Central and North West London NHS
NHS Foundation Trust

Milton Keynes Community Health Services

Milton Keynes Clinical Commissioning Group

Milton Keynes Annual Report on the Health of Children in Care

1 April 2015 – 31 March 2016

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Section 1 Executive Summary

I am pleased to present the Seventh Annual Health Report; an overview of the statutory health services provided to Milton Keynes Children in Care (CIC) from April 2015 to March 2016. 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).

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. The profile of the health needs remain the same mainly developmental delay for children below the age of five (particularly speech and language delay) and emotional health and conduct difficulties in the older age group.

The Saturday clinics continue to be run successfully. It has retained its flexibility in clinic appointments availability to ensure compliance with statutory timescales despite increase in the number of children coming into care. Delays in obtaining consent continue to impact on timescales for initial health assessment. We are optimistic that with continued joint working with our partners in the local authority this would improve in the coming year. The numbers of health assessment requests for unaccompanied asylum seeking children appear to have stabilised after the huge increase seen in the previous two years.

The LAC health team continues to ensure the delivery of high quality health assessments through the weekly quality assurance meeting, service audits, supervisions/peer review and training. The plan in the coming year is to introduce a staged quality assurance with individual practitioner taking responsibility and completing stage1 of the quality assurance process.

This has been a very fruitful year; we conducted a joint training for health practitioners involved in LAC heath assessment and successfully introduced the adolescent well-being questionnaire for early identification of emotional health issues not just in the unaccompanied asylum seeking children but in children above the age of 10years. This has the advantage of rapid assessment and scoring and immediate discussion with the young person in the clinic. The SDQ is still used as part of national directive. We introduced some changes into the health assessments forms completed by practitioners to evidence the voice of the child and assurance that a review of all available health records has taken place. Health plans are smarter; identifying issues and making clear recommendations not just a 'list'. The health assessment protocol has been updated and ratified. Hepatitis B audit identified that majority of our foster carers are not immunised. The local authority is actively looking into resolving this.

There is a continuing increase in children coming into care. This has placed pressure on services with consequent challenges in meeting statutory timescales. We have continued to achieve high rates in immunisation, developmental assessment and dental registration. Our overall statistics remain better than national, geographic and statistical neighbours. We continue to work closely with all relevant partners and agencies and the exemplary joint working between health, the local authority and the CCG remain strong.

National challenges in the area of service provision to meet the complex emotional needs and behavioural difficulties of children in care apply also in Milton Keynes. The health forum group is working closely with the CCG and the local CAMHS to ensure these needs are met. There is an on-going whole health economy review of CAMHS provision.

We are proud of our achievements despite the challenges. There is still more to be done and we will continue to work closely with the local authority, the CCG and all our partners. We plan to strengthen existing partnerships to ensure the health needs of looked after children are met. We look forward to the coming year and we will continue to do our best to deliver high quality health service, achieve our performance indicators and be advocates for children and young people in care.

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Dr Adeola Vaughan

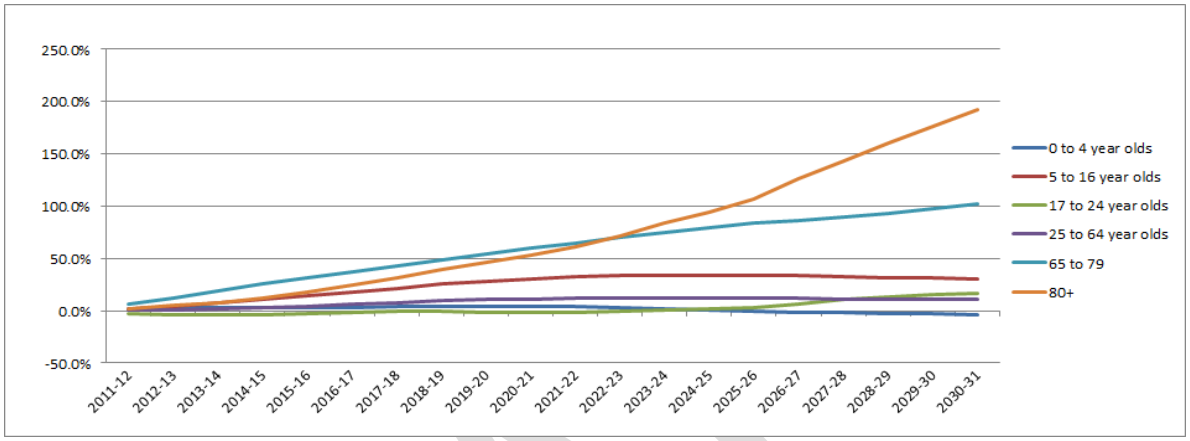
Consultant Community Paediatrician
Designated Doctor for Children In Care

Section 2 Milton-Keynes

2.1 Demographic Information: (Statistics provided by MK Planning and Transport Service Group)

Milton Keynes Population Projections 2011-2031 (Milton Keynes Population, Household & Labour Market Projections 2011-2031 Research & Geospatial Information Team Luton Borough Council June 2015)

Cumulative Population Change since 2011 in Milton Keynes



Key Points from the Population Projections:

The Milton Keynes population is growing in size and diversity. It was the fastest growing UK city between 2004 and 2014, expanding by 16.5 per cent (Office for National Statistics, Mid-year population estimates, 2004 and 2013 data).

In 2016, the estimated population of Milton Keynes Borough will be 266,650.The population is expected to rise by around 16% from 266,650 to 309,400 by 2026, and by 2031 the population is expected to reach 315,500.

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 38%. (MK School Census - Spring Term, 2015).The school age population is projected to be around 44,000 in 2016. The population is projected to rise by around 17% from 44,000 to 51,800 by 2026.

It has a relatively youthful population with 2016 figures showing the under 16 age group estimated at 22.9%. The average age of population is 36.5 years, compared to an average age of 40 years in England. (ONS mid-year population estimates, 2014).

MK Age range (2016-2026):

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 17% from 44,000 in 2016 to 51,800 by 2026.

Young Adults - 17 to 24 year olds – projected to rise from 22,000 in 2016 to 23,000 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 Children In Care (CIC) - National Statistics: (Department of Education National Statistics 2016)

The number of children in care has steadily increased over the past 7 years and is now higher than at any point since 1985.

