

# **Review of health services for Children Looked After and Safeguarding in Milton Keynes**

# Children Looked After and Safeguarding

## The role of health services in Milton Keynes

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<b>Name(s) of CQC inspector:</b>	Daniel Carrick Liz Fox Jennifer Fenlon Emma Wilson
<b>Provider services included:</b>	Central and North West London NHS Foundation Trust. Milton Keynes University Hospital Foundation Trust.
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<b>CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:</b>	Janet Williamson

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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Milton Keynes. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Milton Keynes, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

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## About the review

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The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 2013*.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

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## How we carried out the review

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We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their wellbeing.

In total, we took into account the experiences of 53 children and young people.

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## Context of the review

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The 2016 Child and Maternal Health Observatory (ChiMat) profile provides a snapshot of child health in Milton Keynes.

Children and young people under the age of 20 years make up 27.2% of the population of Milton Keynes with 38.4% of school age children being from an ethnic minority group.

On the whole, the health and wellbeing of children in Milton Keynes is generally better than the England average.

The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Milton Keynes.

The most recent average SDQ score (2015) of 13.1 is slightly lower than the England average of 13.9. The average score fell in 2014 and increased in 2015 which suggests that the emotional health and wellbeing of looked after children in Milton Keynes has fluctuated slightly but during this time has remained normal and below the England value.

The DfE reported that Milton Keynes had 220 looked after children that had been continuously looked after for at least 12 months as at 31 March 2015 (excluding those children in respite care). The percentage of children who had their annual health assessment was 95%, higher than the England average of 89.4%.

*Commissioning and planning of most health services for children are carried out by Milton Keynes CCG*

*Commissioning arrangements for looked-after children's health are the responsibility of Milton Keynes CCG and the looked-after children's health team. The designated nurse for LAC is provided by Milton Keynes CCG. The designated doctor for LAC and operational looked after children nurses are provided by Central and North West London NHS Foundation Trust.*

*Acute hospital services are provided by Milton Keynes University Hospital Foundation Trust*

*Health visitor services are commissioned by Local Authority and provided by Central and North West London NHS Foundation Trust (Milton Keynes, CNWL-MK)*

*School nurse services are commissioned by Local Authority and provided by Central and North West London NHS Foundation Trust*

*Child and Adolescent Mental Health Services (CAMHS) are provided by Central and North West London NHS Foundation Trust*

*Contraception and Sexual Health services (CASH) are commissioned by Local Authority and provided by Brook*

*Child and young people's substance misuse services are commissioned by Local Authority and provided by Compass*

*Adult substance misuse services are commissioned by Local Authority and provided by Compass*

*Adult mental health services are provided by Central and North West London NHS Foundation Trust*

*The last inspection of health services for Milton Keynes children took place in July 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.*

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## The report

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This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

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## What people told us

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We spoke with children who were being provided with care and support in the Emergency Department (ED) at Milton Keynes University Hospital. One child we spoke with told us:

*"It's been really nice here. The nurse has spoken to me and not my mum and she asked me lots of questions about what happened."*

We then spoke with the young person's mother. She told us:

*"We haven't been kept waiting long at all. I feel like we are being looked after well and I'm certainly being told what's happening. It's all very relaxed."*

We heard from a young person who had used CAMHS and specialist mental health placement services for several years. When asked about the CAMHS service the young person told us:

*"I have had quite a few different CAMHS workers over the years. It takes a long time for me to be comfortable enough to open up so it's not always good having different people to work with. I'm not offered any choice when there is a change. I'm just given what I get and have to get on with it. Some of them have been good though."*

The young person went on to tell us:

*"I have been a patient at a special hospital for some months now and am about to be discharged. I feel like it's out of my control though. I know there is a plan for my move but I don't know what it is. I've just started work with a new doctor and CAMHS worker and they seem pretty good so hopefully things will improve. It actually makes me feel like they care about seeing me. They seem interested."*

We asked the young person how involved they were in the discharge process from the hospital back into the community. They told us:

*“No, I’ve not been very involved. They just tell you what is happening and I just get on with it. I said it wasn’t ideal that I would be discharged back home but apparently they can’t afford to put me in supported living or somewhere else so I have to go with it and make the best of what’s available. I have been asked by my new CAMHS doctor what has helped me in the past and what will help me this time and they have also spoken with my family and mum about how to deal with things. It does make me feel like I am getting somewhere now though so that’s good.”*

We heard from looked after children and young people who attended a summer scheme meeting. They told us:

*“The LAC (Looked After Children) nurse is kind and helpful. I like the fact they come to my house but I have only seen them twice. I get nervous asking questions but I feel that I could ask questions if I wanted to. I feel that my health needs are met and don’t think anything is missing in Milton Keynes.”*

Another said:

*“I am happy with my LAC check-ups but find them a bit boring. They measure me and weigh me every year and tell me when things have changed. I have to go to Oxford Hospital which is far and takes ages to get to it - I wish it was closer.”*

Another young person told us:

*“I don’t know anything about my health.”*

Others we heard from said:

*“I don’t like my check-ups at home. I would prefer to go to the Dr’s instead as I feel awkward at home and having my carers there is awkward and I might not want to talk to them. I don’t think they asked me if I wanted my carer there. Having check-ups makes me feel that I am different to other young people. I think everyone, not just looked after children, should have a check-up to make sure they are healthy.”*

*“The nurses asked me if I wanted to meet at home and I said that was fine. They asked me if my carer should stay or go. I think she is helpful and I feel that I can say anything to her and she will give me good advice. I don’t have access to my medical history but I would like to as I am interested in my medical past. I would like more information on what is available to me in Milton Keynes and different health services as I don’t always think young people know where to go or what is available.”*

Another looked after young person we spoke with told us:

*“My physio is really nice, she was really kind and it’s helped me lots. I got a copy of my health action plan. The LAC nurse was really nice, there’s nothing I would change.”*

We spoke with a young person who had recently moved from long term foster care into supported living. They told us:

*“I liked having an allocated nurse. She gave me leaflets and told me about eating well and helping me sleep. I think its good someone is there to make sure you’re physically and emotionally alright.”*

We also spoke with foster carers. They told us:

*“I found the health assessment really useful. The doctor and the nurse really explain the development assessment and this helps you to understand how you can help the child and it keeps you updated. I am able to access the GP with no problems. The social worker for the children has changed though. They do not communicate with you.”*

Another said:

*“The child I look after had to wait from February until July for a physiotherapy appointment and during this time she really struggled. Now we are in the service this is really helping but the wait was too long. We are travelling to Great Ormond Street hospital weekly for support for her emotional health and this is a really good service so we will travel to make sure she gets the help she needs.”*

Another we spoke with told us:

*“My child refused to go to CAMHS that has been really difficult as I don’t know how I can help her and she has just been discharged. We have a named GP at the surgery and this is really useful.”*

We spoke with the local authority’s participation worker from the looked after group, which children were accessing during the summer break. She told us:

*“The LAC nurses have been brilliant in referring young people to the LAC youth group. This group has enabled these young people to form positive friendships and access extra curricula activities. The LAC nurses are working with the group to form a health participation group which is due to take place in October 2016.”*



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## The child's journey

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This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

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### 1. Early help

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1.1 Milton Keynes University Hospital ED has made some good improvements to ensure the safety and confidentiality of children and young people attending the unit. However, further improvements are required to assure safeguarding risk is appropriately identified. For example, children attending the unit undergo an initial assessment using specific children's ED assessment cards. These cards prompt practitioners to ask some important safeguarding questions but do not ask for parent, carer or sibling information to be added in detail, a common feature in serious case reviews. (**Recommendation 1.1**)

