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Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

National Inspection Safeguarding and Care Planning of looked after children and care leavers, who exhibit vulnerable or risky behaviours

Inspection of Isle of Anglesey County Council

August 2014

Digital ISBN 978 1 4734 2074 8

WG 23017

1.0. INTRODUCTION

1.1. This report provides an overview of inspection findings in respect of: Safeguarding and care planning of looked after children and care leavers who exhibit vulnerable or risky behaviour, within Isle of Anglesey County Council.

1.2. The inspection was carried out as part of Care and Social Services Inspectorate Wales (CSSIW) national thematic inspection programme. The methodology for the review included three and a half days fieldwork in each local authority across Wales, between January and May 2014.

1.3. The aim of the national inspection was to assess the quality of care planning across Wales and whether it effectively:

- Supports and protects looked after children and care leavers;
- Identifies and manages the vulnerabilities and risky behaviour of looked after children and care leavers;
- Promotes rights based practice and the voice of the child;
- Promotes improved outcomes for looked after children and care leavers;
- Promotes compliance with policy and guidance

1.4. Findings from the individual local authority inspections will inform a CSSIW national overview report to be published later this year.

2. THE INSPECTION

2.1 The inspection focused on the work undertaken with looked after children over eleven years of age and care leavers who were identified as being vulnerable and/or involved in risky behaviours, against defined criteria.

2.2 It is important to recognise that given this focus the case sample reviewed in each local authority encompassed some of the most challenging and complex case management issues and represented only a small cohort of each authority's wider looked after children and care leaving population.

2.3 As well as inspecting cases in respect of the assessment, care planning and review systems the inspection also considered the extent to which the corporate parenting, management and partnership arrangements acted to promote improved outcomes for looked after children and care leavers. Also how organisational structures including, workforce, resources, advocacy and quality assurance mechanisms impacted on the quality of care planning.

The inspection considered these areas against the following five questions.

A summary of our findings is presented below

QUESTION 1

Did the authority effectively discharge its corporate parenting roles and responsibilities promoting the stability, welfare and safety of looked after children and care leavers?

POSITIVES

- Children's services were recognised as a corporate priority. The authority had established a corporate parenting panel, chaired by the Chief Executive, whose membership included the Leader, lead and shadow member for social services, as well as officer and partner representatives. The panel met regularly and reported to full council. The reporting system had been put in place to provide greater accountability and transparency. The panel had begun to interrogate both thematic issues and performance compliance and had recognised that more proactive action was needed to progress the decisions it made. The authority was looking to develop a corporate parenting strategy that included 'pledges' that Anglesey as a council would aim to deliver for looked after children.

- The authority had developed systems that provided officers, members and partners with a general profile of the looked after children and care leavers' population. These systems also monitored compliance against issues such as young people not in education and employment (NEET). Senior officers were informed about individual looked after children's vulnerability through internal mechanisms including established panel arrangements. A joint commissioning panel had responsibility for determining out of authority placements with funding agreed by the head of children's service.

- The authority had arrangements in place to ensure that looked after children had access to education and primary health services. The location of the looked after children educational support service (LACES) and the looked after children nurse within the Looked After Children and After Care team was said to promote more effective communication.

- The authority had benefited from the work undertaken as part of its improvement agenda. The authority was now looking to progress a new model for the provision of services to children and their families with an emphasis on improving and supporting family resilience and independence. The authority would, however, need to consolidate the progress it has made and ensure that any future change programmes also maintained a clear focus on improving outcomes for those young people currently receiving looked after services.

- The Children's Safeguarding Board (CSB) was in the early stages of moving to a regional footprint. There were plans in place to establish a 'virtual' team

across North Wales, specifically for the assessment of young people exhibiting sexually harmful behaviour. The local joint CSB continued to work to progress agreed priorities.

- Stabilising the children's social services workforce had been a priority for the authority over a number of years. The social work establishment was now described as stable but needing to grow in experience. The authority's management arrangements, however, still contained agency and interim posts at team manager and senior officer level. These posts need to be filled on a permanent basis before the workforce can be described as stable.

- The authority had structured its social work teams to ensure a heightened profile for looked after children. The Looked after Children and After Care team held case responsibility once a care order or plan for permanence was in place. However, in order to minimise the disruption to the child the social worker from the looked after children team co-work the case prior to its transfer from the Family Intervention team. This system of double allocation was viewed as supporting opportunities for children to make more sustainable working relationships with social workers. Issues such as staff sickness and vacancies within the looked after children team was reported as impacting on the sustainability of these arrangements at times. Management and accountability for the case needs to be clearly understood by all those involved including parents and carers. All looked after children were allocated to a social worker and caseloads within teams were described as busy but manageable.

