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Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

National Inspection of safeguarding and care planning of Looked after *Children and Care Leavers* who exhibit vulnerable or risky behaviours

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1. Introduction

This report explores the quality and effectiveness of care and pathway planning in relation to safeguarding and promoting the outcomes of children and young people looked after by the local authority or who are care leavers.

Care and Social Services Inspectorate Wales (CSSIW) undertook an inspection in all local authority areas in Wales and the report draws on evidence from 220 cases as well as the views of children, young people and their carers, and from professionals across both local authorities and partner agencies.

2. Background to the inspection

The potential vulnerability of children in care and care leavers has long been recognised, and was recently highlighted by high profile court cases and inquiries including Rotherham, Rochdale and Oxfordshire. The reports by the Children's Commissioner for Wales - 'Lost after Care'[1] and Missing Voices'[2] reiterated the vulnerability of looked after children and care leavers.

Research tells us that whilst children and care leavers have positive experiences in care, issues such as inappropriate placements, lack of accurate assessments and multiple placement breakdowns, all potentially impact their safety. These factors increase the vulnerability of children in care and potentially exacerbate young people's own risk-taking behaviour. The findings from these and other national reports reinforce the need for ongoing vigilance in terms of protection as part of care planning.

Although the above inquiries did not directly relate to practice in Wales, the issues raised were of such concern that it was determined CSSIW should undertake a thematic inspection of care planning practice, with a particular focus on safeguarding and risk management.

This inspection also provided an opportunity to reflect on the progress made in relation to issues identified in earlier national reviews undertaken by CSSIW, including:

- National Review of Independent Reviewing Officers Services 2008-09.
- National report Safeguarding and Protecting Children in Wales the review of local authority social services and local safeguarding children boards published October 2009.
- National inspection in respect of 'The role of the Statutory Director Social Services published June 2013 National Inspection of the role of the Statutory Director.

[1] Lost After Care July 2011 Children's commissioner for Wales

[2] Missing Voices March 2012 Children's commissioner for Wales

3. Methodology

This national report summarises the findings from inspection visits undertaken across Wales' 22 local authorities between January and May 2014. The inspection was part of CSSIW's national thematic inspection programme.

The national inspection aimed to explore the quality of care planning in promoting:

- Effective support and protection of looked after children and care leavers.
- The identification and management of vulnerability and risk including that resulting from the young person's own risk-taking behaviour.
- Improved outcomes for looked after children and care leavers.
- Rights based practice and the voice of the child.

The inspection also considered how the authorities' understanding of the needs of and risks to looked after children and care leavers informed:

- The authorities' corporate parenting responsibilities.
- Strategic and service planning.
- The expectations of and contributions made by other agencies, including the police, education, health and the voluntary sector.
- The extent to which policy and guidance provided an effective framework for good interdisciplinary practice.

Each inspection visit involved three inspectors undertaking three and a half days of fieldwork. A range of documentation was provided by the local authority and examined by inspectors prior to the visit.

A sample of 10 cases were selected for inspection in each local authority against defined criteria that concentrated on work undertaken within a specific time period with:

> *Looked after children, over 11 years of age, and care leavers identified as potentially vulnerable and/or involved in risky behaviour (appendix 3).*

During the inspection each inspector tracked one of the 10 sample cases by accessing case records, and undertaking individual meetings with the young person and their family. Interviews were also conducted with the social worker and team manager with case responsibility, as well as a multi agency group meeting convened with all professionals and carers involved in delivering the current care plan. Individual or group interviews were also held in each local authority with elected members, officers, staff, partner agencies and providers.

Inspectors examined the remaining cases using the local authority's electronic and paper case file record systems. A total of 66 cases were tracked in detail and a total of 220 cases were examined during the national inspection.

To promote a culture of shared learning and transparency, CSSIW extended the opportunity in each local authority for an officer from social service to join the inspectors for the first day of case file reading.

Discussion groups were held in each local authority with both looked after children (aged 11+) and care leavers. The young people attending these meetings often included those from the wider looked after children and care leaving population. This report therefore draws on the evidence provided from a total of 171 looked after children and young people, 129 care leavers and 178 returned survey responses. The quotations included in this report are from children and young people spoken to during the inspection visits.

The practice examples highlighted in the report illustrate activity in a particular aspect of work. It has not been possible to include all the examples seen and there is no implication that they reflect or suggest exemplary practice in every aspect of the case, or that other approaches seen by inspectors were of a lesser value, importance or significance.

4. Characteristics from the file sample

What we know

According to published data[3]:

- The number of looked after children in Wales over recent years has grown from 2,991 in 1998 to 4,591 in 2004, 4,784 in 2006 to 5,755 in 2014 (as at 31 March each year).
- The number of looked after children across local authorities in Wales ranges from 67 to 684.
- The largest category (58%) of need for children starting to be looked after was "abuse or neglect".
- In the year to 31 March 2006, 47% of children aged 16 or over who ceased to be looked after, had at least one GCSE or GNVQ. This had increased to 58% in 2014.
- 55% of the young people in touch with local authorities who had their 19th birthday in the year ending 31 March 2014 were in education, training or employment.
- 10 to 15 year olds made up the largest group of the total looked after children population with 2,025 children. There were 975, 16 to 17 years old looked after children (31 March 2014).
- Research studies have highlighted that both current age and age at point of entry into care are crucial variables and that young people entering the system over the age of 11 often experience less placement stability.[4]

The criteria for children and young people include in this inspection deliberately targeted some of the most challenging and complex case management issues, and the sample only represented a small cohort of each local authority's wider looked after children and care leaving population.

Prior to becoming looked after, most of the children and young people had experienced some degree or combination of:

- Absent /chaotic and often grossly inadequate parenting.
- Chronic abuse and neglect.
- Sexual abuse, often at a young age or over a sustained period.
- Exposure to the impact of relationship breakdown, domestic abuse, offending behaviour, substance misuse and mental health issues.

[3] National Assembly statistical bulletins

[4] Understanding permanence for looked after children: A review of research for the Care Inquiry April 2013

Since becoming looked after, the young person's experiences included complex combinations of the following:

- Disengagement from birth family.
- Greater identification with birth family and a strong view of their own family home as their base.
- Unhappiness with the circumstances resulting in them becoming looked after and not wanting an alternative family.
- Inability to settle either at home or in care.

Other common issues included:

- Disengagement or underachievement in education.
- Over identification and dependence on friends and peers.
- Social isolation.
- Poor emotional well-being including low self-esteem.
- Lack of trust in adults including professionals.
- Engagement in risk taking behaviour or associated risk resulting from going missing, potential to become the victim or perpetrator of crime, substance misuse and self harming behaviour.

Messages from children and young people

"I am happy, my foster carer is lovely and I know I cannot live with my mum but me and my brother are OK … School is fine but still I would rather that things were different and I wasn't in care." (12 year old looked after child)

5. Summary of Findings

Theme 1: The Corporate Priority

Summary Findings

Corporate parenting

- The review confirmed that there was good member and corporate officer awareness of safeguarding and corporate parenting responsibilities. However, the extent to which this translated into tangible action that supported children's services to deliver improved outcomes for looked after children and care leavers, was variable.
- Authorities' strategic focus was increasingly on the development of early intervention strategies to reduce the need for children to become looked after. However, in some authorities this focus was not sufficiently matched by an enduring strategic emphasis on securing permanency and good outcomes for those already looked after. The best authorities recognised the need for both.
- Most local authorities had developed a shared corporate parenting strategy and had the equivalent of a corporate parenting board in place, but there was considerable variation in the status attributed to these arrangements by both the local authority and partner agencies.
- Delivery against corporate parenting priorities was often still too narrowly focused on the activities and role of councils' children's social services departments. The engagement of health and other external partners in councils' corporate parenting governance arrangements was either not evident or found to be limited.
- Local authorities need to assure themselves that membership of the corporate parenting board is of sufficient breadth and seniority across all departments to ensure the services provided to looked after children and care leavers effectively protects and promotes their well being.
- The ability of corporate parenting boards to maintain a comprehensive overview of the progress of children who are looked after and for care leavers remained variable. Greater attention is needed by boards as to how well looked after children are doing as well as a closer understanding of the qualitative factors that enable looked after children to secure success.
- A number of local authorities had analysed the demographic profile of their looked after children and care leavers' population and demonstrated an understanding of strategies to manage demand. However, few had developed a profile of their assessed needs or could point to a detailed thematic picture regarding vulnerability and risk. This should become core corporate parenting board business and should inform commissioning intentions.
- Members, officers and partner agencies need to do more to assure themselves that strategic aims are effectively developed, owned and translated into timely action across local authority services and partner organisations.

Strategic partnership working

- Despite a greater emphasis on supporting educational achievement by looked after children, this often remained too narrowly defined in terms of academic attainment.
- Local authorities' corporate parenting ambitions for looked after children need to be supported and owned more effectively by schools. This was reflected in the reaction of individual schools to the admission of looked after children or the responsiveness they showed to meeting their needs.
- The engagement of health boards in supporting the emotional and mental health needs of looked after children was generally found to be weak and much remains to be done to meet the aspirations of the policies and guidance associated with 'Towards a Stable Life' and 'Together for Mental Health'.
- Most authorities were yet to develop a flexible continuum of supported and independent accommodation for care leavers. Given the age profile of the looked after children population, this is an area that will require significant attention.
- Councils need to have a stronger focus on building more effectively integrated support for care leavers. Vulnerable young people were being let down by rigid eligibility criteria in relation to services for adults.

Placements

- Despite local authorities' strong commitment to ensuring placement choice and stability most were struggling to recruit foster carers in sufficient numbers to provide the range and choice of placements needed, particularly for those young people with challenging behaviour and with additional needs. Local authorities also reported similar shortages in the independent sector. This apparent deficit in the foster carer market raises complex challenges across Wales.

Advocacy

- All local authorities had commissioned formal advocacy services and there was a strong commitment to promoting access to these services. 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.
- Most corporate parenting boards received regular feedback from the advocacy and participation services, as well as information and feedback regarding any complaints received from looked after children and care leavers. Local authorities recognised that the advocacy service was not always available to children placed outside Wales in their first language and they were actively seeking to address this.

Participation

- Local authorities were working hard to create ways to engage looked after children in the wider participation agenda, but enabling looked after children and care leavers to influence policy and practice remained challenging for most. Some care leavers believed that their insight into being 'looked after' could be better utilised by the authority to support other looked after children.

Workforce

- Despite a strong emphasis on workforce and improvement in recruitment, there was evidence of an imbalance in the level of experience of social workers in children's social services. Local authorities were often reliant on less experienced staff and caseloads were frequently high. These staff were often managing complex cases, and this placed significant additional burdens on managerial supervision to ensure safe and effective practice. Some authorities were also experiencing recruitment difficulties at team manager level.
- In some authorities, caseload pressures meant that staff were unable to prioritise and address looked after children's needs consistently. This meant that the quality and timeliness of the service was inconsistent across Wales.

Safeguarding Children Boards

- Links between the corporate parenting board and the safeguarding children boards need to be strengthened to ensure explicit ownership of a joint safeguarding agenda for looked after children.
- Safeguarding children boards need to strengthen the systems in place to gather, share and analyse multi agency information in respect of concerns about the welfare of looked after children, including those placed outside their home local authority boundary.
- Safeguarding children boards need to develop a more systematic approach to assuring themselves of the quality of safeguarding practice in relation to looked after children and care leavers.

Theme 2: Care and Pathway Planning

Summary findings

Assessments

- The care plans of those children and young people who were looked after for long periods were often not informed by an updated assessment that supported decision-making.

Care planning

- Often, the quality of the care plans seen did not reflect the positive intervention and support that was being provided, or identify that discernable differences were being made to the child's life.
- Care plans are only as effective as the outcomes they achieve for looked after children and care leavers. Most children and young people had a current care plan or pathway plans but the quality was not always sufficient to shape the services they required.
- The extent to which the children, young people and the people caring for them had been involved in the development of the care plan was not always clear.

Pathway planning

- Initial pathway plans were not consistently underpinned by a good quality assessment and not all care leavers had a pathway plan.
- Care leavers were generally positive about the support they received from their personal advisors, although they did not always understand the difference in the role of their social worker and personal advisor or the different planning mechanisms.

Case recording

- The quality of case records overall was not of a consistently high standard, and social work visits and reports were not always easy to find on the authorities' own electronic system.

Risk and vulnerability

- The inspection confirmed that the vulnerability of looked after children and care leavers was understood by staff and considerable work had been undertaken to heighten awareness in the identification and management of risk factors.
- The extent to which young people contributed to or were aware of risk management plans was not always clear.
- Risk assessments and risk assessment matrices need to be better understood as a means of informing professional judgment and decision making. There needs to be a shared understanding of risk across all professionals and agencies. The progress made in mitigating risk was not always evaluated or well recorded.
- The assessment and management of risk particularly when involving more than one agency needs to be more effectively recorded and shared. Local authorities and partners would benefit from streamlining the risk management systems they have in place to prevent duplication and ensure a greater clarity of shared purpose with all parties involved.
- Local authorities and partners would benefit from shared learning processes to identify what has worked well for children in mitigating risk. This learning should explicitly include the perspective of children, young people and their carers.

Emotional and mental health

- Despite some very committed work by individuals within health, the employing health services did not give sufficient priority to the emotional and mental health needs of children in care and care leavers. This resulted in the burden of responsibility being placed on local authority children's social services.
- There was recognition of a long standing disconnect between the access threshold applied by the Children and Young People's Mental Health Service (CAMHS) and the presenting emotional resilience needs of looked after children and care leavers.
- The issue of looked after children and care leavers' rights to an appropriate range of provision to meet their psychological and emotional health needs, when they need it and for as long as they require it, including the transition into adulthood, needs to be urgently addressed on an all Wales basis.

Theme 3: Safeguarding

Summary Findings

Child Protection

- Child protection processes were used appropriately to manage concerns about the welfare or safety of children that were defined as in need of protection, and interventions resulted in prompt initial action.
- Managers had some well-developed information systems to support oversight of compliance in respect of statutory child protection procedures, but these could not always be interrogated regarding the looked after status of the child.
- There was good evidence that agencies took the risks to looked after children seriously. All agencies were found to be working proactively together in relation to child sexual exploitation and children who go missing from placement.
- Whilst close adherence to policy is essential, the factors that often made a difference in managing these issues included the quality of the assessment, the skill of staff in helping children with such complex needs and the resilience and quality of the children and young people's relationship with their carers.
- Although statutory child protection procedures and thresholds were generally well understood, greater clarity was needed regarding the relationship between child protection, risk management and care planning processes, particularly for looked after children and care leavers exhibiting 'risky' behaviour. The development of a mechanism such as multi-agency risk conference would be one means of ensuring effective coordinated actions to reduce risk.

