electronic record system Systmone as well as to LCS for direct access by the social care team. We also ensure a copy is sent to the child/young person’s GP as central record holder.

A copy of the health care plan is sent to carers and the young person themselves if age appropriate.

5.1 Initial Health Assessment (IHA) Process:

Assessment Clinics exclusively for our children in care have run on a Saturday morning and have been based at the Children’s Development Centre at Milton Keynes Hospital. This reporting year double clinics have increased to meet the demand of the increase in CIC and clinics are also now being run midweek.

All Initial Health Assessments are completed by the Community Paediatric Team. The first assessment should be undertaken by a registered medical practitioner in accordance with the Children Act (Miscellaneous Amendments) (England) Regulations 2002. The framework used for health assessment completion is the British Association for Adoption and Fostering (BAAF) electronic form.

In Milton Keynes the community paediatric team has seen all children below the age of 5 for their statutory 6 monthly reviews. This is in recognition of the complexity of medical conditions that could arise in the younger age group. This also has the advantage that should an adoption medical be required a separate appointment is not required, reducing the frequency of medical appointments. The health assessment should not be seen as an isolated event but part of a continuous process reviewing and monitoring the health needs of every child and young person in care.

Initial Health Assessments completed in 28 day statutory timescale:

<table>
<thead>
<tr>
<th>Initial Health Assessments completed in 28 day statutory timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of IHAs due in month</td>
</tr>
<tr>
<td>April 2016: 100</td>
</tr>
<tr>
<td>May 2016: 89</td>
</tr>
<tr>
<td>June 2016: 24</td>
</tr>
<tr>
<td>July 2016: 12</td>
</tr>
<tr>
<td>August 2016: 67</td>
</tr>
<tr>
<td>September 2016: 67</td>
</tr>
<tr>
<td>October 2016: 12</td>
</tr>
<tr>
<td>November 2016: 13</td>
</tr>
<tr>
<td>December 2016: 17</td>
</tr>
<tr>
<td>January 2017: 11</td>
</tr>
<tr>
<td>February 2017: 14</td>
</tr>
<tr>
<td>March 2017: 8</td>
</tr>
</tbody>
</table>

Graph 4:

This highlights number of Initial Health Assessments due each month following admission into care.

Total due: 174
Number completed within 28 calendar days statutory timescale: **108= 62%**

This equates to a 3% decrease as compared to last year’s total of **65%**

**Factors impacting on delay of 66 cases:**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Impacting on cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent not received in reasonable timescale: (average used over 7 days after CIC status)</td>
<td>28 cases</td>
</tr>
<tr>
<td>Out of area request over which we have no control:</td>
<td>4 cases</td>
</tr>
<tr>
<td>Placement moves:</td>
<td>8 cases</td>
</tr>
<tr>
<td>Total DNA appointment’s offered:</td>
<td>3 cases</td>
</tr>
<tr>
<td>Carers unable to attend agreed appointment:</td>
<td>2 cases</td>
</tr>
<tr>
<td>Baby/child/young person in hospital at time of appointment:</td>
<td>4</td>
</tr>
<tr>
<td>ICO required:</td>
<td>4</td>
</tr>
<tr>
<td>No notification of when CIC status commenced:</td>
<td>8</td>
</tr>
<tr>
<td>Young person missing from care:</td>
<td>3</td>
</tr>
<tr>
<td>Capacity of clinic:</td>
<td>5</td>
</tr>
</tbody>
</table>

**Analysis of delay:**

It should be noted there is a significant increase in the cohort of children entering and leaving the care system in the last reporting year. (See section 2.3). Some children are made CIC status for safeguarding reasons and then leave care again before there is an opportunity to have an IHA. **It should also be noted cases can be affected by more than one factor impacting on the overall delay.**

There have been some highly complex cases; one involved a family of 3 siblings, where the local authority had obtained an Interim Care Order through the courts. These cases were known to health and as such, an impact on timeliness was predicted.

Obtaining consent remains the highest factor in delay. The complexity of individual cases and additional pressures affecting obtaining consent is recognised, such as refusal of parental/young person engagement. However, this would not account for the significant figures affected due to late consent.

In the month of November out of 13 IHAs due, only four were completed in timescale. In two cases consent was not obtained until day 19-21.
In the month of December, in one particular case consent was not obtained until day 42, despite repeating escalation and the health team going directly to the SW on two occasions. These levels of delay must be avoided.

In the month of January out of 11 IHAs due, only one was completed in timescale. In nine cases consents incurred excessive delay and in nine cases, consent was not obtained until day 10-33.

Reviewing the process of obtaining consent promptly has been a core part of our work through the year.

There were a total of 12 unaccompanied asylum seekers who required a process of age assessment. This can be a lengthy process and can lead to delay in progressing IHA.

There were a total of eight out of area requests for Milton Keynes children over which we have little control. When a request for completion has gone to a different local authority because of geographical distance we have limited influence of timescale. Placement moves in complex cases are sometimes necessary for the child part way through the process. This will add to delay but is unavoidable. We must recognise every child’s needs are assessed fully by MK-CSC and placement will only change after careful consideration.

There were a total of 3 young people who missed their booked appointment. 2 related to carers not bringing them as agreed, 1 was a young person who required a mental health assessment and was subsequently admitted to a specialist unit.

In five cases, capacity of clinic was an issue due to demand, and this took the timescale just outside the 28 days.

CIC Nurse went to see one young person in placement due to the complexity of her presentation, which meant she was unable to attend an assessment in clinic. Consideration of how to complete an effective assessment must be given in individual cases, particularly of young people hard to engage. The complexity of this case was known by the Designated Doctor. IHAs are all quality assured by the Designated Doctor.

There is a robust process where Health Administration notifies the Named Nurse CIC when appointments are missed. The Social Worker of that case is then informed.

**Obtaining parental consent for the Initial Health Assessment:**

In order to meet statutory timescales, co-ordinate, complete and process assessments, we aimed to have paperwork, including parental consent received from the SW for the assessment within 3 days of CIC status. The responsibility of obtaining consent and sending all paperwork required for the Consultant Paediatrician to complete an IHA for a child brought into care, lies with the local authority. The assessment cannot proceed without written consent.

In reality, this is a tight timescale and does not take into account loss of 2 days over weekends or bank holidays. If consent is not received from the social worker within 7 days, protocol is that cases are escalated to Management. This ensures health aim for completion within the statutory timescale of 28 days to the best of our ability.

There is an agreed target between MK-CSC and health for completion of Initial Health Assessments within a timeframe of 25 days from health receiving consent. This was in recognition that the health team do not have control over gaining consent from the parent.

**Quarterly percentage of consent obtained within 3 days of becoming a looked after child:**
Consent received from SW within 3 days of CIC status - percentage per quarter:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>32%</td>
<td>10 out of 35</td>
<td>24%</td>
</tr>
</tbody>
</table>

This equates to a total annual percentage of 26% and is an improvement on last year’s total annual percentage of 9%. An additional problem relating to the remaining cases being seen in time scale was the extensive delay which affected numerous cases.

Initial Health Assessments completion within 25 days of receiving consent:

**Graph 5:** Number of IHA’s due monthly following receipt of consent and number of IHA’s which were completed within 25 days of receipt of consent, including monthly percentage: April 1st 2016- March 31st 2017

**Due:** 170.
**Completed:** 136 = 80%

Factors impacting on delay of 34 cases:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of area request over which we have no control</td>
<td>10</td>
</tr>
<tr>
<td>Baby/child in hospital</td>
<td>3</td>
</tr>
<tr>
<td>Just outside timescale-Day 29/30</td>
<td>8</td>
</tr>
<tr>
<td>Carer missed appointment booked</td>
<td>2</td>
</tr>
<tr>
<td>Young person declined</td>
<td>1</td>
</tr>
<tr>
<td>Child best interest</td>
<td>1</td>
</tr>
<tr>
<td>Reason</td>
<td>Count</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Child moved placement day before appointment</td>
<td>2</td>
</tr>
<tr>
<td>Appointment booked but young person went missing from care-(subsequently re-booked)</td>
<td>2</td>
</tr>
<tr>
<td>Clinic capacity affected cases</td>
<td>3</td>
</tr>
<tr>
<td>Request delayed from CSC end, in error</td>
<td>3</td>
</tr>
</tbody>
</table>

**Analysis of factors affecting delay: Initial Health Assessments completed within 25 days of receiving consent:**

Of the IHAs due in the month following receipt of consent, **136** were completed in the 25 day timescale equating to a percentage of **80%**.