1.2 Young people aged between 16 and 18 attending the ED are routinely admitted to the adult assessment unit unless they have a learning or physical disability. They are not asked if they would prefer to be seen on the paediatric unit despite legally still being classed as children. As a result, their details are recorded on adult specific ED assessment cards although different coloured folders are used to identify children, 16 to 18 year olds and adults. However, children's cards do not prompt practitioners to ask those important safeguarding questions and, as with the children's ED assessment cards, do not ask for parent, carer or sibling information to be added in detail. In two records reviewed we saw that the adults attending the unit with children and young people had a different surname or family name but it was not recorded what their relationship to the young person was. Immediate action was agreed by the head of emergency care to rectify the situation. (**Recommendation 1.2**)

1.3 Young people admitted to the ED in mental health distress are supported well. The CAMHS Liaison and Intensive Support Team (LIST) is a tier three service commissioned specifically to provide urgent CAMHS assessments, short term review and intensive monitoring for children up to age 18 who present at the unit. This is a 24 hour, 365 days a year service. Following assessment, intensive monitoring for up to 72 hours can be offered at home, school, college or other suitable area of choice. The primary aim of intensive monitoring is to prevent admission to the Milton Keynes University Hospital paediatric ward or the predominately adult mental health Campbell Centre which has a reserved, separate bed where young people can be located to await specialist placement elsewhere.

1.4 If admission is required to the paediatric ward to await a specialist placement then the CAMHS LIST practitioner will undertake a full psychiatric and social needs assessment in liaison with the CAMHS doctor or child psychiatrist. A care plan will be actioned by the CAMHS practitioner and one-to-one care and support will be provided by a mental health nurse. A CAMHS psychiatrist will further assess the young person on the ward within 24 hours. CAMHS LIST practitioners will also visit the young person daily until a specialist placement can be found. This is strong practice.

1.5 The Milton Keynes maternity department have a well-developed team of specialist midwives who support pregnant women with increased vulnerability. The specialist midwives lead on perinatal mental health, teenage pregnancy, child protection and vulnerable families. We were advised that caseloads are between 18-30 active cases for each specialist midwife. They offer a flexible service and promote a high level of joint working with other disciplines and agencies to support vulnerable pregnant women and unborn children.

The team take referrals based on a maternity social risk assessment matrix from the community midwives. Women also have the choice of remaining with the community midwives and also receive additional support from the specialist midwives. This ensures that vulnerable women are well supported and receive co-ordinated services throughout their period of care.

1.6 There is an expectation by midwifery managers at Milton Keynes Hospital that all women are asked on more than one occasion during their pregnancy if they are at risk of domestic abuse. We are aware that midwives have received additional training in domestic abuse, but records examined did not facilitate the recording of domestic abuse information and we could not be assured that those important domestic abuse questions are being asked. Research recognises that there is an increased risk of domestic abuse beginning or escalating during pregnancy. Further, we were not assured that there is a standardised approach to seeing women on their own at different stages of pregnancy, which would assist in asking those important questions and identify women at risk not only of domestic abuse but also disclosure of other risk factors. (**Recommendation 1.3**)

1.7 Milton Keynes University Hospital midwives have access to an Independent Domestic Violence Advisor (IDVA) who is able to risk assess and manage onward support and referrals, giving additional independent support to pregnant women. This is a positive step. The specialist midwives work closely with the IDVA service empowering women to keep themselves and their unborn baby safe. Evidence was seen in records examined, of cases being escalated to social care when a more robust response was needed to safeguard the unborn child and expectant mother.

1.8 The specialist midwife for teenage pregnancy has developed excellent working relationships with the Brook young people contraceptive service and is available to see young people who are pregnant at the Brook Centre on a weekly basis as required. The contact may be opportunistic or by prior arrangement with Brook practitioners or outreach workers. Pregnancy booking can also be undertaken at the Brook centre and all teenage mothers are referred to the Brook for contraceptive advice by the specialist teenage midwife. This offers early intervention and a level of flexibility in accessing sexual health services.

1.9 The Family Nurse Partnership (FNP) in Milton Keynes is well established and cases examined highlighted positive outcomes for young people and their infants supported by this service.

*In one case examined we saw that there were significant safeguarding concerns for the baby of two young parents and the child was ultimately removed and placed for adoption. We saw that the nurse was able to manage this difficult challenge whilst continuing to maintain a therapeutic but open relationship with both parents. Multi-agency working was frequent and effective and every possible effort was made to support these young parents to be able to meet the needs of their child. Unfortunately, they were not able to meet those needs but the FNP programme enabled them to recognise this. The delivery of the programme was sensitively adapted to meet the parents' learning needs.*

*The FNP nurse has continued to work with the foster carer and newly adoptive parents to ensure that the child's own needs were met and the child continued to have the consistency of a familiar face and voice during his transition into care. The FNP nurse has supported the parents to be able to help voice their wishes and feelings for their child's future to the adoptive parents, and the FNP nurse plans to continue some post adoption support.*

1.10 Although school nurses in Milton Keynes do not provide a 'drop-in' service at secondary schools, the team plan to be more actively involved in the similar programme currently employed by independently employed school matrons. School nurses link into the programme and are continuing to build links with the school matrons to provide care and support to children in the area. School nurses are excited at the prospect of being able to work more proactively in the early help arena, since funding was agreed with NHS England (NHSE) to fund the Milton Keynes children's immunisations programme which has allowed for the development of a specific immunisations team.

1.11 School nurses quote good working relationships with Brook sexual health services across Milton Keynes. Brook outreach workers will visit schools on request to provide sexual health advice and guidance and likewise, school nurses will, where appropriate, signpost young people to the service. Brook will also provide training and guidance to school nurses regarding sexual health.

1.12 Milton Keynes CAMHS practitioners offer consultation clinics at 13 secondary schools across the area, twice a month. This is a well-used service where children, young people and school staff can gain advice and guidance in relation to mental health issues. The service is commissioned as a tier two service by the local authority provided by CNWL-MK and is a valuable resource for those children and young people seeking early help with their mental health.

1.13 Tier two CAMHS also provide an 'open access' telephone advice and referral service (TRS) to CAMHS advice and support between the hours of nine am to five pm Monday to Friday. Professionals, children and young people and members of the public can seek advice using the service or even refer into CAMHS for further assessment. Referrals made by telephone directly to CAMHS practitioners mean that those practitioners can illicit information that might otherwise not be included on a paper referral. Young people with other issues can often be signposted directly to other forms of support, including self-help, where cases do not meet the CAMHS threshold for further intervention. The service works proactively with schools, children and family practices, children's social care and other non-statutory providers ensuring children and young people are given appropriate early advice.

1.14 Within adult mental health there is a designated perinatal team to provide specialist support to pregnant women and newly delivered mothers who live with mental health difficulties. This better promotes the safeguarding of vulnerable women and their unborn or newly born children.

1.15 Brook offer contraception and sexual health services to young people up to age 25 across Milton Keynes. On attending the service young people have the process of confidentiality explained in full by the assessing practitioner and it is further explained that, should any serious safety issues be disclosed, then referrals to relevant agencies can take place without the client's consent if necessary.

1.16 The Brook service has considered their client base in developing services. Milton Keynes has a high 18 to 21 year old student population who are mobile during the year due to university or college attendance; therefore, prescriptions for oral contraception have been increased to one year for non-complex clients.

The service also recognised that the number of GP's offering a coil service for emergency contraception had reduced, and so Brook now have a trained nurse available to undertake this work to fill the gap. Both initiatives are working to support young people and reduce the likelihood of unplanned pregnancies.

1.17 The Brook service in Milton Keynes is creative in trying to reach young people and raise awareness of contraception and sexual health support services. Sexual health practitioners have attended local festivals, Fresher's week and are also involved in community days run by the local authority.

