WARDS AFFECTED: ALL WARDS

ITEM 4

CORPORATE PARENTING PANEL

19 SEPTEMBER 2017

MILTON KEYNES ANNUAL REPORT ON THE HEALTH OF CHILDREN IN CARE

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Purpose of Report:

To provide information to inform the panel's annual discussion with health professionals with lead responsibility for work with social care colleagues to assess and ensure appropriate responses to the health needs of the children and young people in our care.

Background: The Looked After Children's Health Team is provided by CNWL NHS Trust. A substantial annual report is completed each year, in line with the Trust's internal governance arrangements, providing wider contextual information about the Milton Keynes care population and highlighting key successes and issues. The following extracts from the team's 2016/17 annual report provide the panel, as corporate parents (who have previously been briefed on the wider contextual data), with specific information about the health needs of, and health provision for, our Looked After children and young people.

Corporate Priorities: The council prioritises its role as a corporate parent, which includes seeking assurance that the health needs of children in care are assessed and well met

Performance Information: The report includes performance data and, where appropriate, detailed explanations of work to improve performance against the key national indicators:

- 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 (emotional wellbeing assessment) completed.

The report also covers the team's wider work in 2016/17, reporting on specific work to ensure that children in care and care leavers with specific needs have access to appropriate health interventions in relation to:

- Sexual Health
- Teenage pregnancies
- Substance misuse
- Emotional Health and Wellbeing
- Health Improvement/Promotion
- The needs of Unaccompanied Asylum Seeking Children Seeking Asylum: (UASC)
- Care Leavers' health needs
- Safeguarding, including Child Sexual Exploitation (CSE):
- Medical Advice to Milton Keynes Fostering and Adoption Services
- Training provided for Social Workers, Foster Carers and GPs to ensure that the team around every child in care has the necessary skills and knowledge to recognise, promote and address their health needs.

Equality and Diversity Impact: Children in care and care leavers are at greater risk of exclusion and poor outcomes. They need excellent support and services to ensure that they have happy and successful childhoods and become successful adults. It is essential that their health needs are recognised and met as part of this provision and that all professionals work closely with children, young people and their carers to identify and address any areas for improvement. The report lists a number of improvement areas identified and addressed in 206/17 and also the priority improvement areas that are being addressed in 2017/18.

Recommendations /Proposals: That panel members, as corporate parents, use this information and the opportunity to talk directly with lead health professionals to obtain assurance that the health needs of our children in care and care leavers are being identified and addressed.

1. Recommendation(s):

That the report be noted

2. Extracts from the 2016/17 Milton Keynes Annual Report on the Health of Children in Care

Introduction

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).

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

Staffing Summary

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

- Designated Doctor for Children in Care, Consultant Paediatrician, and Advisor for Fostering & Adoption Panel.
- Consultant Paediatrician hours to complete all IHA and RHA for under 5 years.
- Designated Nurse for Children In Care and Safeguarding.
- Named Nurse for Children In Care.
- Specialist Nurse for Children in Care.
- Business Support Children in Care.

Performance Indicators

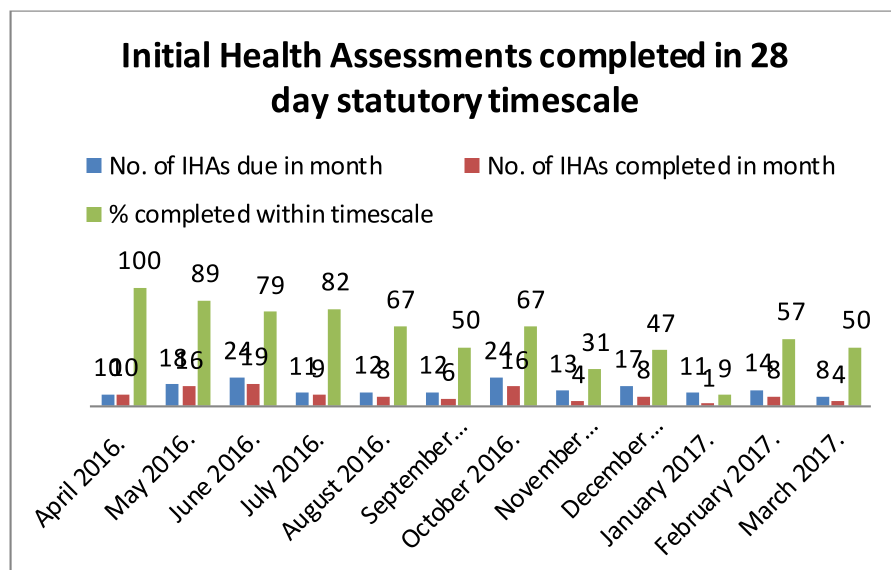
National Targets/Statutory requirements:

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.