On analysing the cause of delay from a health provision perspective it should be noted **multiple factors affecting delay are sometimes identified**. The highest cause of delay in **10** cases was ‘Out of Area’ requests over which we have limited control. **2** related to highly complex cases and the children required had rapid placement moves to ensure their needs were fully met.

The remaining causes of delay are outlined in the above table. Sometimes young people do go ‘missing’ from care and in all cases they are located. The two young people highlighted above, did subsequently attend their appointment.

Social workers work hard with young people to engage them in the process. We are also respectful if the young person chooses not to have an assessment. Only one young person chose not to attend.

Clinic capacity has been affected but only affected **3** cases. Due to the increase in numbers of children and young people requiring health assessments, clinics have been double and have also been arranged mid-week when needed.
Actions by health & CSC to monitor and improve practice:

1) **Joint work commenced between health, CCG and MK-CSC on the development of ‘Consent to Placement and Medical Assessment form’**.

The benefit of this is twofold:

It enables the SW to obtain parental consent for the statutory health assessments to be carried out at the same time as parental consent to Section 20 when a child/young person is brought into care. This reduces the need for delay in what is a highly stressful situation. In cases of Interim Care Orders (ICO) and Full Care Orders (FCO) the SW can give consent.

It ensures parents have clarity of what is required as a statutory duty of care at the point of CIC status and that they are made aware of the reasons the assessment is required. They can then recognise our joint commitment to their child between health and CSC to ensure all their child’s health needs are assessed and monitored while in the care of the local authority.

2) **A monthly analysis of delay is compiled by the Named Nurse to track the cause of all delayed cases.** A report is sent to Head of Service Delivery, Head of Corporate Parenting and Team Manager of Corporate Parenting. This is so that any possible performance issues can be jointly addressed.

In addition to in the coming year the analysis will also be sent to the Service Director- children and families.

3) **Email requests for consent and the required paperwork is sent to the allocated SW immediately the child/young person is made CIC.**

4) **Liaison with the Safeguarding Team to notify health immediately a child/young person is made CIC.**

Preciously health was reliant on ‘LCS’ notifying us a child had been brought into care. Evidence showed this was not a robust method of notification.

5) **Performance is reviewed at each Health and Social Care Forum.** Actions if required relating to consent and paperwork process can be cascaded to teams.

6) **Training has taken place through the year across the SW teams.** This was to ensure all are up to date with their statutory responsibilities when bringing a child into care.

7) **BAAF assessment paperwork has been updated.** This was already in process and is in line with recommendations made by the Care Quality Commission (CQC). The assessment paperwork has increased to capture robust information from all health professionals, which takes additional time to collate from across health systems. Nurses have full access to Systm1; assessments include a health promotion section and over all compiling the assessment in a more lengthy process. An assessment for one complex case can take on average up to 6/7 hours to compile. This includes travel, seeing the child/young person, gathering multi-professionals views for a holistic overview and writing the report.

8) **Business support from MK-CSC has been reviewed and hours increased:**

The complexity of co-ordination for CIC Business Support and recommendations is well evidenced. The *Intercollegiate Role Framework Guidance for Children In Care (2015)* advises on the complexity of co-ordination across services and different electronic systems and advises the need for this to be a dedicated role. Meetings took place on three occasions between health and CSC to review the admin
requirements, procedures and allocated hours. The business support role has been increased to a full time position from CSC.

**Review Health Assessment Process**

Annual Review Health Assessments for children and young people 5-18 years of age are completed by the CIC Nurse. This role has significant advantages for the children and young people in the care of Milton Keynes Authority. One key area being that review health assessments are completed by the same nurse therefore promoting continuity for the child/young person. This is our Specialist Nurse’s 7th Year working within the MK-CSC Team. Consistent knowledge of the health and wellbeing of the child through their time in care is highly valuable in the assessment process for the child/young person and for their carers.

The child/young person can be seen either at home, at school or at an alternative suitable venue of their choice. Liaison takes place with the child/young person’s foster carer so they can be involved as appropriate in the process. Health assessments are usually requested to be completed outside school hours so as not to interfere with education. Such appointments are offered after school and the Specialist Nurse can also offer to see young people on a Saturday on occasion if needed.

**Review Health Assessments completed within statutory timescale:**

![Graph 6: Number of Review Health Assessments due completion each month and how many were completed within timescale: April 1st 2016- March 31st 2017](image-url)
Due: 306
Completed in timescale: 242 = 79%
Factors impacting on delay of 64 cases.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of area placement</td>
<td>25</td>
</tr>
<tr>
<td>Carer unable to attend appointment offered</td>
<td>2</td>
</tr>
<tr>
<td>Child in hospital</td>
<td>2</td>
</tr>
<tr>
<td>Care Missed booked appointment</td>
<td>2</td>
</tr>
<tr>
<td>Young person declined</td>
<td>3</td>
</tr>
<tr>
<td>Paediatric review required</td>
<td>3</td>
</tr>
<tr>
<td>Wrong Carer details sent to hospital</td>
<td>3</td>
</tr>
<tr>
<td>Placement of child changed</td>
<td>3</td>
</tr>
<tr>
<td>Unaccompanied Asylum Seeking Child had DOB lowered, which affected need for RHA</td>
<td>1</td>
</tr>
</tbody>
</table>

Analysis:

There were a total of 306 review health assessments due in the reporting year. This is an increase of 20 assessments requiring completion compared to last year’s figure of 286.

Children who are placed out of area continue to have the biggest impact on delay for RHA completion totalling 25 (8%).

The CIC Nurse will travel up to two hours to see children in the care of our authority. There are occasions when the distance to travel to a child makes it impractical for the CIC Nurse to complete. Each case is considered individually. It may also be more beneficial to the child if completed by a local professional who knows them and who has knowledge of local health resources. This is in line with recommended good practice: The need for a ‘child-centred approach’ is highlighted ‘staff where the child lives are more likely to be aware of the availability of local services which can meet the child’s needs’. Statutory Guidance on Promoting the Health and Well-being of Children In Care (DCSF&DH 2015). In this instance an agreement would be secured via the Children’s Commissioner for the assessment to be completed locally. Challenges to this process are not exclusive to Milton Keynes but are a nationally recognised problem. It is acknowledged that timescales for completion are varied in other authorities due to their own individual pressures of work load. We are experiencing increasing numbers of CIC Teams covering other authorities who are declining to see MK children due to their own problems with capacity to do so. This not only leads to additional delay, but also to time spent having to source a GP who will complete an RHA for us.

We do accept on occasions appointments may need to be changed at short notice as the carer or young person may not be able to attend an agreed date.

In the cases where a young person declined, two of these had Care Leavers Health Reports compiled. Although we endeavour to see all young people up to the time of leaving care, we are also respectful when a decision is made by the young person declining. In each case, there were no raised health concerns.

One young person was connected to the Youth Offending Team (YOT). In this case, the nurse working for YOT liaised with the CIC Nurses and we discussed areas of concern and the actions she was implementing. This young person frequently declines seeing professionals, so we were already highlighted to the fact it would be problematic for him.
We had three children with complex health issues who we assessed as it being beneficial for the child to be reviewed by the Consultant Paediatrician who knew them child well.

Accuracy of paperwork from SW has been problematic on occasions. Sometimes children are moved and health is not notified. This leads to additional delay for some children and compromises timescales.

The complexity of cases has increased and been recognised across health. Though we have not compiled an analysis on this, experienced clinicians have highlighted an evident impact. Examples of this would be increased Child Sexual Exploitation and drug misuse identified leading to risk in presentation and safeguarding required, children requiring significant attachment and trauma work due to their levels of distress and impact on their mental health, children affected by their background prior to coming into care, leading to difficulties for them securing a stable placement.

