AGGCC
CSSIW

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 Conwy County Borough Council

August 2014

Digital ISBN 978 1 4734 2088 5

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 Conwy 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

- The authority had a corporate parenting strategy that articulated the authority's commitment to looked after children and care leavers in the form of 5 pledges that reflected the 7 core aims. The strategy emphasised collaborative working. Senior officers and partners reported progress against their designated lead area of responsibility to a Corporate Parenting Team. The corporate parenting team also received periodic feedback from the looked after children participation group 'Loud Voices'.

- The authority had also established a 'virtual school 'as a sub group of the corporate parenting team. This aimed at providing members and officers with opportunity to interrogate information providing a better understanding of school related issues such as performance, school attendance and fixed term exclusions. Members found this process particularly useful.

- The authority had systems in place that supported officers and member's oversight of compliance in respect of the authority's statutory responsibilities for looked after children and care leavers. These systems also monitored compliance against such issues as young people not in education and employment (NEET). Senior officers were kept informed about the vulnerability of individual looked after children through mechanisms such as a Multi agency 'Strategic Multi Agency Panel' (SMAP) which managed access to services and agreed out of authority placements and funding arrangements.

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

- The Children's Safeguarding Board (CSB) was in the early stages of moving to a regional footprint. There were plans 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

- At the time of the inspection the authority was progressing a 'transformation programme'. Once implemented structural changes would locate children's and adult social services in one directorate with education. The authority were also progressing the introduction of a vulnerable peoples service (aged eighteen to sixty five). Transition arrangements were established between children and adult social services but the new vulnerable peoples service would potentially provide access to services for individuals who did not currently meet adult service thresholds. This was an ambitious agenda but it was too early to evaluate the impact of the new

arrangements or potential resource implications.

- The organisational structure in children's services had been configured in part to improve the authorities responsiveness to the expectations of the public law outline. The arrangements were such that all teams held some looked after children cases but responsibility transferred to the permanency and pathway team (pod7) once a care order or plan for permanence was in place. Staff recognised that the transfer points between teams resulted in some initial change but believed that young people had better opportunity to make more sustainable working relationships with social workers in the longer term. The authority reported that all looked after children were allocated to a social worker. Staff generally described current caseloads as manageable.

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. Members need to further assure themselves regarding what difference is being made and the extent to which strategic aims were being owned and translated into timely action across the local authority and by partner agencies. The corporate parenting team would benefit from the inclusion of adults social services.

- Issues in relation to risk and the vulnerability of young people were discussed and shared across some partner agencies through the multi agency 'Strategic Multi Agency Panel' (SMAP) However, the authority did not routinely capture a profile of the lac and care-leaving populations assessed needs. This information is essential if the authority is to evaluate the effectiveness of its placement, permanency and prevention strategies to predict future resource needs. The information presented to the 'Strategic Multi Agency Panel' (SMAP) could contribute to a more detailed profile of presenting need.

- Children's social services were working with Housing Services in respect of the range and availability of accommodation for looked after young people. Consideration of the impact of the 'when I'm ready' proposals had raised the profile of this issue and scrutiny and the corporate parenting team recognised housing and supported accommodation as a priority. However, despite improving operational relationships and the recent development of both a Youth Accommodation Strategy and a Youth Homelessness Strategy progress remained slow. Staff and young people identified the gap in appropriate 'move on' housing had impacted on effective planning for independence. Examples were raised were young people on becoming at 18 did not know were they were going to live and stated that the options were homelessness or a hostel.

- Despite some good operational engagement the resilience of the authority's relationship with health services appeared overly dependent on children's social services providing funding and resources to assess and meet the therapeutic needs of lac 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 were understood and operational relationships between staff including the Youth Offending Service helped support communication. Social workers and their managers generally had a good understanding of the young people they worked with including knowledge of presenting vulnerabilities. However, evidence from files was that in some complex cases decision-making and the direction of the case was not clear at the point of transfer.

- The authority had well-established in house support and therapeutic services. A recent realignment of these arrangements had been undertaken to develop a generic Family Intervention Team, which included therapeutic oversight of cases. This service aimed at providing a holistic response to children and their family's including looked after children and carers. The authority intended to evaluate its impact over time but some concerns were raised regarding young peoples timely access to the service and potential loss of expertise. Despite some constructive relationships with the Child and Adolescent Mental Health Service (CAMHS) including bi monthly consultations the lack of timely intervention by CAMHS professionals was raised as adversely impacting on care planning for young people.

- 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 additional tuition was provided including a summer school and mentoring. School stability was a priority and considerable efforts were made to maintain school placements despite placement disruption. A DVD had been produced by looked after children young people to provide foster carers and social workers with their views on promoting attainment in education. The authority seeks to ensure that PEPs are meaningful and they are updated to capture and reflect the young persons ability. Despite good relationships with schools and colleges some cases reflected the difficulty young peoples had in engaging with education particularly when they wanted to leave placement at sixteen.

