18 December 2019

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Dear local partnership

Joint targeted area inspection of the multi-agency response to children's mental health in Milton Keynes

Between 14 and 18 October 2019, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMI Prob) carried out a joint inspection in Milton Keynes. In the inspection of the 'front door' of services, we evaluated agencies' responses to all forms of abuse, neglect and exploitation, as well as evaluating responses to children living with mental ill health.[1] This inspection included a 'deep dive' focus on the response to children subject to child in need and child protection plans, and children in care who are living with mental ill health.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Milton Keynes.

The partnership in Milton Keynes is clearly focused on driving improvements to ensure the appropriate recognition and response to children with mental ill health.

Children can access a wide range of services to help them with their emotional well-being and mental health needs. A variety of partners, including schools, provide services, and different approaches are being developed to ensure better access to support, for example the web-based counselling service. Recent re-design and improvement of the Child and Adolescent Mental Health service (CAMHS) means that more children can access specialist support and that waiting times have reduced.

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

Partners have worked together to produce a Local Transformation Plan (LTP), which, together with a recent children's mental health needs assessment and an NHS improvement review of the local mental health provision, provides a good basis to develop and improve services. There is still more to do, however, to ensure that strategic leaders have a clear overview of all services within Milton Keynes, and partners cannot yet be assured that there are enough of the right services to meet the needs of children with mental ill health. For example, there is a gap in provision for those children with complex needs who do not meet the threshold for CAMHS intervention.

Across many of the services inspected, there is a good recognition of children's mental health and safeguarding needs. Professionals spoken to during the inspection appreciate the support and advice they can receive from staff within the multi-agency safeguarding hub (MASH), and they are clear about thresholds for referral. Children experiencing abuse, neglect and exploitation have their needs promptly assessed by the MASH and are directed to appropriate services.

Some frontline staff have not had enough training about children's mental health. Police have not received training, for example, which means that frontline officers and those in the custody suite do not always identify or understand the impact of mental ill health on vulnerable children.

For some children who have been involved with agencies for some time and who have complex needs, progress of plans to improve their health, well-being and safety is not sufficiently well monitored to ensure that children are making progress. There are examples of drift in some children's cases where decisions have been delayed and children have been left for too long in circumstances that may be detrimental to their mental health.

Key Strengths

- There is clear drive and determination at a strategic level in Milton Keynes to improve outcomes for children. Effective governance structures and agency attendance at a wide range of boards provide evidence of a collective commitment to working in partnership in relation to safeguarding, and to meeting the needs of children with poor emotional and mental health.
- Partners have worked together to develop and implement strategic plans on children's mental health, to understand the needs of children in Milton Keynes and to drive improvements in services. The LTP on children's mental health is a clear document that sets out the priorities for the partners over the next four years to address children's mental health needs. Children's mental health needs were analysed in a comprehensive and detailed review conducted in July 2019, with contributions from a wide range of agencies and service users. The

recommendations provide a sound platform for further improvements, and some recommendations are already being progressed, for example the development of the locally based THRIVE model to coordinate services for children.

- Partners recognise the need to address issues early to support children and families and prevent adverse impacts on children's mental health. This is supported by the provision of a wide range of universal and early help services for children and families in Milton Keynes. For example, Milton Keynes has maintained its 17 children's centres. These offer a comprehensive range of services, including youth information counselling sessions.
- Children have access to a wide range of services to meet their differing needs in relation to their emotional and mental health, including support from schools through a range of school-based initiatives. A clear structure of support for schools is provided by the local authority and coordinated through the LTP. The Clinical Commissioning Group (CCG) has developed a programme of training for schools involving a nationally recognised charity, and this has resulted in 98% of schools having a mental health lead, and 92% of governing bodies having a mental health champion.
- Children now have improved access to CAMHS because of the swift action of partners in addressing deficits in practice and management identified in an NHS improvement review completed in March 2019. Partners, through the Milton Keynes Together Partnership and the Health and Well-being Board, have provided challenge and have maintained close oversight of the progress made to implement the recommendations of the review. This, together with the rigour of the CCG commissioners in supporting the provider to implement the action plan, has resulted in swift improvements.
- Children referred to CAHMS are assessed in the newly established Single Point of Access (SPA), and this team provides onward referral to alternative services for those who do not meet the threshold for a service. This reduces the time that children wait to access a service. Establishing a short-term intervention team means that more children are helped quickly. CAMHS staff also support professionals when the child they are working with does not meet the threshold for a specialist CAMHS intervention. We saw examples of this working well during the inspection, with many professionals, including GPs, reporting that advice is now readily available to support them when they are considering the risk and level of intervention needed for children.
- There are other examples of how partners respond promptly when needs are identified. Following a presentation on self-harm from public health to the Local Safeguarding Children's Board in January this year, the board recognised the need for frontline staff to be supported to recognise risks of self-harm and agreed to implement a new universal toolkit. A multi-agency group has developed the toolkit for frontline workers in universal services in order to support them to