**Actions taken by health:**

For the first time since the CIC Nursing Team was developed to ensure the CIC Nursing team had capacity to comply with additional numbers of children requiring a health assessment, we were authorised to use two Bank Nurses who had specialist experience to support when demand on assessments indicated. This is the first year we have required Bank staff due to increase in numbers of CIC.

It should also be noted that there has been a difficult year for SW stability, leading to frequent SW changes for some children and young people. This does have an impact on placement stability and also new SW being knowledgeable on their responsibility in sending timely and correct paperwork for a health assessment to be completed, including up to date placement information. This is recognised by CSC and is being addressed.

**Out of Area Requests:**

Statutory guidance states: Under the Children Act 1989, CCG’s and NHS England have a duty to comply with requests from a local authority to help them provide support and services to Children In Care’. (Promoting the health and well-being of looked-after children-Statutory Guidance for local authorities, clinical commissioning groups and NHS England March 2015 P.8)

This year we received a total of 51 requests to complete a health assessment for children placed in our area by another placing authority. The health team prioritise MK children/young people, as other providers do for their own locality. Four of these were subsequently cancelled by the requesting authority.

*(Statistics supplied by Performance Management Team Children’s Social Care)*:

**5.2 Immunisations**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milton Keynes: Published 2015/16</strong></td>
<td>89%</td>
</tr>
<tr>
<td><strong>Milton Keynes Average Provisional 2016/17</strong></td>
<td>88%</td>
</tr>
<tr>
<td><strong>England Average Published 2014/15</strong></td>
<td>87.8%</td>
</tr>
<tr>
<td><strong>England Average Published 2015/16</strong></td>
<td>87.2%</td>
</tr>
<tr>
<td><strong>Stat neighbour Average published 2014/15</strong></td>
<td>92.1%</td>
</tr>
<tr>
<td><strong>Stat neighbour Average published 15/16</strong></td>
<td>88.1%</td>
</tr>
<tr>
<td><strong>South East Average Published 2014/15</strong></td>
<td>82.2%</td>
</tr>
<tr>
<td><strong>South East Average Published 2015/16</strong></td>
<td>82.1%</td>
</tr>
</tbody>
</table>
Immunisations remain at a high completion rate. There will always be some young people who refuse to have immunisations as advised despite the need being highlighted. Health promotion is always given by the health team in each case.

In addition we have had parental refusal for MMR’s being administered for children in care. Parent’s refusal to consent is fully documented.

All asylum seeking young people all require immunisations as per HPA guidelines for ‘Incomplete Immunisation Status’. This programme of immunisations is given over a three month period. Despite young people having this as a clear action on their health plans, not all are actioned by the Carer/SW.

Notification goes out to foster carers, social workers and IRO’s to heighten awareness and ensure this area remains central to health monitoring and is outcome as completed on recommendation of the health care plan.

5.3 Dental Checks Completed

<table>
<thead>
<tr>
<th></th>
<th>Milton Keynes: Published 2015/16</th>
<th>Milton Keynes Average Provisional 2016/17</th>
<th>England Average Published 2014/15</th>
<th>England Average Published 2015/16</th>
<th>Stat neighbour Average published 2014/15</th>
<th>Stat neighbour Average published 2015/16</th>
<th>South East Average Published 2014/15</th>
<th>South East Average Published 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90.9%</td>
<td>88.5%</td>
<td>85.8%</td>
<td>84.1%</td>
<td>83.3%</td>
<td>84.7%</td>
<td>86.1%</td>
<td>86.5%</td>
</tr>
</tbody>
</table>

**ANALYSIS**

Dental check statistics completion rate remained higher than the national average. Accurate recording of when a child/young person has attended is a difficult task; however we do endeavour to capture data as robust as possible. In addition the Independent Reviewing Officers are very proactive at recording health statistics to reflect the highest possible care in their Child Care Review Minute.

Some young people do refuse to attend appointments despite encouragement. The SW will continue to offer support and encouragement to attend. If specialist provision is needed due to a child or young person’s complex health needs, anxiety, or additional support for any other reason, they are referred to specialist dental services.

5.4 Registration with GP

All children and young people who are CIC are registered with a GP. Evidence for this is through all completed health assessments being posted as a statutory record as a central record. If a child or young person is not registered at the GP we have on record, the assessment is returned. This then triggers investigation from CIC Business Support, who contacts the carers, who ensure they are effectively registered. The assessment report is then re-sent.

5.5 Developmental Checks

<table>
<thead>
<tr>
<th></th>
<th>Milton Keynes: Published 2014/15</th>
<th>Milton Keynes Average Provisional 2015/16</th>
<th>England Average Published 2013/14</th>
<th>England Average Published 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>86.70%</td>
<td>89.40%</td>
</tr>
</tbody>
</table>
Milton Keynes developmental check statistics remain consistent at 100% completion rate.

### 5.6 Annual Health Assessments

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Keynes: Published 2015/16</td>
<td>93.2%</td>
</tr>
<tr>
<td>Milton Keynes Average Provisional 2016/17</td>
<td>91.8%</td>
</tr>
<tr>
<td>England Average Published 2014/15</td>
<td>89.7%</td>
</tr>
<tr>
<td>England Average Published 2015/16</td>
<td>90.0%</td>
</tr>
<tr>
<td>Stat neighbour Average published 2014/15</td>
<td>89.0%</td>
</tr>
<tr>
<td>Stat neighbour Average published 2015/16</td>
<td>91.3%</td>
</tr>
<tr>
<td>South East Average Published 2014/15</td>
<td>85.2%</td>
</tr>
<tr>
<td>South East Average Published 2015/16</td>
<td>86.8%</td>
</tr>
</tbody>
</table>

Milton Keynes statistic for completion of annual health assessments remains consistently high. It should also be highlighted the increase in demand of our service due to significant increase in figures as indicated in section 4.2.

### 6 Other Clinical Activity

#### 6.1 Sexual Health

This area of health is reviewed on all age appropriate cases as a key section in their CIC health assessment. If a need is identified, consideration may include discussion with the carer as appropriate with the young person’s consent. Confidentiality for the young person can be upheld by the health team as long as there are clearly no safeguarding concerns.

Milton Keynes has a specialist service BROOK Young People’s Contraceptive and Sexual Health Services for young people up to the age of 25 year’s. Confidential services include sexual health, contraception, counselling and education. They also run a Health and Wellbeing programme which can be 1/1 or group work, supporting young people to improve their own health and wellbeing and teach life-long skills. Programmes include focused interventions helping fostering of healthy relationships, avoiding risky or in-appropriate sexual behaviour, as well as developing greater confidence and self-esteem. Young people can access the provision, or can be referred by a health professional.

MK-CSC also has regular invites to training which is free to attend. An outreach service is provided in schools, MK College and other partners’ premises developing greater accessibility for young people.

BROOK Nursing Team has a close working relationship with the CIC Nurses, recognising the vulnerability and complexity of this group of young people. Complex cases/young people identified as at risk are discussed with BROOK on an individual basis. A robust service is actioned for young people who are of significant concern. BROOK also provided an outreach service for young people difficult to engage. This is a highly valuable resource for Milton-Keynes young people.
BROOK also work with newly arrived communities, refugees and asylum seekers. Work can explore the laws within this country relating to sexual relationships, consent and safety. Often young people will not have received education in their own country and also may be embarrassed by the subject being broached with them. It is important to offer them a confidential space to explore any issues related to relationships, sexual health and also feeling safe.

This service will be discussed and highlighted at the young person’s health assessment.

6.2 Teenage pregnancies:

One young person became a CIC who we knew was already pregnant and in need of support and safeguarding. There were four young people who became pregnant while CIC and have on-going support in place. Two gave birth in the last reporting year and are fully supported by health services and by CSC.

