KENT COUNTY COUNCIL

SELECT COMMITTEE - CORPORATE PARENTING

MINUTES of a meeting of the Select Committee - Corporate Parenting held in the Swale 3, Sessions House, County Hall, Maidstone on Monday, 2 March 2015.

PRESENT: Mrs Z Wiltshire (Chairman), Mr R E Brookbank, Ms C J Cribbon, Mr M J Northey, Mr R J Parry, Mrs P A V Stockell and Mrs J Whittle

IN ATTENDANCE: Ms D Fitch (Democratic Services Manager (Council)), Mr G Romagnuolo (Policy Overview Research Officer) and Ms K Sanders (Business Intelligence Officer)

UNRESTRICTED ITEMS

15. 2.00pm- Susan Cruickshank - CAMHS Clinical Lead for Children in Care in Kent & Medway, Sussex Partnership Foundation Trust.
(Item 2)

(1) The Chairman welcomed Susan Cruickshank to the meeting. She was accompanied by Jo Scott (Programme Director - Kent and Medway Children Young Peoples Services, Sussex Partnership NHS Foundation Trust).

(2) Susan outlined her role as the Clinical lead for the Children in Care (CIC), Children & Young Peoples' Mental Health Service (ChYPS) in Kent and Medway. She explained that KCC made a significant contribution to this service which provided mental health services to support Kent and Medway children placed with foster carers and in care homes. It was a specialist service targeted at Kent and Medway CiC but not children who had been placed in Kent and Medway by another local authority. CiC that had been placed in Kent were supported by the mainstream ChYPS service.

Q – How many Kent and Medway CiC do you support and how many CiC placed in Kent are supported by the mainstream CAHMS service?

(3) Susan stated that there were 450 Kent and Medway CiC who were currently accessing the service. There were 20 non Kent and Medway CiC placed in Kent who were identified as accessing the mainstream ChYPS.

Q – Are these children spread across the County?

(4) Susan replied that the majority of looked after children were placed in the Thanet area. However, the volume of referrals vary and where they access the service would depend on where they are placed not where their social worker was based. She stated that there were CIC team members in all 4 ChYPS hubs located across the County and data was being complied on which areas referrals were coming from.

Q – As you have stated that 20 CiC placed in Kent accessing the mainstream CAHMS, these means that those who have tier 2 or tier 3 needs are not getting a service is that the case?

(5) Jo explained that a lot of these young people are referred into the mainstream service via an emergency service. If these young people are referred by their GP and meet the threshold for access to the mainstream ChYPS then they receive a service. Also some of these CiC may receive support from the CAMHS teams in the area which they come from. She acknowledge that the number reported as CiC accessing the mainstream service in Kent and Medway was surprisingly low and there may be under reporting. Jo undertook to supply the Committee with the up to date figures for these CiC accessing Kent and Medway services.

Q – Can you explain why CiC need a special CAMHS?

(6) Susan stated that this was a complicated question. She explained that prior to coming into the care system, young people are likely to have experienced a range of traumatic events e.g. neglect and abuse. Whereas the majority of mainstream young people are less likely to have had such traumatic experiences in their earlier years, therefore CiC were at a disadvantage because of the range of problems that they had experienced. Some children were more resilient than others and were able to get on in the world but some did end up needing specialist interventions. Also there were some CiC in tier 4 inpatient beds because they needed intensive mental health support that can only be provided in an inpatient setting.

Q – In relation to the Troubled Families programme, 55% of those in the programme needed support from CAMHS and could potentially become CiC, do you support this programme?

(7) Jo stated that we are not aware of the statistics quoted and therefore cannot comment on the accuracy of the 55% quoted. The ChYP service is part of a network of provision including well-being services.

(8) Susan referred to the Hackney Model which had a dedicated team of social workers who were trained to support young people who were on the cusp of being taken into care. She agreed that the Troubled Families initiative was a great addition to KCC service. She offered to supply written evidence to the Committee on the Hackney model. In relation to young people on the cusp of becoming a CiC as they were not LAC they would not meet the criteria for the CIC team.

Q – From evidence that we have heard from foster carers and Independent Review officers, it is evident that CiC had appointments with various professionals during the school day, foster carers in particular felt that this impacted upon the CiC parity of esteem with their peers. ***Do you have any suggestions as to how this impact can be minimised by professionals working together?***

(9) Susan stated that she was an advocate of the Hackey model, she had worked with mental health and social workers for 27 years and she had seen in recent years an erosion in the confidence of social workers to work directly with children. Social workers needed support and the Hackney model provided this.