identify risks of harm early and to know how best to respond to children. The toolkit is due to be disseminated in November.

- The early support project (ESP) within the youth offending team (YOT) has proven to be particularly effective and is an example of good practice. The project focuses on engaging children at the earliest possible stage to reduce the number of first-time entrants into the formal youth justice system. Early intervention includes identification and assessment of young people's speech, language and communication needs (SLCN) and emerging emotional well-being and mental health difficulties. Since April 2018, of a cohort of approximately 120 children who have accessed the ESP, just three have reoffended. This project has also contributed towards a 24% reduction in first time entrants to the youth justice system in this period, which is an impressive and a significant achievement.
- In the children's cases tracked as part of this inspection, we saw that schools are strong and active partners in multi-agency working. Staff in schools recognised and understood the emotional and mental health needs of their pupils and worked closely with professionals to make sure that children get the services they needed. For a number of children, services were provided directly by the school. Children spoken to during the inspection also valued the bespoke packages of support provided to help them access education.
- The partnership has recognised that some children are particularly vulnerable to being excluded from school, and engaged with the Office of the Police and Crime Commissioner to fund support programmes in schools. A senior specialist educational psychologist and a speech and language therapist train staff in schools to recognise children with SLCN and special educational needs so that they can be provided with appropriate support. This increases the likelihood of children remaining in mainstream school.
- Across many of the services inspected, there is a good recognition of children's mental health and safeguarding needs and a prompt response to meet these needs. This was seen to be particularly effective where staff are co-located.
- The CCG have supported the co-location of the CAMHS worker in the YOT and a CAMHS worker one day a week in the MASH. This arrangement means that frontline staff in both services have access to specialist advice and support. There is clear evidence of the co-location of these workers having a positive impact on children. In the YOT service, for example, the CAMHS worker has successfully worked with children who have previously not engaged with other services, and through the worker's persistence and tenacity, this has resulted in positive outcomes for children and their families.
- Children presenting to Milton Keynes Foundation Trust (MKFT) accident and emergency department (A&E) with mental health problems are referred to the multi-agency safeguarding hub (MASH) for consideration for early help and assessment of any safeguarding risks. This supports joint agency information-

sharing and discussion to ensure that a response is given to support the child's level of need.

- There is a responsive service from the liaison and intensive support team (LIST) within CAMHS for children attending A&E. This team operates 24 hours a day, 365 days a year, and provides intervention at the point of crisis. LIST is also accessible and available to offer advice to hospital staff on the clinical management of children and young people. All children and young people seen by LIST are discussed at the CAMHS multi-disciplinary meeting so that partners can consider what further help is required to manage their mental health needs in a timely manner.
- Partnership work within the MASH, and between the MASH and other services, is well established and effective. Professionals across the partnership report that they have confidence in the safeguarding front door, that thresholds and processes are clear, and that advice and support are readily available.
- Most professionals make referrals about children's safety and mental health when necessary, and the quality of referrals to the MASH from schools, police, national probation service (NPS), community rehabilitation company (CRC), and YOT is good. This enables managers to make appropriate decisions.
- Good representation of agencies within the multi-agency safeguarding hub (MASH), including a named representative from both NPS and the CRC, and a representative from the children and young people's drug and alcohol service means that information about children is shared swiftly in most cases. Children's social care services respond promptly when safeguarding concerns are raised about a child. Decisions about next steps for children are well informed. For example, there is evidence of good and timely information-sharing between police and children's social care within the MASH, and regular updates are made to police records by the MASH staff. Decisions made are supported by a clear rationale.
- Clear processes support practitioners to identify children who are at risk of child exploitation. Risks are identified in a timely way and children are offered support to reduce risks. Learning from these interventions informs wider strategic planning and actions.
- Children and families who are assessed by children's social care have their assessments completed in a timely manner, within a timescale which reflects their needs. Assessments include historical and current information to succinctly analyse this information and identify risks to children or unborn babies. Children's needs relating to their emotional well-being or mental health are well considered. Initial plans are clear and address the needs of the child and family. Most plans identify what needs to change, enabling the next service, whether it is statutory or early help, to understand what the focus of its intervention should be.
- Children from diverse backgrounds receive a sensitive service from professionals in the MASH. They demonstrate a good understanding of children's needs,

particularly in relation to those arising from their culture, ethnicity, gender, sexuality or their emotional well-being and mental health.

