

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

Inspection of Pembrokeshire 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 Pembrokeshire 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.

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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 a corporate parenting strategy reflecting the principals of 'If This Were My Child'. A corporate parenting board had been established that met quarterly and there was a strong commitment to collaborative working. Although still developing membership of the board was such that it was able to make decisions and exert influence, as evidenced by the early introduction of 'when I'm ready' and changes to leaving care grants. Young people were being consulted regarding how they would like to contribute to the board
- The authority had well 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). The authority had recently reported to the Corporate Parenting Board on looked after children identified as vulnerable or involved in risk taking behaviour.
- Senior officers were well informed about individual looked after children's vulnerability. Systems such as a weekly Head of Children's service meeting to discuss 'significant events' as well as a monthly permanency panel supported officers to have an understanding of placement and risk issues. A monthly multi agency 'Continuing Care and Out of Area Placement Panel' managed out of authority applications with funding agreement from the Head of Children's services.
- Health partners had a database of all looked after children placed in Pembrokeshire by other authorities.
- Children's Social Services was located within a directorate for Children and Schools. The authority had benefitted from the significant focus that had been given to safeguarding and information sharing across social services, education and schools. Close partnership working arrangements have been developed in relation to commissioning across adults and children's services. The introduction of a joint commissioning hub across adult and children's services was reported as improving young people's access to services. The authority was also beginning to address shortfalls in the range of move on accommodation for care leavers

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- Children's social services workforce was a recognised priority. The authority had invested in the recruitment, retention and development of staff and the workforce was described as stabilizing, however, there remained some dependence on relatively inexperienced staff. All looked after children were allocated to a social worker and staff described caseloads as manageable.
- The authority had sought to configure its services to ensure that looked after children had a more significant profile. A Corporate Parenting Team assumed case responsibility for looked after children with a plan for permanence and also young people leaving care. Staff believed that the team arrangements supported better opportunities to make sustainable relationships with young people, staffing stability permitting. Social workers were encouraged to undertake planned direct work with young people however time constraints were raised as a potential barrier and social workers recognised that some support staff had greater expertise in this area.

AREAS FOR IMPROVEMENT

- Elected members had recognised the significance of both their safeguarding and corporate parenting role but need to ensure that strategic aims effectively translate into action across the local authority that achieve best outcomes for looked after children and care leavers. The Corporate Parenting Board would benefit from the inclusion of adult social care representation.
- The authorities systems had only recently begun to 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.
- Despite some good operational engagement the authority's relationship with health services often appeared dependent on children's social services providing resources to assess and meet the therapeutic needs of looked after children and care leavers.

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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 in place. Operational relationships between teams including the Youth Offending Service and partner agencies support communication. Social workers and their managers generally had a good understanding of the looked after young people they worked with including knowledge of presenting vulnerabilities and risky behaviours.
- Managers have systems in place to monitor permanency planning and the importance of promoting placement choice and stability for looked after children was recognised. The authority had been active in working to increase the range of in house foster carers able to meet the complex needs of some young people however this remained an on-going challenge.
- Relationships with health services were described as significantly improved. The authority had been proactive in trying to increase the availability of therapeutic services for looked after children and had established a link worker post with Children and Adolescent Mental Health (CAMHS) that offered consultations. The authority were also intending to fund a psychology post to work alongside children's services. In response to the identified needs of some young people, for higher tiered therapeutic services, children's services were now undertaking the continuing care support assessment with health colleagues for consideration by a combined Children and Young People (CYP) Continuing Care and Out of Area Placement panel. Despite these developments timely intervention by the CAMHS remained problematic.
- Care leavers responded well to the support they received from their personal advisors. The formats of some pathway plans were 'young people friendly'. The quality of pathway plans seen were variable, but included some good quality examples. Young people generally appreciated the practical focus of the plan and there was evidence that they were more actively engaged with the process. However, decision making particularly in relation to financial and resources remained an issue.
- The work of the looked after children educational support service (LACES) was clearly valued including their ability to directly negotiate and resolve issues within schools. Educational attainment was promoted and monitored but not seen as the only measure of achievement. The underpinning ambition was

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described as 'looked after children being able to do as well as any other child'. School stability was a priority and considerable efforts were made to maintain school placements. The authority had identified that the format and quality of personnel education plans remained an area for improvement.