1.18 There is no current provision in Milton Keynes for Compass substance misuse services to provide any support to children and young people who are affected by parental drug misuse, other than by referral to children's social care. This is a missed opportunity to utilise the young people's services to provide preventative and safety work to this population who do not themselves misuse substances but witness its use in close proximity. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

1.19 Compass substance misuse practitioners write to GPs regarding all clients who are part of the prescribing service; for example, those prescribed methadone. A copy of their medical plan is also sent to their GP and this includes a section regarding any recognised concerns regarding the safeguarding of children and young people. It is not routine that GPs are informed regarding adult patients with parental/carer responsibility who are registered with Compass and who are misusing other substances such as alcohol, amphetamines or new psychoactive substances. As primary record holders, best practice would dictate that GPs are notified of all significant interactions between other health practitioners and their clients. This would help to facilitate GPs in maintaining a complete health record, further identifying safeguarding risks posed to children and young people and further enabling universal services to work together to provide early intervention work. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

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## 2. Children in need

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2.1 Children and young people attending the ED at Milton Keynes University Hospital have their demographic details recorded in the main reception area before being directed to the specific paediatric ED. We observed that the best efforts are being made to respect the confidentiality of people attending the ED and that other patients are directed to wait a respectful distance away from those at the reception desk.

2.2 School nurses have made positive inroads into Milton Keynes faith schools and special schools. Although they are not encouraged to provide sexual health advice unless it is in a limited way, they are able to direct children to other services that can provide care and support when required.

2.3 School nurses are commissioned to deliver a service to all school aged children in Milton Keynes. This includes home educated children, unaccompanied asylum seekers and traveller families. School nurses are proactive in identifying home educated children and this is done using shared information from the local authority. School nurses will actively try to engage with this potentially vulnerable group of young people and, if contact is unsuccessful, then the young person's GP will be notified. This is good practice in order to meet the needs of this potentially vulnerable group of children and young people.

2.4 School nurses also have input into the Youth Offender Team (YOT) on a weekly basis, to meet the health needs of young people who, as a result of the lifestyle they lead, do not routinely attend education.

2.5 School nurses are involved in the care planning process for young people in their care but those care plans are paper records and are kept at the school. Currently, copies of the care plans are not kept on the SystemOne electronic client record system, which means that the electronic health record is not complete. (**Recommendation 2.1**). *This issue will also be brought to the attention of Public Health, as the commissioners of the service.*

2.6 In CAMHS, where a young person is to relocate out of the Milton Keynes area, but who continues to have mental health needs and requires continued CAMHS input, a transfer process is instigated which involves CAMHS practitioners sharing information with the identified receiving service, involving fully the young person in the transfer process. This can include, where practical, face-to-face meetings between the current CAMHS practitioner, the young person and the receiving practitioner. This aids a smooth transfer and builds trust.

2.7 Young people transition from CAMHS to adult mental health services (where appropriate) at age 18. The transition process generally starts at age 17½ although it does start earlier in more complex cases. There is a policy in place to ensure a smooth transfer process, which includes face-to-face meeting between CAMHS practitioners, young people and adult mental health practitioners.

2.8 Where a CAMHS LIST practitioner has assessed a child or young person in mental health crisis at the ED and it is considered their need is so severe that they require immediate specialist care and support, then consideration will be given to them being admitted to the Campbell Centre. Operational procedures dictate processes about how young people should be admitted to the Centre and what care and support must be provided to them during the temporary stay. Although admission to the Campbell Centre is not ideal, there is a recognised lack of appropriate beds for paediatric patients in mental health crisis in Milton Keynes and we were assured that policies and procedures are in place to ensure the placement at the Campbell Centre is a safe one.

2.9 When a young person attends Brook for sexual health care and support a comprehensive assessment of need and risk is undertaken. Separate documentation is used for those young people aged 18 and over than for those aged 18 and under. Details requested for those aged 18 and under include; an assessment of risk from digital activity (such as social media), current and previous sexual activity (including multiple partners), coercion or bribery. Other questions include neglect or emotional abuse, physical violence and domestic violence. Risk of CSE and FGM is also considered during the assessment process. Where children aged 13 years or under disclose sexual activity, an immediate urgent referral is made to social care via the Milton Keynes Multi-Agency Safeguarding Hub (MASH).

2.10 Compass work with young people who are at risk of or already using substances with an emphasis on early intervention and prevention in order to prevent long term harm caused by substances. Compass provides targeted and specialist substance misuse services for children and young people up to the age of 18. Practitioners deliver one-to-one and group based interventions on an outreach basis in schools, youth centres and other community venues. There is a strong emphasis on building and maintaining therapeutic relationships with young people receiving care and support.

*In one case examined, we saw that the Compass practitioner was working closely with a young looked after child who was abusing substances and was also recognised as being at risk of CSE. It was also recorded that the young person had a history of self-harm and suicidal ideation.*

*Despite being previously difficult to engage, determination on the part of the Compass practitioner meant that, over time, a good working relationship built on trust was developed. The young person was encouraged to be part of the risk assessment process and they were also seen to be involved in the planning of their care and support interventions. This included support in relation to self-esteem, substance misuse, developing and maintaining appropriate relationships, sexual health and making appropriate choices in life.*

*Since Compass began working with the young person, we saw that recognised risks, although still present, have now reduced.*

2.11 We could not be assured from records examined, that all GPs in Milton Keynes are taking into account the child's demeanour or parent/carer interactions during consultations. For example, in one case examined we saw that a child was the subject of a child protection plan and had been seen by their GP for a medical review but no mention was made of how the child presented or interacted with the GP or accompanying adult. This important information could not then be shared with other agencies involved in the child protection process. (**Recommendation 3.1**).



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### 3. Child protection

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3.1 On attending the Milton Keynes ED, demographic details are recorded at the reception desk and children, young people and their parents/carers are directed through automatic, locking, alarmed doors to wait in the paediatric ED area. This is good practice as it helps prevent children and unauthorised adults easily gaining access between the main reception area and paediatric ED. We acknowledge that the route to paediatric ED was only set up on the day of inspection and therefore is new, however, there is still risk that once through the doors, unaccompanied children could take a different route, as the area between the doors and the paediatric unit are not supervised. We saw for example, that medical equipment is stored on the route to the paediatric assessment unit and there is the possibility that children and young people at risk of self-harm might access this equipment if unaccompanied. We were advised that this will be reviewed accordingly. (**Recommendation 1.4**)

3.2 Effective systems are in place to alert practitioners that children and young people with increased vulnerability are in attendance at the ED. Practitioners can use the MKUH IT patient record system to generate a 'promoting child welfare' flag, indicating the reason for their concern so that practitioners accessing the record will be made aware. GPs are also automatically informed of attendances at the ED.

3.3 A 'three part blue form' can also be generated by staff to alert the named nurse and liaison health visitor of children they have identified as a concern. These forms are then disseminated to other services in health when it has been indicated that those services are, or might be, working with the child. Although these are not collected daily, we were assured and saw that practitioners would contact the named nurse if a quicker response was needed, including health visitors and school nurses.

3.4 The Milton Keynes University Hospital 'Did Not Attend' (DNA) or 'Was Not Brought' (WNB) policy for children and young people highlights the preferable use of WNB as opposed to DNA for children that might not have the option to decide for themselves whether or not to attend an appointment at the hospital. The use of the WNB term highlights the vulnerability of children who have medical needs but are unable to access medical care if their parent/carer chooses not to prioritise the child's needs. Pathways are in place for practitioners to follow in the event of WNB. This ensures the safety and wellbeing of vulnerable children should there be a concern. The pathway includes verbal and written communication and liaison with other relevant professionals including primary care and children's social care.