Theme 4: Reviews

Summary Findings

Compliance with Guidance

- The inspection identified that reviews were for the most part timely and convened as needed to reflect the presenting circumstances of the young person. Attendance, although prioritised by relevant professionals, was not always consistent.
- The relationship between the review and other decision-making mechanisms needs to be more explicit. Clarity is needed regarding the status of "conclusions" or "decisions" reached which are then subject to another internal process or panel.
- Local authorities need to ensure oversight, at intervals, of the operation of their reviewing processes, considering both the ways they maintain the momentum in implementing plans for children, and also lessons for the local authority in improving services.

Independent Reviewing Officers

- All authorities had independent reviewing officer (IRO) arrangements in place but the resilience of the service was inconsistent and case loads were often reported to be demanding.
- The independent reviewing service often did not see itself as providing a core quality assurance function and having a role in driving up performance. Independent reviewing officers within and between authorities were not always sufficiently confident in exercising their own authority or the authority of their role.
- Despite efforts to make reviews more inclusive, independent reviewing officers did not always meet with children and young people prior to or following reviews in a way that was meaningful. Overall the independent reviewing service needs to improve how it engages, listens to and reflects the views of looked after children.

Review reports

- Social work and other agencies' reports to the looked after children reviews were not always timely and in some instances not of a quality to capture significant events or the progress made against the plan.
- The minutes resulting from the review meetings were not always promptly provided or of a quality to support the shared ownership of what had been agreed.

Review process

- Most young people interviewed told inspectors that they were actively encouraged to attend their reviews and that they were also regularly informed about and encouraged to use the independent advocacy service.
- Despite considerable effort by staff, and even when provided with the support of an advocate, many looked after children told inspectors that they preferred not to attend their review.
- Many of the concerns raised by children reflected a thematic deficit in the capacity of reviews to be a meaningful or effective way of ensuring that care plans achieve what they need to achieve to improve outcomes.

Messages from looked after children and care leavers

"I didn't like being in care but it was the best thing for me, as if I hadn't gone into care I don't think I would have any sort of life now. I am at university and I am doing OK but I still worry about my family." **(Care leaver)**

6. Key Messages and Findings

Members, officers and partner agencies need to have arrangements in place to assure themselves that strategic aims are effectively developed, owned and translated into timely action across both local authority and partner organisations, to improve outcomes for looked after children and care leavers.

Too many looked after children and care leavers are still not able to access the range of appropriate services to meet their psychological and emotional health needs, when they need them and for however long they require them. Urgent action is required on an all Wales basis to address this deficit in service provision.

Whilst statutory child protection process and thresholds are generally well understood, greater clarity is needed regarding the relationship between child protection arrangements, risk management and care planning processes particularly for children looked after and care leavers. The development of a mechanism such as a multi agency risk conference would be a consistent method to ensure effective coordinated action is taken to reduce risk.

Whilst there was a strong strategic focus on the development of early intervention strategies to reduce the need for children to become looked after, this was not always matched by an enduring strategic emphasis on securing permanency and good outcomes for those children already looked after. It is critical that local authorities and their partners recognise the need for both an early intervention strategy and a permanency strategy that secures best outcomes for children already looked after.

Many of the concerns raised by children reflected a thematic deficit in the capacity of reviews to be a meaningful or effective way of ensuring that care plans achieve what they need to achieve to improve outcomes. The effectiveness of existing statutory arrangements for care planning and reviewing cases would benefit from being revised to better support improved outcomes for looked after children and care leavers. Any review of statutory arrangements must be undertaken in conjunction with children and young people.

7. Themes

Theme 1: The Corporate Priority

The inspection considered how local authorities discharged their corporate parenting roles and responsibilities to promote the stability, safety and improved outcomes for looked after children and care leavers.

Issues Identified

Structural Arrangements

The structural arrangements underpinning the delivery of children's social services were variable across local authorities and it was not possible to conclude that the vision underpinning one structural model was better than another, to secure good outcomes for looked after children and care leavers. However, it was evident that the following features were associated with better outcomes for looked after children:

- Stable structural arrangements and continuity of senior children's services leadership.
- Strong corporate and elected member focus on meeting the needs of looked after children, particularly through robust corporate parenting arrangements.
- An effectively developed strategic approach to population needs analysis, service design and permanency planning.
- Well developed, and flexible services that are responsive to the needs of care leavers.
- Good engagement with and listening to the voice of looked after children and care leavers.
- A realistic appreciation of the costs of meeting the needs of looked after children linked to good quality assurance.
- Structural arrangements that effectively reflect the accountabilities of the statutory director of social services.

Strategic Leadership

All local authorities included children's social services, corporate parenting and safeguarding as a priority in their strategic policy documents. All the strategic documents reviewed reflected the Welsh Government's seven core aim commitments that summarise the United Nations convention on the rights of the child.

Members and corporate officers were more cognisant of their authority's safeguarding and corporate parenting responsibilities since that was identified in CSSIW national inspection Safeguarding Children in Wales 2009[5]. However, the extent to which this translated into tangible action that supported children's services to deliver improved outcomes for looked after children and care leavers, was too variable.

[5] CSSIW national report Safeguarding and Protecting Children in Wales the review of local authority social services and local safeguarding children boards published October 2009

Inspectors confirmed the findings of the 2013 National Inspection of the role of the Statutory Director that:

> *"The Head of Paid Service has a pivotal role in empowering the statutory Director of Social Services and ensuring that they are supported by the corporate infrastructure to meet their statutory accountabilities".*[6]

There was growing corporate recognition by officers and members regarding the complex challenge councils face in balancing the diverse and dynamic needs of the looked after children population, against increasing and significant resources pressures. Most authorities, particularly those who had experienced an ongoing rise in the numbers of looked after children, had undertaken significant work to interrogate the reasons behind this and had developed systems that captured the general profile of this population and the children on the edge of care.

Local authorities were actively using this information to inform their placement strategy to decrease the number of children and young people in care placed out of area. Although there are good reasons to want to reduce the number of children placed out of county, the primary consideration underpinning any decision should always be to meet the needs of the child.

Local authorities were also proactively looking at 'safe reduction strategies' in relation to their looked after children populations. For the older age range of children this involved the use of alternative legal orders such as Special Guardianship Order; reunification with family, often using placement with parent regulations; or profiling those young people able to move towards independent living. To be successful, the complexity and specialist nature of such work needs to be understood and resources allocated to ensure the potential risks to the child associated with placement disruption are minimised.

It was of concern that the corporate drive on early intervention was often shaped principally by the need to reduce costs against a shrinking budget base. Whilst this is clearly appropriate in financial terms, expectations regarding the speed with which services could be safely reconfigured and realise savings were not always realistic, looking to the immediate rather than the medium and longer term. In addition, the extent to which such strategies required sustained investment was often significantly underestimated.

Conclusion

A critical factor in the development of an effective strategic focus on securing better outcomes for looked after children was the extent to which partner agencies actively contribute to this priority. Despite some good working relationships, the engagement of partners in joint planning arrangements was limited and often confined to the provision of advice. This was illustrated in the areas of emotional well-being and the provision of accommodation for care leavers. In both of these areas there was too little evidence that partners were actively designing or developing services dedicated to looked after children and care leavers.

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[6] CSSIW National inspection in respect of 'The role of the Statutory Director Social Services published June 2013

Corporate parenting boards

All local authorities had governance arrangements in place to oversee and deliver on their corporate parenting responsibilities and most had developed a shared corporate parenting strategy reflecting the principles of Welsh Government guidance 'If This Were My Child'. However, the arrangements across local authorities were at different stages of development.

Practice example: Corporate parenting

Several authorities had developed or were in the process of developing corporate parenting pledges to children in care and care leavers as part of their corporate parenting strategy. The intention was to monitor and evaluate progress against the pledges. **(Newport, Pembrokeshire)**

For example such pledges included:

- *To provide looked after children with good quality, stable placements where they feel safe, valued and cared for by excellent carers.*
- *Ensure that looked after children achieve the best possible educational outcomes.*
- *Improve the health outcomes of looked after children and provide them with appropriate health care and advice.*
- *Support and encourage looked after children to enjoy a wide experience of leisure, cultural, sport and social activity to enable them to fulfill their potential.*
- *Support looked after children and care leavers to prepare for the future and make positive choices for independent living, in order to become successful, fulfilled members of society.*

Other examples included:

- A charter for looked after children that set the standards that the local authority would aim to deliver for looked after children. **(Carmarthenshire)**
- One authority had acted to adopt the United Nations Conventions on the Rights of the Child and the rights of children into council policy. **(Swansea)**

Inspectors found considerable variation in the status attributed to corporate parenting boards (boards) by both councils and partner agencies, and differences in the seniority of membership and arrangements for ensuring effective scrutiny and accountability. The best boards had a membership that was able to challenge performance, direct improvement and influence outcomes for looked after children and care leavers. In some good examples, the chief executive and the leader of the council were also identified as being strong champions for children and young people.

The effectiveness of a number of boards had been hampered by organisational change, fluctuating membership, and a perceived lack of authority. In these circumstances boards were yet to progress beyond the level of a discussion forum. Members became more confident in their corporate parenting role with experience.

The ability of the board to maintain a comprehensive overview of the progress of children who are looked after and for care leavers was variable, and most boards remained largely unsighted regarding the quality of their service provision including placements.

In too many cases, delivery against corporate parenting priorities was still narrowly focused on the activities and role of councils' children's social services departments. The more developed boards received accompanying narratives with their data that included an analysis of performance linked to intended outcomes that also identified potential risks. In some instances, anonymised case examples were used to reinforce the impact and experience of the child. Most boards received reports from wider service areas such as health, housing and leisure, but a frustration was often cited regarding the extent to which boards were able to exert influence on these services against identified issues.

The statutory duties enshrined in Section 27 of the Children Act 1989 and the Children Act 2004 make it incumbent on health, education, housing, and other partners to improve the well being of children in their area, including looked after children. Despite some recognised progress, the contribution made to corporate parenting functions by the wider local authority was often found to be too dependent on the extent to which it reflected the existing priorities of other council departments, or simply the aspiration of key lead officers, rather than reflecting a shared corporate ambition for looked after children.

Safeguarding

Corporate parenting boards had a greater recognition of their safeguarding responsibilities. Some authorities had benefited from their investment in Safeguarding and Quality Assurance Units working across children and adult social services or children's social services and education. In some instances these were viewed as providing a more holistic approach to information gathering. Most boards now receive some data regarding children missing from care, children in care missing education or at risk of child sexual exploitation, but this needs significant further development across all authorities and should become core corporate parenting board business. This would be supported through strengthened links with safeguarding children boards that ensure explicit ownership of a joint safeguarding agenda for looked after children.

The complex interrelationship between young people's looked after status and their vulnerability is one that needs to be continually reinforced. Members and officers outside children's social services had a good understanding that children and young people became looked after because they were 'vulnerable', but found it difficult to appreciate the extent to which young people were vulnerable because they were looked after. This ongoing vulnerability was evident at a number of levels:

- **Deficit on entering the looked after system** – in a significant number of cases seen, children brought substantial deficits with them in terms of educational attainment, challenging behaviour or emotional damage; those outside of children's social services and specialist services did not always understand that being looked after was not enough itself to mitigate these factors.
- **Choice of placement and matching** – the inability of authorities to secure a sufficient range of placement options meant that matching children to placements was often a question of compromise. This in turn increased the likelihood of placement

breakdown. As the cycle progressed and the number of breakdowns increased, the ability of a placement to meet individual need successfully and promote good individual outcomes diminished.

- **Looked after status as stigma** – The inspection saw examples where the simple fact of being looked after caused difficulties for children in other aspects of their lives whether in their local neighborhood or school.
- **Looked after status as risk** - being identified as 'looked after' also heightened the potential for being targeted by unsafe adults.

Clearly these matters continue to raise policy issues and wider questions for society as a whole.

Practice issue: Safeguarding and technology

Access to IT and the use of mobile phones was a subject which evoked strong views from young people. It was disappointing that over half of the young people who responded to the CSSIW service user survey reported difficulties in accessing the internet to complete the survey. The vulnerability of these young people might make internet access a risk but lack of access effectively excludes them from the positive aspects of information technology.

Carers were reported to have a high degree of anxiety about young people's access to the internet. This is a significant issue and highlights the corporate parenting dilemma of not wanting to disadvantage looked after young people whilst also acting to ensure that effective protection is in place that takes account of their potential vulnerability.

Education

A greater emphasis was being given to the educational achievement of looked after children. The underpinning ambition of authorities was increasingly that *children in education should not be disadvantaged by their looked after status*. Local authorities had invested in specialist staff or services within education directorates to appropriately promote this agenda.

Most corporate parenting boards effectively monitored attendance, school stability and attainment, as measured in terms of key stages or examination results. The best avoided the trap of recognising achievement purely in terms of academic metrics and had a more holistic view of achievement that included the progress made in relation to the child's known potential. However, corporate parenting ambitions were not always as well reflected in the reaction of individual schools to the admission of looked after children or the responsiveness they showed to meeting their needs. School placements were often determined by the known attitude of the school to looked after children rather then their quality.

Corporate parenting arrangements were often less well developed regarding the progress and experience of young people once they had left school and moved into further education. The exceptions to this being the interest shown in the growing number of young people entering university and also the requirement to monitor compliance against young people not in education and employment (NEET).

Practice examples: Corporate parenting

- One authority had established a 'virtual school' as a sub group of the corporate parenting team. This was aimed at providing members and officers with the opportunity to interrogate information providing a better understanding of school related issues such as performance, school attendance and fixed term exclusions. **(Conwy)**
- The role of a designated teacher for looked after children had been maximised by the education support service. This increased the capacity and enhanced the service provided. **(Carmarthenshire)**

Housing

A number of local authorities had worked hard to strengthen the relationship between children's social services and housing. Most had developed young peoples' homelessness strategies and protocols for the assessments of 16 and 17 year olds, further strengthened in light of the Southwark and Lambeth judgments[7] [8]. The planned introduction of the Welsh Government's "When I am Ready" scheme had also raised the profile of placement and the accommodation needs of young people post-18 years. Some authorities were officially piloting the scheme at the time of the inspection or had elected to introduce early arrangements in line with the principles of the scheme.