(10) Susan explained that the CIC team tried to promote good mental health without needing to see the child, this could be done where possible by skilling up the network around the child, which was frequently better for the child than sitting in a room with a therapist. She had seen evidence over the past 12 years that this had worked and the less people involved with the child the better. She had found that often people, such as foster carers wanted the child to attend a therapy session but also wanted to prescribe when this should be held. She stated that secondary school aged CiC were prioritised for 3.30pm onwards appointments.

(11) In relation to a child with attachment problems, Susan stated that it was more appropriate to promote a safe foster carer placement rather than seeing a therapist.

(12) I also offer support to staff in schools to carry out low level work with children for example play therapy, she did not advocate taking children out of school for therapy unless it was absolutely necessary to do so. However, if it was a case of a child being taken out of school to receive one hour's therapy in order to support them to be better able to work at school then a balance needed to be struck.

(13) Jo pointed out that the appointments also needed to be convenient for the person giving the child a lift.

(14) Susan stated that she had evidence of people putting a child in a taxi to attend an appointment but she did not think this was appropriate.

(15) Susan stated that 8% of the caseload of CAMHS was CiC with CiC making up 1% of the general population.

Q – Are there staff in place to upskill social workers to provide the necessary support?

(16) Susan stated that there was a 9 to 5 duty clinician available to provide advice and support for an professional including social workers, this was an ongoing piece of work which still required some tweaking.

(17) Jo stated that there was inconsistency across Kent in relation to how well this service was used.

Q – Could you expand on what early interventions you have in schools for CiC please.

(18) Susan stated that the Virtual Schools model has had a positive impact on academic attainment for CiC. The CIC team had a good working relationship with the Kent Virtual School. In the mainstream school system there was one designated Teacher for LAC in each school.

(19) Susan explained that there were only 13 full time staff in her team and therefore it was not possible to visit all schools.

Q – What are you views on the current CAHMS contract?

(20) Susan stated that things were now different regarding multi agency working. She mentioned that Ofsted in 2013 had indicated some areas for improvement. She

referred to the significant amount of money that the local authority spent on assessment during care proceedings for CiC and also referred to the Hackney model.

Q – If we introduce the Hackney Model what percentage what referrals be reduced by?

(21) Susan stated that the benefits of a specialised CAMHS service for CIC was the level of need 70% of CiC were likely to develop some kind of mental health problem and therefore there needed to be a systematic approach.

Q – Why are CiC excluded from wellbeing services?

(22) Susan highlighted that currently the wellbeing services commissioned by KCC exclude LAC which is a problem as the Sussex Partnership Service works as part of a network of provision to support young people of all levels of need. The decision to exclude will have been a KCC decision and todo with access being via CAF in some cases it was what these young people needed.

Q – Are GP's able to refer CiC for a Family Common Assessment Framework (fCAF)?

(23) Susan explained that CiC were automatically in this system and therefore they did not have a fCAF.

Q – When a child leaves care does the CAHMs follow them?

(24) Susan explained that because KCC who had commissioned the service did not have corporate parent responsibility for the young person unless a home or care order was in place we close the case and refer on if there is alternative provision.

(25) Jo confirmed that if the young person was being seen by the mainstream service then this would continue.

(26) Susan explained that she worked with the Kent and Medway Partnership Trust regarding the referral of a young person from the CAMHs to the adult service. This was monitored on a monthly basis. She stated that she liked to think that children accessing the CAMHs had improved mental health.

Q – Are you seeing an increase in the number children and young people referred as a result of mum's excess alcohol consumption in pregnancy? What impact does foetal alcohol syndrome have on a child's mental health?

(27) Susan explained that unless there were obvious facial features, it was not until the child went to school and was slow to develop that this problem would be picked up. She stated that there was only one psychiatrist in the county who specialised in this area of work, foetal alcohol syndrome was an under researched area.

Q – How can we get the much needed integrated approach to supporting CiC?

(28) Jo stated that arguably anyone who worked with a CiC, e.g the school, health service and social workers should work together, however she acknowledged that the

system was often not good at doing this and that there was not a reliably cohesive whole service around a young person.

(29) Susan stated that there was a need to weigh what people were asking for against what it was possible to provide. It was important to focus on what could be achieved rather than set services up to fail. The key was establishing how to meet the needs of the child with the pot of money and services available. Outcomes needed to be realistic "think child - think family" and then how this can be commissioned.

Q - Do professionals and commissioners ever sit down in the same room to discuss the problems?

(30) Susan stated that one of the positive things to come out of the service that she managed was the good relationship with the commissioning officers and therefore when problems occur we look for solutions.

(31) Jo mentioned the need to focus on the core issues for specific areas at district or multi-district level rather than at county level.

Q – Would "west Kent" be too large an area to focus on?