Initial Health Assessments completed in 28 day statutory timescale:



Graph 1:

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:

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

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.

The 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.

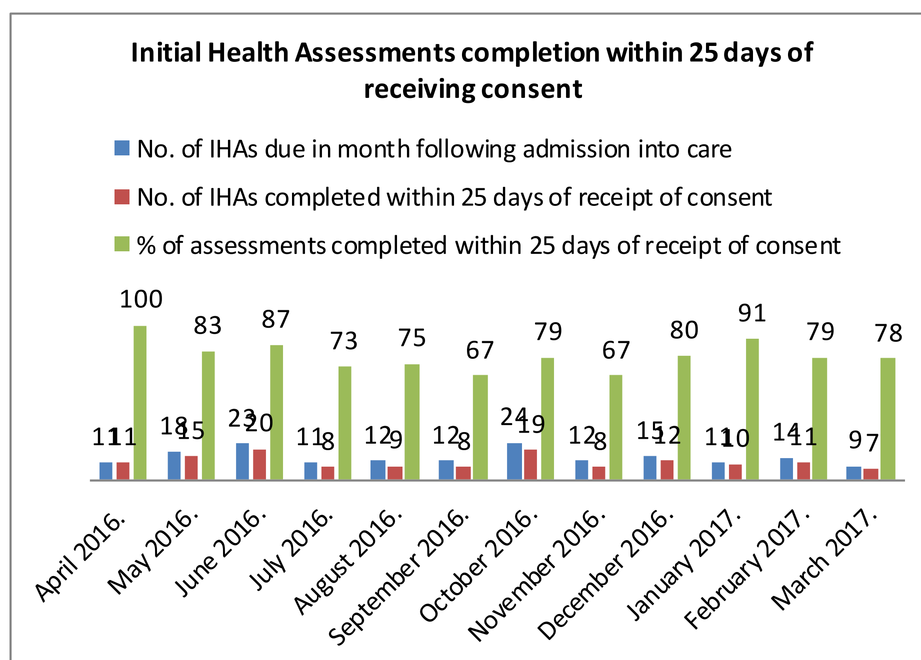
There is an agreed target between MK-CSC and health for completion of Initial Health Assessments within a timeframe of 25 days from health receiving consent. This was in recognition that the health team do not have control over gaining consent from the parent.

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:			
Q1	**Q2**	**Q3**	**Q4**
20%	32%	10 out of 35 28.6%	24%

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 2: 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: 1 1 April t 2016 – 31 March t 2017

Due: 170.
Completed: 136 = 80 %
Factors impacting on delay of 34 cases:

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

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 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**. Previously, health was reliant on 'LCS' notifying us a child had been brought into care. Evidence showed this was not a robust method of notification.

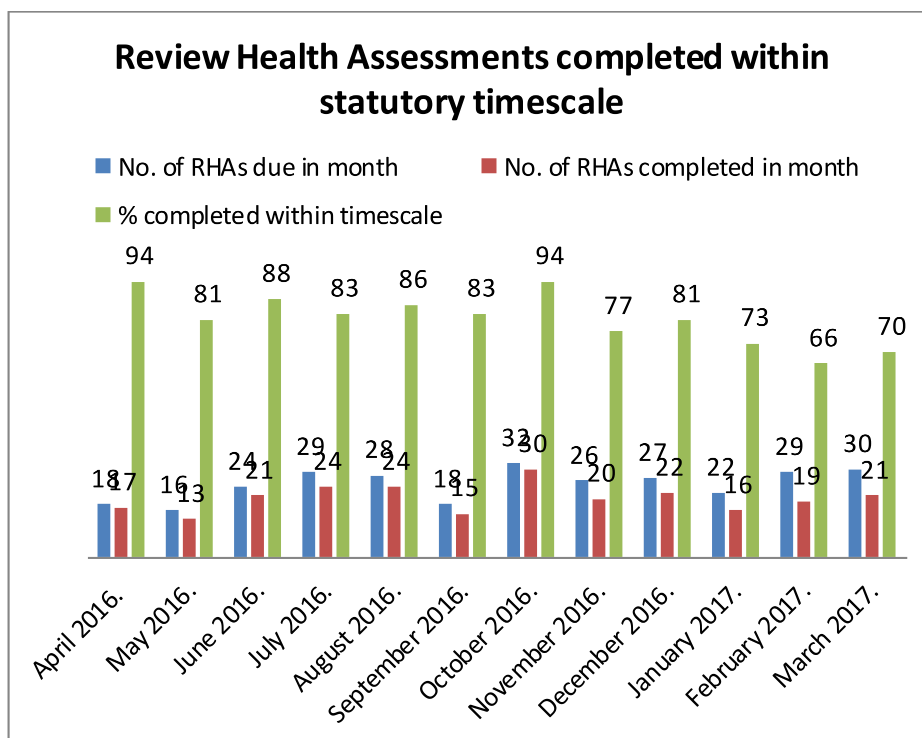
5) **Performance is reviewed at each Health and Social Care Forum**. Actions if required relating to consent and paperwork process can be cascaded to teams.