As of 31st March 2015 there were 69,540 children in the care of local authorities in England compared to a figure of 68,800 in 2014. Looking at figures over the last 5 years there has been an increase of 5,140 (7.4%).

Ages and male/female ratio of children in care:

Of the 69,540 figure, 38,530 (55%) were males and 31,010 (45%) were females.

5% of children were under 1 year old, 15% were between 1 and 4 years old, 21% were between 5 and 9 years old, 38% were between 10 and 15 years old and 22% were aged 16 and over.

The reasons why children start to be looked after have remained relatively stable since 2011; the percentage starting to be looked after due to family dysfunction has however increased slightly. (16% of children in 2015 compared with 14% in 2011. The majority of looked after children (61% in 2015) are looked after due to abuse or neglect. (CORAM BAAF 2016)

Commencing children in care status:

A total of 31,070 children became children in care during the year ending 31st March 2015. This is an increase of 2% from the previous year's figure of 30,540 and an increase of 13% from 2011. In 2015 there was a slight increase in the number of children aged 5 and over, while the number of children aged 4 and under fell slightly.

The percentage of children aged 10 to 15 decreased from 31% in 2011 to 29% in 2015.

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

In 2015, 16% 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 steadily over the past five years. This may be due to adoption, the granting of a special guardianship order, a residence order or a child arrangements order. It may also be due to assessment of risk means the child can go back to the care of the parent/parents/guardian.

31,000 children ceased 'child in care' status during the year ending 31st March 2015, an increase of 2% from the previous year's figure of 30,600 and an increase of 15% from 2011.

In 2015, 8,410 children aged 1-4 years ceased to be 'child in care' status. The percentage of 1-4 year olds increased from 24% in 2011 to 27% in 2015. This reflects an increase in the number of children adopted during this period.

In contrast, the percentage of 10-15 year olds has decreased over the same period from 20% to 16%. 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 7,390 children who ceased 'child in care' status when they were 18 years old. This represents 24% of all children ceasing to be a 'child in care'.

Unaccompanied Asylum Seeking Children:

Of the 69,540 children in care, 2,630 (4%) were unaccompanied asylum seeking children. The number of unaccompanied asylum seeking children increased by 5% between 2013 and 2014, and 29% between 2014 and 2015. A higher percentage was boys (90%) with 75% reported to be aged 16 and over.

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

There were 523 children in the care of Milton Keynes Local Authority at some point in the period in comparison to last year's figure of 471. This indicates a significant increase of 52 cases (10 %) and an increase of 18% (96) cases since 2012. 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 31/3/16:

Total 220: This figure indicates a relatively stable picture of children continuously looked after by comparison to last year's figure of 221.

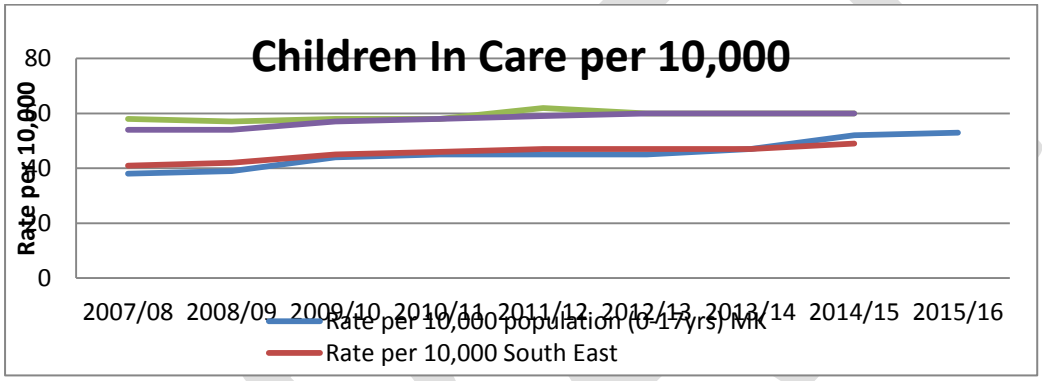
The number of children in the care of Milton Keynes Local Authority as on 31st March 2016:

Total: 345. Data shows that number of children coming into care continues to rise. In the past decade this would amount to a 35.59% increase. This has been due to a combination of factors including serious case reviews from high profile cases and the continued and rapid growth and diversity of the population locally (Strategy for Children In Care 2013-2016).

However 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.

Rates of Children In Care:

Graph 1: Numbers and Rates of Children In Care Captured (2007- 2016)



Graph 1 shows that the rate per 10000 children and young people in the care of Milton Keynes Local Authority (age 0-17) has begun to rise above the current recorded rate 2014/2015 for South East England. It remains below current recorded figures for our Statistical Neighbours and England.

NB: The statistics for England, South East and our Statistical Neighbours have yet to be reported on for 2015/2016.

2.3 Local Statistics:

Age and Gender:

Under 1	14 children (4%)
1-4 year's	35 children (10%)
5-9 year's	67 children (20%)
10-15 year's	139 children (40%)
16/17 year's	90 young people (26%)
Gender split: Males 210 (60%)	Females: 135 (40%)

The age distribution of Milton Keynes Children In Care (MK-CSC) is comparable to national data. There are less children in the under 5 age group.
The majority of the current cohort in the 10-15year age group. The overall picture of causes for why children become looked after remains fairly consistent. It must be recognised that most cases have more than one cause for being in care.

Causes for children becoming looked after by Milton Keynes Local Authority:

Abuse and neglect- (Including issues such as domestic violence resulting in significant harm of a child/young person, abandonment in dangerous circumstance and a lack of basic care)	156 (45%)
Family/parent dysfunction- (Including homelessness, change in family circumstance, conflict in adolescence, death of parent/family, environments/neighbouring factors)	54 (16%)
Unaccompanied young asylum seekers	38 (11%)
Emotional & behavioural difficulties	32 (9%)
Offending behaviour with complications indicating risk	7 (2%)
Parental illness, including chronic mental health or disability	13 (4%)
Domestic violence within the home	14 (4%)
Alcohol/drug abuse by parents	15 (4.4%)
Children disability	9 (2.6%)
Risk of child sexual exploitation and /or engaging in unsafe sexual behaviour	5 (1.5%)
Children privately fostered	2 (0.5%)