- Health assessments were generally available for reviews and the lac health service provided primary health, healthy eating and sexual health advice to young people and their carers. Case examples were seen where looked after children health service and foster carers worked well together to engage with some young people who had been resistant to seeking and accepting health advice. The notification mechanisms in place and the relatively small numbers of children placed outside the local authority helped health professionals maintain oversight of this cohort of young people. Issues were raised that the notifications from authorities placing young people in Conwy were less

reliable.

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. The authority had been active in working to increase the range of in house foster carers however this remained a significant challenge. The authority was in the process of reviewing their fostering service.

- From the cases seen it was identified that the care plans of young people who remain looked after for longer periods were not routinely informed by a relevant shared written assessment even where there had been considerable changes in circumstances. Where assessments were undertaken some good information gathering was evident but the quality of the analysis remained variable. The authority had recently redesigned the core assessment format moving to a narrative format that encouraged a more explicit exploration of risk.

- The current identification of risk was not always timely and the management of risk appeared fragmented. In some cases reliance was placed on informal information sharing between the workers involved and on the social work report, prepared as part of the statutory review, however this report provided information rather than analysis. The resulting impact of the actions taken were not always reflected within the looked after children review and care planning process. The authority needs to ensure that risk assessments and resulting actions are more clearly collated and recorded.

- Children’s services had invested in whole service training on a framework for analysis tool. This tool includes a scoring system that supported a shared understanding of need and risks and provides a starting point against which progress could be gauged. Whilst staff found this approach helpful, particularly in relation to managing child protection and child in need cases, the application and relevance of the tool in relation to looked after children was less clear.

- The quality of the care plans seen were variable. Most included broad overarching statements but did not routinely articulate the objectives and how the desired outcomes for the young person would be achieved. The recording of care plans at times reflected the principal of the best interest of the child but did not accurately acknowledge conflicting differences in planning objectives, for example, in one case it was recorded that the young person would remain in placement when in fact the young person clearly stated that they did not want to remain in care. Some young people told us that they were not given a copy of their plan while others told us that they had a copy but that they were ‘boring’. Despite the efforts made by staff young people did not appear to view the plan as theirs.

- The quality of pathway plans seen were inconsistent and often lacked detail and contingency planning, particularly in relation to such known issues as housing.

Care leavers found the practical focus of pathway plans helpful but still experienced decision making in relation to financial and resource issues as slow and inconsistent.

- Care leavers were generally positive about the support they received from their personal advisors and saw this person as acting as their advocate. However caseload pressures and turn over of staff, in a small team, meant that some young people had experienced delays in the allocation of a personal advisor or had several changes of worker. The Personal Advisor service appeared to need further development.

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 although the authority did not have a specific protocol in relation to risk taking behaviours these issues were included in core safeguarding documents. There were well-developed information systems in place to support oversight of compliance in respect of statutory child protection procedures.

- Child protection processes were being used to manage risk for this group of young people. However the operational relationship and communication between social services and the police appeared inconsistent. Issues were raised in one case that the older age of the child had resulted in a less proactive police response. Agencies were generally working well together in relation to child sexual exploitation and missing children The regional partnership arrangements across North Wales had also been strengthened by the police appointment of a missing person's co-coordinator and this had resulted in significantly better information sharing and coordinated actions to reduce risks to young people. Funding was 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's structural arrangements meant that services for long term looked after children and care leavers were mainly located within a specialist team. Staff in this team undertook child protection work in relation to their own cases and this was recognised as a priority. Staff expressed mixed views regarding whether they had the time and confidence to undertake direct work with young people.

- Workers were clear that safeguarding was a priority and reported that a range of training was available to support them in their child protection and safeguarding practice. Including where the risks resulted from the young persons own behaviour. The authority had a relatively stable workforce and there was a good level of experience within teams. The authority had acted to

support newly qualified staff in their early years of practice, for example, through training and mentoring although time constraints were raised as sometimes preventing staff from utilising these opportunities.

- Following discussions initiated at the Multi agency 'Strategic Multi Agency Panel' (SMAP) the authority had acted to develop a service for children and YP who display sexually harmful and inappropriate behaviour. This service was to be launched in the next few months supported by a training programme.

AREAS FOR IMPROVEMENT

- Although statutory child protection procedures and thresholds were well understood the management pathway for looked after young people and care leavers exhibiting 'risky' behaviours needed greater clarity. The assessment and management of risk particularly when involving more than one agency needed to be more effectively shared and recorded. The progress made in mitigating risk was also not always clearly evaluated. The extent to which young people were directly involved in the process was not always apparent.