- Health practitioners within the MASH gather information from a variety of health services. This information is analysed effectively and is followed up by the most appropriate health professional. Information on responses to referrals is shared by children's social care services with most health professionals, and this means that when children come to the attention of health professionals, their vulnerability is flagged on their health record.
- There is evidence in most agencies of a strong commitment to, and understanding of, the importance of listening to and engaging with children about their emotional well-being and mental health. Staff across the services inspected are highly committed and motivated professionals who demonstrate a good understanding of children living with mental health issues. In all cases seen, children's mental health needs had been identified.
- Social workers make efforts to gain the views of children and incorporate these in plans. Manageable caseloads mean that they have time to get to know the children they work with well, and social workers can demonstrate how children's views have influenced care planning in most cases. This is mirrored in the children's education setting, with staff having a secure knowledge of the specific, individual needs of children and families, and the voice of the child is generally strong in children's health records. Police domestic abuse and child protection templates include sections which ask specifically about the views and behaviour of children.
- Within children's social care, schools and the YOT, there are examples of professionals working creatively and persistently to engage with children who are reluctant to engage, or whose circumstances make it difficult for them to engage, with professionals. Professionals are diligent in working to build trusting relationships with children who in many cases have experienced abuse, neglect, disruption in placements and significant loss in their lives. Most of the children we spoke with during this inspection reported to inspectors the importance of these relationships. We know from research and practice that having a trusting relationship with one adult can make a significant difference to children and support them to build relationships with wider networks of professionals and potentially engage in therapeutic support.
- Children within the YOT receive assessments that are timely and are informed by a range of information to give a holistic view of the child. Staff understand the links between adverse childhood experiences, emotional well-being and mental health and offending behaviour. This means that children receive support with their emotional and mental health needs, prior to interventions to address their behaviour. The team understands that this approach means that work to reduce offending is more likely to be successful.

- Looked after children have review health assessments that are of a good quality and that demonstrate positive engagement with children. Detailed assessments by the looked after children health team demonstrate a thorough exploration of children's emotional and mental health. Risk and protective factors are identified, the voice of the child is evident, and details of the child's demeanour and presentation are included.
- There is strong and effective senior leadership in children's social care, as well as a clear commitment to developing innovative and child-focused practice to support vulnerable children, including those with emotional and mental health needs. The extensive range of training for social workers and child and family practitioners (CFPs) means that a skilled workforce is being trained in a variety of techniques, including specialist attachment-based training, assessment of parent/child interaction, and developmental trauma in childhood. All social work staff and CFPs have access to clinical supervision to enhance and develop their practice, as well as to support them in the emotional impact of their work.
- Milton Keynes children's services have a stable and experienced workforce, and managers are creative in making opportunities for professional development to secure the most experienced staff. Social workers spoke very positively about working in Milton Keynes. They feel supported by middle and senior managers, and they receive regular supervision. Therefore, senior leaders are creating a secure and nurturing environment to support staff to manage complex cases and develop best practice.
- There is effective management oversight of safeguarding cases in the children's substance misuse service. Managers have a clear picture of all the children who are subject to a child protection, child in need or early help plan. Regular safeguarding discussions between the team manager and the staff ensure that current or evolving risks are well understood.
- Effective work within the YOT is supported by a stable and experienced management team, with a designated operational manager taking the lead on children's health. The CAMHS worker benefits from both day-to-day YOT supervision and specialist clinical supervision from CAMHs.
- The named GP and the primary care nurse (PCN) in Milton Keynes have worked collaboratively to improve and standardise safeguarding practice. Examples of this include the development and promotion of the electronic patient records system commonly used by GPs, and the 0–19 service. This has enabled safeguarding information, including referrals and multi-agency safeguarding records, to be accessible to GPs and staff in the 0–19 service, and facilitates informed discussion at practice multi-disciplinary meetings.
- GPs are well supported by the Milton Keynes CCG to access level 3 training in safeguarding, and this is highly valued by GPs. Safeguarding lead GPs at each practice are also supported through bi-monthly meetings offered by the named GP and PCN. The effectiveness of this support was evident in the generally good

safeguarding practice and sound safeguarding systems in the GP practices visited during the inspection.

