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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 Monmouthshire 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 Monmouthshire 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 a corporate vision that the council would work as one organisation to achieve its priorities which included vulnerable people and promoting educational achievement. A recently adopted corporate parenting strategy outlined it's priorities for looked after children and young people. Elected members supported improvements in services for looked after young people and had approved plans to improve opportunities for care leavers to maximise their economic independence.

- Senior officers were well informed about individual young people's vulnerability and risky behaviours and could direct resources where they were most needed.

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

- The authority had developed a placement strategy in 2011, which included a profile of need for the looked after population at that time. A number of key actions to improve outcomes including increasing the range and stability of placements had been identified.

- The Director of Monmouthshire Social Services is the chair of the regional South East Wales Safeguarding Children's Board (SCB) which had been in place since April 2013.A comprehensive strategic plan had been developed and priorities had been agreed. 'Adolescents who exhibit harmful behaviours' has been planned as a focus for 2014/15, this development included significant key actions which could be expanded to include risky behaviours in addition to those of child exploitation and missing young people.

AREAS FOR IMPROVEMENT

- The authority had identified that corporate parenting was not embedded across the council, and arrangements were still at an early stage of development. Elected members were committed to supporting better educational outcomes but did not appear to have a good understanding of the level of needs of vulnerable and at risk looked after young people. There appeared to be little corporate influence to help ensure that the housing needs of looked after young people and their families and care leavers were prioritised when considering how they could be supported to achieve and sustain independence in the

community. There were no mechanisms in place for senior officers and elected members to communicate directly with looked after young people to assure themselves that corporate parenting was making a difference to the quality of their lives.

- The progress of the implementation of the placement strategy had been reviewed once since it was agreed but the profile of the looked after population had not been updated. This was a barrier to forward planning and to sharing information with partner agencies and for joint planning.

- The terms of reference for the complex needs panel should be re-visited to ensure membership is at an appropriate level to support timely decision making and avoid delays in providing necessary therapeutic services and placements. There did not appear to be arrangements in place to meet the requirement of 'Stable Lives Brighter Future' guidance or to report 'out of county placements' to the lead member for children's services.

- The authority was aware of the need to take action to stabilise the workforce which had experienced a degree of disruption particularly in respect of the head of service post. The most recent appointment had been made in April 2014, and corporate officers were committed to providing stability for this crucial role. The workforce had been re- structured in April 2013 and workers reported the transition arrangements had a negative impact on their confidence and morale which was still evident at the time of the inspection. The changes had also resulted in looked after children and young people experiencing a loss of continuity and inconsistency in relation to social work support they received. Issues were raised about some lack of management oversight at this time which had adversely impacted on the continuity of care planning.

- Despite good working arrangements the resilience of 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. A joint social services and health commissioning board across the Gwent authorities had not been established long enough at the time of the inspection to evidence any improvements in the provision of therapeutic services.

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 with the Youth Offending Service. There was a clear shared understanding and commitment from staff to safeguard young people and improve their outcomes.

- Care leavers were positive about the support they received especially from their personal advisors, and social workers. Some young people had good experiences of foster care and support for further education. The authority had plans in place to support care leavers by developing initiatives such as work experience placements, apprenticeships and a post to support a 'Children in Care Council'.

- The education support service for looked after children and young people was making good progress in improving educational outcomes. There were effective arrangements with schools in the authority to support looked after young people which were focussed on their well being in addition to education.

- 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

- The quality of assessments seen was inconsistent, they were not updated and did not reflect the current needs of looked after young people.

- Risk assessments seen were underdeveloped and staff had not received the appropriate training to support the development of the skills needed in this area. It was not evident in cases reviewed that young people had been engaged in their assessment or that they were aware that it had been completed. There was some inconsistency in the arrangements with partner agencies in agreement around levels of risk. Staff reported that working with partner agencies to manage risk could be a challenge. Some young people had more than one assessment in place but it was not evident how these were shared between agencies and carers.

- Care planning was not well recorded and it was difficult to determine what services were being accessed. Health assessments seen lacked detailed information to support good planning. Where services were identified as needed these were not always provided in a timely way. There was significant delay in accessing specialist mental health services, especially for those young people who were displaying sexually harmful behaviour.

- The range of in house placements available was not sufficient to provide for young people with challenging behaviour and additional needs. The authority had developed a psychological service to support carers and social workers but this was yet to impact on placement stability. Young people reported some very negative experiences around moving placements. While they were able to recognise that in some cases the circumstances were difficult to manage they expressed disappointment that social workers had not acted to better support them. Carers and social workers would benefit from joint training in this area of practice.