• Health assessments were generally compliant and either the looked after children or school nurse attended reviews. Health services had also developed a tool kit for teachers and other professionals to help skill the workforce in managing children's behavioural problems.

AREAS FOR IMPROVEMENT

- From the cases reviewed 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 undertaken some good information gathering was evident but the quality of the analysis remained variable.
- Although staff were active in relation to identifying risk, risk assessment processes were underdeveloped and issues were not clearly recorded. In some cases seen the young persons presenting behaviours did not appear to be understood in the context of recent experiences such as a foster placement breakdown while in other cases the quality of recording as well as changes in staff and placements made it difficult to determine if issues had been resolved.
- The quality of care plans seen were inconsistent and not always updated. Most included broad overarching statements but did not routinely articulate the objectives and how the desired outcomes for the young person were to be achieved. In one example the recording of the care plan obscured significant underlying risk issues.

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 well-developed information systems in place to support oversight of compliance in respect of statutory child protection procedures. The authorities structural arrangements ensured a level of consistency as all child protection referrals, including those on open cases,

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were managed through one team.

- Child protection processes were being used appropriately to manage risk for this group of young people.
- The authority and the Safeguarding Children Board had heightened awareness of the vulnerabilities of looked after children and care leavers, including children missing from placement. Training in respect of a sexual exploitation risk assessment framework (SERAF) had been provided. The Pembrokeshire Safeguarding Children's Board had recently developed a multi agency protocol in respect of Children and Young People with Risk Taking Behaviour, but this was yet to be disseminated.
- There appeared to be good working relationship with the police. Social workers and police described a proactive response to children missing from placement; strategy meetings were convened as needed and routinely following three 'missing' episodes. The police would consider prosecution in respect of those harboring young people if needed. The police had commissioned a third sector provider to undertake return to placement interviews.
- Regionally the Dyfed Powys Police were introducing a Vulnerable Children Living Away from Home (Missing – Pre- Placement Risk Assessment). An initiative developed in response to concerns raised regarding children placed from outside the area.
- Workers were clear that safeguarding was a priority and it was evident there was good 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. Issues were raised by more experienced staff that training needed to be refreshed if it were to remain relevant. Risk assessment training specific to adolescents would improve consistency in this area.
- The frequency of supervision was formally monitored through performance management system. However, the quality of the supervision was not well reflected in the case records seen and decision-making was not always clear.

AREAS FOR IMPROVEMENT

• Although statutory child protection procedures and thresholds were generally well understood the management pathway for looked after young people and care leavers exhibiting 'risky' behaviors needed greater clarity. The introduction of the 'Children and Young People with Risk Taking Behaviour' protocol will provide an opportunity to ensure that the interface between risk management and care planning mechanisms are clear.

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- The assessment and management of risk particularly when involving more than one agency needed to be more effectively recorded and shared. The progress made in mitigating risk was also not always evaluated or well recorded. The extent to which young people contributed to or were aware of risk management plans was not always clear.
- Managers were described as approachable and staff reported that there was oversight of cases within the service. However, contingency planning, including in relation to risk management, was not well evidenced.
- The level of experience within teams was beginning to improve but staff still needed to build their confidence and expertise in working with looked after young people. The authority had acted to support newly qualified staff in their early years of practice for example through mentoring, however time constraints were said to adversely impact on how well these supports could be consistently tilised.