Although housing protocols and strategies were usually inclusive of care leavers, the extent to which authorities had developed a flexible continuum of supported and independent accommodation was highly variable. The ability of some local authorities to meet the needs of care leavers along this continuum was often significantly influenced by a fundamental gap in the supply of appropriate accommodation. There is evidence that this has been exacerbated by changes to housing benefit entitlements.

In the best examples local authorities mitigated these factors through the establishment of shared functions, often by establishing a care leaver/young person homelessness post located in a housing advice service. Functions of this kind, however designated, acted to support the preparation of individual pathway plans in readiness for taking up accommodation; provided an effective bridge between care and community based support; and performed a role in assisting care leavers whose first attempts at independent living failed.

Less satisfactory arrangements were characterised by a low level of preparation for coping with independent accommodation; little allowance for failure especially in relation to those with lower social and emotional resilience; unrealistic expectations about care leavers' abilities simply to present as homeless to generic homelessness services; and what is best described as a 'cliff-edge' effect in moving from a direct care setting to independent living.

[7] The Southwark judgement made by the Law Lords in May 2009

[8] A v Lambeth High Court judgement July 2010

Given the significant and continuing growth in the size of the care leaver cohort across Wales, authorities will need to have effective strategic plans that anticipate the resource requirements needed to improve the prospects of success for care leavers as they approach independent living. Given the nature of the challenges faced by young people as they establish themselves in the wider community, the need to design and provide services has to be more fully embraced as a more direct responsibility by universal services, the broader community and third sector agencies.

The considerable challenge that this presents is already acknowledged by children's social services but the extent to which housing providers have modernized their approach to develop a more flexible range of accommodation remains unclear. There are some notable exceptions where forward looking providers have already begun to develop dedicated provision in partnership with local authorities. Local authorities and providers will need to work in partnership to accelerate this kind of development if the needs of care leavers are to be met effectively.

Practice example: Corporate Parenting

- A 'team around the child' programme had been developed and Newport City Homes were making more properties available for care leavers. A tenancy preparation course has also been developed. **(Newport)**

Good examples were seen across Wales of local authorities utilising third sector housing provision such as:

- Llamau that provide a four-bed unit for supported living and gaining independence for care leavers. This service was integrated into the 16+ team. **(Torfaen)**
- Solas that provide supported accommodation for young people aged 16+. **(Newport)**

Transition

Transitional arrangements to support the pathway of children into adulthood were not sufficiently developed to support young people who remained highly vulnerable and in need of more intensive support than is provided under the Leaving Care Act. Some authorities were beginning to undertake innovative work looking to reconfigure services around more flexible, people-centered thresholds.

Practice example: Corporate parenting

- One authority had recently developed a vulnerable adults panel staffed by representatives from children's and adult services aimed at sharing relevant information regarding looked after children moving into adulthood. **(Caerphilly)**
- As part of a 'transformation programme' one authority was looking to progress the introduction of a vulnerable people's service (aged 18 to 65). This new vulnerable people's service if successful could provide access to services for individuals who do not currently meet adult service thresholds. **(Conwy)**

Economic wellbeing

Services to improve the economic wellbeing of looked after young people and care leavers were found to be underdeveloped. Most authorities had not sufficiently exploited the opportunities they can provide as an employer to support looked after young people and care leavers into the work environment. Some authorities were more ambitious than others in their efforts to improve looked after children and care leavers' employment, education and training, and had for example developed work experience schemes for looked after children. Initiatives such as good quality apprenticeship schemes were often only aspirational and at the discussion stage or at an early stage of implementation.

Practice examples: Corporate Parenting

- The local authority had developed work placement traineeships and apprenticeship schemes for looked after young people and care leavers. Further support for young people in relation to work readiness was also available through the 'Just Ask Plus' service. **(Bridgend)**
- The local authority had launched a work placement scheme championed by senior officers within the council aimed at ensuring that looked after young people and care leaver had the opportunity to access work experience. **(Cardiff)**
- The local authority had developed work placement and traineeships for care leavers. Part of the corporate ambition was identified as breaking the cycle of care. **(Carmarthen)**
- The local authority had embedded a not in education, employment or training (NEET) project in the looked after children/leaving care team, funded by the National Lottery for four years. The project focused on developing educational and occupational outcomes for young people leaving care and sought to engage with prospective employers in the area. **(Ceredigion)**
- The local authority had appointed a Children and Young People's 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. **(Pembrokeshire)**

Leisure

Planning in relation to involvement in sport, leisure and/or other community based activities was often very inconsistent, but there were some good examples of children and young people being proactively supported to pursue their interests. Many young people raised the issue of needing permission to participate in activities from social services and reported that this caused some delay at times due to the need for risk assessments. Inspectors also saw examples of opportunities being offered but not being taken up and of looked after children and care leavers being given leisure passes. Most authorities recognised that they had been slow in progressing initiatives to promote leisure and recreation opportunities.

Practice example

- There had been good corporate co-operation to provide looked after young people with free access to leisure and sporting activities. **(Denbighshire)**

Health

Despite some good working relationships, the engagement of health or other external partners in council's corporate parenting governance arrangements was either not evident, or remained highly variable. The information scrutinised by corporate parenting boards was largely confined to the numbers of children and young people registered with primary health services and compliance with the number and timeliness of looked after children health assessments.

The resilience of authorities' relationships 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. In some instances children services were also funding the looked after nurse service or had experienced a reduction in this service despite a growing looked after children population.

Conclusion

Local authorities need to assure themselves that membership of the corporate parenting boards is of sufficient breadth and seniority across all department to ensure the services provided to looked after children and care leavers effectively protects and promotes their well being.

Elected members, officers and partner agencies including health, need to do more to assure themselves that strategic aims are effectively developed, owned and translated into timely action to support improved outcomes for looked after children and care leavers.

Advocacy and engagement

All local authorities had commissioned and developed formal advocacy arrangements and children's social services had made significant progress in promoting access to these services. However, authorities recognised that the advocacy service was not always available to children placed outside Wales in their first language and they were seeking to address this.

Practice examples

- 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. **(Wrexham)**
- All looked after young people were routinely contacted before their reviews to see if they wanted to have an advocate to support them. **(Monmouthshire)**

Many authorities had participation groups to seek the views and opinions of children/ young people about their care. Most corporate parenting boards received regular feedback from the advocacy and participation services as well as information and feedback regarding any complaints received from looked after children and care leavers. In some authorities, board members had opportunities to meet with young people and in a few examples, the membership of the corporate parenting board included former service users and or young people delegates elected from the participation groups.

The young people interviewed as part of the inspection had very mixed views regarding whether they welcomed opportunities to meet together or with officers and members. Some looked after children clearly found it very supportive and empowering while others stated that they didn't like or want to viewed 'the same' as other looked after children. Some care leavers believed that their insight into being 'looked after' could be better utilised by local authorities to support others, but equally highlighted the importance of understanding the 'unique experience' of a looked after child or young people.

Despite some positive exceptions, authorities were not always able to evidence how the views and experience of children and young people were routinely used to inform service development, improve professional practice or have a tangible influence on outcomes. Children who lived away from their home authority were often particularly disenfranchised from meaningful involvement in the shaping of services for looked after children.

Conclusion

Despite a real belief in the importance of promoting the engagement and participation of looked after children and care leavers, and notwithstanding some positive practice examples, inspectors found that local authorities were still striving to find ways of delivering this commitment in a way that was meaningful for both the young people and for the organisation.

Practice examples

- The local authority had an established looked after children /care leavers forum/ participation group (Rainbow Group) chaired by a care leaver and supported by a social worker. Young people told us they had been able to bring issues to the leadership team around changes they wanted made, for example that foster carers could make decisions regarding 'sleep overs', instead of having to get permission from local authority managers. **(Merthyr Tydfil)**
- The local authority had commissioned a consultation with the looked after children population and had responded to the concerns raised by children and young people about frequent changes of social worker and placement moves. Fieldwork teams had been restructured to improve social workers' capacity to complete direct work with young people. **(Blaenau Gwent)**
- The local authority had developed a 'buddy' group that involved former care leavers acting in an advisory role to meet children who were currently looked after. The buddy group has been trained and supported to undertake this work. **(Conwy)**

- '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 and helped inform the corporate parenting board. **(Gwynedd)**
- The local authority held a "corporate parenting challenge" where looked after children and care leavers met with members and professionals to review the progress made against corporate parenting objectives in the last year and identify next steps together. **(Swansea)**
- To promote the voice of the child, membership of the corporate parenting panel includes two young people. The post-16 team (route 16) organises three consultation events each year to ask looked after children for their views. The feedback from these events was then reflected in the looked after children improvement programme. **(Neath Port Talbot)**

Information sharing

Most children's services had well embedded information and performance systems. Inspectors found that members, officers and partners were routinely informed about children's social services' compliance with statutory requirements in relation to looked after children and care leavers. Where local authorities' performance systems worked well there was an emphasis on capturing reliable, cross directorate information that was regularly analysed and reported against intended outcomes.

However, wider local authority and partner agency performance systems were not always as well attuned to identifying the contribution that agencies made to the delivery of the corporate parenting functions. It was evident that all agencies gathered discrete data in order to meet their own pre-existing requirements, and that there were some examples where this data was further analysed to enable insight into the needs of looked after children. This bringing together of 'data silos' enabled a fuller picture, but stopped short of a genuinely integrated and whole systems approach to multi-disciplinary understanding of need or joint management of whole systems performance. This meant that most authorities were yet to develop a detailed profile of their looked after children and care leaver populations' assessed needs including their vulnerabilities and associated risks. This would necessitate a more systemic approach to information gathering.

Panel arrangements

Senior officers and managers in children's services were generally well informed about individual looked after children's vulnerability and risky behaviours. Many children's services had developed internal panel arrangements to provide oversight of planning and permanency decisions. In some instances these panels were also the means of allocating additional targeted resources and identifying placement pressures. Where these arrangements worked well, the remit and interrelationship of the panels was clear and supported a holistic view of the child, timely decision-making, and the escalation of cases as needed. Inspectors saw evidence of some assertive intervention and challenge to prevent drift. However, the plethora of panel activity in some authorities did not support the effective analysis of information and the line of sight on the child was fragmented, leading in some cases to serial decision-making rather than decision-making in the round.

In some instances the activity of 'referral to a panel' itself became viewed as the plan, and the bureaucratic demands of some panel arrangements delayed decision-making. Information from these panels if effectively collated could support a better understanding of assessed need.

Placements

The importance of promoting placement choice and stability for looked after children was well understood and reflected in relevant strategic documents. The progress in updating and tracking placement delivery against strategic aims was less well embedded in some local authorities. Most local authorities had developed systems so that once a child entered the looked after care system, their circumstances were reviewed by a panel and all changes of placement and services were agreed or ratified by these mechanisms.

In the cases tracked by inspectors, the rationale for matching children with specific care placements was not always well recorded on the child's file. Whilst most local authorities had matching protocols in place, in the most complex cases, the overriding matching determinant was the availability of a suitably experienced carer or the willingness of an external placement to accept the referral. Some good examples were seen where children were given a real choice in their placements, and in a few instances young people told inspectors that they had an opportunity to "try out" several possible placements before moving. Some children recognised they had waited for the "right placement" but valued the time taken by their social worker to "get it right". In contrast, in other examples children and their families did not have a good understanding of why placements had been chosen and young people often described and internalised the decision as resulting from their own "negative" behaviour. Young people told us in these circumstances they felt they had little ability to exert influence or choice around where they were placed. However, some of these views need to be balanced against the authority's child protection responsibilities to take protective action.

Messages from children and care leavers: Placements

- *"I said I wanted a single carer, they took that into consideration and my foster carer is single…. It's easier."* **(Looked after child)**
- *"They didn't listen to me, I was placed (out of county) and made the best relationship of my life but they still moved me back."* **(Looked after child)**
- *"The placement was fine but it never felt like my family and I didn't want to stay, so I left when I could. Social services still help me. I like living on my own and feel more in control."* **(Care leaver)**
- *"I have had some terrible times moving placement. I was taken to a foster home – I had never been there before, I had to sleep in a room with two other children I had never met. My social worker only stayed with me for 10 minutes. I think of that as one of the saddest things that has happened to me."* **(Looked after child)**
- *"I am happy where I live because they treat me good like I am one of the family and I trust them and they trust me."* **(Looked after child)**

Young people often highlighted the quality of their relationship with their carer as the most significant factor in determining how they viewed their looked after experience. Inspectors saw a number of examples of carers going above and beyond expectations to support young people but also heard that, for some, being looked after intrinsically meant being different.

Local authorities were found to be genuinely concerned to maintain family, school and community links and actively promote the ethos of family based care within the child's own community where possible. Most also demonstrated a strong commitment to meeting the needs of looked after children, even when this required the use of external specialist placements that incurred significant costs. However, local authorities were honest in acknowledging the realistic need to contain these costs. In some cases this meant the authority only utilized purchased placements when all other options had been exhausted.

All local authorities had systems in place for authorising external or out of area placements and most were actively developing systems to monitor the notification of children placed by other local authorities within their borders.

Local authorities had prioritised the need to increase their range of in-house foster carers, but despite concerted efforts and some success, all were struggling to recruit foster carers in sufficient numbers to provide and retain the comprehensive range and choice of placements needed, particularly for those young people with challenging behaviour and with additional needs. A growing difficulty in accessing such placements through independent providers was also reported. This apparent shortage in the foster carer market raises complex socio-economic questions about the way looked after young people are viewed by society, about what it is that incentivises potential foster carers to come forward and about their preparedness to take on children with complex needs.