- Communication between housing and children's social services was said to have improved and the authority were working to develop a more strategic approach in relation to the provision of housing and support available for young people. A quarterly meeting had been established between housing and social services to improve planning for young people preparing to leave care. Whilst only involving small numbers the range and availability of appropriate 'move on' accommodation for looked after children and care leavers continued to be raised as an issue by staff and service users.

AREAS FOR IMPROVEMENT

- Elected members had recognised the significance of both their safeguarding and corporate parenting role but needed to provide greater challenge to ensure that they are achieving best outcomes for looked after children and care leavers, including the most vulnerable and challenging. Members needed to assure themselves that strategic aims are effectively owned and translated into timely action across the local authority services and by partner agencies. The corporate parenting arrangements might benefit from the inclusion of representatives from the housing service on the panel.

- There appeared no system in place for the corporate parenting panel to routinely obtain feedback on the 'experience of the child 'from looked after children and care leavers.

- The authorities systems did not routinely capture a profile of the looked after children populations assessed needs. This information is essential if the authority is to evaluate the effectiveness of its placement and permanency strategies and predict future resource needs. The information presented to the various panels could contribute to a detailed profile of presenting need.

- The corporate arrangement located children's social services within a corporate directorate –Community. The scope of these broad arrangements included adult social services and housing. The intention being to provide greater coherence across departments. Despite some improved relationships it was recognised more work was needed in respect of transition arrangements and the operational thresholds between children and adult services.

- The authority's relationship with health services remained overly dependent on children's social services providing funding and resources to assess and meet the therapeutic needs of looked after children and care leavers.

QUESTION 2

Were care and pathway plans informed by relevant assessments, including explicit risk assessments, which supported a comprehensive response to the needs and experiences of children and young people?

POSITIVES

- Referral and information sharing processes between professionals were understood and operational relationships between staff helped support communication Social workers and their managers had an understanding of the young people they worked with including their presenting vulnerabilities and risky behaviours. However, staff changes particularly at team manager level meant that the history and context of case decisions was not always well understood.

- The authority had introduced a Risk Model to provide staff with a clear risk assessment framework. This suite of tools included a means of routinely screening cases, to inform decision-making, also a structured approach to the detailed assessment of risk of significant harm. However, training in this framework needed to be consolidated to ensure that staff and partners were skilled and confident in its application. The tool appeared better understood in relation to child in need and child protection cases. Some partner agencies only had a limited awareness that a risk model was used.

- The authority was planning to develop their own in house support and therapeutic services to provide a more flexible and effective response to looked after children. For example children's services were looking to reconfigure the remit of a social work post currently located in Child and Adolescent Mental Health Service (CAMHS), to provide more dedicated time to looked after

children. Consideration was also being given to employing a psychologist to ensure emotional health was more actively promoted as part of the care plan.

- The work of the looked after children educational support service (LACES) was valued including their ability to directly negotiate and resolve issues within schools. Educational attainment was promoted, for example through the provision of teaching mentors. School stability was a priority and efforts were made to maintain school placements; however the use of out of authority placements made continuity more difficult to achieve. The authority was looking to develop a greater focus on outcomes that would include more than just educational attainment. Issues had been raised with the corporate parenting board regarding some placements being made without due consideration of whether suitable education provision was available. The inclusion of LACES on the permanency panel was aimed at addressing this issue.

- Health assessments were available for reviews and these often included a health plan. Any delays were discussed at the corporate parenting board. The looked after children nurse provided primary health, healthy eating, exercise and sexual health advice to young people and their carers, case examples were seen were this worked well for the young person.

AREAS FOR IMPROVEMENT

- Managers had systems in place to monitor permanency planning and the importance of promoting placement choice and stability for looked after children was viewed as a priority. However the range of in house placements available was not sufficient to meet the needs of some young people. The authority had recognised it's over reliance on external placements and the impact this had on care planning. The authority was now acting to address this issue through a new foster carer's strategy including a review of the training for carers. A new recruitment and marketing post had been developed to implement an "invest to save" strategy, looking to assess and approve ten new fostering families by mid 2014. It was too early to determine the impact of these recruitment initiatives but it would be critical to the success of the recruitment strategy that the authority also maintains a strong focus on the retention of its current carers.