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 were generally timely and convened as needed to reflect the presenting circumstances of the young person.
- The authority had a relatively stable and experienced Independent Reviewing Officer (IRO) team who maintained responsibility for the same cases.
- The authority had developed mechanisms that supported the influence of the IRO service for example monthly meetings between the IRO manager Head of Children's Service and the Director of Social Services. IROs were represented on some of the authority's panel's. Despite these positive initiatives, the profile of the IRO service appeared underdeveloped.
- Young people told us that they were encouraged to attend their reviews and there was evidence that advocates were available to support or represent young person's views at such meetings.

AREAS FOR IMPROVEMENT

- From the cases seen it was identified that , looked after children reviews, were overly focused on the immediate needs of the young person and gave insufficient weight to securing better outcomes over the longer term. Issues such as placement choice changes in social worker and lack of therapeutic interventions were all identified as issues.
- Some staff did not seem confidant in their understanding of the role of the IRO. Despite the mechanisms in place it was unclear that IROs were routinely made aware of changes or events that potentially impacted on the relevance of the care plan.
- Although staff experienced reviews as providing challenge, this was not reflected on case files. There was limited evidence that IROs were able to exert influence and in some instances tensions were reported between the IRO service and operational teams regarding respective roles and responsibilities.
- Capacity within the IRO team was raised as reducing their ability to routinely meet with young people prior to reviews in a way that was meaningful. Concerns were raised that social workers looked after children documentation was not appropriately provided prior to the review impacting on preparation and that the IROs ability to track cases was not supported by the authority's current electronic systems. The authority was planning a review of the service.
- Although some young people said they liked their reviews young people also told us that they did not like the process. Despite the efforts made by professionals to make the process more accessible young people often found being the centre of attention difficult and experienced the meetings negatively.
- The authority had established a quality assurance framework that included a system of case audits. However, the role of the IRO service in relation to quality assurance lacked clarity.

QUESTION 5

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

POSITIVES

- The authority had introduced early interim arrangements to support young people to remain in placement in line with the ethos of 'When I'm Ready'.
- The Corporate Parenting Team had recently identified a property and developed a weekly drop in venue for young people where they were able to

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meet, learn how to cook, share leisure activities, and get information from professionals etc. young people viewed this positively but its availability was currently limited and care leavers told us that they did not feel well prepared for independence. Some good examples were seen where young people were encouraged to participate in sporting and leisure activities.

- The authority had independent advocacy arrangements in place. The issue-based service receives a high number of self-referrals from young people. There was also evidence that advocacy was discussed at looked after children reviews. The advocacy provider reports on a quarterly basis and produces an annual report for the Corporate Parenting Board, young peoples questions are also raised with the board. Only one worker currently delivers the advocacy service although take up is said to be growing. All young people seen during the inspection were aware of advocacy and those who had used it were mainly positive about the service if not the outcome.
- Despite mixed views children and young people told us that they experienced professionals and carers as persistent in their efforts to engage them and to try to ensure their voices were heard.
- The authority had appointed a Children and Young Peoples Rights Officer and was developing two trainee posts for young people. Care leavers who met the criteria were to be prioritised for one of the posts.
- The authority were looking to establish 'pledges' for looked after children that set the standards Pembrokeshire, as a council would aim to deliver for looked after children. Also trialing a sponsorship program for looked after children.

AREAS FOR IMPROVEMENT

- During the inspection young people told us that they liked their social worker but that they didn't see their social worker enough, found them hard to contact and slow to return calls. Care leavers were able to compare this level of service with what they felt was the good communication and responsiveness they currently experienced from their personal advisors. Young people however, all raised issues regarding speed of consent and inconsistent funding decisions
- Looked after children and care leavers said that they felt they had little choice or ability to exert influence around placements or accommodation. It was particularly difficult for young people placed in rural locations where they felt isolated and unable to maintain contact with friends. Although these views need to be balanced against the authority's child protection responsibilities to take protective action.
- Young people interviewed highlighted the significant impact changes of social

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workers and placement had on their ability to form trusting relationships.

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Lead Inspector – Katy Young