Within Milton-Keynes there is a specialist Lead Midwife for Teenage Pregnancy. She cares for young people 17 years of age or under at the time of booking. She provides all antenatal care throughout pregnancy and continues to visit postnatally. All antenatal care is provided in the family homes of the young parents unless the women request otherwise. This provides the young parents with continuity of care/carer and reduces the risk of missed appointments. Between April 2016-2017 there were a total of 46 bookings for Pregnant Teenagers 17 or under at the time of booking. Of these 14 were open to Children Social Care and 6 were open to Children and Families Practices. As the Lead Midwife for Teenage Pregnancy she also attended Child Protection Conferences, Core Group Meetings and Family Support Meetings.

The CNWL- Milton Keynes Family Nurse Partnership was decommissioned 1 April 2017 and transferred to the universal health visiting service. Alternative models of intensive support for young parents within health visiting for vulnerable families are being explored and a multi-agency Vulnerable Families Pathway is being launched to ensure early identification and referral to access services is maintained.

6.3 Substance misuse

Substance misuse is significantly more prevalent in the looked after population; evidence cited in the Care Matters White Paper (DfES, 2006) indicates that Children In Care are four times more likely than their peers to smoke, drink alcohol or use street drugs. The Government requires local authorities to collect statistics about those who have been looked after continuously for more than 12 months. They must also capture how many of those young people identified have accepted intervention for support. BAAF: Promoting The Health of Children In Public Care (2015).

All young people have substance misuse covered as a key area in their CIC health assessment. All who are identified as having a difficulty with substance or alcohol use or who may present at risk of developing a difficulty, will have access to support. The importance of early intervention and prevention is fully recognised and social workers are active in accessing/offering support immediately a problem is identified. The importance of moving towards a wish to make change is promoted, though not always accepted by the young person.

Compass is a national charity which MK-CSC commissions to provide a service for young people under the age of 18 living in Milton Keynes. They deliver targeted and structured work supporting young people with drug and alcohol problems and also support parents/carers. Compass use a range of interventions including Cogitative Behavioural Therapy, motivational interviewing, harm reduction and solution based therapies. 1/1 work is not time limited, rather goes on the presenting needs and engagement. Guidance can also be provided for family/carers if there is a young person who is causing concern.
There is no reliable data captured on this statistic in MK-CSC. This is due to the fact the current way of capturing this data robustly via LCS is too complex. Through the year changes to the process for capturing the statistics were unsuccessful. It will therefore be on next year’s priorities.

6.4 Emotional Health and Wellbeing

The Needs of Children in Care:

Children in Care and young people have consistently been found to have much higher rates of mental health difficulties than the general population, with almost half (three quarters of whom will be in residential homes) meeting the criteria for a psychiatric disorder. (NSPCC 2014 P.7: What works in preventing and treating poor mental health in Children In Care)? There are many reasons for this, including the experiences they have once they enter care which can further contribute to both the causes and the nature of difficulties. Despite this, there is evidence to suggest that many children, depending on individual circumstance, do better remaining within the care system as opposed to being returned home. Evidence also suggests that early intervention to promote mental health and wellbeing can prevent the escalation of challenging behaviours and reduce the risk of placement breakdown (SCIE 2010:28).

The clinical commissioning group commissions CAMHS services for young people who are placed out of area and require CAMHS support from their local service.

SDQ scores completed as a statutory duty:

From April 2008, all local authorities in England were required as a statutory duty to provide information on the emotional and behavioural health of children and young people in their care. The assessment tool used is the Strength and Difficulties Questionnaire (SDQ). This is a short behavioural screening tool assessing five key areas - emotional difficulties; conduct problems; hyperactivity or inattention; friendships and peer groups; and also positive behaviour, plus an “impact supplement” to assist in the prediction of emotional health problems. It is completed for all who have been in care for a period of 12 months or more who are between the ages of 4 and 16 inclusive (www.gov.uk).

212 scores required completion in the reporting year and of these 183 (86.3%) are recorded. The remaining 29 SDQ’s would have a ‘reason for no SDQ’ recorded meaning the reason is reviewed by the CIC Nurses. Some young people decline completion. Other reasons for no SDQ may be a child’s disability or level of cogitative function indicated on assessment by the Specialist Nurse it would not be a valuable tool to use for assessment.

The average score of the SDQ’s was 14. Scores of 17 and above indicate there is an area where the child/young person may be struggling.

It is significant that 70 out of the 183 (38.2%) were marked as having a score of 17 and above which is an indication of concern. This remains consistent with last year’s figure. In each case where a high score is identified, the CIC Nurses review and assess what additional support may be required or is already being provided.

The child’s social worker and IRO should also be monitoring the child’s progress and flagging cases of concern to the nurses for joint discussion.

Adolescent Wellbeing Tool:

How young people feel in themselves is central to any assessment. The limitations of the SDQ were recognised when assessing asylum seekers at their IHA. The Adolescent Wellbeing Scale is a tool devised as by Birleson to pick up possible depression in older children and adolescents. This scale is
completed in IHA clinics for all young asylum seekers to promote assessment of their needs to ensure their emotional needs on entering care were understood.

It can also be used as one tool for any young person in the age range 11-16 as need indicates either at assessment or if concern is raised that there may be symptoms of depression emerging.

**Play Therapy:**

Children in care can be referred to the MK-CSC Play Therapist for individual work if they present with difficulties relating to emotional regulation and it is an age appropriate intervention. Group work is also offered to help young people identify, manage and regulate their feelings by using narratives, sensory play and relaxation techniques. Feedback is given to carers and the children are provided with information to take home so they can be encouraged and supported to continue using whatever strategies they have learned at home. 4 children have received 1/1 therapy and 8 children within a group setting. In addition there have been 7 children who have had an assessment of their therapeutic needs completed to enable the social work team to access the correct provision for that child.

**Mental Health Service Provision:**

A Primary Mental Health Worker for Children In Care (PMHW-CIC) post is jointly funded between CSC and the Child and Adolescent Mental Health Service (CAMHS). This is in accordance with guidelines which state “In sites where CAMHS workers are co-located for part of the week, or where they are fully integrated into looked-after children and young people teams, the result is better and speedier access to CAMHS for looked-after children and young people.”(NICE guidelines CIC 2010)

The service has experienced some challenges of the past year in relation to retaining a PMHW in this position. The Role of the Primary Mental Health Worker for Children in Care and its functions has been revised as part of the work of the local CAMHS transformation plan. The liaison and support function of the role has been strengthened the focus of working with other agencies to ensure that the emotional wellbeing and mental health needs of Children In Care (CIC) remain prioritised, acknowledging that these children are some of the most vulnerable within our community.

The new revised role will ensure all children in care will have an assessment when they become looked after, with a clear programme of intervention.

In addition consultation and advice to professionals and carers supporting the child will be provided and will work alongside the Primary Mental Health worker; this will be a key interface.

The commissioners acknowledge that children in care from outside the Milton Keynes area may require services. The expectation is that the provider will liaise with the responsible commissioner regarding the charges for such activity. This should not reduce the resource available for Milton Keynes children.

**6.5 Health Improvement Activities:**

**Well and Wise Event:**

In October we held a ‘Well & Wise’ event for young people aged 11-16 years. This was to involve young people in creative ways of talking about health and their thoughts and visions for the future. A total of 14 young people attended, including two sibling groups.

Heath Team involved in the event: Andrea Piggott - Designated Nurse for Children In Care, Emma Hosking - Youth Participation Worker, Carol Baines & Susan Johnson - Children In Care Nursing Team, Jane Bidgood - Health Watch MK, Richard Lee & Tara Tomlin - Youth Participation Team.
Activities included smoothie bikes, a session relating to sugar content in drinks, and a ‘cool’ and ‘not cool’ board session run by the CIC Nurses to capture feedback on health assessments. The final activity was a first aid session, run by St John’s Ambulance.

This event was well received by the young people who participated. It promoted ‘health’ as an area of focus for them and they were pleased to be involved in health promotion.

A second event, run by Emma Hosking - Youth Participation Worker, took place in December 2016 with a group of 20 young people in care. The aim was for them to identify issues that ‘Our Voice’ could concentrate on during 2017.

