



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 Gwynedd County Council

August 2014

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 Gwynedd 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

- There was a strengthening recognition of Children's services as a corporate priority. The authority was developing a corporate parenting strategy including 'pledges' that Gwynedd as a council would aim to deliver for looked after children. The authority had established a long standing corporate parenting panel that met on a quarterly basis. The panel, although still developing, had begun to interrogate both thematic issues and performance compliance. Examples were identified where the panel had exerted its authority to challenge partner agencies regarding delivery against their responsibilities. The panel had engaged with care leavers to seek their perspective and were now progressing issues that they had highlighted.
- To strengthen lines of accountability in relation to safeguarding the authority had developed a strategic in-house safeguarding panel that included members and senior officers. This group reports to cabinet in relation to progress against cross cutting safeguarding priorities. Safeguarding champions had been identified across all departments.
- 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 well informed about individual looked after children's vulnerability and systems such as a monthly permanency panel supported officers and partners maintain oversight of placement issues, A Joint commissioning panel chaired by the Head of Children services had responsibility for determining all out of authority placements.
- The authority had arrangements in place to ensure that looked after children had access to education but access to primary health services had been weakened by the reconfiguration of arrangements by the health service.
- The Children's Safeguarding Board (CSB) was in the early stages of moving to a regional footprint. Plans were 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.

- Formal cabinet had instigated a review of children's services in 2012, aimed at improving services in relation to looked after children as well as achieving better value for money. The remit of this project had been extended to become an 'end to end' review that included non-statutory services. At the time of the inspection the authority was looking to implement some of the review findings, included the creation of a new 'edge of care team' located in children's services. The focus of the service was prevention but also work to support children's early rehabilitation home when safe to do so. The authority was financing the new service arrangements on an 'invest to save' basis. The 'success' of this service would be reliant on good inter directorate working and the authority's ability to re-direct resources, currently allocated to early prevention.
- Children's social services workforce was a recognised priority. The workforce was described as stable with a growing level of experience. All looked after children were allocated to a social worker and staff considered caseloads busy but manageable. The authority had sought to ensure that looked after children had a significant profile. The teams were configured so that children under 16 years received support from social workers within area teams who had elected to specialise in this work, cases then transferred to a 16 + team. These arrangements were said to provide children and young people with better opportunities to make more sustainable working relationships with social workers.

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 young people. Issues were raised that young people, although gaining educational qualifications, were under achieving in relation to their known ability sometimes due to the limited curriculum provided by their placement.
- Members needed to assure themselves that strategic aims are effectively owned and translated into action across the local authority services and by partner agencies. Currently there appeared an over reliance on children's services to deliver this agenda.
- As part of the end-to-end review some retrospective work had been undertaken to better understand the reasons why young people were placed out of authority and the impact of resulting costs. However, the review's change of remit appeared to have resulted in a loss of focus on improving outcomes for those young people currently receiving looked after services. The lack of engagement of partner agencies in the review process was also a lost opportunity to promote greater collaborative working.

- The authority's systems did not routinely capture a profile of the looked after children population's 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 Children's and Family Support Department includes both statutory and early intervention/prevention services. The departments line of accountability was through the Director of Social Services and also the Lead Director for Children's Services. The structure had been strengthened by the appointment of a head of children and a head of adult services however these changes were very recent. 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 availability of appropriate 'move on' housing and accommodation for looked after children and care leavers was identified as a gap in service by staff and service users. Given the age profile of the looked after children population this is an area that will require a greater focus.
- 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 appeared well-embedded. Operational relationships between teams and partner agencies support timely communication. Social workers and their managers had a good understanding of the young people they worked with including knowledge of presenting vulnerabilities and risky behaviours.
- The authority had invested in whole service training program in relation to a Risk Model that provided 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. Staff believed the approach gave them confidence and they valued the ongoing training provided. The tool appeared to be well used in relation to child in need and child protection cases, however, its application was less evident in relation to looked after children including those involved in 'risk taking behaviour, although this could be easily refreshed.

- The authority was looking to further develop their own in house support and therapeutic services to provide a more flexible and effective response to meet the needs of looked after children. Two social work posts, part of the children's services establishment, located in the Child and Adolescent Mental Health Service (CAMHS) service were to be relocated into mainstream services including one in the fostering team. Placement stability was also supported through the availability of a part time clinical psychologist working with carers and social workers. Children's social service acted to commission therapeutic assessments and interventions for individual children as needed.
- 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 bursaries were provided for extra tuition and mentoring. School stability was a priority and efforts were made to maintain school placements despite placement disruption. Despite a clear focus on attainment there appeared to be limited ambition for some looked after young people. The authority had identified the timeliness and quality of Personal Education Plans as an area for improvement and was intending to develop exemplars to schools.
- Care leavers were generally positive about the support they received from their personal advisors, although they did not always understand the difference in roles and planning mechanisms. Care leavers found the practical focus of pathway planning helpful; although some young people told us that they had not seen their plan until they left care. Issues were raised that decision making in relation to financial and resource requests were often slow and inconsistent.