(32) Susan explain that it would depend on the population, if you looked at the number of CiC, there were not many in Sevenoaks compared to Thanet.

(33) The Chairman thanked Susan and Jo for attending the meeting and for answering questions from Members, their responses had been very helpful.

16. 3.00pm - Nancy Sayer - Designated Nurse for Looked After Children for Kent and Medway
(Item 3)

(1) The Chairman welcomed Nancy Sayer to the meeting and invited her to introduce herself and to briefly outline her role before answering questions from Member.

(2) Nancy explained that as the designated Nurse for Looked after Children (LAC) for Kent and Medway she covered all 8 CCG (Clinical Commissioning Group) areas. She was a shared resource hosted by Swale CCG. Her role was to provide expert advice on clinical matters regarding LAC, both Kent & Medway's own LAC and those placed in Kent by other local authorities. It was her responsibility to support the CCGs in meet their statutory responsibilities to LAC.

Q – How do you encounter LAC and if you identify issues how is the next stage?

(3) Nancy explained that the health service was split between providers and commissioner (CCG's). I work with both the commissioning groups and providers to ensure that they put in place what is required to provide a good level of service to LAC's. I am a bridge between the commissioners and providers. At the moment we are looking at the capacity of services to provide hands on work for LAC and if

necessary look at what needs to be done to commission additional services for this group.

Q – Please provide an outline of the health needs of children and young people in care in Kent.

(4) Nancy stated that two thirds of children entering care had one or more physical ailments. Other's may not have had for example standard vaccinations early in life or had speech/language issues assessed and addressed. All of these young people come with emotional needs by virtue of being in the care system.

(5) Nancy referred to a health needs analysis that had been carried out last October which showed that health professionals did not keep enough data on LAC and therefore it was not currently possible to accurately assess the health needs of our population of LAC. For example the data on dental and optical needs of these children was not readily available. In relation to the speech and language development and ASD needs it was important to make sure that there was capacity in the system to ensure that LAC are dealt with quickly.

(6) Nancy stated that she needed to get a data tool in place so that when a child became a LAC and a health assessment was carried out within 28 days to gather and record the information. However currently this information tends to be handwritten and typed in free text rather than entered into a database. Therefore information on LAC health was kept but not in a form that enabled it to be analysed.

(7) Nancy confirmed that the evidence on LAC had not been available for the Health and Wellbeing Board's Joint Strategic Needs Assessment. A database was needed to enable this information to be produced easily, Medway had such a system and it was hoped that a version of this could be used in Kent. Discussions were being carried out with Medway Maritime NHS Foundation Trust's IT service to see if they would be willing to sell this database to Kent and if so would they be willing to support an expanded Kent database. Once the database was established it would take a year before data was available to analyse.

Q – In order for the LAC to have treatment such as a vaccination or an eye test is the birth parents permission required?

(8) Nancy explained that this depended on the legal framework around the child e.g. the legal agreement between the social services and the birth parent. Foster carers have certain delegated consents e.g. for vaccinations and eye tests.

(9) Nancy stated that there were still a minority of birth parents who held onto control and maybe reluctant to have, for example MMR vaccinations. If a child came in to care via a care order then parental responsibility was shared between the Council/Social Services and the birth parent, with the Council making the decisions on the child's care while keeping the birth parents informed.

Q – If the seven Kent and Medway CCG are working together why have there been difficulties in service provision?

(10) Nancy explained that each of the CCG areas had specific issues relating to LAC. The CQC (Quality Care Commission) had carried out a review of services for

LAC in west Kent it was clear that there was a need to bring the seven CCG's together.

(11) Nancy referred to the Kent Joint Adoption and LAC Group which was chaired by Hazel Carpenter (Accountable Officer for South East Coastal CCG). This group provided an opportunity for a senior officer from each of the CCG's, officers from KCC and herself to discuss issues relating to LAC in order to ensure that improved decisions were taken in a timely way. In relation to non-Kent LAC and care leavers the group looked at pathways for the child through the system without delays and barriers.

Q – What information is available about the health of foster carer's health, for example obesity in order to make sure that they could have targeted advice about achieving a good diet and how this should be handled?

(12) Nancy explained that foster carers had to have a health assessment and a report from their GP which was sent to the designated Doctor for LAC who would look at this report and provide health advice to the foster carers. There was a lot of debate regarding obesity and whether it was right to prevent people from being foster carers if they were overweight. Nancy expressed a personal view that if you have issues around the health of yourself and your family then it is difficult to put a LAC in that setting but then if the foster carers are able to provide a good level of care for the LAC then there is a balance to be stuck. There is no government guidance on this issue but the British Association of Adoption and Fostering had produced some guidance

Q –Does the same apply to foster carers and smoking?