3.5 The Milton Keynes ED matron spoke positively of working relationships with children's social care. The named nurse maintains oversight of social care referrals made by ED practitioners using the Multi-Agency Referral Form (MARF). A number of referrals were examined during our visit to the unit and, although they included descriptive dialogue, they were weak in the analysis of risk to support the social care decision-making process. We were assured however, that practitioners relay important risk information during the initial telephone contact with the MASH when they are seeking advice and guidance, and that the MARF is then used as a tool to 'back up' the call. We also saw in examples examined that mentions is sometimes made of the initial telephone contact, but not always.

3.6 Specialist training is being undertaken by the safeguarding team to the ED in supporting practitioners in making good quality referrals to social care using the 'signs of safety' approach and this is ongoing. Milton Keynes Safeguarding Children Board (MKSCB) also provides training to practitioners on how to make good quality referrals to children's social care.

3.7 On the paediatric wards, we saw that specific ward location risk assessment was not undertaken when a young person was admitted to await an urgent care mental health placement. Although young people in mental health distress are cared for appropriately by mental health nurses, the area of the ward on which they are located is not assessed for risk over and above the standard ward ligature point risk assessment. Case-by-case risk assessments would offer reassurance to both the young person and their family/carers and also the mental health practitioner providing care and support to the young person. We saw however, that whilst being assessed by a CAMHS practitioner on the ED, a personal risk assessment is undertaken and this is then included in the intervention plan which is shared with the mental health nurse undertaking one-to-one care and support and also the children's ward staff. (**Recommendation 1.5**)

3.8 The Milton Keynes University Hospital IT system in use by midwifery services generates a 'promoting welfare' flag when a safeguarding concern has been identified. The system then requires the practitioner to further access a template where further detail of the concern is recorded. However, two records examined during our review did not have a 'tick' in the required box to identify that a child protection plan was in place. Immediate action was taken to rectify this when we identified the risk. A more robust approach is required to ensure all safeguarding information is appropriately recorded and made available to those practitioners accessing patient records. (**Recommendation 1.6**)

3.9 There is a clear expectation that core safeguarding meetings are prioritised and attended by health visitors. Numerous records reviewed demonstrated that health visitors were attending child protection meetings, strategy meetings and core groups. Reports written for child protection conference were seen to be risk and strength focused and gave sufficient detail to allow appropriate safeguarding decisions to be made. Copies of child protection plans are scanned onto patient electronic records and there is evidence that these plans were being used to inform practice.

3.10 SystmOne is in its infancy across CNWL-MK. Managers recognise there are ways in which record keeping could be improved and work is ongoing to ensure this. Records reviewed in the health visiting service were seen to be descriptive but some contained no clear analysis of risk and associated health plans.

Record keeping gives good detail about the child and parental interactions, but when there is risk associated with parental behaviour, such as in relation to mental health or domestic abuse, this was not reflected on the child's record. The current system of directing staff to 'see mother's record for further information' does not effectively safeguard vulnerable children. Two records reviewed gave no indication that parental mental health was impacting on the ability of the parent to meet the needs of the child and this is a concern. When children transfer to school nursing parental records are not closed but do remain on SystmOne. (**Recommendation 2.2**). *This issue will also be brought to the attention of Public Health, as the commissioners of the service.*

3.11 There is consistent flagging of safeguarding concerns in children's records maintained by health visitors using the same system as in CAMHS. In some records examined, we saw that chronologies were used but there is currently no standard operating guidance to streamline what is entered onto those safeguarding chronologies; the current method is not consistent and this was identified as an area for development. Groups and relationships are not consistently updated and, in one record reviewed, a male was mentioned on several occasions but it was not clear who he was, what his surname was, the relationship to the child or if he posed any risk. (**Recommendation 2.3**). *This issue will also be brought to the attention of Public Health, as the commissioners of the service.*

3.12 Specialist health visitors are in post for safeguarding, continence and sleep. There is however, no specialist health visitor post for substance misuse and links with the local adult substance misuse service is reported to be poor. In records examined we saw no evidence of any liaison between health visiting and substance misuse services. There is a risk therefore, that parents with substance misuse concerns are not being appropriately supported by a multi-agency approach, which could increase risk to vulnerable children in their care. (**Recommendation 2.4**). *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

3.13 School nurses attend monthly safeguarding meetings held at many GP surgeries across Milton Keynes, but not all. Attendance has had the effect of raising the school nurse profile with GPs and educating them as to the services they can offer. Likewise, important safeguarding information is shared at the meetings, which might better inform GP interaction with vulnerable young people.

3.14 MARF's to children's social care, as submitted by Milton Keynes CAMHS practitioners, were seen to be comprehensive in the description of events leading up to the referral being made, identifying individual and family structures and also supporting mechanisms either already in place or required. They also clearly articulated risk. This is good practice as it aids the decision making process when considering further action.

3.15 CAMHS practitioners make good use of SystmOne by the use of a 'blue boy' icon that alerts to any safeguarding concerns, the same icon as used across community services. Links are provided to access this information so that those practitioners can easily see and understand the concerns, to better inform their interactions with vulnerable children and young people.

3.16 Patients who fail to attend an initial CAMHS appointment without prior communication will be discharged from the service unless there is a clinical risk identified. This is assessed on an individual basis. Those not attending follow up appointments will be contacted to reappoint, and failure to attend any subsequent appointment will result in discharge from service. We examined a case where the young person attended an initial appointment but was reluctant to engage. At the second appointment their mother attended instead and a third appointment was made for both the young person and their mother. Neither attended the third appointment and, on considering the strength of support services already in place for the young person, and that risk was therefore significantly reduced, the young person was appropriately discharged from the service. Appropriate other agencies, such as GPs will also be notified of the discharge from service.

3.17 A street triage team has been developed within adult mental health services. They are based at the local police station with remote access to adult mental health electronic records. We were told that this has reduced the number of section 136 admissions to custody suites as a place of safety, by 60%. This will have a 'knock on' effect, in that children and young people in the care of those adults will not necessarily be without support during the adult's time in custody.

3.18 In adult mental health, the patient homepage within SystmOne does not consistently identify when a patient has parental or carer responsibility for, or significant contact with, children and young people. Where we observed that children had been mentioned within the SystmOne record, their full details were not recorded. This will hinder quick identification of them and further checks with, for example, children's social care. Likewise, we could not be assured that questions were asked or checks made with children's social care to ascertain if identified children were known to the service or had been allocated a social worker. (**Recommendation 2.5**).

3.19 The 'think family' model could not easily be evidenced in all cases examined in adult mental health. In some cases seen, we saw that practitioners were clearly recording what they had seen and heard when visiting clients in the family home. In other cases however, we saw that practitioners were simply recording what they were told by clients and not, for example, recording children's demeanour or the quality, safety and cleanliness of the surroundings and interactions between young people and adults. There was variability in the way that practitioners record conversations and observations, which could impact on the way that decisions are made in relation to protecting hidden children. (**Recommendation 2.6**).

3.20 Young people attending Brook for sexual health care and support, who disclose risk, will be referred to social services via the MASH where appropriate. If, following the referral, the young person disengages from the service, then Brook practitioners will make several attempts to reengage with them before they are discharged from the service.