After a discussion and vote, the one topic ‘Our Voice’ wished to focus on was Health/ Health Assessments.

Exploring health through the ‘Well and Wise’ event helped put health on the radar for 2017. Work will continue with children, young people and care leavers to unpack what they would like to improve about their health and the health assessment process.

They are currently working on ‘Understanding Consent- What young people need to know’. A leaflet is under development.

Feedback from one young person aged 12:

\[
\text{‘It was sensational to learn about all the different aspects to health. I was happy that young people were being asked about their health assessments and we were able to say what we thought about it. We would like more events like this in the future.’}
\text{Looked After Child}
\]

**Invitation to GP Safeguarding Meeting:**

In January the Named Nurse CIC was invited to a Safeguarding meeting to discuss the health needs of CIC. This was a welcome opportunity to meet with GPs from across Milton-Keynes and highlight the role of the CIC Health team and promote joint working practice. We discussed statutory guidance, the roles of the multi-disciplinary teams- including the roles of foster carers in addressing health needs highlighted at assessment and the vital role GP services provide for CIC. We discussed evidence of good practice and we also considered what the CIC Health Team could do to support GP services. We reviewed the specific needs of ‘Care Leavers’ and the fact that these young people remain the most vulnerable group, post CIC status and beyond, as they move into adulthood. It was highlighted that if a young person had been a CIC at any point, being mindful of that would be highly beneficial, when they access support from their GP.

We promote strong links with GP services. Evidence indicates we receive from GP Services in relation to our CIC and queries come directly to the CIC Nursing Team.

**Milton-Keynes Safeguarding Children’s Board (MKSCB) on-line Safety Task and Finish Group:**

Named Nurse CIC was invited to join the ‘Online Safety Task and Finish Group to promote education regarding on-line safety. This was chaired and co-ordinated by MKSCB. This recognised the need for increased awareness by professionals, parents, schools, parents and children and young people. An Internet Safety day was held titled ‘Be the Change: Unite for a better internet’. (See Appendix 1).

MKCSB supported the day and also worked with the fostering team to look at internet safety for foster carers and CIC. Child Sexual Exploitation (CSE) was made core training for all foster carers and as part of this- internet safety training is covered.
**Health Promotion has been added to all IHA and RHA assessments.**

MK-CSC and Independent Reviewing Officers were notified of the additional section being added to all Health Care Plans. Health promotion is ‘Everyone’s business’ and is driven by the CIC health team.

**6.6 Overweight/Obesity**

Eating problems and food-related behavioural difficulties are more common in those who are, or have been, in care. 24% of children aged 4 to 11 years who were looked after showed difficulties with eating patterns, including over eating, stealing and storing food Tarren-Sweeney (2006). Eating issues can relate to experiences of poverty, chronic neglect and emotional distress.

As part of the health assessment process, all children and YP are weighed and measured. This is a great way to engage the children and many love to see how much they have grown. The BMI is calculated if we have a concern about their weight either being too low or a high. Centiles are also recorded.

We use the assessment process for health promotion and will of course advise and support the child/carer where needed. Often children can be very food focused so it is important to be sensitive about this and advise accordingly.

**Signposting for support:**

If a child/young person is overweight and it is felt external support/guidance may be helpful a referral can be made to *MK Dons Sport & Education Trust ‘Get Set Parenting’*. This is a 10 week programme and is a resource for MK families. It has been designed to deliver fun, interactive and informative sessions that provide parents and their children with accredited and evidence based information, strategies and tips to live a healthier family life, both emotionally and physically.

If a child/young person is placed out with MK then a local re-source is sought. Dietician referrals are also considered when there is concern. Health promotion is also put on the health plan as a resource for carers and young people to access together:

**6.7 Unaccompanied Asylum Seeking Children Seeking Asylum: (UASC)**

In the last reporting year there have been 12 young people seen for an Initial Health Assessment. Of these 12 young people, only 1 was female. There were a further 2 females who were due to be seen, but they went missing from care.

Comparing these figures to the previous year there were 24 young asylum seekers who required an IHA. Of these, 3 were female. This is a 50% drop in the last reporting year.

In addition to this figure, there have been young people seeking asylum who have been age assessed by CSC as clearly over 18 years of age. When a young person is assessed as being above the age of 18 they are directed to adult service provision for support.

Assessment for all young people seeking asylum is additionally problematic due to language barriers. MK-CSC provides translators for all health assessments and for parents/carers where a language barrier is evident. It is acknowledged the process can be difficult and upsetting. Some young people present as traumatised from their journey and experience. ‘Unaccompanied children often have additional factors related to their past, experiences of loss and bereavement, often including war trauma, torture, trafficking. They may have specific health issues relating to their country of origin, experiences on their journey and situation and circumstance since entering the UK’. *BAAF Promoting the health of children in public care (2015).*

The health team and the Social Workers aim to handle this with the utmost sensitivity and compassion and the Initial Health Assessments are undertaken as quickly as possible. The health
history for young people who are seeking asylum will be incomplete as they do not have traceable health records. Immunisations are offered as per Health Protection Agency (HPA) guidelines for ‘Incomplete or Unknown Immunisation Status’. They also tend to have travelled from countries where health resources and health screening are limited. The Consultant Paediatricians refer to ‘Country of Origin’ information, which gives guidance on the prevalence of certain health issues of concern in various countries. The Initial Health Assessment is key in identifying and actively addressing health problems in these children.

The CIC Health Team has a joint protocol for confidential sharing of health information with Thames Valley Police Nursing Team. This is currently under review.

MK Hospital have an agreed process for a direct link with the Paediatric on-call Consultant to ensure young people requiring further medical assessment or intervention when they are initially assessed are referred to the hospital and seen without delay. It is acknowledge for young asylum seekers, that their journey will have been long, distressing and frightening. They will not be used to hospital environments and as such, the care they receive from our health provision is aimed to be as supportive as possible.

As of 31st March 2014, there were 41 UASC (Unaccompanied Asylum Seeking Children) in the care of the local authority.

Unaccompanied Asylum Seeking Children Seeking: Specialist Provision from MK-CSC:

A representative from the Children’s Section Advisor for the Refugee Council runs an ‘immigration surgery’ on a fortnightly basis for the UASC (He is notified what YP would like advice and can access information on their case in preparation. Interpreters are provided by MK-CSC. This provides young people with advice and guidance on any aspect of their immigration. This is a highly useful provision where young people can be helped to understand the process of their immigration claim more fully and hopefully alleviate any worries they may have. The Refugee Council, where possible, will also attend appointments with the UASC at the Home Office and often provide UASC with contact details during their ‘surgery’ appointment so they can be contacted independently if support is required in the future. The Refugee Council can visit a UASC at their placement after their initial surgery appointment if the young person or their carers makes direct contact. The refugee council are an invaluable resource that can offer ongoing support throughout the asylum claim if required and accessed. The process of family tracing through the Red Cross, where children would like to trace their family, both in the UK and abroad is also supported.

Improvements have been made to ensure that CIC medicals are booked in as promptly as possible. The business support for CIC at MK Hospital liaises directly with a named person in the Social Work (SW) team ensuring Initial Health Assessments are scheduled and interpreters and transport are arranged for attendance and the plans are clear. This also ensures the clinic appointment runs smoothly and children are seen within timescales, where feasible.

Young people will have a daily welfare check arranged through the MK-CSC Team with a professional from the interpreter service. If there are any concerns or queries, this will be relayed directly back to the CSC team. This service is adapted depending on individual need, so that welfare checks can continue until the young person is settled and as secure as possible. This can be a process over months depending on need.

Youth Services run a youth group specifically for asylum seeking children called ‘New2UK’. This offers socialisation opportunities and informal learning around cultural differences, practical skills, language, employability etc. for MK based young people aged 13 to 19 and new to the UK. The project can also offer targeted support to individuals in any areas we feel would be beneficial. The young people we have attending have really enjoyed it. Day trips and smaller afternoon trips out are arranged to explore the local community and wider areas such as London. Last year the youth service
also offered the 3 day ‘Outward Bound’ residential trip to Wales which will be an annual arrangement and last year a number of UASC were able to attend. The programme is designed to give young people an opportunity to enjoy a variety of adventurous and challenging activities in a safe and supportive environment.