AREAS FOR IMPROVEMENT

- Managers have systems in place to monitor permanency planning and the importance of promoting placement choice and stability for looked after children was well recognised. However the range of placements available was not sufficient to meet the complex needs of some young people. Staff acknowledged that "matching" needs to foster carers' skills did not always take place due to availability issues. The authority was active in working to increase the range of in house foster carers, however, this remained a significant challenge.
- From the cases 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. Some staff raised issues that the authority's templates and electronic systems did not support easy oversight of cases.
- Despite evidence of some constructive relationships with the Child and Adolescent Mental Health Service (CAMHS) and the efforts made to reduce waiting lists 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 availability of primary health care assessments for looked after children had been adversely affected by changes in the way the health service configured the looked after children nurse arrangements. Despite efforts the issue remained unresolved resulting in a gap in service.
- 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. The format of the care plans whilst comprehensive was also very long and this made it difficult get a picture of the child as an individual. The template was not 'child friendly' and there was little evidence that care plans were consistently shared with young people or their families. Some young people told us that they were not aware they had a plan.

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 was needed regarding the use of strategy meetings and that of multi agency planning meetings.
- Agencies were generally working well together in relation to child sexual exploitation and missing children. The regional partnership arrangements across North Wales around these issues had been strengthened by the police appointment of a missing person's co-coordinator, although due to changes in personnel this was not yet fully embedded. 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 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 frequency of supervision was formally monitored through performance management system. Staff identified that caseloads were busy; that IT equipment was not available to support flexible working. Time constraints were raised as impacting on social workers ability to undertake direct work with young people.

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 and staff reported that there was oversight of cases within the service. Despite knowledge of presenting issues contingency planning in relation to managing risk was not always well evidenced.

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 authority had an established experienced Independent Reviewing Officer (IRO) team who maintained responsibility for the same cases. The timeliness of reviews were improving and staff reported that reviews were also re convened as needed to reflect the presenting circumstances of the young person.
- IROs routinely sought to meet with the young people prior to or following the review, although time constraints were said to impact on the effectiveness of these arrangements.
- 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 authority was in the process of introducing a cross cutting children and adults safeguarding and quality assurance unit, which would include the IRO function. It was too early to determine the impact of these changes. 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 did not appear confident in their understanding of the role of the IROs and there was little evidence of the IROs ability to exert effective challenge. In one example the IRO sought to promote better contingency planning but this appeared to have little impact on the plan. Lack of progress against the care plan, even in the most complex cases, needs to be effectively raised and blockages to care plan objectives particularly in relation to placement choice, stability and leaving care arrangements should be pro actively monitored and escalated if they cannot be resolved within appropriate timescales.
- The IROs role in monitoring cases between reviews was limited and mainly related to compliance against process for example the number of statutory visits were monitored but not the content or quality of the visit.
- Young people held mixed views regarding the review process but overall they found it a negative experience. Some young people were positive about the IRO as an individual but believed that they could not make a difference. 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 undertook some audits of cases and had mechanisms to include staff in this process. However, it was recognised that these systems were under developed. The authority’s understanding and oversight of its LAC population would benefit from the development of a quality assurance framework and the better coordinated of its quality assurance systems.
- The local Anglesey /Gwynedd Safeguarding Children Board (SCB) subgroup had not undertaken any recent case audits, this was said to be the result of poor 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 ‘end to end’ review appeared to have impeded progress in relation to the authority’s commissioning strategy. The commissioning arrangements for children’s services appeared overly confined to contractual rather than quality assurance matters. However, it was positive that team managers visited external placements to assure themselves of the standards of care.

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 Looked after Children 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.
- 'Speak Out' events for looked after children, supported by the independent advocacy service and attended by the head of children services and elected members had been undertaken. Findings from these events helped inform the corporate parenting board. These arrangements whilst positive were recognised as being at an early stage and needing further development. For example they need to engage with more looked after young people including those placed out of authority.
- 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 that despite this, adults did not pay sufficient attention to what young people were telling them.
- There had been some good corporate co-operation to improve looked after young people access to leisure and sporting activities.

AREAS FOR IMPROVEMENT

- Take up and referral to the advocacy service was recognised as being low. The issue based approach, which requires a new referral for each episode was not viewed by staff as supporting agile access to the service, e.g. an advocate's attendance at a review could not be agreed as part of the plan. There was also a delay in identifying advocacy for first language Welsh speakers placed out of authority.
- The evidence from case files and interviews were that although some young people said they liked their social worker others said they didn't see their social worker enough that they were not reliable; they didn't keep appointments or arrived late which meant that they missed opportunities for meeting their friends or attending after school activities. Social workers were said to be more in evidence at a time of crisis. The lack of clarity in relation to delegated authority meant that young people were left not knowing what was happening in relation to issues such as permissions for school trips, over night stays etc. This was a source of great frustration and often embarrassment to young people.
- Care leavers were able to compare this level of service with what they felt was the better communication and responsiveness they currently experienced from

their personal advisors. Personal advisors were described as showing more interest in the young person as an individual.

- 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 highlighted the significant impact changes of social workers and placement had on their ability to form trusting relationships.
- The authority had developed a small number of work experience schemes for looked after children, provided by children's social services. Any plans to provide wider ranging opportunities such as apprenticeships were only at an early stage of discussion.