Case study: highly effective practice

Children who enter the YOT system are assessed promptly. The assessment focuses on understanding any underlying factors, such as emotional and mental ill health, and speech, language and communication difficulties, which may contribute to the child's offending behaviour. Direct access to a CAMHS worker and a speech and language therapist mean that children who need these services receive them swiftly.

Thoughtful and creative responses from staff within the YOT mean that children who are reluctant to engage, because of a history of trauma or because of their complex needs, are able to build sound and trusting relationships with staff. One child who had complex emotional and mental health needs did not want to work with mainstream mental health services. Her YOT worker focused on helping her to think about, and explore her, strong emotions, including her anger. Because the young woman found it difficult to articulate her feelings, the worker used creative ways to engage the child, such as magic tricks and gaming, to begin to explore the challenges she faced and to work together to develop ways of addressing and overcoming these problems.

Areas for improvement

Leadership and management

- While there have been some noteworthy improvements in accessibility to mental health services and plans for the future of young people's mental health services in Milton Keynes are in place, there are still some areas that require further work. This includes, for instance, ensuring that young people whose mental health needs mean they sit just below the threshold for CAMHS can receive a service that meets their needs well. The partners identified this gap in service provision in their needs analysis in July 2019.
- Although commissioning intentions are discussed at various strategic forums, for example the Sustainability and Transformation Partnership and the Health and Well-being Board, the procurement and contractual arrangements for mental health services are still the responsibility of individual accountable commissioners. Until the THRIVE model is completely developed and embedded, Milton Keynes continues to have a range of services commissioned by the CCG, public health and social care, and services provided by the third sector. There is no clear

means for measuring whether these services meet the needs of the population. For example, some community and voluntary services report that they are operating at full or nearly full capacity, and some services have stopped accepting referrals due to the extent of their waiting lists. Leaders recognise that work needs to be done to understand the capability and capacity of, as well as the access to, this group of providers as they develop the THRIVE model.

- There is no directory of services that children, parents and carers and professionals can access in Milton Keynes if they want to know what services and resources are available for supporting children with mental health needs. This is a significant gap.
- Performance management in children's social care requires further development. The MASH managers use manual trackers to monitor timescales for decision-making and assessment completion. Frontline managers across children's social care, however, do not currently have access to 'live' performance information, other than being able to request specific reports from the system. Work is in place to develop a new reporting tool which will address this issue, but, currently, managers' ability to access and analyse 'live' data on performance is limited.
- Audit activity in children's social care includes monthly and themed audits, but the audits completed for this inspection were insufficiently rigorous. They were overly descriptive and lacked sufficient analysis of the impact of interventions and of whether they have resulted in positive, timely services for children that have led to improvements in their circumstances.
- Police staff in the custody suite have had insufficient training on the importance of identifying children's vulnerability and risks when children are brought into or held in custody. Thames Valley Police does not have a programme of mental health training for its workforce, although student officers have some training during their induction. The absence of training about vulnerabilities arising from mental ill health means that the workforce is not fully attuned to the increased risks of harm that affect such vulnerable children. Opportunities to intervene, support and refer children may be missed. It also means that information that could be used for multi-agency intervention and prevention is not always gathered.
- When frontline officers in the police are dealing with adults who may have a mental health problem, they can call on an 'assessment car' for advice. This is a joint agency service involving a mental health nurse and police officer. The arrangement is highly successful and has reduced the number of adults detained under the Mental Health Act section 136 from 35 to 12 cases a month. This service is not routinely available for children, meaning that the officers responding to children with mental health needs do not have access to the same level of support and advice. A business case is being prepared to extend the service to children.

