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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 Wrexham County Borough 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 Wrexham County Borough 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

- We saw clear leadership and a positive ethos within the management team. Moreover, we heard that all managers were visible and accessible. We also observed that regular mechanisms were in place which facilitated collaborative budget management across the authority within which children's services were clearly recognised as a corporate priority. One example of the strong commitment to looked after children and young people was evidenced by on-going investment in the multi-agency Wrexham Repatriation & Prevention Project (WRAPP).

- Corporate parenting arrangements were strong. Elected members were well informed about many issues facing looked after children and care leavers. We saw examples of training events for members which included active input by/ from care leavers.

- Relationships with partner agencies facilitated gathering and sharing information about many of the potential risks posed by looked after children and care leavers. These were supported by systems for ensuring that senior officers were well informed about individual looked after children's vulnerability and risky behaviours and could direct resources accordingly. For example the Missing Persons (MISPER) policy, the WRAPP Joint Placement Panel and the recently established Multi Agency Safeguarding Hub (MASH).

- The authority appeared to have a sufficient volume of suitably skilled and experienced staff working with looked after children and care leavers. Recruitment and retention of social workers had clearly been prioritised over recent years. Staff and managers we spoke to conveyed commitment, enthusiasm and motivation to undertake the work they carried out.

- The Safeguarding Children's Board (SCB) was in the process of moving to a regional footprint. Work continued at a local level especially with regard to improving arrangements for managing child sexual exploitation (CSE) and missing young people.

- Generally there were resilient and supportive relationships within social services and between partners to ensure looked after children and care leavers had access to services that met their needs. Operational examples of constructive cross-directorate relationships we saw were: close working

relationships between children's services and looked after children education workers (LACES); and effective arrangements for housing and children's services to jointly undertake young people's housing assessments.

- Arrangements were in place to ensure that looked after children had access to education and primary health services. We recognised the additional pressures placed on these services, as well as other partners, resulting from the high proportion of looked after children placed within this authority's boundaries by other local authorities.

AREAS FOR IMPROVEMENT

- Elected members had limited awareness of the potential for CSE in the area.

- The effectiveness of service planning and identification of gaps in service provision could have benefited from a collated profile of the most vulnerable children and young people presenting with risky behaviours and/or complex and challenging needs shared across children's services and partner agencies.

- Placement and commissioning strategies were underdeveloped. We recognised that work was underway to address this; evidenced by an emerging contemporary analysis of the generic needs of looked after children and care leavers. This was still in draft format.

- Despite good operational engagement and Local Health Board (LHB) contribution to WRAPP, 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.

- Poor communication to front line staff about contractual changes to services delivered by the 3rd sector, including the ending and/or renewal of contracts, had led to confusion and uncertainty about the sustainability of some provision.

- Arrangements for supporting care leavers in their transition to adulthood were not generally pro-active. However, we noted that a recent reorganisation of council structures appeared to have strengthened the effectiveness of communication between adult, and children's services and that clearer transitional arrangements were in place to support young adults with a disability.

- Although the authority had some good mechanisms in place to seek the views and opinions of children and young people about their care, for example Children in Care Council we saw only limited evidence of how feedback was used to plan and develop future 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 between teams, including the Youth Offending Service, were effective. A good example of this would be the regular attendance of children's services at Resettlement Support Planning Meetings; a multi-agency forum in which arrangements for preventing remands in custody/release from custody are discussed and reviewed. There was clearly a shared understanding and commitment from all professionals to safeguarding children and young people and to improving outcomes for them.

- We noted arrangements in place for the case transfer of looked after children and young people to the Leaving Care team included early introduction to Personal Advisors. The authority had expanded access to a range of services for care leavers through co-location of the Leaving Care team with other providers, such as drug and alcohol team as well as youth and advocacy services. These services complimented the work of the Leaving Care team and were highly valued by many of the staff and the children and young people we spoke to.

- There was a focus on improving placement stability through on-going health and social services investment in WRAPP. This project aimed to prevent children and young people from reaching out of county or residential placements for reasons principally associated with their therapeutic needs. The main operational focus of WRAPP was provision of intensive therapeutic support, whether through direct work with the child or young person or foster carers, in support of placement stability. This approach did not detract from the use of either residential or out of county provision where there was a clear assessed need for such a placement.

- We observed that interventions from WRAPP were in some cases able to compensate for lack of Child & Adolescent Mental Health Services (CAMHS) provision.

- We saw examples of LACES and the looked after children's nurse being proactively involved in assessment and planning for looked after children evidenced by up to date personal education and health plans on files.

- 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 education demonstrated on-going commitment to continuity of education for young people.

- Most plans clearly articulated overarching objectives, included timescales and named people responsible for delivery. Evidence from file reviews also demonstrated that social workers were mindful about explicitly including the child or young person's wishes and feelings in plans.

AREAS FOR IMPROVEMENT

- Very few care or pathway plans were outcome focussed or clear about how risk was to be managed. Nor did they routinely include relevant *shared* assessments of need or robust analysis. Where more than one agency was involved with the same child or young person, planning for risk management was not well co-ordinated. The care plans of those children and young people who were looked after for long periods were often reliant on informal information exchange between professionals rather than updated written assessments; this was even in circumstances where there had been significant change.