6.8 Care Leavers:

There are currently 149 Care Leavers open to the Corporate Parenting Team. CSC is in touch with 98% of these young people. Health professionals play an important role in promoting health and helping to empower young people as they prepare to leave care. Transitions to adult health provision need to be secured in plenty of time to ensure no young person falls through a gap in service. Preparing to leave care is a highly anxious time for young people, as they incur a lot of change and disconnections from professionals who have been caring for them. It is imperative they are central to all plans of care and understand who will be available for them.

A Care leaver group CIC+ was launched in Feb 2017 offered to all those age 16 and above. The group meets every other Tuesday evening. Two care leavers were also involved in the recruitment of the chair of the trustees for the Royal College of Paediatrics and Child Health.

In the last reporting year there were 31 Care Leavers Health Records compiled for young people who had CIC status ended. The care leaver’s health record gives young people a health history of what information we have compiled since they have been in care. They will also be provided with a list of useful health re-sources and invited to contact the nurses at any point either directly or via their personal advisor. (See appendix 2).

6.9 Other Complex Case Work

Strategy Meetings:

As part of the role of the CIC Nurses, we are requested to attend strategy meetings in relation to complex or high risk cases. Tasks we have been involved with can relate to accessing health provision a young person may need, e.g. sexual health screening or support, liaising with services to fast track reports-e.g. Police medicals, child protection reports, and generally giving an overview of the young person’s health or supporting identification of where risks may lie.

Liaison also takes place directly with GPs, such as if a young person has a possible eating disorder. There have been three cases where direct links with GPs have been made, prior to them seeing the young person, so they know why they are attending and know where we have identified risk. We highlighted the history of the young person’s presentation and where our concerns were in particular in relation to risk. We requested specific health checks and supported referral to CAMHS.

We had one child where concerning medical information came to light from a social worker which required liaison with the On-Call Paediatric Team out of hours, to advise on risk. A child protection medical then followed.

The benefits of health teams working together are very much at the forefront of our service.

Child Sexual Exploitation (CSE):

Children and young people who are looked after can be highly vulnerable to child sexual exploitation. All those involved in their care must be clear and proficient at noticing warning signs, completing risk assessment screening tools and raising concerns whenever a child may be at risk of, or potentially subject to, sexual exploitation. No CIC should be considered low risk. Cases of concern are referred for discussion to the Multi-Agency Risk Management Meeting (MARMM). Social care, police, health
and voluntary sector professionals will scrutinise the plans and put actions in place to protect the child, disrupt CSE activity and deal with potential and actual perpetrators.

The current level of CSE cases in MK has increased and this is in line with a national picture. An analysis was completed indicating significant gender split of female/male ratio showing 27 (76%) female and 8 (24%) male, young people requiring intervention and on-going monitoring.

The low rate of identified males is a reflection of the national picture and recognition of the risk of under reporting.

Ages of CSE cases ranged as young as 12 through to 18 years. Females in the age range of 15 years were of significant risk.

7. Adoption & Fostering: National Statistics:

National Adoption Statistics:

Statistics for reporting year 2017 have yet to be released however there is evident decrease nationally on children adoption figures. The Child and Family Courts who grant adoption status support the aim that children are placed within their family network under Special Guardianship Orders granted by the courts, unless there are safeguarding concerns or indications that this is not in the child’s best interest.

Milton-Keynes adoption figures in the last reporting year:

Adopter approvals completed: 4. This indicates a decrease of 8 adopter approvals when compared to the previous reporting year of 12.

Adoption orders granted: 11. This indicates a decrease of 12 adoption orders granted when compared to the previous reporting year of 23.

36 children were assessed as adoption being in their best interest. This indicates an increase of 24 children, when compared to the previous reporting year figure of 12.

Age range below 1 year: 5. Previous reporting year: 2.
Age range 1-4 year: 22. Previous reporting year: 6.
Age range 5-9 year: 9. Previous reporting year: 3
Age 10-15 year: 0. Previous reporting year: 1

At the current time 10 children are ‘waiting’ for a family to be identified for them compared to previous reporting year of 4.

The approval figure for adopters is significantly different this reporting year owing to a halt in our recruitment of adopters. This was a nationwide action by other adoption agencies owing to the marked reduction in children who were being placed for adopter’s vs the high volume of approved adopters who were waiting for a placement.

MK-CSC Adoption Team has now resumed adoption recruitment and has several couples in the process of assessment.

Special Guardianship Orders (SGO) Granted:

In the last reporting year there were 24 SGO granted through the courts. This is an increase of (50%) on last year’s figure of 12.

Review of possible options and move to proceeding to assessment for an SGO is considered best practice to promote a secure placement for a child if possible with family members or close family friends first.
CNWL-MK Designated Doctor as Medical Adviser

The Designated Doctor in her role as Medical Adviser is a member of the Fostering and Adoption panel. The Fostering and Adoption panel is going through a period of significant changes due to changes in legislation and national directives.

Meetings are held between the Medical Adviser and the MKC Professional Adviser to ensure all relevant health issues are fully considered for each case. The Medical Adviser also reviews the health assessments of prospective adopters and foster carers completed by their GP and provide written comments for consideration at panel.

Medical Advice and guidance are provided to panel. The Medical Adviser also meets with all potential adopters to clarify individual health needs of the child. Some may have health issues which cause the prospective adopters a level of uncertainty. It is crucial that they are given expert advice, guidance and time to explore concerns fully and openly. Advice and guidance is also offered to social workers required for presentation at fostering and adoption panels when there are particular health issues which require specific consideration for a secure placement.

Consultant appointments also take place in relation to ‘best interest’ decisions for a child. It is imperative that a child’s health needs are fully discussed to ensure they have the best possible decision made for them so their long term health needs are fully supported.

There have been 215 adult health medicals reviewed which is an increase of 6 cases on last year’s figure of 209. There has been an increase in adult medicals for connected persons or family members who are putting themselves forward to be considered as carers. There is higher level of medical issues or lifestyle issues in these group of carers compared to carers who are not related to the children. This has its intrinsic challenges in ensuring the welfare of the child remains paramount.

‘Best Interest’ decisions and Paediatric Consultant meetings with prospective adopters:

There were 15 ‘best interest’ decisions in the year, compared to 16 in the last reporting year.

9 children were discussed with prospective adopters, compared to 7 in the last reporting year.

By comparison, 16 children were discussed with prospective adopters, of reporting year 14/15.

This indicates a clear reduction in the number of medical discussions, a reflection of the overall reduction in the number of children who are placed for adoption.

Foster and Adoption Panel Process:

The Named Nurse and the Specialist Nurse are members of the fostering and adoption panel which meets every two weeks. Their attendance is alternated to ensure there is health representation at panel. Health representation covers all aspects of physical and emotional wellbeing in relation to the child and the prospective foster carers when considering placement suitability. Individual requirements are considered and discussed with the key focus being for a secure, stable and nurturing placement. Foster carer reviews, terminations and change to agreed placement are also heard.

This reporting year 27 panels were held-as compared to the previous reporting year of 26.
There were 3 adopter approvals, 3 adoption matches and 1 child placed for adoption through panel.
Training:

CIC Health Team Medical and CIC internal Training:

There was a joint CIC medical and nursing team training in December. The health assessment training was to ensure consistency in assessments across both the nursing and medical team and share practices on health promotion in CIC assessment following the CQC inspection in August 2016. The updated CoramBAAF health assessment forms were also reviewed to improve quality of information obtained, encourage professional curiosity and identify children and young persons that are at risk of harm. The importance of the ‘voice’ of the child, young persons and their Carers and their contribution to their health plans was also emphasised. There is a follow up plan to audit the impact of the training on the quality of health assessments and health plans. A second joint medical and nursing team training took place on substance misuse in young persons in Milton Keynes. It was delivered by ‘Compass’ manager. The updated BAAF form now includes section exploring if the young person is known to Compass and if they would like a direct referral to Compass.