- From the files seen it was identified that the care plans of those young people who remain looked after for longer periods were not routinely informed by a relevant shared written assessment. Where assessments were seen information gathering and the quality of the analysis was variable. It was also often difficult to follow the child's journey and understand on what basis decisions were made.

- Despite evidence of some constructive relationships with the Child and Adolescent Mental Health Service (CAMHS) lack of consistent access and intervention by the service was identified as a barrier to effective assessment and care planning. For example those young people who were placed out of county had to wait to be reassessed before they could access support for their mental health. Issues were also raised regarding the quality and impact of therapeutic interventions provided by some out of authority placements and the

need for greater quality assurance mechanisms. Currently Child and Adolescent Mental Health Service (CAMHS) only monitor the therapeutic service to looked after children/young people placed out of authority where they make a financial contribution towards the placement.

- The quality of the care plans seen was variable. Most included broad overarching statements but did not articulate the objectives and how the desired outcomes for the young person were to be achieved. There was little evidence that young people viewed the care plan as 'theirs '. The format of the care plan was not seen as helpful in ensuring the focus of the plan remained on the child.

- The quality of pathway plans seen was found to be inconsistent and the extent to which pathway plans were informed or owned by the young person was not always clear. The role of the Personal Advisor and the Leaving Care social worker was embedded within the Looked after Children and After Care team. The small size of the leaving care population was reflected in the size of the service, which had little resilience. There did not appear to be any contingency to cover staff absence and this had adversely impacted on the continuity of planning in some cases. Care leavers did not always understanding the difference in roles and planning mechanisms.

QUESTION 3

Were operational systems and procedures in place that ensured responsive coordinated action was taken to mitigate risk and achieve safe continuity of care?

POSITIVES

- Staff had access to key policies and there were information systems in place to support oversight of compliance in respect of statutory child protection procedures. All workers were clear that safeguarding was a priority and there was heightened awareness of the vulnerabilities of looked after children and care leavers. Child protection processes were being used to manage risk for this group of young people. However greater clarity would be helpful regarding the use of strategy meetings and that of multi agency planning meetings.

- The local Anglesey /Gwynedd Safeguarding Children Board had undertaken work on child sexual exploitation, missing children and children involved in sexually harmful behaviour. The regional partnership arrangements across North Wales in relation to these issues had been strengthened by the police appointment of a missing person's co-coordinator, although this was still in the process of being embedded. There was also funding in place for additional workers who would de-brief young people who went missing to improve information about risk, help reduce 'missing' episodes and support better risk management. Children's social services staff had also led work on improving the recognition of child trafficking.

- The authority had a strong commitment to training. Staff reported that they were provided with good support and development opportunities including mentors during the first and second year of practice. The supervision records seen on electronic files were brief, but more information was located on paper files, it would be important to ensure relevant supervision records are recorded on the child's file and evidence decision making.

AREAS FOR IMPROVEMENT

- Although statutory child protection procedures and thresholds were generally well understood the management of looked after young people and care leavers exhibiting 'risky' behaviours would benefit from greater clarity, for example through the development of a risky behaviours protocol.

- From the information provided risk assessments and on-going risk management arrangements particularly when more than one agency was involved, needed to be more effectively shared and coordinated. For example the progress made in mitigating risk was not always well evaluated or recorded. Also the extent to which young people were directly involved in the process was not easily apparent.

- Managers were described as approachable but there had been some significant changes at team manger and principal officer level for example some key posts were only filled on an interim basis. These changes impacted on the consistency of case oversight and contingency planning was not always apparent.

- Some staff identified that time constraints impacting on their ability to undertake direct planned work with young people.

QUESTION 4

Did Independent Reviews and quality assurance arrangements promote safe care and best outcomes for young people?

POSITIVES

- The authority's independent reviewing arrangements were compliant with guidance. Reviews seen were timely and ensured that care plans were updated. The IRO post holder, one individual, was experienced and committed to ensuring that young people were involved in their reviews and were aware of the advocacy service. Reviews were reconvened to reflect the presenting circumstances of the young person.

- Young people told us that they were encouraged to attend their reviews and there was evidence that advocates were available to attend with or represent the young person's views at such meetings.

- The IRO provided a regular report to the corporate parenting panel that highlighted compliance and provided some analysis of issues, for example the impact of the number of placement moves experienced by some young people. This report included a summary of service user's feedback in relation to reviews but in the example seen it was foster carers who mainly completed the questionnaires.

