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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 Denbighshire County Council

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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 Denbighshire 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

- The authority had identified 'keeping vulnerable people safe 'as a priority. A corporate parenting strategy was developed in 2012, and it's implementation had been reviewed. There was a current action plan in place which identified the key improvements needed. Elected members interviewed were knowledgeable about the issues facing vulnerable looked after children and young people and very committed to improving the services they were received.
- The authority had systems in place that support senior management oversight of statutory responsibilities. Senior officers were well informed about individual looked after children's vulnerability and risky behaviours and could direct resources where they were most needed. There were systems in place to share this information across partner agencies, and evidence of good practice in relation to those young people who were missing or at risk from sexual exploitation.
- The senior management team was proactive in working to achieve the best outcomes for looked after children and young people. The stability of the workforce had improved in the past three years and arrangements had been revised to promote opportunities for social workers to carry out more direct work with children and young people.
- 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.
- The authority had arrangements in place to ensure that looked after children had access to education and primary health services.
- There was a system in place to gain feedback on the quality of services from service users including looked after children and young people.

AREAS FOR IMPROVEMENT

- The authority had identified that corporate parenting was not embedded across the council and steps were being taken to address this issue. Although the corporate parenting strategy was clear about the outcomes being aimed for there was little evidence of how actions by elected members had influenced improvements in services especially in areas such as supported housing for care leavers.

- Although the CSB had started reporting on missing children and young people the authority did not routinely report on the profile of the looked after population. A placement strategy was developed in 2011 but it had not been updated. There was no analysis of need available and the profile of vulnerability and risky behaviours was not collated and shared across partner agencies to facilitate joint planning. Despite good working engagement the resilience of the authority's relationship with health services remain 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.

- The range of in house placements available was not sufficient to provide for young people with challenging behaviour and additional needs. Plans were in place to undertake a foster care profile and to project the level of needs likely to be required over a five year period.

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

- Information sharing arrangements were effective between workers and teams, including the Youth Offending Service. There was a clear shared understanding and commitment from staff to safeguard young people and improve their outcomes. Children's services was introducing a range of tools including a generic risk assessment model which was relevant for vulnerable looked after young people, the sexual exploitation risk assessment framework (SERAF) and ' signs of safety'. All workers were not trained and confident to work with these tools at the time of the inspection.

- Care planning did identify what services were needed to support vulnerable looked after young people. A number of support and therapeutic services had been developed by the authority to provide a more flexible and effective response to meet the needs being identified in children and young people. There were constructive relationships with the Child and Adolescent Mental Health Service (CAMHS) .Efforts had been made to improve access to the service but there was still a significant waiting list, and those young people who were placed out of county had to wait to be reassessed before they could access support for their mental health needs.

- There had been an improvement in the education support service for looked after children and young people. Personal education plans had been updated and a good level of involvement in the reviews of care plans was reported. There was recognition that further interagency working was needed especially with regard to inclusion. There was good support for the access to further education with an education liaison officer in post who was college based. The timeliness of health assessments was reported to have improved and there was good liaison in relation to reviewing plans.

- Care leavers were positive about the support they received from their personal advisors which was timely and effective. There was financial and practical support for young people to take up university places.

- There was evidence that young people were being empowered to have an effective voice and engage meaningfully in the decisions that affect their lives.

AREAS FOR IMPROVEMENT

- Some good examples of risk assessment led by residential providers were seen where young people were engaged in their assessments which were effectively shared. This approach could be expanded to ensure more co-ordinated planning. However the quality of assessments seen was generally inconsistent and workers had identified that transition arrangements into independent living especially with regard to sharing risk were not working well. Assessment Progress Records (APR) were being completed for looked after young people but there was little focus on identifying risk and vulnerability.

- Social workers reported they lacked information about rights and entitlements of care leavers particularly in relation to financial support. Care leavers were confused about their entitlement to housing benefit and had no written information about their rights. The arrangements for delegated decision making were not timely or effective; decision making was reported to be slow and inconsistent. This has had a negative impact on young people establishing their independence, particularly the opportunity to acquire somewhere suitable to live. The authority had identified that lack of housing and tenancy support were areas for development.

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

- Workers were clear that safeguarding was a priority and it was evident there was good identification and awareness of the risks to and the vulnerability of looked after young people. There was a range of training and development opportunities which workers were encouraged to undertake. Peer support and joint team meetings were appreciated as further opportunities to develop practice.

- Child protection processes were being used appropriately to manage risk for this group of young people. There was evidence that agencies worked well together especially in relation to child sexual exploitation and missing young people. The regional partnership arrangements across North Wales around these issues had been strengthened by the police appointment of a missing person's co-coordinator. Mechanisms for better information sharing and coordinated actions to reduce risks to young people had been developed. There were examples of their effectiveness in preventing further harm to young people. There was also funding in place for additional workers who would de-brief young people who went missing to improve information about risk and help reduce the 'missing' episodes.

- The arrangements for supervising staff consisted of a practice leader supporting a low number of social workers as a unit so that case discussion and direction was more accessible. There was a focus on reducing bureaucracy and promoting direct work with service users. Social workers and practice leaders were positive about this model of working.

- A regional commissioning hub had been developed and had made a positive start in working on improving consistency of quality and value for money in relation to placements.

AREAS FOR IMPROVEMENT

- The format for assessments and plans did not facilitate the effective organisation and recording of information especially for children and young people who were being looked after in the long term as it was difficult to update information.

- Consistency in risk management would benefit from the development of an agreed protocol .Although cases were also risk assessed in supervision, this process and the decision making which resulted was not routinely recorded on case files. Risk assessment training for staff which was specific to adolescents would also improve consistency in this area

- There was little evidence on case files seen of the recording of decisions made in supervision.

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.The independent reviewing service had been under pressure because of low capacity but the authority had acted to minimise the impact of this and reviews seen were timely, and ensured that care plans were updated.

- The independent reviewing officers (IRO) were well informed and committed to ensuring that young people were involved in their reviews and had an opportunity to have their say. However the lack of capacity in the team because vacancies were being covered had impacted on the time IROs could spend on engagement with children and young people.

AREAS FOR IMPROVEMENT

- Given the number of care leavers receiving a service the arrangements for reviewing pathway plans were not sustainable. This substantial task was carried out by a practice leader in addition to her key responsibilities with her team.

- The quality assurance system had been identified as an area for development. Progress in addressing this work had also been impacted on by the interim staffing arrangements in the independent reviewing service. A quality assurance framework report was produced but appears to focus almost entirely on process. The areas for improvement which are identified relate to lack of timeliness or the need to gather more data. It was not clear who this report is for or how it helps to improve quality of practice and outcomes.

QUESTION 5

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

POSITIVES

- Looked after young people were supported with direct work or therapy to help them understand their lives.

- There had been good corporate co-operation to provide looked after young people with free access to leisure and sporting activities.

- The advocacy arrangements were well developed and monitored. There was evidence that the advocacy service was discussed at each review. All young people seen during the inspection were aware of the service and those who had used it were positive about the outcomes.

AREAS FOR IMPROVEMENT

- The opportunities for care leavers to attain economic independence were very limited. Young people were unhappy that the council was not providing work placements or apprenticeships.

- There was a lack of information for looked after children and young people in relation to their rights and entitlements. There was little opportunity for looked after children and young people to participate in influencing service development. Workers were confident that looked after children did not want to meet up as they would interpret this as stigmatising. However the children and young people seen by inspectors said they would value the opportunity to get together as they could relate to each other's experiences and access peer support.