- The arrangements for supervising staff consisted of a senior practitioner managing a small number of social workers as a unit or pod so that access to case discussion and direction was more accessible. A principal practitioner managed the service practitioner and was available for consultation on cases. Staff were positive about this model of working but recognised that some changes would result from the transformation agenda. The frequency of supervision was formally monitored through performance management systems; however, the quality of the supervision records seen were very variable and in some instances, despite supervision training, there was an evident lack of challenge and direction.

- 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 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. Reviews were generally timely and convened as needed to reflect the presenting circumstances of the young person.

- The authority had a stable and experienced Independent Reviewing Officer (IRO) team who maintained responsibility for the same cases. Caseloads were identified as pressured. However, the IRO team were well informed and committed to ensuring that young people were involved in their reviews and had an opportunity to have their say. IROs routinely meet with young people

prior to the review and put time into trying to make the review experience more comfortable for them. Evidence was seen of some young people chairing their own reviews.

- The authority had developed mechanisms to better support the IROs ability to exert the influence of their role for example the IROs had recently started to attend monthly meetings with team managers to discuss issues and concerns. IROs are also able to record concerns on file. The IROs meet with the director of social services and produce an annual report. An escalation protocol was in place, which staff said they felt able to use as needed.

- 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.

- Children's services had a well-developed quality assurance framework. Information was drawn from performance systems, file audit, supervision, feedback from service users' comments and complaints. Findings from these mechanisms were reported to the corporate management team, the corporate parenting team and also to staff. Evidence was seen of audits being undertaken involving operational staff to support ownership of the improvement agenda. Recent thematic audits had included one on statutory visits and another on permanency.

- The authority were in the process of restructuring and in the near future the IRO team will be managed within a cross cutting children and adults quality standards service. This was planned to include safeguarding, workforce development, policy development, quality assurance and complaints. It was too early to determine the impact of these changes but it was recognised that this was a wide ranging management portfolio and that the changes would need be carefully managed and evaluated.

AREAS FOR IMPROVEMENT

- Looked after children reviews seen were overly focused on the immediate needs of the young person and gave insufficient weight to securing better outcomes over the longer term.

- Although IROs were confident in their abilities to provide effective challenge this was not always evident. 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.

- In some instances there was a significant over reliance on foster carers to deliver against core aspects of the plan. Whilst this might be the best means of engaging the young person it would be important to ensure that the stability and resilience of the placement is effectively supported

- The IROs role in monitoring cases between reviews was unclear.

- Young people held mixed views regarding reviews some said they enjoyed them while others were more negative. Even when provided with the support of an advocate and despite being asked for their views young people often felt they were not listened to and felt that they had little ability to influence the plan.

QUESTION 5

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

POSITIVES

- A forum for looked after young people “Loud Voices” had been established supported by the independent Advocacy Service. They had selected their first project to be the preparation of a welcome pack for children entering foster care. These packs were now routinely provided to young people in care. This group had also produced two DVDs, one following 4 care leavers and their research into leaving care in Conwy. The second called looked after ambitions aimed at raising awareness regarding how the Local Authority should support looked after children to meet their potential within the education environment.

- The authority had independent advocacy arrangements in place, this was described as providing an issue based service and there was evidence that advocacy was discussed at Looked After Children reviews. This service was also contracted to attend the authority’s children’s home on a fortnightly basis to enable young people to raise issues or to talk to someone independent from the home. 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 some mixed views children and young people generally experienced professionals as persistent in their efforts to engage them in planning. However, young people highlighted the importance of ensuring consultation is meaningful and expressed exasperation about repeatedly being asked about ‘wishes and feelings’ but not feeling listened to.

- The authority had developed a ‘Buddy’ group that involved former care leavers acting in an advisory role to meet with children who were currently looked after. The buddy group has been trained and supported to undertake this work.

AREAS FOR IMPROVEMENT

- The evidence from case files and interviews were that although some young people liked their social worker others were more ambivalent. Young people often said they didn't see their social worker enough that they were not reliable; they didn’t keep appointments or arrived late. The social work role was seen as one of preventing young people ‘doing things’ rather then being encouraging

and enabling.

- 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. Although this was dependant on the relationship they had with the individual

- Young people seen felt they had little ability to exert influence around choice of placement or accommodation. Although these views need to be balanced against the authority's child protection responsibilities to take protective action.

- Young people highlighted the significant impact changes of social workers and placement had on their ability to form trusting relationships. Issues were raised regarding the problems associated with delegated responsibility such as agreement to stay overnight with friends.

- Despite some positive experiences care leavers also described feeling socially isolated and unprepared for independence. The lack of appropriate move on housing was clearly a cause of some significant distress for care leavers.

- Young people had mixed views regarding whether they would like opportunities to meet together. Care leavers believed that their insight into being 'looked after' could be better utilised by the authority to support others.