Messages from fostering service workers

- *"There is a gap in provision for specialist support for children and young people who experience placement breakdowns. It is difficult to find carers to manage challenging behaviour and the high level of emotional needs which have already led to previous disruption for the child".*

In a few local authorities, the stated ambition to maintain the young person in the locality and particularly to maintain the school placement appeared to be the priority rather than meeting the young person's needs. In these circumstances young people were found to experience a significant number of predictable placement breakdowns. It is important that members and officers interrogate placement information and develop a better understanding of what placement moves mean in relation to the child's experience. More attention and debate is needed given some young people's need for the opportunity to experience an emotionally neutral placement i.e. residential care, particularly if they have experienced dysfunctional and/or abusive family relationships together with a series of foster placements. Given the wide range of children's needs and backgrounds, it is evident that residential care will represent the best option for some children; for these children, foster placements as a necessary first resort may not best meet their needs

and can be counterproductive. Where residential placements are used, children and young people need to be in good quality service provision with strong commissioning arrangements in place to assure the quality of the service.

Practice example

- The authority had developed an internal service, the Miskin project to work with young people who are looked after to support placement stability (also to prevent care or facilitate discharge from care). This project also provided a SERAF based service for young people potentially at risk of sexual exploitation. **(Rhondda Cynon Taf)**
- To develop a better range of placement choice and avoid the need for children to move out of area, the authority had re-commissioned their own resources and commissioned specific independent residential providers to create capacity within the authority area. **(Swansea)**
- Children's services had a commissioning strategy in place which outlined a detailed breakdown of the looked after children's population. A holistic approach to addressing the need to support more children to live with their families, balanced with the need to transform services for looked after children, was outlined in the document. **(Vale of Glamorgan)**

'Towards a Stable Life and Brighter Future'

Multi-agency panels to support the requirements of the Stable Lives and Brighter Futures guidance had been established to varying degrees in all local authorities. There was evidence that where they were functioning effectively, they were bringing together assessment intelligence about individual children, enabling a level of quality assurance about the capacity of placements to meet educational, health and social needs and playing a role in addressing drift. Some provided a vehicle for challenge where resources and services were not meeting needs. However, panels functioning at this level were not widespread and in too many cases the effectiveness of the panel was undermined by issues such as attendance, a lack of proactive focus on the quality of placements, or an absence of contingency planning.

Children placed out of area are inherently the most challenging within any looked after children population, but panels rarely looked at new solutions to individual challenges, and children's services were often impotent because they could not direct the right kind of resources to address need. A frequent example of this was where a panel agreed that a young person needed intensive psychological intervention but was unable to agree how this should be provided or who should resource it. In other cases, panels were ineffective in ensuring that children who were receiving support from CAMHS professionals within the health authority area, continued to receive a similar level of support when they moved to another health authority area. Continuing health care arrangements remained ineffective in many cases.

Some concerns were also apparent in relation to education, with examples of children whose educational prospects were good or better having in effect to settle for much lower aspirations when placed out of area. This was often a function of the need to prioritise the

placement's ability to contain or address risky behaviour, often leaving agencies with less scope to stipulate good quality and appropriately ambitious educational programmes when seeking placements. This again related to residential or independent placements often being seen by partners as a placement of last resort rather than the most appropriate placement for a child.

It was often the case that young people became increasingly challenging as they moved through a series of placements, and that the focus inevitably shifted on to the need to stabilise behaviour so that the young person might have at least some opportunity to derive benefit from the placement. This raises the question of whether commissioning arrangements are able to ensure that high cost providers add value to the child's prospects of successful long-term outcomes. Although there were some good examples where this was the case, too many were failing children on one or more dimension of the child's overall needs.

Conclusion

A more sophisticated interagency approach is essential if local authorities are to evaluate the effectiveness of placement and permanency strategies and predict future resource needs. Local authorities and partners are yet to develop a detailed profile of the assessed needs of looked after children and care leavers including their vulnerabilities and associated risks.

Multi-agency arrangements for placement decisions remain ineffective and need to be strengthened to include:

- Decisions routinely informed by a shared comprehensive assessment of the social care, health and educational needs of the child or young person
- A negotiated protocol for sharing payment for placements that have a healthcare component, and the effective use of pooled and aligned budgets for looked after children and young people likely to require highly specialised care placements for a significant period.
- Joint mechanisms to monitor the quality of services for children and young people who have been placed out of the area, including how to support care leavers if they choose to remain out of the area, and how these services are sourced from local providers (including CAMHS and adult mental health services).

Workforce

Most local authorities succeeded in filling vacancies, though there were concerns about maintaining the improved staffing levels and supporting the increased proportion of less experienced staff. These staff were often managing complex cases, which when added to their lack of experience placed significant additional burdens on managers at all levels.

Local authorities all highlighted the challenge of recruitment and retention of experienced social workers and increasingly of team managers and principal officers. There are worrying signs that the challenge of meeting the increasingly complex needs of a growing looked after children population is devolving onto a diminishing base of experienced and well-developed practitioners and managers. If unchecked, this drift away from the profession has potentially serious consequences for local authorities' capacity to meet

their duties to looked after children. It raises significant practice issues, which for looked after children include the difficulty of maintaining good working relationships with social work professionals and management oversight of cases.

The factors most closely associated with retaining experienced social workers are well known. These include: workload, remuneration, positive working conditions and cultures, supervision and professional and career development. All local authorities were giving attention to these issues but this was often in the context of continuing high referral rates and competing financial pressures.

It was positive that all local authorities shared the same ambition to routinely allocate a social worker to every looked after child and also a personal advisor as appropriate. However, this commitment was not always put into practice and some cases were unallocated or allocated to an experienced support worker. In these instances managers acted to maintain a level of oversight, and ensure compliance with (for example) statutory visits but continuity for the child and progress against the plan was often lost.

Inspectors identified considerable variation between and within authorities in the caseloads of staff working with both looked after children and care leavers. Caseloads in some authorities were known to be high. The continuity of arrangements were also often vulnerable to the impact of competing caseload priorities. This was often compounded by gaps in teams particularly where sickness absences and maternity leave positions were uncovered.

Inspectors saw examples, in all local authorities, of some excellent social work interventions and work by support workers which was making a difference and helping to improve the outcomes and life chances of the child. In these cases staff often saw themselves as corporate parents for the child. They had worked hard to form a positive working relationship to ensure the child was listened to and was involved in their own plans. Social workers were often found to be very strong advocates on the child's behalf.

Practice example

- The transition into the 16+ team was managed in a way that minimized the effect of the change in workers on young people. Young people were very positive about these arrangements as they included a significant period of joint working between teams. **(Powys)**
- In order to minimise the disruption to the child, the social worker from the looked after children team co-worked the case prior to its transfer from the family intervention team. This system of double allocation was viewed as supporting opportunities for children to make more sustainable working relationships with social workers. **(Anglesey)**

In contrast, in some cases, social workers and their managers expressed their worry that they did not always know the children well enough at the time they were making important decisions about their lives. It was of concern that even where the social work relationship worked well, too many examples were seen of young people excusing their social worker's inability to keep appointments or be on time because they understood that they had to prioritise other work on their caseload such as going to court or child protection.

Messages from looked after children and care leavers

- *"My social worker is lovely and has helped me a lot. She is always late and sometimes doesn't make it at all. She is so busy and has too many children to see."* (Looked after child)

It was disappointing that in some cases where social workers described a manageable workload, many continued to cite lack of time as impeding their ability to prioritise direct planned work with young people. In a number of examples, specialist teams of unqualified staff undertook and were very skilled at this work.

Many looked after young people and care leavers told us that they were unhappy about the significant number of changes in social workers they had experienced. Social workers were described as mainly being visible during periods of crisis and children and young people wanted positive contact with social workers. This was often characterized as the ability to develop trust in the social worker, particularly in their ability to be the bridge with their family and to keep them informed. A number of young people believed social workers sought to overprotect them from difficult realities. The social worker was valued most as someone able to resolve immediate problems and make decisions.

Conclusion

It would be timely for Welsh Government and local authorities to re-define the social work role. In many examples inspectors identified that the social worker's focus was task driven and measured against compliance with statutory functions such as the attendance at meetings. Opportunities to work alongside the young person, even within this narrow context, were not always recognised as a form of direct work. Important questions need to be asked as to why despite the ongoing focus on the workforce, experienced social workers leave the profession and why social work management is not viewed as a more positive career route.

Messages from looked after children and care leavers:

- *"If ever I need (my social worker) I text her and she rings me back in the morning."* (Looked after child)
- *"She's never given up on me, I'd given up on myself but they (16+ team) never stopped being there."* (Looked after child)
- *"I'm really glad I've had the same worker now for 2 or 3 years, she really knows me and treats me like a person."* (Looked after child)
- *"Why have I had so many social workers - 6; I keep having to repeat myself… it gets confused; I feel like they have all listened to me though."* (Looked after child)
- *"First time I met my new social worker he told me I was moving placement and I had to go with him … it's worked out OK but that's not a good way to get to know someone."* (Looked after child)
- *"Social workers just do the business. I don't think it is their fault. It's the job."* (Looked after child)

Supervision

Most social workers and managers expressed confidence that they had access to policies, protocols and procedures, relevant training, accessible advice and support from managers and regular formal and informal supervision.

Supervision protocols were in place and staff were mainly positive about the supervision they received. However, the written supervision records seen by inspectors were of mixed quality and often focused overly on immediate issues rather then the management of the overall plan. Despite staff reporting that supervision included constructive challenge and the opportunity for contingency planning, this was not well recorded and there was limited evidence that time was given to reflective practice.

The guidance relating to social workers'[9] first and second year of practice was generally well established and viewed positively. Inspectors saw some good examples where additional mentoring, group learning and peer support opportunities were provided to help develop confidence in practice. However, the level of caseload protection and designated time to take up these supports was variable. In some instances, staff needed to be more rigorous in prioritising their own time to make use of the training provided.

Practice example

The arrangements for supervising staff consisted of a practice leader supporting a low number of social workers as a unit so that case discussion and direction was more accessible. There was a focus on reducing bureaucracy and promoting direct work with service users. Social workers and practice leaders were positive about this model of working. **(Denbighshire)**

Safeguarding Children Boards

Local Safeguarding Children Boards (LSCBs) had actively progressed the move from a local authority footprint to a public service delivery model of six Safeguarding Children Boards (SCBs) and are each at very different stages in their development.

The onus for leading the SCB remained with children services and a director of social services chaired all regional boards. However, not every director of social services is a board member in their respective region, representation is being delegated. This meant that the Director of Social Services did not always have the same visible presence on the SCBs. Local authorities will need to assure themselves that the SCBs reporting arrangements support the statutory director of social services to deliver against their statutory safeguarding accountabilities.

SCBs had developed sub group arrangements and some included the equivalent of an operational board at local authority level, as a means of identifying local issues and practice priorities. In some areas the interface between these arrangements was not well understood and the standing afforded to the sub groups,particularly the local groups, by partners was mixed. SCBs will need to review their governance arrangements, as they evolve, to prevent duplication or gaps in safeguarding activity.

[9] Making the most of the first year in practice: a guide for newly qualified social workers (Care Council Wales 2008).

Some SCBs, particularly those with high numbers of independent providers in their region, had developed sub groups with a focus on looked after children. A number of social services and health partners maintained a database of all looked after children placed by other authorities, and some proactive work was being taken forward with independent providers aimed at strengthening the system for notification of children placed within Wales across authority boundaries.

LSCBs and Safeguarding Children Boards had been active in embedding protocols and training aimed at improving the identification and management of child sexual exploitation, child trafficking and children who go missing. Some SCBs had streamlined these into a "risky behaviours" protocol. A number of SCBs had also developed sub groups to focus on practice in these areas. This activity although not specific to looked after children had acted to reinforce them as a SCB priority. Safeguarding Children Boards will want to evaluate themselves against the recommendations from the independent enquiry reports arising from recent high profile cases, for example, the Jay report[10].

Conclusion

Safeguarding children boards need to strengthen the systems in place to gather, share and analyse, multi agency information in respect of concerns about the welfare of looked after children, including those placed outside their home local authority boundary.

Whilst SCBs undertook case audits that included looked after children as part of the sample, there was little evidence that work was systematically undertaken by the boards to assure themselves regarding the quality of safeguarding practice, in relation to looked after children and care leavers, or to learn from service users' experience.

Agencies and SCBs were found to be responding in policy terms to the changing or newly emergent issues that potentially expose looked after children to risk. However, there is a danger that as each of these developments prompts a separate new strategy, policy or procedure, the fundamental focus on child protection becomes blurred in the complexity of overlapping protocols.

Practice examples

- The Western Bay Safeguarding Children Board had acted to audit agencies' compliance and practice in relation to child sexual exploitation. The analysis of this work was then to inform the board's future work plan.
- The business plan for the Safeguarding Children Board in Powys had acted to prioritise such vulnerable groups of children and young people as those placed in Powys by other authorities. This had been identified as a particular issue given the higher number of these placements in comparison to the local authority's own looked after population.

[10] Independent enquiry into Child Sexual Exploitation in Rotherham (1997 to 2013) published 2014.

- The Cwm Taff Children's Safeguarding Board had reviewed and developed a range of joint protocols/policies to streamline these into a Risky Behaviours Protocol. They had also established a risky behaviour task and finish group that were developing multi-agency risk assessments and plans.
- The Cardiff and Vale of Glamorgan Safeguarding Children Board had revised the risk assessment and management tool and there has been a focus on implementing protocols in respect of child sexual exploitation. The board also regularly reviewed progress in respect of a thematic inspection of arrangements for managing young people who display sexually harmful behaviour.

Theme 2: Assessment and care planning

The inspection considered how care and pathway planning was informed by relevant assessments, including risk assessments, which supported a comprehensive response to the needs and experiences of children and young people.

The inspection focused on current practice, and as most of the cases reviewed involved children and young people who had been in the looked after system for some time, this report does not consider the timeliness of the initial decision to accommodate the child in detail. However, examples were seen of young people who had been left too long without an effective service before they became looked after. Inspectors found no evidence of children entering the care system unnecessarily.

Issues Identified

Referrals

Referral and operational information sharing arrangements within and between professionals were well embedded in most local authorities. These arrangements acted to ensure that where concerns were identified in respect of children, including looked after children and care leavers, referral responsibilities and contact points were known and information was passed to the appropriate social services professional.

Assessment

Looked after children guidance sets out clear expectations that *'when a child or young person becomes looked after, an up-to-date core assessment is required and is used to inform his or her first care plan'*. The remit of this inspection meant that inspectors only reviewed a small number of cases where the child or young person was a recent entrant into the looked after system. While all these cases had a core assessment, the quality was inconsistent, and there was a lack of professional analysis needed to inform care planning. Core assessments did not appear to be consistently shared with partners or service users.