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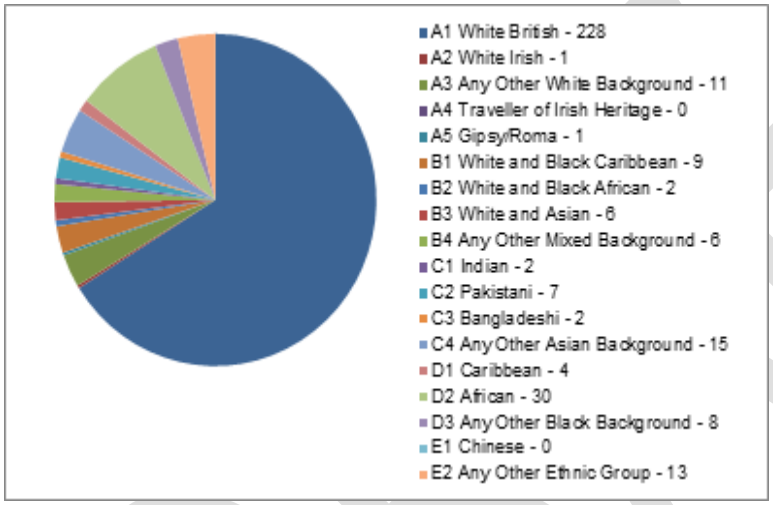
Graph 2: Ethnicity of Children In Care: March 31st 2016



The ethnic diversity in Milton Keynes is changing. In 2001, 13.2% of the Milton Keynes population were from a black and minority ethnic background. 34% of the current population are from black and minority ethnic background.

The ethnic profile of the children in care population remains predominantly white British at 66% which reflects the local ethnic spread.

Young People seeking Asylum:

Young people seeking asylum with MK-CSC this reporting year has been relatively stable (31-34). The male/female ratio was 9:1. Young people assessed have been in need of varying levels of health care support. Of these 34, 3 young people have actively gone missing during the assessment process and 4 were assessed as 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. In terms of safeguarding all young people, those who go missing from care will be immediately notified to police and CSC to enable immediate action from those services. This will be followed up with a multi-agency strategy meeting within a period of 5 days. If they remain missing, a further 2 strategy meetings will be held alongside the Police. Risk assessments and information sharing is vital to ensure as much as possible is done to locate them. The service recognises the particular vulnerabilities of this group to trafficking and CSE and we work closely with CSC and police to minimise and manage these risks. When such concerns are identified following a referral to MK MASH and the completion of the CSE screening tool, they will automatically be considered as medium or high risk and discussed at the monthly Multi-Agency Risk Management Meeting (MARMM). Information from

these meetings, in addition to being recorded on LCS is recorded on health records on Systmone. A safeguarding information alert will also be included.

Assessment for 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. 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 (HPA0 guidelines for 'Incomplete or unknown Immunisation Status'. They also tend to have travelled from countries where health resources and health screening are limited. The Initial Health Assessment is key in identifying and actively addressing health problems in these children.

The LAC Health Team have liaised with Thames valley Police's Clinical Lead Nurse, in order to identify the immediate health screening process they have in place, when young people present for asylum. The nursing team have a robust screening process in place and we have initiated a joint protocol for confidential sharing of health information. In addition MK Hospital have authorised a direct link with the Paediatric on-call Consultant to ensure young people requiring further medical assessment or intervention 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. The protocol is currently in its final stages.

Young People Seeking Asylum: Specialist provision form 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 (Unaccompanied Asylum Seeking Child). He is notified what YP would like advice and can access information on their case in preparation. Social Workers can book specific time slots for those who wish to and interpreters are provided by MK-CSC. This provides the opportunity for any of your young people to get 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.

Improvements have been made to ensure that LAC 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 ensuring 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.

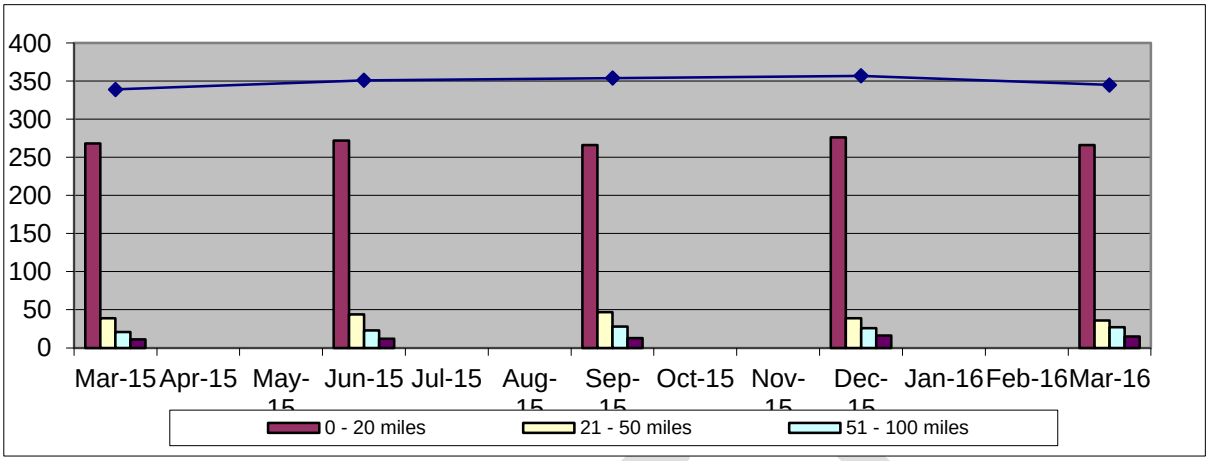
Young people will have a daily welfare check arranged through the MK-CSC Team with a professional from the interpreter service. If there are any concerns or queries, this will be relayed directly back to the CSC team. This service is adapted depending on individual need, so that welfare checks can continue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

Youth Services have started a youth group specifically for asylum seeking children called 'New2UK'. This group 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 may be suitable and this can be identified on the referral form. The young people we have attending have really enjoyed it. They are now planning day trips and smaller afternoon trips out to explore both the local community and wider areas such as London.

The team can also support the process of family tracing through the Red Cross, where children would like to trace their family, both in the UK and abroad.

Distance of Geographical Placements:

Children in Care Placements in and out of Milton Keynes (April 2015- March 2016)



Graph 3 shows that 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 21-50 miles out with Milton Keynes and 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.