(13) Nancy explained that a LAC under 5 would not be placed with a foster carer who smoked and with older children the foster carer must only smoke outside. She stated that when she worked as a nurse in Medway she had issues with one or two foster carers who smoked and she tried to help them understand the importance of giving up smoking.

Q- What statutory responsibility do you have for LAC placed in Kent by other local authorities?

(14) Nancy explained that this was limited. These LAC had a right to a healthcare service and there was a limited service to provide a health assessment for these children. The local authority placing the child remained the corporate parent and the CCG for the area from which they came were responsible for them. Nancy confirmed that it was possible to cross charge for providing health assessment for these children. She stated that the London Borough of Greenwich sent nurses into Kent to carry out health assessments, as Kent did not carry out these assessments she did not know what the state of health of these children was nor their needs other than any referral from a GP. This lack of information about the health of LAC placed in Kent did not help with the commissioning of services for LAC generally.

Q – we have heard from another witness that LAC placed in Kent did not have access to the specific LAC CAMH service provided for Kent LAC, and that records showed that only 20 non Kent LAC had received a service from the

mainstream CAMH service do you think that this is number is under-reported or that these LAC's are not receiving CAMH treatment that they may need?

(15) Nancy stated that she believed it to be the latter. LAC place in Kent would have similar health and wellbeing needs but received a different level of CAMHs service; there was therefore a risk that problems were being stored up for both these young people and for those around them. Some LAC were place in Kent because the placement in their home area had broken down these young people may have a higher risk of behavioural or health needs and therefore have higher health needs. They may either go without receiving the service that they need or go back to their own local authority area for this service we do not have any information on this.

Q – Do you have a statutory right to go onto approved Children's homes and if not would you like to have this right?

(16) Nancy stated that she did not have this right and would like to have the right to go into Children's Homes if it was suspected that they were not providing the appropriate level of health care. There was nothing stopping her from asking if she could go into a Children's Home but she had no right to do so. She stated that it is difficult sometimes when placing Kent LAC in that there was not enough choice in placements if they had behavioural difficulties and they may be placed in a setting that was not the best fit for their needs.

(17) Nancy agreed that foster carers did an amazing job and it was important to make sure that they had the skills that they need to support the child that was placed with them.

Q – Do you have any suggestion as to how we can improve the information flow with placing authorities, such as Greenwich, who carry out their own health assessments so that you can have an accurate picture of the health needs of these LAC?

(18) Nancy confirmed that this was a difficult issue, it would be possible to ask colleagues in Greenwich send all the Healthcare plans for their LAC placed in Kent but then what would be done with them as she was struggling to provide a robust service for Kent's own LAC. She stated that when the Kent database was in place it may be possible to add information on LAC placed in Kent who were not our responsibility and so gather health information to inform the future commissioning of health services

Q – Would be helpful for schools to know what the needs of this non-Kent LAC were?

(19) Nancy stated that schools were often in a better position with regard to being aware of these children and their needs, they should all have a personal education plan which would go with them to their new school. Often the first time that health colleagues were aware of these children was if they had to visit hospital maybe via A & E. What should happen is that the CCG for the area that the child in place in should be informed by the placing authority but I am not sure that this happens 100% of the time. One issue is that there is no national email address to send this information to so you need to know which individual in the CCG to send it to and care needs to be taken as this is sensitive data.

(20) Nancy mentioned that in Kent there was the additional challenge of the increasing numbers of unaccompanied asylum seeking children which could impact on public health issues such as TB.

Q – All Elected Members are Corporate Parents, what can we do individually or collectively to make improve the lives of LAC?

(21) Nancy explained that when she worked in Medway she sat on the Parenting Board. In the year that she had been in her current role in Kent she had not been asked to provide any information to the Corporate Parenting Board on the health of Kent's LAC. If I was a Corporate Parent I would want to know what the health issues of these children were and if there were public health issues e.g. measles what could be done to make sure that LAC were immunised. I would have thought that this type of information would be vital to you in your role as Corporate Parents but I have never been asked to supply any such information.

(22) Nancy stated that she did not understand the relationship of the Corporate Parenting Group with the Corporate Parenting Panel and how Members, as Corporate Parents, pick up information coming from the Group, which is an officer group. Although the minutes from the officer group go the Members Corporate Parenting Panel, Members miss out on important discussions that take place in the Group.

(23) Nancy expressed the view that the Corporate Parenting Panel and the Corporate Parenting Group should be merged to insure that there is no gap in the information coming to Members to support their role as Corporate Parents.

(24) The Chairman thanked Nancy for attending the meeting and for providing very helpful responses to Members questions.