- Management of safeguarding practice within CAMHS and the school nursing service does not focus on all areas of risk. For example, there is no managerial oversight of how many children within either of the services are on child protection or child in need plans or are looked after children. This means that managers do not have a good understanding about some of the most vulnerable children within their services and cannot use supervision to focus on these children or to ensure that children receive the services they need.
- Monthly group supervision for school nurses is not sufficient to enable staff to feel supported with their caseload of vulnerable children, and nurses report that they feel under resourced and stretched beyond capacity. Vacancies in the leadership of the 0–19 public nursing teams had impacted on their capacity to support practitioners. Recruitment has been proactive, however, and posts have now been filled.
- Staff in the school nursing service and the looked after children nurses have not received specific training in mental ill health. School nurses and CAMHS staff have not received recent safeguarding training in specialist topics beyond level 3. This means that staff might not identify safeguarding risks to children and vulnerability to mental ill health.
- The MASH health function is under-resourced and does not include coverage for periods of absence. This means that health checks and the analysis of the results of this research have to be gathered by non-health service MASH staff or by health staff who do not have specialist safeguarding expertise.
- YOT staff have no knowledge of the findings of recent serious case review or learning reviews and told inspectors that findings have not been disseminated. This limits the opportunity for wider learning and understanding of recommendations from local and national reviews.
- Not all the recommendations of the multi-agency YOT audit in November 2018 have been implemented, for example improving planning and case recording.
- Despite the success of the early support project within the YOT, the funding stream beyond March 2020 is uncertain. Identification of more secure funding streams would enable progress to be sustained across the partnership.
- The young people's consultation that informed the mental health review in July 2019 did not include feedback from children known to the YOT. Children and young people known to the YOT are highly vulnerable and have complex needs, including mental health needs, and this was a missed opportunity to consult with this group.

Responses to children with mental ill health at the 'front door'

- Flags and markers are available on police systems to highlight risks to children from mental ill health, but these are not well used. This means that officers do not have a holistic understanding of the risks and needs of children.
- Despite strong efforts by recently appointed leaders to raise the profile of the children and young people's drug and alcohol service, most referrals to this service are from schools and the YOT, or are self-referrals. There are no recent referrals from GPs and CAMHS. This means that young people with poor emotional well-being or mental ill health who also misuse substances may not have the benefit of a joint approach to assessment and planning to meet their needs. This is a significant gap given the findings from a recent learning review.
- Young people accessing the YOT are not receiving an enhanced school nursing offer. Just one referral has been made by the YOT to school nursing this year.
- The looked after children health team does not have clear oversight of how many young people experience mental health difficulties and there is no assurance process in place to ensure that children's needs are being met.
- While good-quality health assessments are completed by the looked after children's health team, subsequent care plans do not always capture the full details of actions needed to improved children's health. In addition, there were examples where interventions to support children with their physical and mental health were in place but not included in the care plan. This means that plans do not always provide a holistic overview of children's needs, and action taken to address these needs. This limits the ability to track and monitor interventions to ensure that children get the services they require.
- The voice of the child is not consistently captured by either paediatric or A&E practitioners, and this means that the views of the child are not informing the assessment of their mental health and well-being.
- Some children needing specific types of CAMHS intervention (such as assessment and treatment for attention deficit hyperactivity disorder, learning disabilities, tics and Tourette's syndrome via the neuropsychiatric problems pathway) still experience significant waits of up to 40 weeks.

Deep dive cases tracked for this inspection

- In most cases seen, the risks of harm to children have been identified and are understood, and children are safe. In all cases, the child's mental health needs have been identified, but this has been done with varying levels of understanding of the wide range of issues that some children face. Planning for children was in place in individual agencies, with clear identification of actions to address children's safety and their emotional and mental health needs. However, plans do not always clearly state the intended outcome for the child, timescales for

actions are not always in place, and measures by which improvement is to be tracked and evaluated are not sufficiently detailed. This makes monitoring of progress difficult.