Number of CIC for 12 months or more on 31st March 2016:

Children/young people placed with foster carers: 166,

Children/young people requiring support placed in residential children's home: 21

Children/young people placed with a parent: 11

Children/young people placed for adoption: 6

Children/young people placed in residential school/residential setting: 10

Children/young people placed in supported living: 6

3 Service Summary

3.1 Staffing and Supervision

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.

Specialist Nurse for Children In Care

The Specialist CIC Nurse is employed by CNWL-MK and is a full time position. The Specialist CIC Nurse completes review health assessments for children in the care of Milton Keynes Authority above the age of 5 year's. The 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.

Administration

It is a complex task to track the volume of children entering and leaving the care system. Administration for the CIC team is provided by a business support administrator. This post is based within the children's social care team and is currently under review in terms of hours allocated to this role.
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 for 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.

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 LAC 2010).

<u>Supervision Arrangements:</u>

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 with the Named Nurse providing the opportunity to consider service provision and wider issues relating to the CIC service.

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 quality assurance for health assessments within the team. These meetings also offer a supervision forum to discuss individual cases, practice issues and service development. The Designated Doctor is member of the BAAF health group and the forum allows for 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 promotion of 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

3.2 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 consists 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 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.

Children In Care Health and Social Care Forum

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 is jointly chaired by the Designated Nurse for Children In Care and Safeguarding, and the Head of Delivery of Corporate Parenting. 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 evident.

Joint work has focused predominantly on the following areas:

- **Addressing the needs and health requirements of young people seeking asylum and improvements to practice.** External speaker Jennifer Hill BROOK sexual health service joined us to highlight the NARA project. (see also section 7. P21)

- **Promoting the 'Voice of the Child/Young Person'**: All areas involving young people in the care system-sharing their
  views, their thoughts and ideas to acknowledge what they feel we are doing well and consider service change and development.

- **Updates from the 'Safeguarding Forum'**. The Primary Care safeguarding forums take place quarterly and all safeguarding lead GP's and Practice managers from MK are invited to attend. The forums are led by the Designated Nurse for safeguarding and looked after children. The forums have raised the awareness of the needs of CIC and offer support to primary care staff in providing effective universal services for CIC.

- **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.

- **A joint review of Statutory Guidance 'Promoting the health and well-being of looked-after children, Statutory Guidance 2015':** A 'GAP Analysis' document highlighted actions to be completed and evidenced for best practice to ensure all guidelines were followed. All 35 action points were reviewed and outcomed through the year.

- **Improving the provision of emotional wellbeing services and CAMHS provision for CIC and carers**. External speaker Hannah Pugliese 'Children &Young People and Maternity Commissioner, MK-CCG' joined us to update on the progress of the CAMHS Transformation programme and how Health and wellbeing services for CIC are being considered as part of that programme.

- **Priorities identified for the reporting year in the annual health report 14/15** were jointly reviewed and concluded. (See appendix 1)

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 2016. 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.

4.2 Local Improvements

Priorities were highlighted for addressing in the Annual Report 2015/2016. All have been completed.

(See appendix 1 for additional information)

5 CIC Team Clinical Activity

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

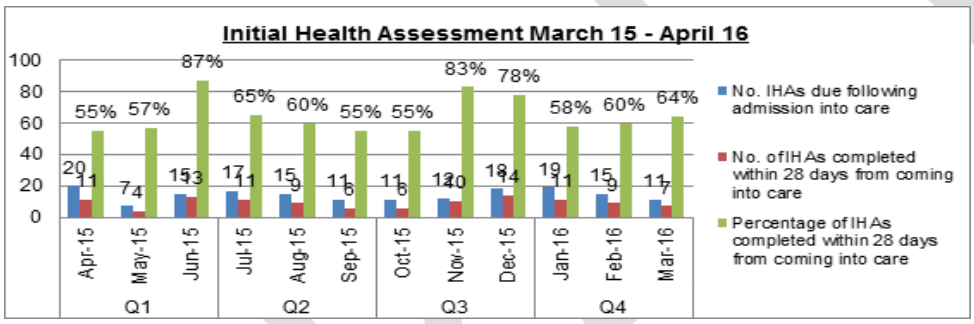
effectively monitored. Close and timely communication with all health and relevant professionals is crucial and as such a full copy of the health assessment is also scanned onto the hospital electronic record system (EDM) and to the community health electronic record system Systmone as well as directly onto LCS for direct access by the social care team.

5.1 Initial Health Assessment (IHA) Process:

Assessment Clinics exclusively for our children in care are run on a Saturday morning from the community paediatric department at Milton Keynes Hospital. The Saturday Clinics offer the flexibility of being able to run double clinics offering appointments as needs indicate. This enables all Initial Health Assessments to be 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 sees 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:



Graph 4: Number of Initial Health Assessments due each month following admission into care, how many were completed within 28 day statutory timescale and monthly percentage: April 1st 2015- March 31st 2016

Due- 171 Completed -111 = 65%

Factors impacting on delay of 60 cases:

Consent not received in reasonable timescale: (average used over 7 days after LAC status)	Impacting on 36 cases
Out of area request over which we have no control:	Impacting on 13 cases
Total DNA appointment's offered:	Impacting on 11 cases
Carers unable to attend agreed appointment:	2
Young Person Refused	3

Analysis of delay:

When analysis is being compared to last year's figures, it should be noted there is also a significant 10% increase in the cohort of children entering and leaving the care system in the last reporting year. (See section 2.3). It should also be noted cases can be affected by more than one factor impacting on the overall delay.

Of the 171 IHA's which were due completion in the reporting year, 111 were completed within 28 days equating to 65%. By comparison to last year' figure of 145 there has been a 15% increase in IHA's requiring completing.

Though obtaining consent remains the highest factor in delay, it is key to take into consideration the complexity of individual cases and additional pressures affecting obtaining consent, such as refusal of parental/young person

engagement. Within this figure, there are a total of 15 unaccompanied asylum seekers who required a process of age assessment. This can be a lengthy process and may lead to delay.

When a child/young person is made CIC status, an alert should be triggered on the LCS system. This is the system which flags CIC status to the health team. Several cases were not flagged which added to consent delay.

There were a total of 13 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.

4 children had specific complex needs requiring highly specialist provisions out of area.