Most social workers and their managers had a good immediate understanding of the young people they worked with, including knowledge of presenting vulnerabilities and risky behaviours. However, there was often significant over-reliance on informal information sharing between the workers involved with the case, and pertinent information was not always clearly recorded in the case file.

Inspectors identified that despite the significant changes in the circumstances of some children and also changes in social worker, the care plans of those young people who remain looked after for longer periods were rarely informed by a relevant shared assessment and analysis of need. Initial pathway plans were also not routinely underpinned by a good quality assessment.

Some good examples of holistic assessments and analysis were seen. The best of these were often instigated and undertaken by the external placement providers to direct their work, rather than being provided or commissioned by the placing local authority. In some examples, the lack of updated information directly impacted on the placement's understanding of the child's needs.

Case recording, although recognised as a priority, was found to be of variable quality and timeliness was said to be subject to work pressures. The case recording seen was often descriptive and practically focused rather then evaluative. In some instances, the quality of recording meant that the overview of the child's progress in care was fragmented and there was a potential for information relevant to the safeguarding and protection of the child to be lost or overlooked.

Conclusion

While assessments should not be over-intrusive, repeated unnecessarily or continued without any clear purpose or outcome, they should be recognised as a valuable tool for supporting reflective practice and key decision-making. This is particularly relevant where the child or young person has experienced significant changes and events including a change in social worker.

Risk assessments and risk management

Inspectors identified the vulnerability of looked after children and care leavers was well understood by staff, and considerable work had been undertaken to heighten awareness in relation to the identification and management of risk factors. Local authorities and agencies had developed a range of procedures and service functions that all included the requirement to undertake and update risk assessments.

Case examples

Case examples were seen across Wales that demonstrated partners working well together to provide a good and safe service with clear outcomes for the young person. The case examples were often extremely complex and presented ongoing difficulties as the young people involved frequently stepped outside the boundaries of safe management. Despite this, professionals worked to help the individuals involved to make informed choices. These case examples also demonstrated the need for staff and carers to be resilient, as issues often occurred concurrently and new issues emerged at any time.

Risk assessments are complex and were found to be understood as a means of delivering assurance against a number of interrelated expectations, including:

- Keeping young people safe.
- Improving outcomes.
- Evidencing defensible decisions in a risk adverse operational environment.
- Supporting collaboration and inter-agency working.
- Informing and improving commissioning.

Professionals often described aspects of risk assessment and risk management activity as a positive means of promoting confidence and legitimising their actions. However, in contrast, young people and their families often experienced risk assessment more as a means of defending decisions and restricting their activity.

Although inspectors saw some good risk assessments, the quality was variable. Some assessments were overly formulaic and lacked the necessary detail, while others were so detailed that issues became obscured. Often, the young person's presenting behaviours were not well understood in the context of their recent experiences, such as a foster placement breakdown. In a small number of cases, the poor recognition of the risks and lack of prompt remedial support directly contributed to the breakdown of the placement and the young person's escalating engagement in risky behaviours. The focus on the child was at times lost in the plethora of risk assessment processes.

Risk assessments were often found to be:

- Understood as a series of discreet processes rather than being integral to the management and reduction of risk.
- Not underpinned by a common language or a shared understanding of risk and shared between professionals within and across agencies.
- Focused on responses rather than positive outcomes and on targeting services rather than needs.
- Based on insufficiently updated information and analysis that maintained a focus on the outcome and the safeguarding consequences for the child.
- Not sufficiently engaged with the young person or their family to promote their active involvement.
- Accompanied by additional bureaucratic demands reflecting the different processes.

Some local authorities had invested in whole service training programs in relation to a particular risk framework. These models included a range of tools to help support a more structured approach to the detailed assessment and management of risk. Training in these frameworks needs to be continually updated and consolidated to ensure that staff are skilled and confident in its application. It was disappointing that despite significant investment by children's social services in such frameworks, partner agencies were often not aware of these models and had not been trained in them.

Risk management

The best examples of the use of risk assessments were when they were translated into risk management plans that were shared and owned by professionals, carers and importantly the young person. These plans were focused and set out the action required, by whom, in what timescale and in what circumstances. Evidence was seen that such plans were reviewed to reflect changes in circumstances and to consider the extent to which identified risk had been mitigated. In less effective examples, the risk management plans were generic, did not include the information needed to support the required response to need, and were not shared or available to other professionals including the police and emergency duty teams. These plans often fell into disuse with little analysis of their impact and were only considered again at the point of crisis.

The inspection identified that although they were subject of a plan to manage identified risks, young people were often not aware of nor had contributed to the plan. Where they had been involved, they did not always share the view that their presenting behaviour was "risky" or that it differed from that of their peers. In some examples, young people described the restrictions imposed on them by such risk management processes as an "over-reaction". Any protective action will be ineffective if the young person does not understand (for example) the concerns associated with them going missing or related to potential exploitation.

Despite some good work, inspectors found social workers were often not confident in their skills in working with young people who are hard to engage. In some instances, there appeared considerable over-dependence on the carer to deliver the detail of the plan and provide the emotional support to the young person. Inspectors saw some determined work being undertaken by very committed and dedicated carers often during unsociable hours. The range of support available to carers across Wales, including that provided by other agencies such as the police and health at crisis points, was found to be very patchy and this significantly impacted on placement stability and carers' willingness to sustain the placement.

Individual agencies often maintained their own elements of the risk management plan and there was significant reliance on informal communication links with the social worker to capture and communicate progress between the professionals. In some instances, the quality of recording as well as changes in staff and placements made it difficult to determine if all the identified risk issues had been resolved. This can have significant implications for young people particularly (for example) where the risks relate to the child or young person's abusive behaviour towards others.

Few risk management plans ensured a clear focus on the implications for the child should the plan not deliver, and did not include or inform effective contingency planning. This often resulted in young people being moved in a crisis. Planning in these circumstances was frequently resource-led rather then needs-led resulting in both the young person and the social worker feeling "out of control".

It is important that risk assessments and risk assessment matrices are not seen as an end in themselves and are understood as a means of informing professional judgment. The application of risk assessment tools was not always well understood in relation to looked after children and it is important that social workers and other professionals

have the skills, experience and the confidence to undertake this work. Relevant risk assessment training specific to adolescents would improve consistency in this area.

Conclusion

Overall the systems used by authorities did not routinely ensure that risk management plans were aligned and reflected within the care plan and the pathway plan. In the good examples seen, risk was re–evaluated as part of the planning and review process.

Practice examples

A number of children's social 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. **(Conwy)**
- A risk model that provided staff with a risk assessment framework. The suite of tools included a means of routinely screening cases, to inform decision-making, also a structured approach to the assessment of risk of significant harm. **(Gwynedd and Isle of Anglesey)**
- The Signs of Safety model and tools designed to help conduct risk assessments and produce action plans for increasing safety, and to reduce risk and danger by identifying areas that need change while focusing on strengths, resources and networks. **(Swansea)**

Care plans

There is only one care plan and this should contain information about how the child's current and longer-term needs will be met to ensure that everyone is working to achieve an agreed permanence plan and improved outcomes for the child.

In the cases reviewed, most children and young people had a care plan but these often failed to reflect ambition, as described by members and officers. The care plan format itself did not always support a focus on the objectives of the plan, or how the desired outcomes for the young person were to be achieved. Most plans contained either very broad overarching statements or identified short-term task-focused actions. The format was often not 'child friendly' and it was apparent that they were not consistently shared with young people and/or their families. Many young people told us they were either not aware they had a plan or if they had seen it they didn't really view it as having any relevance. The significance of the care plan was not well appreciated by staff as the means of shaping the service for the child; rather, there was a risk that completing the care plan template was seen as yet another bureaucratic requirement.

This was disappointing as the quality of the care plan frequently did not capture the positive intervention and support being provided by the workers involved, or identify the positive and discernable difference that was being made to the child's life, often despite the limited resources available.

Case example

The young person interviewed showed ownership of plan and said that she enjoyed participating in reviews; she was confident her voice was heard and gave examples of this. The young person described her journey and how she had had multiple placements but how the commitment of the staff had helped her. She had ambition for the future and was hoping to go on to higher education. **(Looked after child)**

Most care plans seen identified practical details such as contact arrangements with the extended family. Few plans reflected the ongoing work needed with the family to help them meet the child's needs during contact, or reflected on the changing significance of the family as a possible source of support for the young person, as they moved towards leaving care and independence.

Partner agencies generally understood planning and review expectations, but there was little evidence that the care plan was routinely shared with them. Rather, the plan was mainly understood in terms of what was reported during the statutory review and through informal communication with the social worker. Partner agencies' contribution to the plan was not always specified.

In most cases, although the views of looked after children and young people and their parents were sought, they were poorly reflected within the plan. In one example the care plan recorded the aspiration that the young person would remain in placement until 18, when in fact the young person had clearly stated their intention to leave care before then.

Conclusion

Inspectors confirmed many of the conclusions of the 2008-2009 CSSIW National Review of Independent Reviewing Officers Services,[11] including that:

> *"the quality of care plans for looked after children across Wales generally needs improvement. Inspectors identified three areas in particular which need to be improved. These were:*
>
> - *clear child-focused outcomes and actions to support these*
> - *a clear relationship between the assessment and the care plan for the child*
> - *timely updating of care plans to reflect changes in a child's circumstances."*

Care plans are only effective as the outcomes they achieve for looked after children and care leavers. The significance of the care plan should be the clarity it brings to how the services provided and the actions undertaken deliver improved outcomes for the child. This transparency should then support the review process to monitor the progress made.

[11] 2008-2009 CSSIW National Review of Independent Reviewing Officers Services.

Case example

The views of the young person and his mother had been carefully considered and although the current arrangements didn't reflect either of their wishes, there were good safeguarding reasons for this (mother's mental health), which have been articulated in the documents. Views of family were heard and taken account of - consideration had been given to retaining family links and ensuring that contact took place with family, despite not being safe for him to return home. The local authority had been sensitive to the importance of the child's Welsh cultural identity when making placement decisions. **(Looked after child)**

Health Assessment and Planning

All local authorities had arrangements in place to ensure that the primary health needs of looked after children were met, although these arrangements were often less secure in relation to care leavers.

The arrangements local authorities had in place to deliver the specialist health service for looked after children differed. These arrangements appeared to be working best where, for example, the looked after children's nurse specialist was embedded within children's services or a specialist multi agency looked after team, and viewed as an integral part of the looked after children system.

Inspectors saw some very committed proactive work being undertaken by staff with children, young people and their carers. The young people and carers reported that they valued the support they received from the looked after nurse and could describe interventions provided by the service including advice about diet, healthy eating and sexual health. The use of school nurses to undertake health assessments, for older looked after children, was seen as a means of improving ease of access, to health advice and lessening young people's anxieties about being identified as 'different'.

The timeliness and quality of health assessments, as well as the level of engagement of young people in prioritising their own health needs, remained variable. In some cases, even when assessments had been undertaken, relevant health information was not always available to the review and was not translated into a plan. In some local authorities the lack of capacity of the health worker as well as the absence of an accessible secure email system had impacted on this information exchange.

The health arrangements for care leavers were not as well embedded and there was evidence that young people left care with only a limited understanding of their health history. Information may be provided appropriately, but can easily become "lost" to the young person due to the changes in their circumstances. The availability of flexible health advice and services including those needed to meet the mental health needs of young people remains a significant issue across Wales.

In most of the cases reviewed, the biggest gap in services identified by inspectors and highlighted by all staff, including specialist health staff, was the limited availability of resources to meet the emotional mental health and wellbeing needs of children on the edge of care, looked after children and care leavers. Despite the shortfall in these services being highlighted over a number of years and identified as blighting the life chances of vulnerable young people, these concerns remain largely unresolved.

Messages from Social Workers

- *"Many of our care leavers have deep seated emotional problems which in adults would be described as mental health problems. They need specialist and skilled help – they have had some really bad experiences which they have to carry round with them for years."*
- *"CAMHS does not work with vulnerable looked after children .You have to work hard to get a therapeutic service for a young person. If there is a diagnosed mental illness the CAMHS service is inflexible, wanting appointments during school time and it means hours of travel for the young person to get to the appointment."*
- *"I refused to leave the young person's placement until someone from CAMHS finally agreed to come out to see her… even then it was like they were doing me a favour … it just shouldn't be that hard for young people to get a service."*

It was positive that most children's social services were taking positive and proactive steps to realign current services to establish a level of in-house therapeutic provision. However these changes were often very recent and service availability was limited and mainly targeted at those young people at risk of placement disruption.

Inspectors also saw some very committed work by individuals within health, but found that the employing health services did not give sufficient priority to the emotional and mental health needs of children in care and care leavers. This resulted in the burden of responsibility being continually placed on local authority children's social services.

The disconnect between the access threshold applied by the Child and Adolescent Mental Health Services (CAMHS) and the presenting emotional resilience needs of looked after children and care leavers remained an outstanding issue. Inspectors identified a number of cases where the delay in accessing services to meet the young person's emotional needs directly contributed to the instability of the placement and the escalation of the individual's own risky behaviour.

There remained an unrealistic expectation that a relatively small, mainly inexperienced children's social services workforce can adequately deliver the range of skilled interventions needed to meet the remedial psychological needs of a growing child in need and looked after children and care leaver population.

Conclusion

The issue of looked after children and care leavers' rights to an appropriate range of provision to meet their psychological and emotional health needs, when they need it and for as long as they require it, including the transition into adulthood, now needs to be urgently addressed on an all Wales basis.