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.**

Review Health Assessments completed within statutory timescale:



Graph 3: Number of Review Health Assessments due completion each month and how many were completed within timescale: April 1st 2016- March 31st 2017

Due: 306
Completed in timescale: 242= 79%
Factors impacting on delay of 64 cases.

Out of area placement	**25**
Carer unable to attend appointment offered	**2**
Child in hospital	2
Care Missed booked appointment	**2**
Young person declined	**3**
Paediatric review required	**3**
Wrong Carer details sent to hospital	**3**
Placement of child changed	**3**
Unaccompanied Asylum Seeking Child had DOB lowered, which affected need for RHA	**1**

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):

Immunisations

Milton Keynes: Published 2015/16	89%
Milton Keynes Average Provisional 2016/17	88%
England Average Published 2014/15	87.8%
England Average Published 2015/16	87.2%
Stat neighbour Average published 2014/15	92.1%
Stat neighbour Average published 15/16	88.1%
South East Average Published 2014/15	82.2%
South East Average Published 2015/16	82.1%

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.

Dental Checks Completed

Milton Keynes: Published 2015/16	90.9%
Milton Keynes Average Provisional 2016/17	88.5%
England Average Published 2014/15	85.8%
England Average Published 2015/16	84.1%
Stat neighbour Average published 2014/15	83.3%
Stat neighbour Average published 2015/16	84.7%
South East Average Published 2014/15	86.1%
South East Average Published 2015/16	86.5%

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.

Registration with GP

All children and young people who are CIC are registered with a GP.

Developmental Checks

Milton Keynes: Published 2014/15	100%
Milton Keynes Average Provisional 2015/16	**100%**
England Average Published 2013/14	86.70%
England Average Published 2014/15	**89.40%**
Stat neighbour Average published 2014/15	**86.6%**
Stat neighbour Average published 2015/16	**93.8%**
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.

Annual Health Assessments

Milton Keynes: Published 2015/16	**93.2%**
Milton Keynes Average Provisional 2016/17	**91.8%**
England Average Published 2014/15	89.7%
England Average Published 2015/16	**90.0%**
Stat neighbour Average published 2014/15	**89.0%**
Stat neighbour Average published 2015/16	**91.3%**
South East Average Published 2014/15	**85.2%**
South East Average Published 2015/16	**86.8%**

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.

Other Clinical Activity

Sexual Health:

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. 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. 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.

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. Between April 2016 and 2017 there were a total of **14** cases open to Children Social Care and **6** were open to Children and Families Practices.

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.

All young people have substance misuse covered as a key area in their CIC health assessment 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.

Emotional Health and Wellbeing

The Needs of Children in Care:

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

Adolescent Wellbeing Tool:

How young people feel in themselves is central to any assessment. 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.

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). The service has experienced some challenges of the past year in relation to recruiting and retaining a PMHW in this position. The Role of the Primary Mental Health Worker for Children in Care and its functions has been revised. The new role will ensure all children in care will have an assessment when they become looked after, with a clear programme of intervention.

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:

'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.'
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 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.

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.

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.
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 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.

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.

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.

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.

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. 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.

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.

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' decision 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.
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 provided by Health Team:

Social Workers Training
Training for Foster Carers

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

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- Community Health 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.

7) COMPASS: Development of joint protocol

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 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 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.

User Surveys

Following the Well & Wise Event 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.

Inspections Completed: CQC & OFSTED

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:

OFSTED 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 are being reviewed and a joint action plan progressed and actioned via the Health & Social Care Forum.

Priorities for the coming year 2017/2018:

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 DfE 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.