In addition to consent there were a total of 10 young people who DNA appointments. 2 related to carers not bring them as agreed, x1 was a young person who required a mental health assessment and was subsequently admitted to a specialist unit, x1 young person became too anxious to attend in a hospital environment and the CIC Nurse went to see him, which was much more supportive. Consideration of how to complete an effective assessment must be given in individual cases, particularly of young people hard to engage. The Designated Doctor is aware of each case and the delay incurred.

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 aim to have paperwork, including parental consent received from the SW for the assessment within 3 days of CIC status. 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 10 days, then the case is escalated for a Manager to review, as delay beyond this, may impact on completion. This is to ensure we 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.

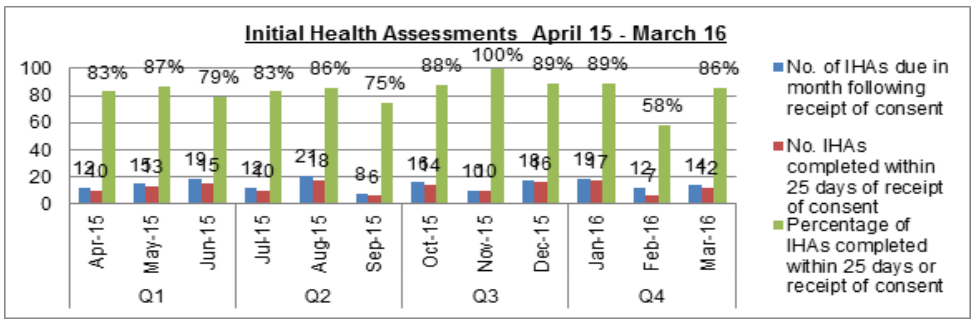
Quarterly percentage of consent obtained within 3 days of becoming a looked after child:

Consent received from SW within 3 days of CIC status- percentage per quarter:			
Q1	**Q2**	**Q3**	**Q4**
18%	10%	21%	19%

Overall %= 17%

These figures have reduced since last reporting year from 23.5% to 17%. The increase in figures of children being brought into care, the complexity of cases and the increased workload for social workers must be considered. The issue of obtaining consent promptly is being actively reviewed by the CSC management team.

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 2015- March 31st 2016

Due 176. Completed 148 = 84%
Factors impacting on delay of 28 cases:

Out of area request over which we have no control	12
Young person DNA appointment booked	10
Young person refused	3
Child moved placement day before appointment	1
Appointment booked but young person went missing from care-(subsequently re-booked)	2

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

By comparison to last year's figure of 148, there were a total of 176 due this reporting year, an increase of 16%.

Of the 176 IHA's due in the month following receipt of consent, 148 were completed in the 25 day timescale equating to a percentage of 84%.

On analysing the cause of delay from a health provision perspective for 28 cases, 12 were Out of Area requests over which we have limited control. These included 4 complex cases where children required specialist provision. 2 young people went missing from care, but were subsequently completed. 1x child moved placement the day before her appointment date and 3 young people refused the initial appointment booked. A total of 10 young people DNA an agreed appointment date but were offered a further appointment.

Young people refusing to attend a booked appointment are always a challenge and social workers work hard with every case to engage them in the process. In addition it should be noted in that multiple causes are sometimes identified in cases.

Joint discussion is central between MK-CSC and Health Teams to ensure all Initial Health Assessments are completed.

Actions by health & CSC to monitor and improve practice:

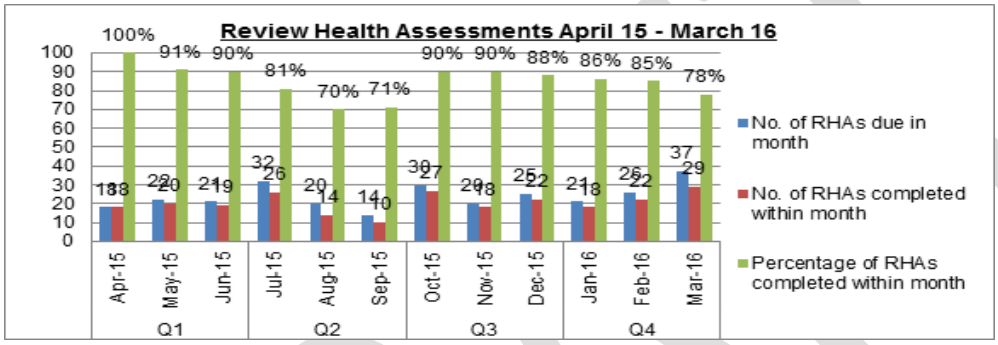
- A monthly analysis of delay is compiled by the Named Nurse to track the cause of all delayed cases. A report is sent to Head of Service Delivery, Head of Corporate Parenting and Team Manager of Corporate Parenting. This is so that any possible performance issues can be jointly addressed.
- In September it was highlighted asylum seekers must have consent obtained as a priority. Co-ordination was strengthened between MK-CSC and Business Support at THQ, to improve communication and organisation of consent. All cases are now allocated a SW upon CIC status commencing.
- The process of gaining consent promptly from SW was reviewed in October with the Head of Service Delivery taking the issue to the Operational Managers meeting. An email reminder was sent to all SW teams in October as a reminder of statutory timescale and need for consent within 3 days of LAC status.
- The 'escalation policy' that is used to notify CSC Head of Delivery Manager when consent is not obtained within 10 days of CIC status starting was reduced to 7 days in March to improve performance. This is an extremely effective process; however only works when the CIC Health Team is notified that a child has come into care.
- SW Teams have been reminded to trigger the alert on the LCS system when a child becomes CIC status. In addition, Business Support CIC based at the THQ, has immediate notification from a safeguarding perspective, as soon as a new child is known and she then liaises with the Named Nurse CIC as a second check to ensure prompt action.
- The management team are currently jointly looking at additional areas for improvement.

5.2 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. 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. As such appointments are offered after school. The Specialist Nurse also offered to see 3 young people on a Saturday, so support the process.

5.2 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 2014- March 31st 2015

Due 286 Completed 243= 85%
Factors impacting on delay of 43 cases:

Out of area placements	20
Carer unable to attend appointment offered	8
Young person's availability	2
DNA booked appointment	8
Young person refused	3
Paediatric review required	2

Analysis:

There were a total of 286 review health assessments due in the reporting year. This is an increase of 15 assessments requiring completion compared to last year's figure of 271. Of those 286 due, 243 (85%) were completed in timescale.