Practice examples

- Multi Intervention Service Torfaen (MIST) project run by Action for Children provides a long term therapeutic service, for children with traumatic experiences, jointly funded by health, education and social services. MIST provides a joint funded CAHMS service for children aged eight and over. The service is well used and weekly updates are provided to social workers on the work being undertaken. The MIST project also supports staff and foster carers, who they train and provide a 24-hour on call service. **(Torfaen)**

  "I've changed loads, they were amazing, they helped me through very dark times." **(Care leaver)**

- A number of children's social services had been proactive in trying to compensate for the shortfall in the availability of therapeutic services by establishing and funding in-house therapeutic provision that included (for example) access to psychologists and play therapy. **(Newport, Gwynedd, Carmarthenshire)**
- The local authority had developed support services to help young people who had experienced loss and uncertainty. The service then moved young people on by mentoring and working to maximise their potential. **(Flintshire)**
- In the local authority the CAMHS team have developed a training DVD for schools to support children and young people with emotional problems, which they were also rolling out to social workers. **(Pembrokeshire)**

Education and the personal education plan

Inspectors found considerable variation in the timely completion and quality of the personal education plan. The more effective personal education plans included the views of the child and their family (as appropriate), academic targets for the young person and the action needed to support improvement against the potential of the child. The less effective personal education plans tended to focus more on behaviour management and attendance and were not sufficiently ambitious for children and young people. Many local authorities recognised the need to improve the format of their personal education plans in order to better engage with young people.

Inspectors found that the personal education plan was often viewed by staff as having limited value, and the more significant driver for change was the effectiveness and ambition for looked after children promoted by the Looked after Children's Education Service (LACES) team.

Where the LACES arrangements worked well, staff were proactive in identifying the young person's education needs and securing the additional help they required. These professionals also had a key role in directly negotiating and resolving issues within schools and colleges.

Inspectors saw some good attention being given to the emotional well-being of children when they moved between schools. There was a greater emphasis on the provision of computers, additional tuition, and mentoring for looked after children but this was too often linked to those children predicted to do well academically.

Young care leavers with aspirations to go to university or who had clear vocational ambitions were often well supported. However, those young people with less clear ambition did not always receive the encouragement they needed to remain in education or support to take up employment. There was strong evidence that young people at risk of not being in education, employment or training were being monitored and receiving greater attention.

Conclusion

Despite some good operational relationships with schools and colleges, the case examples seen highlighted the difficulty young people experience in their engagement with formal education, particularly when they want to be independent and leave their placement at 16. The support provided to enable achievement, in addition to being too heavily focused on academic attainment, often gives too little attention to the importance of providing "second chance" opportunities to support looked after children and care leavers who 'fail' in conventional terms. This is reflected in the attitude of too many schools.

Practice example

- A DVD had been produced by looked after children and young people to provide foster carers and social workers with their views on promoting attainment in education. The authority seeks to ensure that personal education plans are meaningful and they are updated to capture and reflect the young person's ability. **(Conwy)**

Pathway plans

The pathway plan, which includes the care plan, is prepared for an eligible child (who is still a looked after child) when they are 16, in order to prepare a young person for the transition to adulthood. Most care leavers had a pathway plan and unlike the care plan, young people were often more aware of these plans and understood their relevance in relation to shaping the services they received. The practical focus of pathway plans was described as being more "helpful" than the care plan.

In the best example of pathway plans, the young person's contribution was explicit. The pathway plan clearly stated the desired outcomes, how they were to be achieved, timescales and contingency arrangements. In some positive examples, plans were in place for children to stay with their foster carers beyond 18 and they had good information regarding their ongoing entitlements. In less positive examples, some young people didn't know where they would live once they left care or what resources or services would be available to help them. Most young people interviewed raised issues regarding the speed of consent and inconsistent funding decisions, but also recognised the need for decisions to be made that reflected their individual circumstances.

Inspectors identified that some confusion remained for staff and more significantly for young people regarding the relationship between the care plan and the pathway plan prior to the young person turning 18. Young people also expressed confusion in the respective roles of the social worker and the personal advisor.

Arrangements for the allocation of personal advisors for looked after children aged 16 to 18 were inconsistent across Wales. In some instances the personal advisors for over 18's had not been involved in developing pathway plans for the young people they were about to start working with. There was also little evidence that social workers from adult services attended the pathway plan review meetings for care leavers likely to be transitioning into adult service.

Some continuity was provided where the independent reviewing officer (IRO) continued to chair the pathway plan reviews, but many young people indicated that they preferred the pathway planning process to be more informal.

In some of the cases reviewed, safeguarding issues that had been managed as part of the care plan remained unresolved at the point the young person was leaving care. Local authorities need to be more vigilant in ensuring matters are addressed in a timely way through the direct work undertaken with the young person and their family.

These issues included:

- support for vulnerable young people placed away from the local authority who did not want to return to the area;
- lack of exploration of the risks for the individual resulting from their potential reunification or loss of ongoing contact with the birth family;
- known but unresolved issues resulting from the young person's own "risky behaviours" and vulnerability.

Practice Example

- Pathway plans had been revised in consultation with care leavers, resulting in a format that was well designed and promoted good engagement with young people. **(Powys and Pembrokeshire)**
- Local authorities had developed or were developing a preparation for independence checklist. This aimed to track young people's progress towards independence and ensure they had been equipped with the essential skills necessary for independent living. **(Gwent local authorities)**
- Every care leaver is issued with a document detailing all the financial aspects of their entitlement to support, as well as how to access other sources of support, for example, attending further and higher education courses; benefit entitlements whilst in education and advice on those colleges and universities that offer financial; and other support specific to young people leaving the care system. **(Swansea)**
- The local authority had developed a creative scheme to support young people's budget management. **(Blaenau Gwent)**

The role of the personal advisor

The configuration and resilience of the leaving care arrangements differed across Wales. There were examples where local authorities had or were developing specialist teams for young people post-16 as a means of ensuring a better-planned transition to independence.

Others had or were developing specialist teams for young people post-16 as a means of ensuring a better-planned transition to independence. In a few areas, these arrangements included 'drop in' facilities where young people could access support from a social worker, personal advisor and youth worker as well as housing, employment, health and substance misuse advice. However, this type of positive wrap-around approach was unusual and for most local authorities mainly aspirational.

Practice examples

- The authority had expanded the multi agency nature of its specialist post-16 supports and the 'Just Ask Plus' service included a drop in centre that provided access to personal advisors, youth workers, employment, health, and substance misuse advice. Case responsibility for looked after children transferred to this service when the young person reached 16 years old. **(Bridgend)**

All young people had a personal advisor in line with guidance, but some personal advisors managed significant caseloads. The quality of the content of the pathway plan often reflected the expertise and confidence of the personal advisor, particularly regarding the young person's entitlements. Where they had a good level of experience and knowledge of services, inspectors saw evidence of them being able to advocate strongly on behalf of the young person.

There is no prescribed professional or occupational qualification determining which professional should carry out the personal advisor function. Care leavers were often much more positive about the support they received from their personal advisors than from their social worker. This has to be viewed in the context of the different responsibilities of the roles and also the young person's ability to exert greater control of their lives, as they become older.

All care leavers are entitled to support but cannot be compelled to accept offers of support. This makes the personal advisor role all the more significant as it is often their ability to work alongside the young person that determines the level of ongoing engagement. The value placed on the personal advisor arrangements by young people was often associated with:

- the opportunity to work with someone who they saw as a support rather than an authority figure;
- availability of the personal advisor, at a time of change when many agencies and services were disengaging from them;
- the young person feeling ready to accept and more able to use the support offered;
- the flexibility and responsiveness of personal advisors.

Young people also appreciated the personal advisor's use of technology and social media as a means of maintaining contact.

Despite some very positive approaches to pathway planning, most young people described feeling unprepared for independence. Some believed that independence was raised at a time when they knew they didn't want to be in care, but when they equally didn't realise that they were not emotionally ready for independence.

Conclusion

Most looked after children currently move to live independently as soon as they reach 18, but they are often not equipped with the practical and social skills necessary to manage independent life and need considerable support. The level of training and preparation to develop the skills for independent living were often found to be underdeveloped and put in place on an ad hoc basis. A more co-ordinated approach is needed across Wales to improve outcomes for care leavers.

Messages from looked after children and care leavers:

- *"My personal advisor is brilliant and really helping me to sort out my move to college, and she is prepared to do all sorts of stuff. She has come with me for interviews and that she is so supportive gave me confidence."* **(Care leaver)**
- *"Personal advisors always seem to be there for you. They never give up on you and go the extra mile. They actually do care about what happens to you."* **(Care leaver)**
- *"Personal advisors are just interested in you as a person. They really want to help you and it's easy to talk to them!"* **(Care leaver)**
- *"My personal advisor is great but they can't make the decisions I need and they have to wait for answers the same as I do."* **(Care leaver)**

Theme 3: Safeguarding

The inspection considered the operational systems and procedures in place to ensure that responsive coordinated action was taken to mitigate risk and achieve safe continuity of care.

Issues identified

Child protection and safeguarding mechanisms

The inspection confirmed that practitioners, professionals and organisations across Wales are striving to safeguard and protect looked after children and care leavers. There was clearly a heightened awareness and response amongst everyone involved regarding the vulnerability of this group of children and young people and a greater awareness of the complexity of the task.

Managers had some well-developed information systems to support oversight of compliance in respect of statutory child protection procedures, but these often did not differentiate and so could not be interrogated regarding the looked after status of the child.

Whilst local authorities has adopted different organisational structures to manage child protection work, child protection processes were mainly being used appropriately to manage concerns about the welfare or safety of children looked after and care leavers.

However, the inspection highlighted differences in practice regarding:

- the approach taken in relation to managing emerging risks;
- the status, use and timing of multi agency planning meetings rather than strategy meetings to determine action;

- processes used where the child's looked after status meant there was no reason to hold a child protection conference, but an ongoing multi-agency approach was required to address risk.

The risk management pathway for looked after young people and care leavers exhibiting 'risky' behaviours therefore would benefit from greater clarity.

Safeguarding children in a range of specific circumstances

All agencies were found to be working proactively together in relation to child sexual exploitation and children who go missing from placement. Police forces across Wales were reported as having strengthened their focus on these issues and a number of specialist services were highlighted as supporting a more co-ordinated approach within authorities.

Sexual Exploitation Risk Assessment Framework (SERAF)

The SERAF process was well embedded as an assessment tool across Wales. Significant training had been provided on the use of this framework and the approach was found to have a good multi agency profile. In some examples the use of the SERAF had informed some positive protective action and direct work with the young person. The inspection also highlighted some positive prevention work being undertaken with placements and establishments to support safe care.

However, in other examples it was difficult to identify from the file or elicit from staff what the direct work involved, and what apart from a change of placement had "worked well" in reducing risks. This information was also often poorly reflected in the subsequent review discussion and in the updated care plan.

Looked after children who run away or go missing from their care placement

The inspection identified heightened priority given to children and young people who go missing from care, including children in care placed by other local authorities. Young people can go missing or absent themselves from placement for a number of reasons and can also be encouraged and adversely influenced in this behaviour by their peers and their family networks.

Good multi-agency work was seen aimed at ensuring that the individual circumstances of children who were missing, or had been missing, were considered in a timely sensitive way, in some examples on a daily basis. Evidence was also seen of direct work being undertaken with the young person on their return, particularly by foster carers, to reduce the escalation of such behaviours and support young people in developing their own keep safe strategies.

Local authorities and police forces applied the definition of "absent without consent" and "absconding" differently, but the cases reviewed reflected that the looked after status of the child immediately heightened the level of social services' and police response.

There appeared to be a good working relationship with the police and most local authorities convened strategy meetings as needed. Evidence was also seen that the police consider prosecution in respect of those harbouring young people if needed.

The operational relationships between children's social services and the police public protection units were mainly positive; this was often attributed to improving communication and trust between services resulting from a greater stability in the children's social services workforce.

Some inconsistency in approach and attitude towards young people was identified in the response of local police services. This often reflected issues regarding the availability of information, particularly where the child was placed outside their home authority. In some cases where repeat "missing" incidents were reported, there was a frustration in the perceived lack of progress made in managing the behaviour, and in these circumstances the placement became viewed negatively and not meeting the needs of the young person. Frequent examples were seen where young people used the police as a safe means of brokering a return back to their placement after being out late. Whilst this safeguarded the child, it was also a source of tension for the police.

The police reported that they routinely undertook return to placement interviews with the young person and that incidents could not be closed until this was completed. However, there was limited evidence that relevant information was then routinely shared with social services. In most cases social workers told us that they also undertook a similar activity. A number of forces had introduced or had firm plans in place for an independent voluntary sector service to conduct these visits in the future and to engage with social services in relation to any identified need.

In some instances young people told us they used going missing from placement as a means of forcing the end of a placement, or as a means of exerting control, wanting "something else" but not always knowing what it was.

Messages from extended family

"The court took my grandson from me because they said he wasn't safe, but social services can't stop him running away and putting himself at risk." (Grandmother of a looked after child)

In a number of cases, despite some extensive work, the escalation of 'missing' episodes and the associated risks led to the disruption of the local placement. The need for a robust response often resulted in an out-of-authority residential placement being identified in a crisis. In a number of examples, moving away from the home area, despite its own built-in risk, did help children to stay safe.

In a small number of cases due to the level of concern, the local authority acted appropriately to apply for a secure order. In these instances the young person was regretfully deprived of their liberty as the only means of keeping them safe. In some of these cases the significant issue was then how to identify a safe 'follow on' placement and end the secure arrangement in a timely way when, often, very little appeared to have changed for the child.

The successful management of risks associated with being missing from placement cannot be understood only in terms of how well professionals adhere to a protocol. The impact of any intervention was often determined by the young person's perception

of the need for any protective action, and how far they were able to accept any intervention in the face of competing social pressures.

The essential factors that seem to make a difference in managing these issues included: the quality of the assessment; the skill of staff in helping children with such complex needs; but often more importantly the resilience and quality of the young person's relationship with their carers.

Practice example

- Gwent-wide Missing Persons Project is a multi agency safeguarding hub, operated by the police, and focusing on missing children including looked after children.

  The missing person's project ensures strategy meetings are held where the overall risk is assessed in the light of the child's circumstances, not just their presenting behaviour. The arrangements included a shared risk assessment, which was available to workers online and could be updated easily to reflect a young person's situation and levels of risk. The service was undergoing evaluation at the time of the inspection having been in place since April 2013. **(Gwent local authorities)**

- Given the geographical challenges of working across Powys, children's services had developed good communication networks across the local authority. This included partner agencies and an ability to update and send out alerts in relation to any young person considered to be at risk. Dyfed Powys Police and the Safeguarding Children's Board were actively introducing a 'Vulnerable Children Living Away from Home' (Missing – Pre-Placement Risk Assessment) **(Powys)**

- Arrangements had been strengthened across the North Wales Safeguarding Children Board area by the police appointment of missing persons co-ordinators. Funding was also in place for additional workers who would de-brief young people who went missing to improve information about risk. **(North Wales local authorities)**

Sexually harmful behaviour

Child protection processes were found to be well understood in relation to children involved in sexually harmful behaviour. The framework for managing these issues was included as part of core child protection training.