- For some children with very complex needs, there is a lack of coordination of plans and no integrated plan that brings together all the risks and needs of the child. This means that not all agencies have a clear and holistic picture of the complexity of children's lives. As a result, in some cases, this means interventions are not sufficiently coordinated or responsive to meet the different needs of the child.
- When actions in plans are not completed, for example actions from looked after children's health assessments, inspectors found little evidence of challenge by independent reviewing officers to address this. Evidence of escalation and challenge by agencies, when outcomes for children are not improving, were limited. Of concern is that there appears to have been little challenge from partners when a police investigation into the grooming of a child has not progressed. As a result of this inspection, police are reviewing the evidence in the case.
- Assessments of children are not regularly updated. This reduces professionals' ability to focus on the current risks and needs of children, or to effectively measure whether the required changes, for example to improve parenting, have been achieved. Due to lack of robust monitoring of plans, there was evidence of drift in a small number of cases, resulting in some children being left for too long in circumstances that may be detrimental to their mental health. Sometimes, this was because of over-optimism about parents' ability to make and sustain changes in the care of their children. For some children, delays in decisions about placement and securing permanency had a negative impact on their sense of belonging.
- While all children who were reviewed as part of this inspection have a service in place to support them with their emotional well-being and mental health, some had to wait too long to receive the service.
- The deep dive review of cases, therefore, identified the need for tighter management oversight of planning, as well as review of complex cases to avoid drift and delay and to ensure that decisions to meet children's needs, including their emotional and mental health needs, are timely and responsive.

Identifying risk and managing harm at the 'front door'

- There is limited research conducted by call takers in the police when dealing with incidents where children are involved and are at risk. The current electronic system does not give them the ability to quickly gain an understanding of a child's history, and, therefore, decisions made are not intelligence-led.

- A backlog of domestic abuse incidents known to the police has not yet been shared with children's social care. The police do not screen and prioritise these cases based on risk. At the time of the inspection, there were 46 domestic abuse incidents awaiting a review by the police in the MASH. In 14 of these cases, children were known to be living in the household. All but one of these cases had been awaiting review for three working days. However, one case dated back to May 2019. Therefore, risk in these cases is left unassessed and where it is required, safeguarding activity may be delayed and opportunities to prevent harm missed. Some children, therefore, are not receiving the support they need quickly enough. The police immediately reviewed these cases when this was brought to their attention.
- Safeguarding activity undertaken by the MASH health practitioner is not always recorded in the shared health records system, meaning that the wider health community, including GPs, may not have access to this information. Similarly, the looked after children health team does not make full use of the shared system for recording. This prevents other health professionals working with the child from having a full picture of the child's current risks and needs, including any need for mental health support.
- Referrals made to the MASH by A&E practitioners, although detailed, lack analysis that would assist in multi-agency decision-making. When adults attend A&E, professionals do not routinely ask questions to enquire about their children or children they care for, so that risks to children may not be explored and understood.
- Children's social care services do not always respond to GPs about the outcome of referrals they make or to share information about a child protection investigation. This means that GPs do not always have a full understanding of the children's and families' needs. Poor attendance by school nurses at primary care meetings and joint discussions of cases over the last year impedes effective liaison between them and GPs. This is a missed opportunity to share information and coordinate care for children known to each service.

Case study: area(s) for improvement

The Safeguarding Partners need to do more to ensure that information about children is shared appropriately when children are in custody and that children receive the help they need early enough.

Recently, one child was detained for 18 hours in police custody without contact with an appropriate adult. He was a very vulnerable child and was kept in a highly stressful situation without the support he needed. The child was told about his rights and entitlements as a child in custody without an appropriate adult being present. This means he may not have fully understood what this meant.

All children kept in custody are assessed by a custody officer and a healthcare professional, but background information about the child is not always sought by the police at this stage. While the MASH and the emergency social work duty team are available to provide advice and share any relevant information about a child in custody, contact is not routinely made with these teams. Information from police intelligence systems is not routinely reviewed to provide a more detailed understanding of the child's history. For example, one child had his mental ill health identified on one occasion when he was in custody. When he had subsequent periods of custody, custody assessments made no reference to these issues. This means that known risks and vulnerabilities are not always fully understood and considered when a child is in detention.

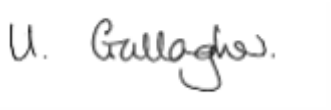
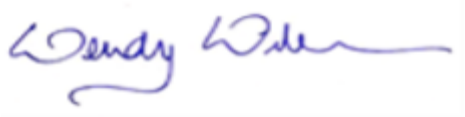
Next steps

The director of children's services should prepare a written statement of proposed action, responding to the findings outlined in this letter. This should be a multi-agency response involving children's social care, the police, the clinical commissioning group and health providers in Milton Keynes, and Youth and Community Services. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.

The Director of Children's Services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 30 March 2020.This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Yvette Stanley National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary and Fire & Rescue Services	**HMI Probation**
 Wendy Williams HMI Constabulary and Fire & Rescue Services	 Helen Davies Assistant Chief Inspector