Children who are placed out of area continue to have the biggest impact on delay for RHA completion totalling 20, (15%). 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 and each case is considered individually as to the best needs of the child. 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.

The second highest cause of delay was the carer or the young person needing to change an appointment offered. We do accept on occasions appointments may need to be changed at short notice.

Appointments which were DNA equated to 2.7%. Two children were due to carer confusion with the booking date. One was due to a mum who was struggling with various pressures and one due to unexpected illness. In all occasions the hospital health administrator informed the Specialist CIC Nurse who notified the social worker.
This figure includes young person refusal. In one case, the appointment was re-booked. In the other 3 cases refusals were from males aged 17 year's, who felt they did not require to be seen. 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.
We had two children with complex health issues and one specific request from a carer who had health concerns for her child to be reviewed by the Consultant Paediatrician who knew the child well. As we do not wish children to have an additional health assessment when not required, the Consultant Paediatrician supported the RHA process for both children the following month.

5.3 Children and young people with disabilities:

There are currently 12 children/young people who are CIC and who are cared for within a specialist team- The 'Children with Disabilities Team' (CDT). 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 CDT 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 LAC 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.

5.4 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 looked after children'. (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 81 requests to complete a health assessment for children placed in our area by another placing authority. This is an increase of 23 requests (28%), from last year's figure of 58. The health team prioritise MK children/young people, as other providers do for their own locality. However, going forward, this requirement must be taken into account, within our own service and provision to ensure we have capacity to complete health assessments for other children in care placed within our area.

5.4 Immunisations

Milton Keynes: Published 2014/15	93.20%
Milton Keynes Average Provisional2015/16 (CHECK)	**90%**
England Average Published 2014/15	87.80%
England Average Published 2013/14	87%
Stat Neighbour Average Published 2013/14	**88.20%**
Stat Neighbour Average Published 2014/15	90.60%

South East Average Published 2013/14	**84.40%**
South East Average Published 2014/15	**82.20%**

Immunisations remain at a high completion rate. There are young people who refuse to have immunisations as advised despite the need being highlighted to them. In addition we have had parental refusal for MMR's being administered for 4 children in care. Our asylum seeking young people all require immunisations as per HPA guidelines for 'Incomplete Immunisation Status'. This programme of immunisations are given over a three month period. We have found 3 young people who have not had their immunisations completed, despite this being advised as required on all their health plans. At the time of writing this report- all have been commenced by the LAC Nurses who have contacted foster carers directly. Notification has again gone out to foster carers, social workers and IRO's to heighten awareness and ensure this area improves in the coming year.

5.6 Dental CHECK REQUESTED 10/6/16

Milton Keynes: Published 2014/15	93.20%
Milton Keynes Average Provisional2015/16	**94.9%**
England Average Published 2013/14	84.4%
England Average Published 2014/15	85.80%
Stat Neighbour Average Published 2013/14	**75.50%**
Stat Neighbour Average Published 2014/15	**83.30%**
South East Average Published 2013/14	**83.40%**
South East Average Published 2014/15	**86.10%**

ANALYSIS

Dental check statistics completion rate has improved by 1.7% to 94.9%. Improvement has been through more accurate recording of when a child/young person has attended, thus making capturing that data, more robust.

Out of the 11 cases not completed, 4 of these are due to young people refusing to attend despite encouragement.

5.7 Developmental Checks

Milton Keynes: Published 2014/15	100%
Milton Keynes Average Provisional2015/16	**100%**
England Average Published 2013/14	86.70%
England Average Published 2014/15	89.40%
Stat Neighbour Average Published 2013/14	**91.6%**
Stat Neighbour Average Published 2014/15	**86.60%**
South East Average Published 2013/14	**87.6%**
South East Average Published 2014/15	**92.90%**

Milton Keynes developmental check statistics remain consistent at 100% completion rate.

5.8 Annual Health Assessments

Milton Keynes: Published 2014/15	**95.45%**
Milton Keynes Average Provisional2015/16	**93.2%**

England Average Published 2013/14	88.30%
England Average Published 2014/15	89.71%
Stat Neighbour Average Published 2013/14	**86.80%**
Stat Neighbour Average Published 2014/15	**88.96%**
South East Average Published 2013/14	**85.20%**
South East Average Published 2014/15	**88.21%**

Milton-Keynes statistic for completion of annual health assessments remains consistently high. (See section 5.2)

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 if appropriate and if the young person gives consent.

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. There have been two particularly complex cases discussed with Brook where they provided a robust service immediately for young people who were of significant concern. They have also provided an outreach service for young people difficult to engage. This is a highly valuable resource for Milton-Keynes young people.

BROOK has developed a project called 'NARA' that works with newly arrived communities, refugees and asylum seekers. Young people can be referred directly to this specialist part of their service. Work will explore the laws within this country relating to sexual relationships. Often young people will not have received education in this area 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.

6.2 Child Sexual Exploitation (CSE):

Children and young people who are looked after can be highly vulnerable to child sexual exploitation and as such all those involved in their care must be clear and proficient at noticing warning signs and raising concerns.

The MKCSB CSE screening tool enables professionals to consider a child's level of risk in a quick and consistent manner and should be used whenever there are concerns that a child is at risk of, or potentially subject to, sexual exploitation. No CIC should be considered low risk. The Milton Keynes Safeguarding Children's Board CSE Strategy includes advice on using the tool and sets out processes to be followed if agencies have concerns about individual children and young people. Cases of concern will be referred for discussion to the Multi-Agency Risk Management Meeting (MARMM) where a range of 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 MARMM helps to co-ordinate multi-agency activity and brings together information

and intelligence to assist in building and maintaining a picture of CSE in Milton Keynes. The tool can be re-done in order to re-evaluate risk at any point as part of an on-going assessment of need.

6.3 Teenage pregnancies:

We have had only one young person becoming pregnant while in the care system below the age of 18. We have had 2 young people who become CIC while pregnant due to their own vulnerabilities and support needs. In this instance they were cared for in a mother and baby placement for additional care and structured support.

The care leaver's team are caring for a total of 9 young people who have been supported as new parents in the last reporting year, two of whom became fathers. There are two expectant mothers at the present time.