Social Workers Training:

The CIC Nurses offer sessions for social workers who join MK-CSC to advise of the health assessment process and their roles and responsibilities. This provides a valuable opportunity to let them know who we are and that we can be accessed for health advice at any time.

The CIC Nurses also provide sessions for all social workers working across teams in MK-CSC. This promotes strong partnership working and gives the opportunity for any health queries or process queries to be covered.

We rely on CSC managers highlighting to the SW the need to be aware of all health related processes.

Training for Foster Carers:

The CIC Nurses provide training for foster carers ‘Good Health for Children In Care’ and ‘Medication Safety’. There is a substantial and embedded training programme run by MK-CSC for carers. The CIC Nurses also attend training sessions for new foster carers to highlight their role and responsibilities in promoting the health of the children in their care.

Fostering Changes Course:

This course is facilitated by two Fostering Social Workers and the CIC Specialist Nurse.

This course provides practical advice and training for foster carers caring for children below age 12 years, to develop their skills in managing difficult and challenging child behavior and forming positive relationships with their foster children. It brings a collaborative approach to training and was designed for use with foster carers in the local authority, voluntary and independent sectors. It draws substantially on ideas from current parenting training programmes using a cognitive behavioural approach in order to develop skills. Evaluation of the course has shown significant improvements in carer–child interaction, specific child problems causing most worry to carers and child emotional symptoms. It has also demonstrated a beneficial effect on carers’ sense of confidence and self-efficacy.

This year’s fostering changes course ran between the end of January to the end of April 2017 and was run by the CIC Specialist Nurse and 2 Fostering Social Workers. A total of 10 foster carers participated- 9 mainstream and one family linked. There can be a misplaced focus from carers on occasion as they think the emphasis is on the child’s behavior being ‘fixed’. Fostering changes central point is in fact about looking at the behaviors a child may be presenting with and then understand what might be behind this. Carers can then learn how to manage these by focusing more on the positives rather than the negatives. Change is therefore effected by using alternative strategies.
Part way through the course one carer left due to placement break down, despite initially doing well with support and guidance, sadly she found she was unable to sustain the placement. One other carer left as the children she was caring had their placement moved. We do ask the SW teams prior to the course starting to identify carers suitable to attend this training. Criteria requires having an appropriately aged child and be in a long term position, so that it is unlikely the child will be moving. Circumstances can change particularly quickly in the fostering world and a move was unavoidable in the latter case.

Feedback from carers:

‘The course helped me be more aware of my relationship with the child. I can now reflect on how I respond to behaviours and use strategies which have positive effect.’

‘I wanted to thank you for the hard work you put in to delivering the course to us all... it was very helpful and interesting. It must be so hard for you all with so much negativity from foster carers and trying to support everyone with their issues! As you know I have worked for most of my fostering time and not really met many foster carers before, so it was nice for me to make some friends from the fostering world’.

9 Service Improvements:

Priorities were highlighted for addressing in the Annual Report 2016/2017. All were completed apart from ‘Improve the recording of substance misuse’.

This is an on-going challenge for MK-CSC due to the fact the current way of capturing this data robustly via LCS is too complex. Through the year changes to the process for capturing the statistics were unsuccessful. It will therefore be on next year’s priorities.

9.1 Specific Improvements:

1) BAAF IHA and RHA paperwork has been updated:

To ensure we have reviewed evaluated existing forms and are using best practice for assessments in line with statutory guidance.

2) Quality Assurance:

To ensure all assessments completed reach the highest possible standard.

All IHA and RHA assessments completed are now quality assured and in addition all practitioners undertaking assessments are required to QA their work as part of that process.

3) Health Promotion has been added to all health assessment care plans to promote general wellbeing, knowledge of health and best practice:

To ensure this essential component of the health assessment is utilised fully as an opportunity for health education.

4) Consent to Placement and Medical Treatment forms developed and agreed by CNWL-MK, CCG and MK-CSC.

To promote consent for the statutory health assessments immediately a child/young person is brought into care.
5) Access for CIC Health Team to Systm1:

All CNWL-MK Health Professionals now have direct access to System1. All have been provided with computer access, including laptops for mobile working, to ensure practitioners can access health information across disciplines and ensure up to date information can be gathered and put directly on to children and young people’s records. The CIC Nursing Team has a designated unit for CIC to ensure health records can be kept up to date. As the CIC nurses are based within the CSC, this ensures Systm1 is used are their main record system.

6) Update of Fostering Referral Forms:

To ensure all known key health issues are clearly documented when looking for a foster placement for a child/young person and this information is shared directly with the carer at time of placement.

Following a child being Police protected and needing an urgent foster placement the Named Nurse identified the fostering referral forms did not contain robust enough health information. Named Nurse liaised with the fostering team management to highlight that additional health information was required to be on all fostering referral forms. From a safeguarding perspective it is imperative these record- All known health or medical issues, medication known to be prescribed, known allergies and who the information was obtained from.

Form updated-January 2017.

7) COMPASS: Development of joint protocol. See 9.3

8) Review of Promoting the Health of Children In Care Protocol:

To ensure our joint protocol for health and CSC is fully updated in line with changes to practice. This will be reviewed through the Health and Social Care Forum.

9) Review of joint protocol with TVP for health information sharing:

To ensure health information gathered when a young person seeking asylum at the point of care by Thames valley police Health Team- is shared with CIC Health Team.

A change in practice of assessment format used by TVP Health Team has initiated a joint review. This is on-going with TVP health, Designated Nurse for CIC and Safeguarding and Named Nurse CIC.

10) Health Promotion Articles written by Named Nurse for foster care newsletter:

To ensure relevant health promotion is shared directly with foster carers articles were provided in relation to:

‘Flu vaccination’ and ‘Promotion of internet safety awareness and link to evidence based resources’.

9.2 Audits

Audit: Hepatitis B uptake and awareness among fostering households as of 31st December 2015:

Some children requiring fostering may have been at increased risk of acquiring hepatitis B infection.

Emergency placement may be made within a few hours: foster carers who accept children as emergency placement should be made aware of the risks of undiagnosed infection and how they can minimise the risks of transmission of all blood-borne virus infections. All foster carers who receive
emergency placement, and their families, should be offered immunisation against hepatitis B. Hepatitis B immunisation is recommended for foster carers and international adopters.

Only 38% of foster carers sampled reported being immunised against hepatitis B. 60% of the carers were not aware they needed immunisation. 78% have not had any training on Hepatitis B Prevention. Discussions have been held with the fostering team on improving hepatitis B uptake. Training /information on prevention of blood borne infection has been agreed in principle with the CIC nurses.

Collating and evidencing information relating to the awareness of all foster carers working for MK-CSC that Hep B immunisation is advised and whether they have chosen to get immunised has been advised to MK-CSC.

9.3 Partnership working:

COMPASS- Development of a joint protocol:

A joint protocol is in development to improve information sharing between health and Compass, promote interagency working and alert health professionals to local patterns of drugs and substance misuse. COMPASS Manager has also been invited to be part of the health social care forum.

COMPASS now highlight alerts of risk directly to the CIC Nurses which are then cascaded to CSC Teams.

Examples:

- **‘Blue Whale’ Challenge:** This is a social media site believed to have originated in Russia. Intelligence from Police indicated that young people are approached in a chat room and then asked to take part in ‘private chats’ before being given a list of tasks to complete. One of the tasks is reportedly getting young people to cut into their skin the image of a ‘blue whale’. Tasks then increase in risk over 50 days. Of high concern was that on the last task they are directed to commit suicide. This alert was cascaded across all CSC teams, including fostering to alert carers. A young person at risk was subsequently identified at risk and was immediately referred to A&E and CAMHS assessed.

- **Risk of death through aerosol inhalation:** After the death of a 12 year old in the UK, this alert was cascaded to SW Teams as a reminder of the dangers and risk some young people may not recognise.