*A young person attended Brook services for sexual health support and disclosed multiple sexual partners over a short period of time, some of which had taken place on receipt of payment. Risk was discussed with the client, including the risk of child sexual exploitation, and a decision was made with their consent, to refer them to children's social care.*

*The young person was then subject to discussion at the Multi-Agency Risk Management Meeting (MARMM) and, in records examined, we saw that Brook practitioners regularly attend those meetings. It was recognised that the young person was at risk due to their sexual activity but a decision was taken that, because they were over the age of sexual consent, no further action could be taken at this stage other than to highlight to the young person how they were putting themselves at risk.*

*Brook ensured that the young person had received up-to-date protective immunisations before they disengaged from the service. Despite this, we saw that Brook made several attempts to reengage with the young person and make it clear that they would be willing to offer sexual health support at any time should it be required.*

3.21 Although the Brook sexual health assessment process does ask clients if there is any risk to others, it does not record family or sibling detail, even where a client discloses safeguarding concerns. This is a missed opportunity to identify hidden children in households where, for example, domestic abuse takes place or where a client might disclose historic sexual assault. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

3.22 Although managerial oversight of individual cases at Compass is good, the service does not use a standardised safeguarding flagging system on either paper or electronic records. When opening both paper and electronic records it is not obvious if there are any safeguarding concerns and this was identified as an area for development during our review. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

3.23 Despite there being no standardised safeguarding flagging system in use at Compass, young people's records examined were seen to be of a consistently high standard. The voice of the child was strong and detailed and there is a comprehensive assessment process in place which enables practitioners to assess risk and develop an outcome-focused risk assessment plan with the client. Action plans examined, were seen to have been developed with the young person and signed by them as accurate. Records showed Compass practitioners using risk assessment tools to identify children at risk of CSE, which is good practice.

3.24 There is a clear managerial expectation at Compass that practitioners will attend child protection case conferences and core groups, and this is monitored. Where a practitioner is unable to attend they are expected to make contact with the social worker and submit a written report. However, it is best practice if a report is always submitted to inform conference, even when the intent is to attend in person, and this was highlighted as an area for development. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

3.25 Compass adult substance misuse services provide one-to-one sessions with clients who are parents or have access to children and young people, to educate them about the effects of their substance misuse on children or even unborn children. It is good practice that, where a child safeguarding risk has been identified, practitioners will visit their clients at home. However, when adult service practitioners are seeing children in the family home they are not routinely documenting this in client records. Records reviewed gave little or no indication of whether the parent was meeting the child's needs, and also did not record the child's presentation or demeanour. This is a missed opportunity to better identify and record risk. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

3.26 Referrals made by Compass practitioners to children's social care clearly identified concerns and the potential impact and risks to children and young people. Team managers have good oversight and review all referrals made to the MASH. This is good practice.

*In one case examined we saw that an adult mother had been misusing heroin and crack cocaine and, since engagement with the service, had produced four positive substance misuse test results. Engagement with the service was sporadic, but despite this practitioners had identified children at risk.*

*Risk assessment documentation clearly identified the risks recognised and a referral was made to children's social care via the MASH. We saw that the referral clearly articulated the risks, and when this was discussed with the client an admission was made that her substance misuse was affecting her ability to properly care for her children which meant that practitioners could better consider this when considering the safety of her children.*

3.27 Compass adult substance misuse practitioners were also seen to actively provide care and support to pregnant clients whilst always considering the safety of the unborn child and this was evidenced in cases examined.

*In one case examined we saw that Compass practitioners had supported a pregnant client throughout her pregnancy via the prescribing service. We examined evidence of regular contact and updates with the client's social worker whenever the client tested positive for substance misuse.*

*Throughout the practitioner/client contact we saw that the expectant mother was encouraged and supported to understand the potential impact of her substance misuse on her unborn child. The client had other children that had been removed and placed into care as a result of her continued substance misuse.*

*We also saw that the Compass practitioner made regular contact with the client's GP to update them, especially when the client refused to consistently engage with the service.*

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## 4. Looked after children

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4.1 Children in care in Milton Keynes benefit from a dedicated and consistent Looked After Children (LAC) health team. A number of cases reviewed found that children had been seen by the same nurse for up to five consecutive years. This has enabled children to develop trust and healthy, therapeutic relationships with practitioners to help improve their health outcomes. Children living out of the Milton Keynes area are tracked by the team and closely monitored to ensure that their health needs are met.

4.2 There has been real commitment from the LAC service to conduct statutory health assessments within timescales. The LAC named nurse has robust systems in place to ensure this is closely monitored. For example, a theme was identified around social workers not gaining consent in a timely manner. A joint escalation policy was subsequently developed with social care. If after seven days of a child entering into care, consent has not been obtained, it is escalated to the social care team manager. This has had a significant impact on enabling the LAC service to carry out initial and review health assessments within a timely manner.

Data reviewed from April 2016 shows that 100% of initial health assessments were completed within statutory timescales and 94% of review health assessments were also completed on time. Data is available to show the reasons for any delay so that specific issues can be addressed as required.

4.3 In LAC, the designated doctor and paediatricians complete both initial and review health assessments for children aged five years and under and only initial health assessments for those aged five years and over. All review health assessments for children and young people aged five years and over are undertaken by LAC nurses. Assessments undertaken by paediatricians are completed on Saturdays with some flexibility for assessments to be undertaken on weekdays by exception. We saw that the LAC specialist nurse (qualified at band seven) will travel for up to two hours to see children and young people placed out of the Milton Keynes area, which is considered effective practice in maintaining close links with this vulnerable cohort of children.

4.4 The LAC nursing team were recording health contacts and actions with young people and carers directly onto social care electronic records. They have access to SystmOne but were only scanning completed health assessments onto it. All other health contact and actions were recorded onto the social care electronic system and not SystmOne. There was therefore, no complete health record for LAC and it was a significant concern that the LAC nurses were not using SystmOne as their primary recording system. There was a risk that, if a child leaves care, valuable health information on the social care record will not be available on SystmOne. We were assured at the end of our review that immediate action had been undertaken to remedy this and that all recording is now made on patient electronic records within SystmOne.



4.5 Health visitors, school nurses, CAMHS practitioners and GPs are not routinely asked to contribute to the health assessment process. This is a missed opportunity to provide an holistic assessment of the child's or young person's health. **(Recommendation 5.1).**

4.6 Operational governance for quality assurance is an area for development within the LAC team. We saw no evidence of completed quality assurance of initial or review health assessments. There is currently no regular review of the LAC specialist team's records to enable management to continuously improve standards. **(Recommendation 5.2).**

4.7 The development of the 'unaccompanied asylum seeker health pathway' is an excellent piece of innovative practice. This has engaged the police custody service, sharing information to reduce repetition and ensure that this vulnerable group of young people are having their health needs prioritised and met by dedicated health professionals in a consistent way.

4.8 Strength and Difficulty Questionnaires (SDQs) are completed by the LAC nursing team with foster carers and we saw consistent evidence of this. It is recognised that best practice would be to also complete the SDQ with the young person. The service is using the 'Adolescent Wellbeing Form' as provided by the Department for Education, but this is not consistent and the LAC team recognise this as an area for development. **(Recommendation 5.3).**

4.9 We examined initial and review health assessments completed by paediatricians and saw that they were generally medically focused, episodic and not holistic. Although some did provide good parental health history with implications for the child's future, the voice of the child and interaction with carers was weak. The health action plans were not SMART and did not facilitate parents, carers or social workers in ensuring the health of the child was improved. The current quality assurance processes are not effective in improving the standard of initial health assessments. **(Recommendation 5.3)**

*In one case example we tracked, we saw that the initial health assessment did not reflect the full picture of what was known about the child, including for example, that there was evidence of significant domestic abuse during the mother's pregnancy. Although the initial health assessment was completed within timescales, signed consent from the birth mother was not present on the paper copy of the initial health assessment or even recorded on hospital electronic records as having been obtained. The initial health assessment did not indicate if the birth mother had been invited to attend or inform the review health assessment.*

*There was a good level of parental health history and maternity information examined in the record but there was minimal focus on the presentation of the infant, or carer interactions. The development assessment was seen to be adequate but the health action plan was poor and there was no evidence of a quality assurance tool being used. The doctor we spoke with advised us that the health assessment was shared with the health visitor, carer and child's GP but there was no audit trail to evidence this.*

4.10 Review health assessments seen, which had been completed by the LAC nursing team for children aged five years and over, were of a very good standard. They were comprehensive and holistic assessments, the voice of the child was strong and the review was personal to that individual child. There was also evidence of ongoing support and assessment, and review of previous outstanding health needs. The health action plans were detailed, timely and accountable.