The Milton Keynes Family Nurse Partnership is a voluntary support programme for first-time mothers aged 19 years and under. They offer regular home visits aiming to build trusting and supportive relationships. They often have backgrounds in midwifery, health visiting and mental health. The family nurse works alongside the MK-CSC Team and Midwives playing a key role in support which continues until the child reaches the age of two. They offer education around how to care for the baby and help prepare and plan for the future. They will also attend appointments and Child Care Reviews. The Family Nurse plays a key role in providing support and continuity through pregnancy and beyond and is a valued service provision.

6.4 Substance misuse:

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 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.

6.5 Emotional Health & Wellbeing:

<u>The Needs of Children In Care:</u>

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 Primary mental Health Practitioner (PMHP) commenced with the team in July 2015 and is funded for 2.5 days per week. The role is currently the only dedicated post for working with CIC from within the MK CAMHS Team. The work encompasses enhancing social workers and foster carers understanding of behavioural presentation and communication of a child or adolescent who has experienced a disadvantaged start to life and providing specialist interventions where appropriate. This is a Tier 2 service provision. The practitioner also works directly within CAMHS as a mental health practitioner and also as a school based resource. The principle task for the PMHW-CIC is to ensure mental health needs are identified and addressed through appropriate services whilst educating all those involved with the child to think holistically about the child's needs and how their experience has affected their mental health and behaviour. Children in care have much higher rates of mental health difficulties than the general population with 50% meeting the criteria for a psychiatric disorder. Children in

care are 4 times more likely than their peers to have a mental health difficulty (NSPCC, 2014: What works in preventing and treating poor mental health in Looked After Children.) 75% will require care within a residential home, due to their high level of need.

69% of the PMHW-CIC role has been direct work with foster carers, promoting therapeutic parenting techniques that address previously unmet attachment needs. This intended to support the stability of placements or limit the opportunity for unplanned moves for the child. While it is recognised placement ending cannot be avoided in all cases, there is more chance of avoiding breakdown by offering appropriate support to carers and directly to the child/young person when there is evident difficulty.

83% of CIC seen by MK- CAMHS in 2015 had input from PMHW. This high percentage is to be expected due to the dedicated PMHW-CIC sitting with MK-CSC who would be involved with concerning cases requiring intervention.

The PMHW-CIC also met on a regular basis with the LAC Nurses to review SDQ scores and jointly discuss cases. 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).

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:

187 scores required completion in the reporting year and of these 168 are recorded. The remaining SDQ's would have a 'reason for no SDQ' recorded meaning the reason is reviewed by the CIC Nurses. There were 3 young people who did not wish to complete it. Other reasons for non-completion would be if the 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.

Of these there were 56 children/young people who had a score identified as 17 and above which is an indication of concern. This is similar to last year's figure of 58. 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.

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. 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.

6.6 Training:

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.

Training took place for the CIC Consultant Paediatric Team who complete CIC Health Assessments. This training looked at evidence of good practice and quality assurance for the health assessment process. It was also an

opportunity for joint discussion and team review. The BAAF assessment paperwork was adapted to enhance practice records.

Social Workers inductions:

The CIC Nurses offer sessions for all 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.

On-going Training:

The CIC Nurses offer 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.

7 Adoption & Fostering :National Statistics:

National Adoption Statistics:

Statistics for reporting year 2016 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 Care Strategy 2013-2016 includes a clear focus on supporting families to stay together when safe to do so, through preventative and intensive joint work across the council through Health, Education, Social Care, Youth Services, Youth Offending, the Police, Probation and the voluntary and community sectors including the Children and Families Strategic Partnership and the Safeguarding Children's Board, minimising the need where possible for children to become looked after.

Milton Keynes Adoption CIC Statistics:

In the last reporting year:

12 adopter approvals were completed.
23 children ceased CIC status as the result of the granting of an adoption order.
12 children were assessed as adoption being in their best interest. 11 of these children were white british and 1 child was of mixed heritage. Of those 2 children were below the age of 1 year, 6 children were between the ages of 1-4 years. 3 children were between the ages of 5-9 years and 1 child was between the age of 10-15 years. At the current time there are 4 children 'waiting' for a family to be identified for them.

Special Guardianship Orders (SGO) Granted:

In the last reporting year:

12 SGO's were granted.
6 of these were part of a sibling group- equating to 3 groups of 2.

Age ranges of children granted SGO's:

1 child was under the age of 1 year.
6 children were between the ages of 1-4 years.
5 children were between the ages of 5-9 years.

CNWL-MK Designated Doctor as Medical Adviser

The Designated Doctor in her role as Medical Adviser is a member of the adoption panel. The Adoption panel is going through a period of significant changes due to changes in legislation and national directives. Medical Advice and guidance are provided to panel and to prospective adopters. 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.

There have been 209 adult health medicals reviewed which is a reduction of 51 on last year's figure of 260. 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.

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**.**

Best interest decision and meeting with Prospective adopters

16 'best interest' decisions in the year, compared to 24 last reporting year.

7 children were discussed with prospective adopters, compared to 16 of last reporting year.

There is a reduction in the number of medical discussions with adopters, a reflection of the overall reduction in the number of children placed for adoption.

Foster Panel Process:

The Named Nurse and the Specialist Nurse are members of the fostering and adoption panel which meets every 3 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.

16 Fostering panels and 10 adoption panels took place within this reporting year. 6 of these were run jointly seeing adoption and fostering cases for panel members to consider. This figure is similar to last year's figure of 17.

8 Service Improvements

8.1 Specific Improvements:

1) **Quality Assurance Checklist:**

In February 2016 we implemented a Quality Assurance Checklist (QAC) for completion of all Health Assessments completed for us by 'Out of Area Teams' and also within our own IHA and RHA Saturday clinics. This tool is recognised nationally as a robust checklist to ensure all health assessments completed are of the highest possible standard with all expected areas detailing information for the child/young person is completed.

Our 'Out of Area' assessments are funded by the CCG. As such, the Named Nurse quality checks all assessments completed on our behalf and gives assurance to the CCG they are of the expected standard. The process of completing IHA and RHA requests is not something all professionals are used to. The QAC is therefore a helpful checklist ensuring all areas of health have been addressed and documented as required.