Children In Care Health and Social Care Forum (HSCF):

The Children In Care’s Health and Social Care Forum meets quarterly aiming to provide operational support to the CIC health team and the MK-CSC team to meet health needs through multi-agency working. It has been chaired by the Designated Nurse for Children In Care and Safeguarding. The Head of Delivery of Corporate Parenting will be joint chairing in this coming year. Panel members include representatives from across health and social care teams to ensure collaborative practice and the sharing of ideas. This includes the Youth Participation Worker – Children’s Social Care. Independent Review Officers are also represented. Commitment to this forum has been impressive, despite the challenges of busy schedules. Joint ownership across health and CSC is promoted.

We invited COMPASS and BROOK to attend our HSCF to promote joint work across services. This can be on an open basis, as opposed to every meeting.
Standard Agenda Items quarterly discussed are as follows:

Updates from the ‘Safeguarding Forum’. The Primary Care safeguarding forums take place quarterly and all safeguarding lead GPs and Practice managers from MK are invited to attend. The forums are led by the Designated Nurse for safeguarding and Children In Care. The forums raise awareness of the needs of CIC and offer support to primary care staff in providing effective universal services for CIC.

Promoting the voice of the child/young person. This covers all areas, hearing and promoting their views and ideas and considers service change and development.

Analysis overview is shared of IHA and RHA assessments completed within timescales. This ensures any delays to statutory timescales are identified and practice issues addressed jointly between health and CSC.

Improving the provision of emotional wellbeing services and CAMHS provision for CIC and carers. Forum is updated on progress of the CAMHS Transformation programme and how Health and Wellbeing services for CIC are being prioritised.

 Priorities identified for the reporting year in the annual health report 15/16 were jointly reviewed and concluded aside from: Point 5- Improve the recording of substance misuse remains a challenge. This will be continued in the coming year’s priorities.

Joint work has focused predominantly on the following areas:

‘Consent to Placement and Medical Treatment’ forms were developed and progressed between Health, CCG and MK-CSC to address delays in paperwork and consent.

Hepatitis B Immunisation for all Foster Carers: Hepatitis B training clarified and to be provided for all foster carers ensuring a record is taken of whether carers have agreed/ or chosen not to be immunised despite advice.

Pathway for newly arrived asylum seekers reviewed: The joint protocol with TVP was reviewed. If during the health screening process the Police Nursing Team identify an issue such as dehydration, carbon monoxide poisoning, suspected TB or any other health issue requiring immediate care they can sign-posting the young person directly to the Primary Health Care Team at MK Hospital. It was recognised these young people require prompt access to assessment. They are likely to have already suffered significant trauma on their journey, are afraid, unwell and have limited English language.

Engaging young people in creative ways to talk about health: We discussed the launch of a health event to be held in October to capture the imagination, thoughts, feelings and ideas about health of young people in care. See also section: 6.5

Promoting the voice of the child/young person: The MOMO APP (Mind of My Own)

Preparation for the launch of the MOMO app across children’s social care:

This is an on line App. It is based on the ‘Signs of Safety’ model used within most areas of CSC. The App can be downloaded to most devices and offers a range of options, with independent access or with support of SW, IRO or other person who the child/ young person places trust. It allows non-verbal communication via the App of any issue- from a difficulty, if they feel angry, if they want a member of the team’s support or if they are pleased about an aspect of their care or they wish to share. A PDF will then be created and sent to their social worker. If support is wished for in relation to a health query, or if they would like contact from one of the nurses, this will be forwarded to the
nurses. Young people are made fully aware this is not an “emergency service”; it is a way of allowing the YP to express how they are feeling. The young person is aware they should expect a response to their contact within 24 hours.

The ‘MOMO Express’ is aimed at younger children. This is an innovative and creative tool to help children communicate their views/wishes/feelings.

There will be joint progress of actions from MK-CQC inspection and the Ofsted Inspection through this forum aiming for the launch May 2017.

**MK Healthy Young People’s Network:**

The CIC Nurses are members of the above network which is run by public health. This gives us access to up to date, evidenced based health resources.

**9.4 User Surveys**

Following the Well & Wise Event-(See 6.5) the youth participation worker collated additional feedback from young people relating to caring for their health.

They felt that they need more support from foster carers to think about their own health and for this to be promoted effectively as a skill for independence. Young people are given a folder by their SW usually at the age of 16 years called ‘Get ready for Adult Life’. This can be used to ensure preparation for making GP appointments, dental appointments and accessing universal services has been practiced.

**9.5 Inspection Updates:**

**CQC**

The CQC conducted a week long review of Milton Keynes health services in safeguarding and Children In Care. This report was published in October 2016.

The focus was on the experience of children and families. The methodology included case tracking the journey of children and the services they received as well as reviewing systems and documentation.

The inspection looked at the role of providers and commissioners, specifically:

- NHS Milton Keynes CCG
- Milton Keynes Council Public Health – as commissioners of health visiting, school nursing, substance misuse and sexual health services
- Milton Keynes University Hospital Foundation Trust (MKUHFT), paediatrics, emergency admission and maternity.
- Central North West London (Milton Keynes) – Health visiting; school nursing; CAMHS; Adult mental health; Family Nurse Partnership; Children In Care
- Primary Care
- Brook Advisory
- Compass – substance misuse services

The CCG coordinated the inspection and all agencies worked collaboratively to support the inspection process.

The inspection highlighted many aspects of very good practice as well as some areas where health services could make improvements. A joint action plan is being progressed.
The inspection report summarises the findings. The full inspection report can be found at http://www.cqc.org.uk/sites/default/files/20161019_clas_milton-keynes-final.pdf

**OFSTED:**

OFSET inspected MK-CSC in September/October 2016. The full inspection report can be found at: https://reports.ofsted.gov.uk

Recommendations from both these reports will be reviewed and a joint action plan will be progressed and actioned via the Health & Social Care Forum.

9.6 **Professional development and Training:**

The health team have access to all training provided by Milton Keynes Safeguarding Children’s Board and all training provided by MK-CSC as a free resource. In addition the health team, MK-CSC and all foster carers have access to a free and substantial training programme run by BROOKS’s services.

There is biannual Team training delivered by the Designated Doctor for Children In Care to the health assessment team.

10 **Priorities for the coming year:**

1) **‘Consent to Placement and Medical Treatment’ form to be embedded.**

**Action:**

To ensure obtaining consent for the IHA and associated paperwork within 3 days of a child/young person being brought into the care of the local authority. Named nurse to monitor through monthly IHA statistical data and data sharing with senior management, CNWL-MK and MK-CCG.

To ensure RHA requests are not delayed due to SW not providing required paperwork and consent- Named Nurse to meet with senior management in MK-CSC and agree a revised escalation procedure for RHA requests which are delayed.

2) **Meeting the emotional wellbeing and mental health needs of all CIC:**

**Action:**

PMHW to be in placed with the Corporate Parenting Team and will be a member of the HSCF, to promote joint working partnership to improve the emotional wellbeing of CIC and work within the CAMHS transformation programme.

3) **Voice of the child: Development of ‘understanding consent for a health assessment’ leaflet:**

**Action:**

Joint meetings will be held between the health team and the Youth Participation worker to support the development of a leaflet devised in conjunction with our CIC.

4) **Improve the recording of substance misuse and interventions accepted by young people:**

**Action:**
Support MK-CSC to review current process for compiling statutory substance misuse statistics for the DofE through discussion with MK-CSC Management. This is to be driven through the HSCF as an agenda item.

5) Audit of IHA and RHA assessments to ensure effective quality assurance:

Action:

Audit 20 assessments and compile audit report to evidence high quality assessments are provided by the CIC Health Team.
References:

The Adolescent Wellbeing Scale is a tool devised as by Birleson corambaaf.org.uk


Department of Health, Care Matters: Time for change (2007)

Department of Health: Healthy lives, brighter futures: The strategy for Young People’s Health (2009)

Department of Health: Making sure health and social care services work together.

Milton Keynes Clinical Commissioning Group/Milton Keynes Council: Joint Strategic Needs Assessment Executive Summary (2012/2013)


SCIE: Looked-after children and young people, NICE public health guidance 28 (2010)

Strategy for Children in Care: MKCSC (2013-2016)


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