However, the complexity of the issues is significant and there are only limited specialist resources available to meet the assessment and therapeutic needs of the children and young people involved in these behaviours. These were often commissioned on a spot purchase basis, although some authorities were working to develop more in-house expertise.

The concern must be that young people often disengage from these services initially and issues, although managed, remain unresolved. There needs to be greater clarity regarding any outstanding risk and the ongoing opportunity for the young person to access appropriate services.

Conclusion

Although statutory child protection procedures and thresholds were generally well understood, greater clarity was needed regarding the relationship between child protection, risk management and care planning processes, particularly for looked after children and care leavers exhibiting 'risky' behaviour. Staff themselves indicated that they would welcome the development of a mechanism such as multi-agency risk conference, which would be a means to ensure effective coordinated actions reduce risk.

Practice examples

Examples were seen where:

- The local authority had invested and piloted its own multi agency backed therapeutic service for sexually harmful behaviour. **(Carmarthenshire)**
- The local authority had acted to develop a service for children and young people who display sexually harmful and inappropriate behaviour. **(Conwy)**
- Plans were in place to establish a 'virtual' team across North Wales, specifically for the assessment of young people exhibiting sexually harmful behaviour. **(North Wales)**

Theme 4: Reviews

The inspection considered how reviews helped to promote safe care and best outcomes for young people.

Reviews

Reviews are a statutory requirement and the mechanism whereby the local authority ensures at regular intervals that they are meeting their obligations to care and plan for a looked after child. They also provide an opportunity for the voice of the child to be heard independently of the social worker's involvement, and for that voice to influence the care plan. The expectation is that the decisions agreed between the attendees at the review, based on updated information, professional judgment and in discussion with the child, carer and family, should be progressed and reflected in the updated care plan.

Issues identified

The independent reviewing service

Local authorities' independent reviewing services were found to be compliant with guidance and all had independent reviewing officer (IRO) arrangements in place that were able to maintain independence from operational services. The level of experience of staff in this role was often more variable. There was good evidence of the commitment of local authorities to ensure continuity of IROs for individual children and young people.

In some local authorities, despite small numbers of looked after children, caseloads were challenging because the IRO service was invested in one person. In other examples the service was under pressure because IRO teams struggled to keep pace with the growing

numbers of looked after children. This was exacerbated by the number requiring additional reviews due to an unplanned change in circumstances and those reviews needing additional time because the child was placed out of authority.

The inspection found that the role of the IRO was generally well understood in relation to:

- chairing statutory reviews, ensuring a focus on the individual needs of the child;
- ensuring that plans take full account of the child's wishes and feelings;
- ensuring the child has timely access to independent advocacy;
- supporting improved care planning and decision-making to prevent unnecessary drift.

There were significant differences identified across Wales regarding the contribution of the independent reviewing service to the local authority's corporate parenting role and responsibility. Some examples were seen where the IRO team were represented on the corporate parenting board and most provided routine written and verbal reports. In the best examples, the IRO was able to provide an insight into the impact decisions had for children.

In some local authorities, the IRO met on a regular basis with the statutory director of social services or the head of children's services. This was to support chief officer line of sight on practice and provide a discussion platform regarding the quality of care planning and review practice. It was disappointing that despite these positive mechanisms, the Independent Reviewing Officers still often did not perceive themselves as having a significant profile or sufficient authority to exert influence.

Quality assurance of services for children

The IRO was generally viewed by senior officers as being a crucial part of local authorities' accountability mechanisms for ensuring that children in care receive a positive service. Some local authorities had or were creating safeguarding and quality assurance teams that included the IRO and reinforced the contribution their role made to this agenda.

Despite some positive exceptions, inspectors concluded that quality assurance arrangements in most authorities remained under-developed. IRO reports seen by inspectors were often focused on practice compliance rather than on outcomes.

Some proactive work was being undertaken between the IRO and operational teams, to improve communication and feedback on practice in individual cases. However, the IRO often viewed their own priority as managing the review and developing the plan, rather than undertaking a wider quality assurance function or focusing on outcomes.

Escalation processes were in place and inspectors saw examples of the IRO referring issues to team managers and senior officers where there were concerns about practice and the progress of plans. In the examples seen, once raised, the issues were taken very seriously and acted upon. Learning from these practice concerns needs to more routinely captured and used to drive improvement.

Monitoring progress against the plan

Concerns were identified in a number of authorities that the IRO was not routinely kept informed of significant events that impacted the child's care plan between formal reviews. This included examples where decisions were delayed or changed by other decision-making panels. The impact of this had greater significance where the IRO did not undertake or did not see themselves as having a responsibility to monitor progress, and compliance between reviews. In the best examples, mechanisms were well embedded to ensure the IRO was able to maintain an oversight of the case and contribute to the progress of the plan. In these examples the IRO also routinely contacted the child between reviews to gain their perspective on progress.

Conclusion

Overall the responsibilities of the IRO and how they discharged their functions was found to be variable. Many IROs were not sufficiently confident in exercising their own personal authority or the considerable authority of their role. However, it was equally evident that many IROs did not see themselves as exercising a role outside of the review event itself. It was disappointing to note that in these examples, the IRO did not appear to recognise their clear corporate parenting responsibilities to follow up perceived deficits in care planning and support for young people, and take action as is commensurate with their role.

Reviews

The inspection found that most local authorities had developed mechanisms to ensure compliance against statutory expectations in relation to planning and review processes. For the most part, reviews were timely and convened as needed to reflect the presenting circumstances of the young person.

Issues identified that impacted on the effectiveness of the review in promoting good outcomes for children and young people

The interface between the review and other decision-making mechanisms needs to be more explicit. Clarity is needed regarding the status of conclusions or 'decisions' reached which are then subject to another internal process or panel. Mechanisms between these arrangements need to be clear, not only to prevent drift and duplication in planning, but to minimize the child's anxiety and uncertainty about what has been decided in their interest; the child should know what has been decided.

Some looked after children did not consistently receive statutory visits and the quality of recording often reflected a lack of understanding of the purpose of such visits. A number of local authorities had already identified statutory visits as an area for improvement.

Time constraints were often reported as hindering social workers and the IRO meeting with children and young people prior to their reviews, or meeting them in a way that enabled them to prepare the child for the review and discuss the potential impact of any decisions. Worryingly, this was particularly the case in relation to children placed away from the home authority.

There was often an uneasy relationship regarding who 'owned' the review. Reviews were recognised as the means by which professionals discharged their care planning responsibilities. The child at the centre of the review equally needs to be able to exert their influence over the conduct of the meeting, who they want to attend and to have an impact on the decisions made.

Where parents were perceived as challenging or difficult, the review meeting became more of a "negotiation" or "consultation" process where adult issues could dominate the agenda – for example, "I don't attend my reviews because my mother always goes and she is such a pain." (Looked after child) In these instances the IRO sometimes appeared to be trying to pacify parents or carers.

Although children's written contributions to reviews were often sought, it was rare to see any real thought being given to the way in which it would be shared. This is particularly crucial if a child needs to communicate difficult messages to adults attending the review. Some young people asked: "How can you say what you really think if the person is sitting in the meeting?" Children and young people often experienced the need for professionals to share information as a "lack of privacy".

Social work and other agencies' reports to the looked after children reviews were not always timely and in some instances not of a quality to capture significant events or progress made against the plan. In some cases the poor standard of reports and the lack of attendance of the allocated worker compromised the outcome of the meeting. Equally, the minutes resulting from the review meetings were not always timely or of a quality to support the shared ownership of what had been agreed.

Children and young people were not routinely provided with a copy of their review or given further opportunity to discuss the decisions with the IRO. Although many young people said they didn't want a copy of the review this may be because review documents are a poor vehicle for capturing issues that are relevant and important to the child.

There were sometimes tensions regarding who owned the recommendations and the care plan decisions. Whilst it was clear that the IRO is not the case manager, they do have a role in monitoring that the local authority does what the plan says. The relationship between the IRO and the operational teams should be one of constructive challenge and needs to be further strengthened.

In too many cases, inspectors found that the IRO did not sufficiently challenge drift and delay in children's lives. In examples where such challenges were seen, it often only occurred after the same issues had been raised at a number of reviews. This was commonly the case in relation to the need for therapeutic work. In some examples, the barriers to progress were due to known persistent gaps in service; however, delays for example in accessing CAMHS provision or appropriate placements should always be robustly addressed. The IRO often identified that they were less confident in their ability to influence or challenge the contribution made by other agencies to the care plan.

In a number of cases, plans were so focused on managing immediate and short-term contact issues including risks, that professionals did not retain sufficient focus on the longer-term plan. In a number of examples young people effectively determined the plan for themselves by going home and refusing to return to placement. The lack of contingency planning for this possibility as well as the age of the individual involved often meant social services had little recourse but to agree to the change in the plan.

Messages from looked after children and care leavers

- *"My carers were alright but I was never really a part of the family, really I was just waiting to get to 16 so I could leave … I'm back with my mum now … I went for a visit and decided I wasn't going back, we get along OK because I'm older and I make my own decisions."* **(Care leaver)**

Conclusion

Local authorities should ensure oversight, at intervals, of the operation of their reviewing processes. Consideration should be given to the way reviews maintain the momentum in implementing plans for children, support contingency planning and identify any lessons for the local authority in improving services and the engagement of looked after children.

Practice example

- Of those seen, review reports were thorough and included consideration of the effectiveness of the plan. There was evidence that reviews were capturing the voice of the child or young person. **(Cardiff)**

Contact

Inspectors saw considerable attention and good efforts being made by professionals to ensure children and young peoples had safe positive contact with their family and friends. The significance of contact cannot be underestimated in determining how children and young people experience being looked after. Although unable to live with their families, contact can provide additional safeguards for young people regarding the quality of their care, but can also create significant safeguarding issues if not appropriately managed.

Contact arrangements were identified as much more difficult to manage positively when children had an insecure attachment to their parents and where parents did not accept that their children should be looked after. In these circumstances the comments and criticisms of the parents as well as promises that the child "can come home at 16" acted to undermine the placement as children had divided loyalties. Sensitive work is needed with both the birth parents and the child to help them understand these complex issues.

Children and young people views about contact were very varied:

- Some young people wanted more contact and experienced any delay in decision making around this issue as "upsetting and stressful", while some young people acknowledged that this could result in them "voting with their feet" on occasions.
- In other cases young people told inspectors that they found the practicalities of the arrangements difficult – for example: "Nobody asked me when contact would be best for me. I have contact every Wednesday when it is football practice after school so I have to miss that. I will never get into the team although the PE teacher says I'm good." **(Looked after child)**

- Children and young people often expressed confusion about why contact had to be supervised and were unhappy about not having contact with siblings especially if they had remained at home. There were some good examples of children being helped to understand the reasons for the contact arrangements but this needed to be periodically refreshed.
- The high level of contact in some cases highlighted the need for more effective ongoing work with the family to support them both in meeting the child's needs during contact, but also to explore the possibility of reunification in the future.

The engagement of looked after children in reviews

Most young people interviewed told inspectors that they were actively encouraged to attend their reviews. There was also evidence that children were regularly reminded about the purpose of the review through leaflets and consultation documents.

Some but not all looked after children had been issued with looked after children packs, and in some local authorities looked after children had helped to design these. There was a mixed reaction to such packs - some young people experienced them as helpful while others said: "Talk to me, don't give me a leaflet". Many young people acknowledged the importance of having access to different forms of information as they recognised that they didn't always remember what they had been told.

Practice issue

- Young people did not have any definite ideas about what would be the best way for them to receive information about being a "looked after" child. When asked if they would use an 'app', they mainly dismissed this as a poor use of their data capacity.

Young people expressed mixed views regarding the significance of the independent reviewing officer (IRO). Some regarded the IRO as having an important role, especially where they provided a level of continuity in planning arrangements, due to changes in social worker. Many young people liked their IRO, but viewed them as "yet another" professional. Some young people described the IRO as someone who "turned up" periodically.

Message from looked after children and care leavers

- *"I really like my IRO, she really knows me well. She makes my review easy. I know she will try her best to get people to listen to what I say."* **(Looked after child)**

Young people said that the way they perceived the IRO and the review often depended on the extent to which they wanted a particular issue addressed. This was often related to contact; the extent to which the meetings could make decisions; and the extent to which they agreed with the plan. The child and young people's perception of the review was often further complicated by how they felt about their current placement and ultimately about the fact that they were a looked after child.

Inspectors saw some good commitment to consultation with children and families across Wales and persistent and creative efforts to make reviews more meaningful and accessible. In some local authorities, all looked after young people were routinely contacted before their reviews to see if they wanted to have an advocate. In other examples young people were encouraged to chair their own reviews. The IRO commented positively on the way that foster carers and some school staff supported children to contribute to their reviews.

The IRO was often very sensitive in seeking to manage complicated family arrangements in a way that supported the child and enabled family members to contribute positively.

Messages from children and young people

Reviews

- *"They do listen, I said I didn't want my sister at my review and she wasn't invited."* **(Looked after child)**
- *"I didn't like the review meetings in school but they listened to me and changed the venue to home. It's much better now."* **(Looked after child)**

Practice issue

Arrangements and placements were found to work best when the child understood why they were in care, had come to understand and accept that they parents could not look after them, and when parents "gave permission" for the child to become attached to their carer and supported the placement.

- *"I think his foster carer is doing a great job and he has come on so much while he has been there...Have you seen his school report?... I am so proud of him … I cannot give him what he is getting there. I feel sad about it but I know he is in the right place."* **(Father of young person)**
- *"I can't thank them enough for what they have done. He is much more settled and they have helped me understand that I am not good for him … Don't get me wrong, I love him and all that, but we just can't live together. He is more settled in his (residential) placement. I think he just accepts that we cannot get on."* **(Mother of 16 year old boy)**

Advocacy

Advocacy can have a key role in empowering children and young people to fully participate in decisions that affect their lives. During the inspection, children and young people told us they were regularly informed about the availability of the independent advocacy service, and those who had used an advocate were positive about the support that had been provided.