*In another case tracked we saw that the review health assessment was comprehensive and child focused. The young person had been in care for over 10 years. The voice of the child was clearly recorded and the health action plan was seen to be SMART. This was an excellent example of how the LAC nursing service had been paramount in ensuring the young person received appropriate care and support. The LAC nurse provided ongoing care, professional curiosity and appropriate challenge to ensure the young person had improved health outcomes.*

*The 'leaving care passport' provided, was seen to be written at a level that could be understood by the young person and it provided them with clear and important health history information.*

4.11 The LAC service is not routinely obtaining consent from young people for their health assessments and they recognise that this is not best practice. Consent is being obtained by social care team managers but this is not always appropriate. For example, when Section 20 of the Children Act 1989 (provision of accommodation) is in place. We did not have assurance that the practitioners carrying out the health assessment always have sight of signed consent, or if they are actually obtaining consent from the young person at all, if they are able to do so. This was identified as an area for development. (**Recommendation 5.4**).

*In one case examined we saw that both the initial and review health assessments did not evidence that consent had been discussed or obtained from the young person. This was despite the need for an interpreter being present to assist in the process, as English was not the young person's first language.*

*In answer to some questions asked during the initial health assessment, we saw that the term 'not known' was used but it was not clear if this was due to language issues, a genuine lack of knowledge or if the young person was not engaging fully in the assessment process. The voice of the child was not clear and there was no indication as to the young person's demeanour.*

*The review health assessment seen, used the foster carer as interpreter but, although the quality of the assessment was seen to be very good, there was no indication that the young person consented to the foster carer taking part.*

4.12 The Compass young person's service does not currently inform the LAC nursing team if they are working with a looked after young person. This is a missed opportunity for them to provide vital information for the young person's annual health assessment. This is also true of the Brook contraception and sexual health service. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

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# Management

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This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

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## 5.1 Leadership and management

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5.1.1 Milton Keynes University Hospital has a dedicated 24hr ED supported by a dedicated paediatric assessment unit. On the ED at least one paediatric trained nurse is available during each shift, supported by an emergency department nurse trained in advanced paediatric life support. The Paediatric Assessment Unit is supported by trained paediatric nurses on each shift. This is in line with RCPCH (2012) and RCN (2010) guidance. A recruitment drive has been undertaken which has resulted in a number of appointments and the new paediatric staff are expected to be in place by September 2016.

5.1.2 Although community midwives start their working week onsite, where they collect their day's work and where they can access and input onto electronic records, we saw that it was difficult to access some important records such as case conference and child protection reports. We could not therefore be assured that patient records were complete and that practitioners had full access to important and up-to-date information. (**Recommendation 1.8**).

5.1.3 There is strong leadership from the named nurse for safeguarding in LAC to ensure detailed and accurate review health assessments are being completed by LAC practitioners and that they are then being sent on to children's social care to improve the health outcomes for children in care in Milton Keynes. The LAC named nurse has utilised her relationship with social care to review health action plans. This has improved independent reviewing officer's practice, ensuring they take ownership of the health action plans. The named nurse is committed to raising the profile of children's health and has a strong presence on the corporate parenting board and health and social care forum.

5.1.4 Over the last year there has been an increase of 14% of the number of looked after children in Milton Keynes, but there has been no additional capacity within the LAC nursing team to account for this increase. There is limited contingency and capacity within the specialist nurse team to carry out one-to-one direct work with children and young people to improve health outcomes. (**Recommendation 5.5**).

5.1.5 CAMHS practitioners we spoke with were positive about the current 'Milton Keynes Children and Young People's Mental Health and Wellbeing Local Transformation Plan, 2015-2020'. They told us that they were kept well informed of the transformation process and how it might impact on their work with children and young people.

5.1.6 Operational managerial oversight for both adult and young people's services at Compass is good. An up to date 'red-amber-green' rated safeguarding database allows managers to identify all children within the service and those at significant risk and it also provides the date for the next planned safeguarding supervision session.

5.1.7 Compass is actively engaged at a strategic level in safeguarding both vulnerable adults and vulnerable children and young people. A dual diagnosis pathway has been developed with adult mental health services, and Compass practitioners attend multi-agency risk assessment meetings for child sexual exploitation. A joint pathway has also been developed with midwives in Milton Keynes for perinatal mental health and Compass regularly attends the multi-agency risk assessment conference for domestic abuse.

5.1.8 In GP practices visited, we saw that there were safeguarding leads in place who oversee SystemOne to identify children and young people who are known to be the subject of child protection measures, who are looked after children or are at risk. The safeguarding leads are proactive in ensuring important information is shared at monthly, multi-disciplinary safeguarding meetings.

5.1.9 GPs are holding monthly, vulnerable families meetings with health visitors and some school nurses. We examined examples of this working well, to safeguard children at risk. This could potentially be strengthened by inviting other agencies such as midwifery, adult mental health and adult substance misuse services to attend.

Minutes from the meetings are currently being held separate to patient clinical records. It is considered that best practice would be to record detail of discussions held regarding patients on their individual electronic records so that those records remain complete. (**Recommendation 3.2**).

5.1.10 Leadership and management at Milton Keynes CCG is strong, due to the experience of the director of nursing and the children's commissioner having both previously held designated safeguarding roles.

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## 5.2 Governance

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5.2.1 Milton Keynes appointed a new named GP in May 2016 and the designated nurse and named GP are working closely to transform and streamline GP safeguarding practice in the area. Leadership from the designated nurse at a strategic level for GP safeguarding is strong. There are 28 GP practices in Milton Keynes and each practice has an identified GP safeguarding lead. There is also a safeguarding forum which meets monthly to review and disseminate safeguarding information.

5.2.2 Milton Keynes CCG leads a strong culture of learning and reflection across providers and this was evidenced in reports examined and in discussion with managers and practitioners alike. The 'Safeguarding Children and Adults annual report of June 2016' highlights completed annual validation meetings of the 'Safeguarding Children Framework', including section 11 of the Children Act 2004 audits with providers to ensure that safeguarding vulnerable children remains a priority in their day-to-day business. Highlights from the 2015/2016 period include: The CCG to lead the Milton Keynes FGM strategy; the implementation of support pathways; a resource pack for practitioner use and guidance and the recruitment of a primary care safeguarding nurse and local named GP to increase support to primary care in their safeguarding arrangements.

Plans to further strengthen practice during 2016/2017 include: Working with primary care to implement the SystmOne safeguarding children template; ensure service developments are informed by the views of children and young people; strengthen the CCG internal safeguarding assurance process and to further develop the health wide DNA and WNB safeguarding guidance.

5.2.3 A review of child death processes and the rapid response pathways led by the CCGs head of safeguarding identified a need to strengthen the child death process. In October 2015 a permanent local Child Death Overview Panel (CDOP) coordinator was appointed by the MKSCB and hosted by the CCG. This has provided support to the panel and ensures a more structured and consistent approach to the management of the CDOP process. The CDOP annual report dated 2014/2015 recommended action to consider ways to reduce deaths related to consanguinity (the quality of being descended from the same ancestor as another person), how to use its influence to reduce smoking in pregnancy and to support campaigns to promote safe sleeping.