2) **Implementation of the Adolescent Wellbeing Scale:**

The health team considered how to improve assessment screening in the area of adolescent's mental health particularly at the IHA. When a young person has just come into care they are likely to be anxious and uncertain of the process and may find it very difficult to express how they are feeling. The limitations of the SDQ was recognised particularly with young asylum seekers (see also section 6.4)

How young people feel in themselves is a vital part of any assessment. The Adolescent Wellbeing Scale was devised by Birleson to pick up possible depression in older children and adolescents. This scale is now completed in IHA clinics for young people in the age range 11-16. It is also used at RHA, if need indicates.

3) **Review of Promoting the Health of Children In Care Protocol:**

This is a joint protocol for health and CSC. It has been fully updated and ratified.

4) **Health Promotion Articles for the foster care newsletter:**

Flu vaccine: An article was produced by the Named Nurse providing educating about the flu vaccine. Areas included why it was being offered, which children should receive it, which children were at higher risk, and which children may not be considered and why. Children who are LAC can be at risk of 'falling through the gaps' when they are moved within the care system, so it was important that all foster carers considered any child who was placed in their care and whether they should receive the vaccine.

Hepatitis B vaccination for all foster carers: This is a standard recommendation from the Medical Advisor for all foster carers. An information leaflet was drafted to highlight this and added to the foster care newsletter.

5) **Public Health Links Promoted:**

The LAC Nurses linked with the public health lead practitioner of MK Council and are members of the Healthy Young People's Network. We will be meeting with the school nursing teams to provide information and open discussion with regard to the health needs and services provided for children in care.

6) **Child Protection – Information Sharing project (CP-IS)**

The 'Child Protection – Information Sharing' was a project launched by NHS England to improve the way health and social care services work together across England to protect vulnerable children. Its aim is to help deliver the Department of Health policy "Making sure health and social care services work together". CP-IS focuses on improving the protection of children who have previously been identified as vulnerable by social services when they visit NHS unscheduled care settings namely emergency departments, walk-in centers, out of hours GP's, minor injuries units, paediatric wards, maternity units and ambulance services. The process of identifying children who have been maltreated, or are at risk of significant harm from abuse or neglect, during a single attendance remains difficult for even the most experienced clinician. Giving clinicians in unscheduled care settings access to relevant social care information is essential to successfully identifying children who may be at risk.

As part of this initiative it was essential to have NHS numbers for all children on the LCS system so that children at risk are flagged and information shared if indicated. Administration teams from MK-CSC and Child Health worked in partnership to ensure NHS numbers were identified and the LCS system updated. This is now fully implemented.

8.2 Audits

Audit 3: Audit Health Care Plans performance, Managed by Independent Reviewing Officers (IRO) at Child Care Reviews:

An initial audit took place in December 2013 to ascertain if recommended actions to address health needs identified at children in care health assessments were being discussed and monitored by MK-CSC Independent Reviewing Officers (IRO) at each child care review in accordance with statutory guidance. The aim of the audit was to ensure the highest possible standard for health outcomes of all the children in the care of Milton Keynes Council. A second audit was completed in March 2015 and a third and final audit completed March 2016.

The third audit identified positive improvement and outcomes shared with the IRO Team will be further consolidated with the CIC Nurses at an IRO Team meeting planned August 16.

8.3 Partnership working:

Milton-Keynes Multi Agency Safeguarding Hub (MASH):

The MASH Team are located within MK-CSC and comprise of a core team of representatives from MK-CSC, Health and Police. The MASH has links with other services such as probation, youth offending and housing.

The MASH Team receive referrals involving any identified risk to a child/young person. They jointly analyse each referral and decide whether it progresses to further assessment by Police and by children's social care. Signposting to a service such as early help or specialist intervention may be indicated or assessment may

indicate no action. If a child or young person is identified at risk of significant harm, the may be brought into the care of MK-CSC and as such, become a looked after child.

Close partnership working within safeguarding is paramount and health play a key role in this core team, ensuring the highest safeguarding process for vulnerable children and families.

See also section 3.2

The role of the CIC Youth Participation Worker:

The youth participation worker is central to progressing work promoting the voices of the CIC to let those caring for them know they are being heard and able to make a difference. A new monthly care leavers group has been set up to support young people aged 16+. The group will meet together to cook, socialise and also be a voice for care leavers.

There is also a Primary CIC Council which meets every half term. This group combines a positive activity as well as a consultation group. The group have met to look at the CIC pledge, what they feel is essential for a good placement and also hearing their voice and ideas on their health care.

The CIC Youth Group is a weekly youth group which offers young people aged 10-16 a safe space in which to participate in a range of positive activities. The youth club is supported by the Youth Faculty and Virtual School. The LAC Nurses promote involvement for young people. It has been highly beneficial for young people to join and feel part of social group with other young people who understand what it may be like as a young person in care.

8.4 Inspection Updates:

An Ofsted Inspection is pending.

8.5 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.

8.6 Priorities for the coming year:

1) Continue to highlight hepatitis B immunisation requirement for all foster carers.

   Action: Audit report will be completed and shared with MK-CSC. Improvements to promoting this area will be jointly progressed at the Health and Social care Forum.

2) Promote the health needs of asylum seekers:

   Action: Complete the Health Screening Pathway for Asylum Seekers-Children and Young people. Promote knowledge and information sharing in this area with other professionals including CSC, GP services and other specialist LAC Teams via information sharing.

3) The quality of health assessments will be strengthened through increased effective information gathering from all involved professionals. This will ensure a complete and holistic history of the child's health is compiled.

   Action: Health team completing the assessment will access Systmone in addition to EDM and will request additional reports/information from relevant professionals if required.

The family questionnaire paperwork completed by Social Workers will be reviewed to ensure information being provided for the IHA relating to the child's background, journey into care and family medical history is as robust as possible.

4) Continue to promote the voice of the child/young person:

Action: A Health Event is being planned to provide the opportunity for CIC to share their views of the health service they receive and what development they may like to see.

5) Improve the recording of substance misuse:

Action: This was an action point in last year's report which needs further attention. Accurate recording on the LCS system of substance misuse and intervention offered/accepted is required for accurate reporting. This will be driven through the Health and Social Care Forum.

6) Links will be strengthened between virtual school and health:

Action: Virtual school to have membership representation at the Health and Social Care Forum to ensure close communication continues between health and education services.

5 References:

corambaaf.org.uk

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