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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 Flintshire County Council

August 2014

Digital ISBN 978 1 4734 2092 2

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 Flintshire 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 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 people safe' and 'ensuring that vulnerable people have their needs met' as priorities. Elected members were knowledgeable about the issues facing vulnerable looked after children and young people and very committed to improving the services they were receiving. Corporate parenting arrangements were strong and evidenced how outcomes had been influenced. There were regular opportunities for children and young people to give their views to elected members and senior officers.

- 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 Children's Safeguarding Board (CSB) was in the early stages of moving to a regional footprint. There were plans in place for the children's services management structure to be revised,as a result it was uncertain at the time of the inspection who would replace the head of service as the operational link into the local CSB subgroups. However the authority had a transition risk mitigation plan in place to manage any proposed change. Work continued at a local level especially in improving arrangements for managing child sexual exploitation and missing young people.

- Children's services had identified the improvement of placement stability as a priority. The structure of children's services was being reviewed with an aim to increase capacity to work with looked after children and young people and to improve continuity for this vulnerable group.

- The authority had arrangements in place to ensure that looked after children had access to education and primary health services.

- Children's services had a proactive approach to facilitating the participation of children and young people, both in their individual plans and in feedback about service provision. There was a regular forum for the engagement with looked after children with a number of opportunities for them to influence improvements and new developments.

AREAS FOR IMPROVEMENT

- Staff interviewed expressed concerns that the planned re-structure of children's services could result in a reduction in capacity in the senior management team. Although staff morale was positive at the time of the inspection, there was also

anxiety that there could be a reduction in administrative support which would adversely impact on social worker's time to carry out direct work with service users. There was corporate assurance that children's service was being protected from financial cuts, and the authority had a transition risk mitigation plan in place to manage any proposed changes. There should be a timely review of these arrangements to ensure that the changes planned do not have a negative impact on outcomes for looked after children and young people.

- Staff were able to articulate a clear strategic direction for the service but this was not captured in a framework which could provide effective guidance for successful implementation. The authority had identified looked after children and care leavers as a priority but it was not clear what actions had been agreed to improve their outcomes. The head of children's services improvement plan identified a high number of objectives which need to be prioritised so that progress can be more effectively monitored and achieved in a timely manner.

- The range of in house placements available was not sufficient to meet the requirements of young people with challenging behaviour and additional needs. This appeared to have been a factor in the relatively high number of multiple placements which was seen in some of the cases we reviewed. Although the authority had included this in its improvement plan the compensatory actions outlined only relate to the causes of placement breakdown rather than the likelihood that there were not enough appropriate placements to meet the high needs of this small cohort of young people.

- The authority had reporting mechanisms in place in relation to the looked after population and safeguarding. The effectiveness of service planning and identifying gaps in provision could be further strengthened if there was a profile of need for the looked after population which included vulnerability and risky behaviours. Workers expressed concern that specialist services especially in relation to emotional well being and therapeutic needs were not being provided in a timely way. 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 arrangements for making out of county placements were managed in partnership with health and the education directorate which facilitated the process. Work had been completed to improve choice and to help ensure' best value'. The terms of reference for the 'out of county' panel were being updated the time of the inspection. These arrangements should be reviewed to ensure they meet the 'Towards a Stable Life and a Brighter Future' guidance.

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. Workers interviewed were experienced in managing risk and were familiar with the process in place. There were some good quality risk assessments on file and professionals were confident that young people were engaged in the process.

- There was evidence that direct work was being carried out with looked after children and young people. Social workers were optimistic about reclaiming the social work agenda, and wanted to increase the range of therapeutic work they could deliver.

- Care leavers were positive about the support they received especially from their personal advisors. There was good preparation for developing independence skills and support for accessing further education. It was evident that workers persisted in trying to engage with young people even when they were reluctant and had been disaffected by their circumstances.

- The authority has support services in place to assist young people who had been subject to loss and uncertainty including mentoring and working with others to maximise their potential.

- There was evidence that social workers had encouraged children and young people to aspire to educational achievement despite obstacles such as frequent placement moves. Similarly it was apparent that professionals within further education demonstrated on-going commitment to continuity of education for young people.