5.2.4 The Milton Keynes MASH went live in September 2014 and the CCG continues to work with partner agencies to support the function of the MASH. The CCG commission the specialist MASH health resource through CNWL-MK and this has shown to enhance the efficiency of information-sharing across health providers and, in particular, primary care. Evidence of this has been provided by CNWL-MK by providing case examples via monthly reports to the CCG. An MKSCB sub group also conducted a quality assurance MASH audit in September 2015. From the MASH going live in September 2014, CNWL-MK has been committed to MASH interagency working and provides a dedicated health resource located within the MASH. This is afforded by a full time specialist nurse provided by CNWL-MK funding (0.5 WTE) band seven specialist post, and supplemented by CCG funding 0.5 WTE.

5.2.5 The Child Protection – Information Sharing Project (CP-IS) is a nationwide solution that connects local authority social care systems with those used by the NHS to enable the exchange of key child protection information and episodes of unscheduled NHS care in place, to alert staff of Milton Keynes' children and young people known to be subject to a child protection plan, or that were looked after children. However, this does not currently extend to children from neighbouring local authorities not signed up to CP-IS. A recent CQC inspection highlighted there were shortcomings in the alert system and the hospital trust have identified the risk on their register and work is ongoing to mitigate this gap.

5.2.6 The MKSCB quality assurance report on CSE dated July 2016, follows an audit to consider the robustness of multi-agency safeguarding responses to CSE across Milton Keynes. The audit considered the effectiveness of assessments and safety planning; multi-agency communication and contribution to the risk assessment process and decision-making and the effectiveness of risk management and outcomes for individual children.

The audit recognised good communication between agencies, appropriate referrals to the MARMM and evidence of planning around perpetrators and significant others. It also recognised areas for development including the inconsistent use of CSE screening tools and other issues in individually examined cases, such as where domestic abuse was identified it was not referred to the IDVA. The MKSCB made recommendations to providers which, if implemented, will ensure Milton Keynes' children and young people are better protected from the risk of CSE.

5.2.7 Milton Keynes midwifery services are progressing toward a paperless, electronic patient recording system over the next 18 months, but currently there remains a mix of paper and electronic records across the service. Managers recognise the operational risk involved in this until implementation of the electronic system, but currently when off site, midwives do not have access to important patient information stored only on electronic records. Patient paper records are only scanned onto the EDM electronic system once the patient is discharged from the service. (**Recommendation 2.7**)

5.2.8 Milton Keynes school nurses have recently negotiated funding from NHS England for the children's immunisation programme across the area. Immunisations are now provided by a specific team within school nursing, freeing other school health professionals to proactively provide care and support to children and young people as well as providing the national 'Healthy Child Programme'.

5.2.9 The CCG designated nurse for safeguarding children and LAC continues to work closely with the CCG and Milton Keynes Council to ensure children and young people in care achieve the best possible outcomes. A recent increase in the numbers of children in care has been associated with an increase in unaccompanied asylum seekers. The 'Looked After Children Health and Social Care Forum' chaired by the designated nurse has been reviewing the health pathways for children who are seeking asylum. Part of the work has been to work with multi-agency partners and charities to access specialist awareness training for practitioners.

5.2.10 The LAC team recognise that they need to improve engagement with children and young people to design and continually improve LAC health services. As a result they have planned a participation group for October 2016 to review the 'leaving care passport' and engage children and young people in the coproduction of LAC health services. The last formal audit with children to improve LAC services took place in 2013. (**Recommendation 5.6**).

5.2.11 The Milton Keynes CAMHS local transformation plan currently underway is considered an exciting opportunity by the service to further improve on what is currently a good service offered to children and young people in the area. Plan priorities include the provision of an enhanced eating disorder service, an integrated care pathway for children and young people with challenging and complex behaviours, an urgent care pathway for hospital liaison and home support and a perinatal mental health care pathway. Local findings from the local review correlate with the published 'National Children and Young People's Mental Health and Wellbeing Taskforce' report (*Future in Mind*) which provides the framework for the transformation.

Since the transformation plan was implemented, waiting times for tier three CAMHS intervention from the point of referral has routinely been maintained at six weeks, a substantial reduction from the previous 28 week average wait. Additional roles within the LIST team have now been appointed.

5.2.12 Compass has provided all substance misuse services in Milton Keynes since April 2015. This is inclusive of a young person's service which provides one-to-one support for young people with substance misuse or alcohol problems, education in schools, training for professionals and community engagement. The adult service includes prescribing and treatment, needle exchange, education, support groups and psychosocial support. A hospital liaison service is provided by a nurse and support worker. This covers the ED and all inpatient wards. The service delivers brief intervention, support for hospital staff, initial assessment and referrals to engage clients in community treatment plans.



5.2.13 In September 2015, the CCG became joint co-commissioners of primary care with NHSE. Although NHSE retains contractual responsibility for primary care and performance, the CCG now takes a greater role in assuring and supporting the quality of care provided, including responses to safeguard vulnerable children in Milton Keynes.

5.2.14 The designated professionals continue to actively support and manage the GP safeguarding forum held quarterly. This has increased the number of supervision, support and advice contacts, particularly for safeguarding children. In one good practice example a GP identified domestic abuse and facilitated consultation with 'MK Act', a local charity working with families to help them move from fear and abuse. This avoided increased risk for the woman and her children and resulted in the family being provided a place of safety.

5.2.15 GPs in Milton Keynes benefit from protected time learning, facilitated by designated leads to address learning from safeguarding reviews as well as specific topics such as FGM and domestic abuse awareness.

5.2.16 All GP practices within Milton Keynes are using SystmOne and this is positive. However, there is currently no standard operating procedure to ensure all GP practices are recording safeguarding concerns in the same way. The designated nurse has designed a comprehensive safeguarding template on SystmOne that will provide support to practitioners in identifying safeguarding and child protection concerns as well as the tools and links to assist with the appropriate action needed. A pilot has just been completed and the imminent introduction of this will help to standardise safeguarding recording across the locality and this is positive.

5.2.17 The new template clearly sets out the level of need using the local authority continuum of need. The template links to early help and MARF referral forms and provides information leaflets which can be printed and given to parents. These leaflets have been coproduced by parents who have been supported by these referrals. A specific case conference form has been developed for GPs and this encourages them to assess risk using the 'signs of safety' approach. However, we were not assured that there is a section on the report for GPs to consider and record the impact of parental health and lifestyles upon the child and this was identified as an area for development. (**Recommendation 4.1**).

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## 5.3 Training and supervision

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5.3.1 Milton Keynes University Hospital safeguarding training, levels one to three, currently stands at 90%. Practitioners are knowledgeable regarding their roles and responsibilities in relation to the safeguarding of vulnerable children and young people including the recognition of CSE, FGM and neglect. Training is delivered face-to-face as opposed to relying on practitioners accessing it online.

The face-to-face training has also supported the inclusion of local serious case reviews and internal cases of concern, allowing practitioners to reflect and learn from those incidents and reflect on practice. The training has also been endorsed by the MKSCB.

5.3.2 The Milton Keynes University Hospital safeguarding team has developed and delivered a number of specialist workshops in both single and joint agency format in relation to CSE and FGM. Practitioners we met, spoke positively of the training, saying it helped their understanding of the subjects and how better to identify risk and report accordingly. It is good practice that practitioners across CNWL-MK have access to CSE and FGM toolkits to assist them to analyse and report risk once CSE or FGM is suspected. We are further aware that a toolkit to use when neglect is identified is also available to practitioners to guide them should they suspect a child at risk of this most common form of child abuse.

We were advised that, although it is a challenge to ensure practitioners attend multi-agency training in an acute hospital due to shift patterns and staff availability, the approach of bringing social care into the hospital to jointly deliver training is a positive initiative.