- The authority were in the process of reconfiguring its service and creating a Safeguarding and Quality Assurance team including the child protection coordinator, quality assurance officer and the independent reviewing officer. It was anticipated that the team would be extended to include the Protection of Vulnerable Adults worker and in the future would help deliver the safeguarding people agenda. It was too early to determine the impact of these changes but the authority will need to resolve the management arrangement for the new team as this was currently filled by an interim agency manager.

AREAS FOR IMPROVEMENT

- Looked after children reviews appeared overly focused on the immediate needs of the young person and gave insufficient weight to securing better outcomes over the longer term. Staff reported that lac documentation was not appropriately provided prior to the review.

- Some staff were not confident in their understanding of the role of the IRO and although there was evidence that the IRO sought to exert challenge this was not always reflected in the resulting actions. For example there appeared to be confusion regarding the status of review 'recommendations'. It was not clear that effective mechanisms were in place to ensure that the IRO was routinely informed of changes or events that potentially impacted on the relevance of the care plan. The IROs role in monitoring cases between reviews was limited to compliance against process for example the frequency of statutory visits. A dispute resolutions protocol had recently been refreshed and was now operational.

- Caseload capacity was raised as impacting on the IROs ability to meet with young people prior to reviews in a way that was meaningful. Carers also said that they were not afforded the opportunity of raising concerns with the IRO before the review. The timeliness of the minutes resulting from the review was acknowledged as problematic. This was described as a capacity issue compounded by the number of out of authority placements and also by an absence of administrative support.

- Despite the best intentions of staff and even when provided with the support of an advocate young people did not appear to view the review process or the resulting plan as "theirs".

- The authority had developed a comprehensive quality assurance framework, including a programme of audits involving team managers, but this was yet to be

fully implemented. It would be important that the authority's transformation agenda does not divert attention away from embedding the quality assurance framework and the development of a service strategy for looked after children. The authority understands and oversight of its looked after children population would benefit from the better coordinated of its quality assurance systems.

- The local Anglesey /Gwynedd Safeguarding Children Board (SCB) subgroup had not undertaken any recent case audits, and this was said to be the result of falling attendance. It is important that arrangements are in place to monitor practice in the 2 authorities it covers and undertake audits on a multi agency basis.

- The commissioning arrangements for children's services appeared overly confined to contractual rather than quality assurance matters. However it was positive that some quality assurance visits were undertaken by staff, such as the Laces team, to assure themselves of the standards of care in out of authority placements.

- External providers of services were not interviewed so their view of children's services has not been able to be included.

QUESTION 5

Did care and pathway planning effectively capture and promote the rights and voice of the child?

POSITIVES

- The authority had independent advocacy arrangements in place, this was described as an issue based service and there was some evidence that advocacy was discussed at LAC reviews. Not all young people seen during the inspection were aware of advocacy although those who had used it were mainly positive about the service if not the outcome.

- Despite some mixed views children and young people generally experienced professionals as persistent in their efforts to engage them in planning. However they also told us those adults did not pay sufficient attention to what young people were telling them.

- There had been a level of corporate co-operation to improve looked after young people access to leisure and sporting activities, although decision-making regarding leisure passes had been protracted.

AREAS FOR IMPROVEMENT

- Take up and referral to the advocacy service was recognised as being low. The issue based approach, which required a new referral for each episode of advocacy was not viewed by staff as supporting agile access to the service, e.g. an advocates attendance at a review could not be agreed as part of the plan. There was also a delay in identifying independent advocacy for first language welsh speakers place out of authority.

- The evidence from case files and interviews were that although some young people liked their social worker others were more ambivalent. Young people raised issues regarding social workers reliability and said they often didn't keep appointments or arrived late. Issues were also raised regarding the lack of a replacement when the social worker was off sick. Personal advisors were described as showing more interest in the young person as an individual.

- Young people told us that a lack of clarity in relation to delegated authority meant that they were left not knowing what was happening in relation to issues such as permissions for school trips, over night stays etc.

- Young people told us that they had little ability to exert influence or choice around where they were placed. Although these views need to be balanced against the authority's child protection responsibilities to take protective action. Young people also said they were not always told why they had to move.

- The authority's plans to develop work experience opportunities or apprenticeships schemes for looked after children and care leavers were still only at an early stage of development.