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

- The authority had worked to stabilise the workforce, increase capacity and had recognised the need to invest in staff training and development. The culture of the management team was supportive and they were confident they could make the positive change needed in the workforce to improve consistency of practice.

- The regional SCB had a plan to develop and deliver training to support practitioners to work with adolescents with complex needs, which could be extended to include the assessment and management of risk.

- The missing children's service which included the five Gwent authorities has significant potential to improve the outcomes for vulnerable looked after children. The service was undergoing evaluation at the time of the inspection having been in place since April 2013.

AREAS FOR IMPROVEMENT

- Social workers reported there was a lack of consistent guidance especially for managing risk for this group of young people. They were uncertain 'what matters' when following up on concerns. Although recognising safeguarding as a priority social workers were not confident in their child protection responsibilities and described a lack of consistent management and direction. From the evidence seen, the outcome of Section 47 investigations was not clearly recorded and in some instances it was difficult to determine whether action had been taken to mitigate risk. The authority were in the process of addressing recognised shortfalls in child protection training and was aware of the need to ensure that the child protection process can be clearly identified on files and that decision making and outcomes are recorded and timescales for review agreed.

- Staff working with looked after children and young people reported that they were often unsure of their responsibilities. They did not have a clear understanding of the relationship between care planning and risk management mechanisms.

- Despite positive operational relationships between partner agencies some partners had concerns that risk management was not effective and that child protection processes were not clearly defined for looked after young people.

- Workforce arrangements had not afforded opportunities for young people to form good working relationships with social services professionals. The arrangements were much more positive for those young people being supported by personal advisors or support staff who had not been affected by the re-structure of the workforce. Senior officers were aware of the need to continue to work on continuity and consistency for service users.

- There was little evidence of the recording of decisions made in supervision on case files seen. Arrangements for formal supervision had been inconsistent having been effected by the churn in the workforce. There was good access to informal consultation and support from managers. Inspectors did not see any evidence with regard to monitoring and reporting on the frequency and quality of staff supervision.

- The authority had a plan in place aimed at improving worker's agility, decreasing bureaucracy and improving the electronic document system. However the revised integrated format for assessments and care plans did not facilitate the effective organisation and recording of information especially for looked after children. This was exacerbated by the lack of procedures and guidance for staff especially those who were newly qualified.

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 independent reviewing officer (IRO) was well informed and committed to ensuring that young people were involved in their reviews and had an opportunity to have their say.

- Review reports were thorough and included consideration of the effectiveness of the plan. All young people seen were very positive about their involvement in their reviews .They regarded the IRO as playing a significant role in their lives and felt that their voice was heard. There was also good attendance from partner agencies and the education support services. Partner agencies were also generally positive about the effectiveness of the reviewing system .The resilience of the service could be vulnerable as it is dependent on one IRO post.

- There is a performance management system in place with monthly reporting to senior officers and quarterly reporting to members.

AREAS FOR IMPROVEMENT

- The I.R.O. felt confident to challenge arrangements for young people and social workers and managers confirmed this was the case. However this was difficult to evidence, and inspectors saw examples of situations which had not been resolved despite the issues being raised especially around the lack of timely therapeutic services. Consideration should be given to how challenges brought by the service could be evidenced and how outcomes are influenced. Arrangements to capture unresolved issues should include corporate reporting.

- Pathway plans were not formally reviewed.

- There was a lack of quality assurance of the service overall. Issues were raised as they occurred rather than being used systematically 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

- Some looked after young people were supported with direct work or therapy to help them understand their lives. Good effort had been made to enable young people to participate in community and leisure activities.

- The advocacy arrangements were well developed and monitored. There was evidence that the service was discussed at each LAC review. All looked after young people were routinely contacted before their reviews to see if they wanted to have an advocate to support them. All service users seen during the inspection were aware of the service and those who had used it were positive about the outcomes.

- A number of surveys had been conducted which included looked after young people to look at safeguarding and access to community services.

- There were examples of how respite services were used positively to promote continuity and permanence for looked after young people.

AREAS FOR IMPROVEMENT

- Although the authority's placement strategy had identified the need to promote permanency it was not clear how this was being monitored apart from when children were to be placed for adoption. The authority needs to develop arrangements which will enable senior officers to be assured that planning for permanence for all looked after children is proactive and effective.

- There was no participation strategy in place for looked after children, young people and care leavers. Although young people had been supported to have a voice in their individual planning it was difficult to evidence what impact their views had on service development.