5.3.3 Milton Keynes University Hospital has developed a safeguarding supervision model for safeguarding practitioners and senior managers. However, no formal arrangements are currently in place for frontline staff where supervision is based on ad-hoc advice and guidance and more likely to relate to challenging an incident that has arisen during the working day. More formal, structured, safeguarding supervision for 'frontline' practitioners would further strengthen safeguarding vulnerable children across Milton Keynes. (**Recommendation 1.7**)

5.3.4 Midwives are specifically identified within the intercollegiate document 2014 as requiring multi-disciplinary, multi-agency level three training at specialist level (a minimum of 12-16 hours over a three year period). The Milton Keynes University Hospital named midwife supports the safeguarding team, delivering level three safeguarding children training to all midwives to the required level. All midwives are rostered to attend a full day's annual safeguarding training with topics reflecting current high profile issues in safeguarding including CSE and FGM. The day also supports a learning culture via interactive learning and by using local case scenarios, serious case reviews and internal incidents. Current levels of compliance are at 90% for level three safeguarding children within the maternity unit. The safeguarding midwives can also attend MKSCB multi-agency training on specialist subjects to meet the multi-agency element of intercollegiate guidance.

5.3.5 The named and specialist midwives receive regular safeguarding supervision. However, safeguarding supervision could be further developed within community midwifery services. This would make it more robust and structured, as currently safeguarding supervision is based on ad-hoc advice and guidance. There is the possibility that risk might not be recognised by individual practitioners, which could be identified in more structured supervision. Managers recognise the gap in provision and have developed a supervision policy soon to be implemented. **(Recommendation 1.7).**

5.3.6 In health visiting there is good operational oversight of safeguarding practice. The service manager and safeguarding health visitor undertake a 'deep dive' every quarter to review the safeguarding practice of practitioner records and use this to improve awareness. There is a culture of learning from safeguarding events and there are also shared learning events which last for two hours, to review themes from serious case reviews and how practice can be better improved.

5.3.7 CNWL-MK safeguarding supervision in health visiting, school nursing and CAMHS consists of monthly group supervision meetings where practitioners can take cases for discussion whether they pertain to safeguarding issues or not. The meetings are facilitated by peer practitioners who have undertaken supervision training which incorporates a safeguarding element. Oversight is maintained by the CNWL-MK safeguarding team. Those monthly meetings are monitored by managers and should a practitioner not attend two meetings in a row they must then receive one-to-one supervision. This process identifies all staff that might need further training. Practitioners also undergo three-monthly clinical supervision and ad-hoc advice and guidance is always available from the CNWL-MK safeguarding team.

5.3.8 In LAC, there is good provision of on-going training for practitioners, and safeguarding compliance is closely monitored by both CCG designated nurse for LAC, the CNWL mandatory training KPIs and also the supervision and appraisal processes. The team are able to access single and multi-agency training, have attended national fostering conferences and have accessed training for unaccompanied asylum seekers, FGM and CSE. They have risk assessment tools to use when the risk of CSE or FGM is identified although evidence of their use was not seen in records examined. Following the unaccompanied asylum seeker training, the team is now using a risk matrix to identify high risk health concerns such as tuberculosis and hepatitis and this is enabling prompt assessment and treatment if required.

5.3.9 Supervision for the specialist LAC nurse is provided by the named nurse on a monthly basis and this is case specific. Supervision detail is then recorded on case records on the social care electronic database which we were unable to examine during our review. We were not therefore able to see if supervision was informing practice on a day-to-day basis to improve outcomes for children and young people. We were assured at the end of the review that immediate action has been taken to rectify this matter.

5.3.10 Compass offers case specific, safeguarding supervision on a one-to-one basis every four to six weeks. Group, peer supported supervision is also held monthly. The outcomes and actions of supervision are not recorded on client records nor are any actions, responsibilities, timescales and review dates. This was identified as a gap in practice. *This issue will be brought to the attention of Public Health, as the commissioners of the service.*

5.3.11 Compass safeguarding training is compliant with intercollegiate guidance and includes multi-agency training events. Compass practitioners have attended FGM and CSE training and it is evident that this has been used to make changes in practice.

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# Recommendations

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## **1. Milton Keynes University Hospital NHS Foundation Trust should:**

- 1.1 Ensure initial assessment documentation used in the ED at Milton Keynes University Hospital prompts practitioners to identify hidden children and family/carer relationships, particularly where safeguarding risk has been identified.
- 1.2 Consider the choices of young people who might prefer to receive care and support in the paediatric ED when aged between 16 and 18 and that their assessment is completed using age appropriate documentation considering their age legal status.
- 1.3 Ensure appropriate queries regarding domestic abuse or other risks are made of pregnant women at different stages of pregnancy (more than once) and that practitioners record the outcomes of those enquiries in patient records.
- 1.4 Strengthen arrangements to ensure that vulnerable young people transfer between the ED reception area and the paediatric ED as safely as possible.
- 1.5 Ensure that consideration is given to assessing environmental risk to vulnerable young people when located on a paediatric ward awaiting a secure placement elsewhere.
- 1.6 Maintain managerial oversight and staff awareness of the importance in recording safeguarding risk and that due consideration has been given to it in patient records.
- 1.7 Strengthen safeguarding children supervision within community midwifery services so that it is structured and not 'ad-hoc'.
- 1.8 Ensure community midwives have ready access to complete client records, including multi-agency discussion and decision making discussions.

## **2. Central and North West London NHS Foundation Trust (Milton Keynes) should:**

- 2.1 Ensure children's health records are complete by including care and action plans on electronic patient records.
- 2.2 Ensure health visitor patient records accurately reflect risk and that that risk is appropriately recorded in children's records so that their record is complete.

- 2.3 Ensure family chronologies remain accurate and that relationships between adults and children are recorded in children's records within the health visiting service.
- 2.4 Develop better information sharing pathways between the health visitor service and substance misuse services, particularly where adults with parental or carer responsibility are identified as misusing substances.
- 2.5 Ensure family relationships and significant parental/carer relationships are appropriately recorded in client records within adult mental health.
- 2.6 Ensure important information pertaining to the potential risk to vulnerable children and young people are attained and recorded in client records.
- 2.7 Ensure patient records are complete and available as a whole to practitioners working in the community.

**3. Milton Keynes CCG should:**

- 3.1 Ensure patient records held by GPs include recording of children's interactions and physical demeanour following consultation, particularly where safeguarding concerns have been raised.
- 3.2 Ensure records of individual patient discussions held are appropriately recorded in those patient records so that a complete record is maintained.

**4. Milton Keynes CCG and NHS England should:**

- 4.1 Ensure GPs are considering and recording the impact on vulnerable children and young people of parental/carer lifestyles.

**5. Central and North West London NHS Foundation Trust (Milton Keynes) and Milton Keynes CCG should:**

- 5.1 Ensure pathways are in place to better seek information across health visiting, CAMHS, School Nursing the looked after children's service and GPs to better inform the health assessment process.
- 5.2 Maintain managerial oversight of initial and review health assessment processes by way of improved quality assurance of initial and review health assessments to improve quality and improve standards.
- 5.3 Ensure children and young people are, where appropriate, fully engaged in the health assessment process including the assessment of SDQs.

- 5.4 Ensure appropriate consent is obtained from young people, parents and carers as part of the health assessment process and that this is recorded accordingly.
- 5.5 Assess the impact of the rising numbers of LAC in Milton Keynes and review staffing levels accordingly.
- 5.6 Continue to improve engagement with service users to learn from them to continually assess and improve service provision.

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## Next steps

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An action plan addressing the recommendations above is required from Milton Keynes CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto:childrens-services-inspection@cqc.org.uk) The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.