- There was a gap in appropriate services to meet the emotional, psychological health or development needs of some children and young people, including those associated with risky behaviours, thus creating an over-reliance on social services. Specifically there is a recognised longstanding disconnect between the access threshold applied by CAMHS and the presenting emotional resilience needs of many looked after children and care leavers.

- There was an insufficient suitable supply of appropriate placements, including supported and move-on accommodation for care leavers, leading to disruption and instability for some children and young people. It was acknowledged that despite a range of possible placements and strong working relationships between the Leaving Care team and housing services, these were not always appropriate to meet the needs of the most vulnerable children and young people.

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 was a stable workforce in place and we recognised the commitment, skills and knowledge of staff at all levels. Moreover workforce arrangements supported the recruitment, retention and the personal/professional development of staff.

- Most of the social work staff we interviewed had a good understanding of the needs and vulnerabilities of looked after children and care leavers. Workers were clear that safeguarding was a priority. We saw evidence from case

reviews and interviews with professionals that demonstrated that staff were aware of their statutory responsibilities.

- Staff told us that they received regular formal supervision and had access to training to support their practice. We noted that managers were available for informal discussion and/or consultation/decision making regarding safeguarding issues. Supervision was reported to be of sufficient quality with a good balance between reflective practice and personal/professional development being achieved.

AREAS FOR IMPROVEMENT

- Social workers had received training in undertaking Sexual Exploitation Risk Assessment Framework (SERAF) assessments. However there was a perception from a partner agency that these assessments were under-utilised. Additionally, social workers expressed concern about limitations on the availability of appropriate services for children and young people assessed as being at high risk of sexual exploitation.

- Risk assessments and on-going risk management arrangements, particularly when more than one agency was involved, needed to be more effectively recorded, shared and coordinated.

- Discussion with staff and team managers suggested casework consultation about risk issues, including decision-making took place however we saw very little evidence on case files to support this.

QUESTION 4

Did Independent Reviews and quality assurance arrangements promote safe care and best outcomes for young people?

POSITIVES

- The authority's arrangements for Independent Safeguarding Reviewing Officers (ISRO) were compliant with statutory guidance.

- Communications between team managers, social workers and ISRO appeared constructive. Familiarity with the role of ISRO was routinely covered in all new staff induction training. ISRO told us they operated an 'open-door' policy for social workers to encourage case discussion and consultation; also that social workers usually submitted reports in good time to allow for ISRO preparation for meetings.

- Looked after children review meetings took place in a timely manner, were generally well attended by other professionals and ensured that care plans were updated. We also saw commitment to sustaining consistency of ISRO for individual children and young people. (Albeit a recent lack of capacity in the

ISRO team had impeded consistency for some children and young people; this situation has now been resolved).

- ISROs told us they felt confident to challenge. Social workers and team managers experienced review meetings as challenging. They reported that care plans were rigorously reviewed and that they were held to account for any changes.

- The authority had systems in place, such as case-note alerts automatically copied to ISRO, to support effective follow-up of actions between reviews.

- Well established performance monitoring arrangements were in place as were reporting pathways to SCB, senior management, scrutiny committees and corporate parenting board in respect of key performance indicators relating to looked after children and care leavers.

AREAS FOR IMPROVEMENT

- We saw limited evidence of the authority's commitment to consultation with children and families prior to review meetings. Some children and young people attended reviews. However, many of those we spoke to told us that, although they recognised the importance of the meeting, they preferred not to attend. The reason for this was often linked to a perception that despite being invited to express their views these contributions were not often valued.

- There were quality assurance arrangements in place but these were insufficiently cohesive to fully capture learning from the review process. However, we noted recent plans to bring together practice, performance management and ICT functions into regular weekly meetings with a joint improvement agenda, as commitment to addressing this deficit.

- Commissioning arrangements for children's services were underdeveloped. However, we noted the positive move to a Results Based Accountability approach for all externally commissioned services with a focus on quality and measuring the impact that services have on the lives of children, young people and their families.

QUESTION 5

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

POSITIVES

- Professionals within this authority were committed to helping children and young people understand their lives, including the impact of their journey, through the care system.

- We saw evidence from case files of commitment to arranging and sustaining contact between families sometimes in the face of significant obstacles.

- The authority had commissioned formal advocacy arrangements for looked after children and care leavers and information about how to contact the service was available, including a DVD produced by the Children in Care Council. Additionally, care leavers had access to a (universal) advocacy service at the 'one-stop-shop' co-located with the leaving care team.

AREAS FOR IMPROVEMENT

- Advocacy services were insufficiently well promoted and there was a lack of clarity about the differentiation in provision offered by the two available services. Furthermore, many of the children and young people we spoke to were not aware of the availability of advocacy services. As a result these services were not utilised efficiently or effectively and did not therefore ensure that looked after children and care leavers had a clear, strong voice.

- Limitations on placement choice, for children and young people presenting with the most challenging and complex needs, especially appropriate move-on accommodation for care leavers, sometimes militated against meeting the child or young person's wishes and feelings whilst simultaneously keeping them safe.

- The children and young people we spoke to reported good relationships with social workers. However, many children and young people said they found them difficult to contact, late for appointments and slow to respond to messages. They also raised issues about the lack of timeliness and inconsistency of decisions; for example in relation to consent and funding.