- A significant amount of work had been carried out to develop better housing for care leavers and to prevent homelessness for this vulnerable group.

AREAS FOR IMPROVEMENT

- Core assessments were not routinely updated and did not reflect the current needs of the looked after young people, and some risk assessments seen were not complete.

- The quality of care plans seen was inconsistent and where they did identify what services were needed to support young people these were not always provided in a timely way. There was significant delay in accessing specialist mental health services; this was particularly evident if young people were placed outside the local authority area.

- There was more than one risk assessment in place for some young people and it was not evident how these were shared and agreed with partner agencies and carers.

- Children's services had funded the development of a Children and Adolescent Mental Health (CAMHS) post designated to provide a service for looked after children. At the time of the inspection this additional support had not been in place long enough to evidence an impact on outcomes particularly for the vulnerable young people who did not reach the threshold for CAMHS but whose emotional well being had been compromised by their past experiences. There was reported to a two year waiting list for example for children needing an assessment because of the likelihood they had 'attention deficit hyperactivity disorder' (ADHD).

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

- There had been a stable workforce in place in children's services and despite staff reporting they were covering sickness and other absences morale was positive. Workers were able to access informal supervision and reported good support for their practice and training, although capacity was sometimes an issue.

- 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. Risk assessment training which was specific to adolescents would improve consistency in this area.

- Child protection processes were being used appropriately to mange risk in 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 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.

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

AREAS FOR IMPROVEMENT

- Social workers were under pressure to cover the work of colleagues who were on sickness or other leave. This had resulted in a number of looked after children being unallocated at the time of the inspection. Workforce arrangements had not supported the need of young people to have the opportunity to form good relationships with the social services professionals. Young people were unhappy number of transitions between workers they had experienced. Independent reviewing officers (I.R.O.s) confirmed that this was an issue raised frequently in reviews.

- There was little evidence on case files seen of the recording of decisions made in supervision. While the authority had a system in place to monitor frequency of staff supervision this appeared to be dependent on whether workers returned the information rather than management oversight .Workers also reported that formal supervision sessions were often missed because of lack of capacity although there was good access to informal consultation and support from managers.

- Workers interviewed found the document management system was not effective at facilitating good retrieval of essential information. It was not possible to locate critical documents such as 'placement with parents' agreements and previous history of concerns. Support from the corporate IT service did not appear to be timely. The format of assessment and plans was not conducive to effective recording and work was being carried out to improve them. However workers who had been involved in these developments were not optimistic about the outcomes.

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. IRO's were very experienced; well informed and committed to ensuring that young people were involved in their reviews and had an opportunity to have their say, and were aware of the advocacy service.

- Review reports were thorough and included consideration of the effectiveness of the plan. It was evident that IRO's had the authority and independence to challenge practice and outcomes for young people. Examples were given of how this had been achieved and there was a sound process in place to record the actions taken.

AREAS FOR IMPROVEMENT

- The effectiveness of the independent reviewing service could be compromised by a recent re-grading of independent reviewing officer posts.

- There were effective performance management arrangements in place and efforts were made to gain service user feedback. However there appeared to be a lack of quality assurance of the service overall with issues being raised as they occurred rather than collated systematically where they could be used to drive improvement and disseminate learning.

QUESTION 5

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

POSITIVES

- Social workers were making strong efforts to ensure that young people were helped to understand their lives and were empowered to represent their views of their care planning.

- The authority had effective formal advocacy arrangements in place and all young people spoken to during the inspection were aware of the service. Those who had used an advocate were positive about the support which had been provided and this was echoed by other professionals.

- There was evidence that the views of children and young people were taken into account and that staff were persistent in their efforts to engage with them. Cultural identity was respected and efforts made to promote a range of community based activities for looked after young people.

AREAS FOR IMPROVEMENT

- Although the authority had set out it's aspirations in relation to permanency for looked after children and young people, the actions outlined in the placement strategy lacked timescales and did not identify staff responsible for it's implementation. It was not evident how the authority intended to improve the opportunities for young people with challenging behaviour to form supportive and consistent relationships with their carers.

- Although there is a 'homeless protocol 'in place for 16 and 17 year olds this does not appear to include arrangements for those who are still looked after or care leavers.