Despite this significant emphasis on advocacy, there is a widely held view that the take up and referral to the advocacy services across Wales remains low. Some professionals questioned if this was because of the issue-based nature of the independent advocacy provision. It was noted social workers and carers saw themselves as very proactive

advocates and this was often found to be the case. It was significant that where the social worker or the carer experienced a positive outcome for the child, resulting from the involvement of an independent advocate, even if it related to a complaint, they were more active in promoting the benefits of the advocacy service. It is important that formal advocacy services invest in activity that raises the positive impact they can have on children and young people's lives, and that they target this promotion at the relevant professionals as well as children and young people.

Conclusion

Despite a positive view of advocacy, children and young people were clear that a 'one size' fits all approach to advocacy does not work well for them as individuals.

A number of the children and young people interviewed told inspectors that they often viewed their foster carers, family, personal advisor or social worker as their advocates and they often didn't want yet another person asking them about their "wishes and feelings". In contrast, the same young people told us that they would use an advocate if they wanted to make a complaint.

The review process

Despite considerable effort made by staff, and even when provided with the support of an advocate, many looked after children told us they preferred not to attend their review and that they experienced the process negatively. The reasons for this were complex but young people often said the meetings reinforced that they were "looked after" and therefore "different".

On a practical level, many young people told inspectors that the frequency of the meetings meant reviews were often "repetitive" and "boring". Many experienced being the center of attention and having to discuss issues in front of a group of professionals as "embarrassing". During the inspection a number of looked after children and care leavers reflected on the process and posed the question "how would you like it?" and they described the reviews as "not treating looked after children as children".

Few young people interviewed believed that they owned the care plan; rather they were realistic that decisions were influenced by their age and the need to "keep them safe". Many expressed concern that plans were overly protective and many did not know what their foster carers could agree to and what their entitlements were as looked after children. Delegated authority was a recurring issue and most young people told inspectors that more "permissions" should be delegated to their carers.

Messages from looked after children

- *"I always go to my looked after child (LAC) reviews, I like it because I get praised"* **(Looked after child)**
- *"I hate (LAC) reviews; it's always about what I'm not doing."* **(Looked after child)**

Conclusion

Many of the concerns raised by children reflect a thematic deficit in the capacity of reviews to be a meaningful or effective way of ensuring that care plans achieve what they need to achieve to improve outcomes. There is a need to improve plans and the conduct of the reviews so that they meet the individual needs and circumstances of the child in a way that is more purposeful and dynamic. Care leavers described the process as 'not fit for purpose'. The issue that now needs to be addressed is whether the planning and review system is agile enough to respond to these expectations.

Case example

The young person reported that she felt social workers and other professionals had listened to her and that they treated her with respect and fairness. She was clear that they had her interests at heart even when making decisions that she was sometimes unhappy with. She felt she could tell workers when she disagreed and why, and that they would change things she asked of them if they could and if it was safe to do so. **(Looked after child)**

Appendix 1

Messages from the survey

Following the inspection fieldwork, CSSIW requested that local authorities send the following survey to all the young people who met the inspection criteria. It was pleasing that 178 responses were received.

The collated findings from the survey of the young people who responded were:

- 95% said they saw their social workers regularly or at least when they needed to;
- 71% knew what their care plan said;
- 82% attended their reviews always or sometimes;
- 87% felt supported with their education.

CSSIW Safeguarding and care planning of looked after children and care leavers survey results

Safeguarding and Care Planning of Looked After Children and Care Leavers, who exhibit 'vulnerable or risky behaviours' - Survey Results.

Summary

- The survey was issued to 22 local authorities.
- A total of 178 looked after children completed the survey.

Summary of the responses

Answer	Count	Percentage
1. How often do you see your social worker?		
Every week	14	7.9
Every month	68	38.2
At my reviews	19	10.7
When I need to	67	37.6
Never	10	5.6
Total	**178**	**100.0**

Answer	Count	Percentage
2. Do you know what your care plan says?		
Yes	127	71.3
No	51	28.7
Total	**178**	**100.0**
3. Can you have a say on how you are looked after?		
Yes	155	87.1
No	23	12.9
Total	**178**	**100.0**
4. If you wanted to change anything do you think your social worker could help?		
Yes	149	83.7
No	29	16.3
Total	**178**	**100.0**
If no, do you think you could get things changed anyway? None of the participants responded to this question.		
5. Do you attend your Looked After Children (LAC) reviews?		
Always	89	50.0
Sometimes	57	32.0
Never	32	18.0
Total	**178**	**100.0**
6. Do you get the support you need to make the most out of your education?		
Yes	157	88.2
No	21	11.8
Total	**178**	**100.0**

Answer	Count	Percentage
7. Do you know who the independent Reviewing Officer (IRO) is?		
Yes	111	62.4
No	67	37.6
Total	**178**	**100.0**
8. Do you feel like you can talk honestly about what is happening?		
Yes	146	82.0
No	32	18.0
Total	**178**	**100.0**
9. Who would you talk to if something was wrong? See below for responses		
10. Do you know how to make a complaint if you are unhappy with your care?		
Yes	154	86.5
No	24	13.5
Total	**178**	**100.0**
11. Did you know you can have an independent person (advocate) to help you if you wanted to get something changed?		
Yes	138	77.5
No	40	22.5
Total	**178**	**100.0**
12. Do you know what the Children's Commissioner for Wales does?		
Yes	45	25.3
No	133	74.7
Total	178	100.0
13. What does corporate parenting mean to you? See below for responses		
Don't know	68	38.2
No response	60	33.7
Response	50	28.1
Total	**178**	**100.0**

Answer	Count	Percentage
14. Can you get advice on any of the following: to keep healthy, to make friends, to keep in touch with family and to learn independent skills?		
Yes	169	94.9
No	9	5.1
Total	**178**	**100.0**
15. If yes, please tick a box (you can select more than one answer)		
To keep healthy	151	
To make friends	121	
To keep in touch with family	145	
To learn independent skills	149	
Total	**566**	
16. Was it easy to access the internet today to fill out this survey?		
Yes	75	42.1
No	103	57.9
Total	**178**	**100.0**

Of those children who responded, the following were identified in response to Question 9.

Question 9. Who would you talk to if something was wrong? (NB Some children identified more than one person)

Identified People	Number of comments
Social worker	51
Other Social Services Staff	9
Residential staff	10
Personal Advisor	6
Foster carer	46
School / Education Staff	15

Identified People	Number of comments
Child Adolescent Mental Health Services	2
Advocate	2
Friends / peers	11
Family	26
Other	9
Named persons	22
No one	5
Don't know / no comment	3

Of 178 responses to question 13, there were 68 responses of 'Don't Know';
60 'no responses' and of the remaining 50, the following comments were provided.

Question 13. What does corporate parenting mean to you?

Corporate parenting is when the family works together instead of having demands.	People who look after you
Council	Partnership needed between people looking after young people and children
Don't like staff acting as my parents	People support me because my mother can't
Everything but we wasn't given the chance to be parents and the reports proved we could parent a baby.	Professional parenting
Everything - could change a child life	Shared responsibility of me
Full care order	Social services and our parents share parental responsibility
Government being your guardian? Don't know	Social worker is in charge of me
Happiness	Social services act as your parents
Helps you change things in care	That there are two parents supporting you and not just one

Helps your foster family	They are not my real parents but they have full responsibility for me
I think you should review 'corporate parenting'	They are there for me like a parent
Improving young people's future and education	They kidnap people's kids and treat them different to other kids. Us kids get punished for our parents mistakes
In contact with parent?	To be on half of the parents responsibility e.g. social worker, foster carer
It is extremely important to family life, it means you can count on both parents if something is wrong with yourself or other people.	To cooperate with the children their looking after
It means a lot as it helps with what will happen in the future	We can understand each other and get on
It means they have a duty to look after me up to 21 or 25 in education	Were you have to corporate when your parenting
Legal guardian	What does that mean
Local authority are looking after me	When a young person is looked after by the local authority and they become the parents
Loving that child/trust	When authority help with the care of a young person by just having a social worker or going in to full time care.
Mam	When local authority can look after you.
My carers	When two parents cooperate together.
My sister acts as my parent	When you are in care.
Not enough help from the one who are responsible for me.	Working together to meet the needs of looked after children and young people and care leaders needs
Not much	Not the birth parents
Nothing	Other people making parent choices

Appendix 2 – Methodology and data profile

Definition of vulnerable or risky behaviour

For the purposes of the inspection a broad definition of 'vulnerable or risky behaviours' was applied that included the following:

- Looked after children (LAC)/care leavers with more than three moves in the last 12 months.
- LAC placed in residential care in the last 12 months.
- Relevant young people living independently.
- LAC placed at home on a care order (as of April 2012).
- LAC who are in out of county placements/placed across borders as of April 2012.
- LAC/care leavers reported as absconding/missing/absent from placement in the period from April 2012.
- LAC/care leavers subject to a strategy meeting or other relevant multi agency meeting including case conferences in the period from April 2012.
- LAC /care leavers engaged in challenging behaviour i.e. behaviour that results in potentially dangerous or frightening consequences for the individual and or for others during the period from April 2012.
- LAC identified as the victims or perpetrators of anti social behaviour or offending in the last 12 months.
- LAC/care leavers not in education, employment or training during the period from April 2012.
- LAC/care leavers who display or are subject to sexually harmful activity.
- LAC/care leavers who are or may be subject to exploitation.
- LAC/care leavers identified as engaged in substance misuse/self harm or needing mental health services.

Local authorities were asked to provide a profile of risk as outlined against the above definitions in relation to looked after children (aged 11+) and care leavers. The resulting sample provided, identified 1,696 looked after children.

Profile of data collated from local authorities for the inspection of Safeguarding and Care Planning of looked after children and care leavers who exhibit Vulnerable or Risky Behaviour.

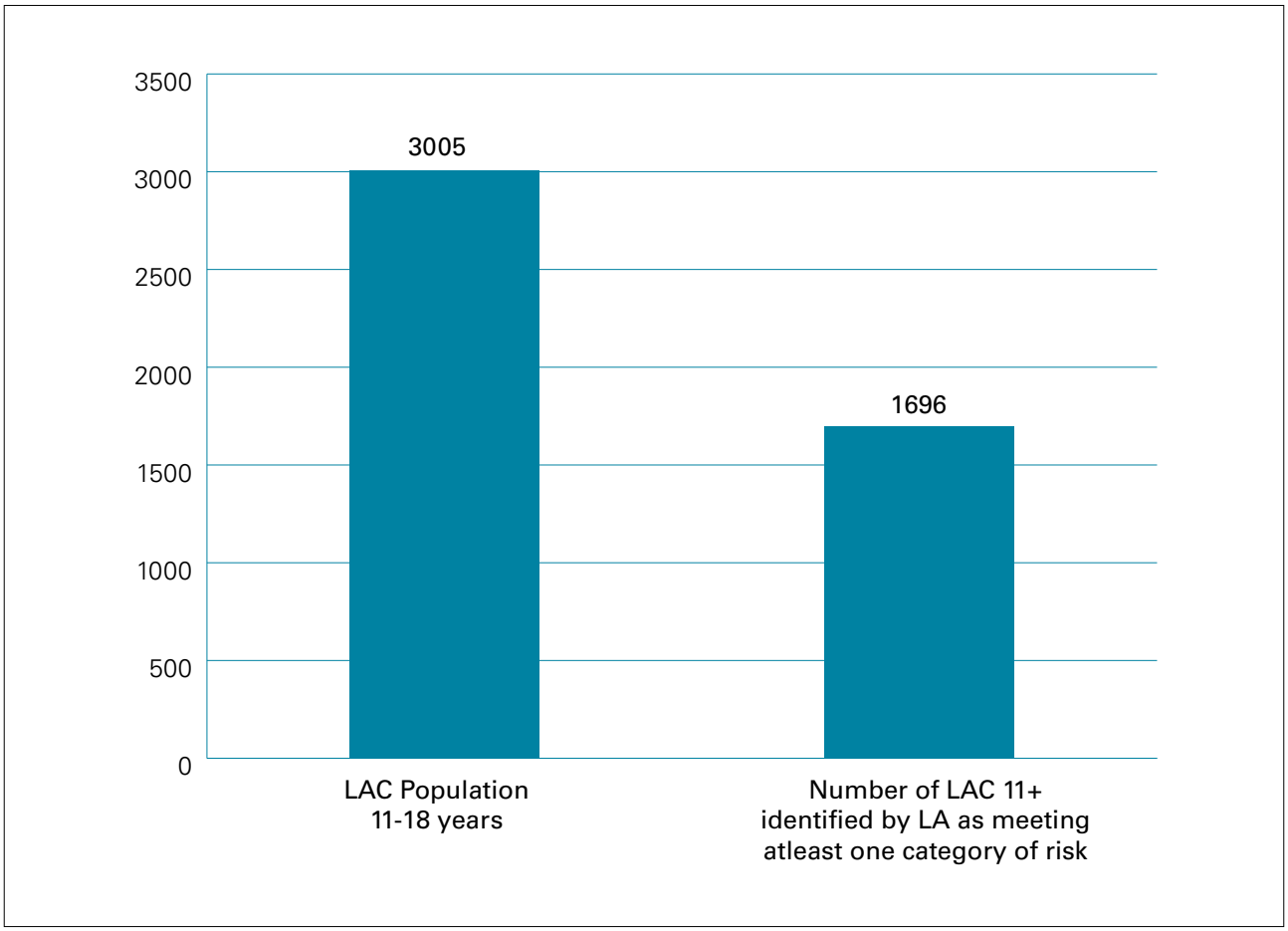
This profile aims to give a context to the work of the inspection and the conclusions which have been reached. It is important to note that the data presented in the following charts has been collated directly from the local authorities against the above criteria. This data has not been validated and is only intended to provide a broad outline of the profile of risk for those who are looked after and between the ages of 11 and 18 years of age. The period of time which was covered was from April 2012 to December 2013, except for those

with more than three moves and those placed in residential which covered a 12 month period before January 2014. From the profile of cases provided by the local authorities we selected 220 cases to be reviewed.

The data been used in the charts which follow to illustrate the findings from the inspection this does not include relevant and former relevant young people.

Chart 1

Number of LAC across Wales aged 10+ in 2013/14 compared with the number of looked after children aged 11+ at December 2013 identified as meeting at least one of the categories of vulnerability listed above.

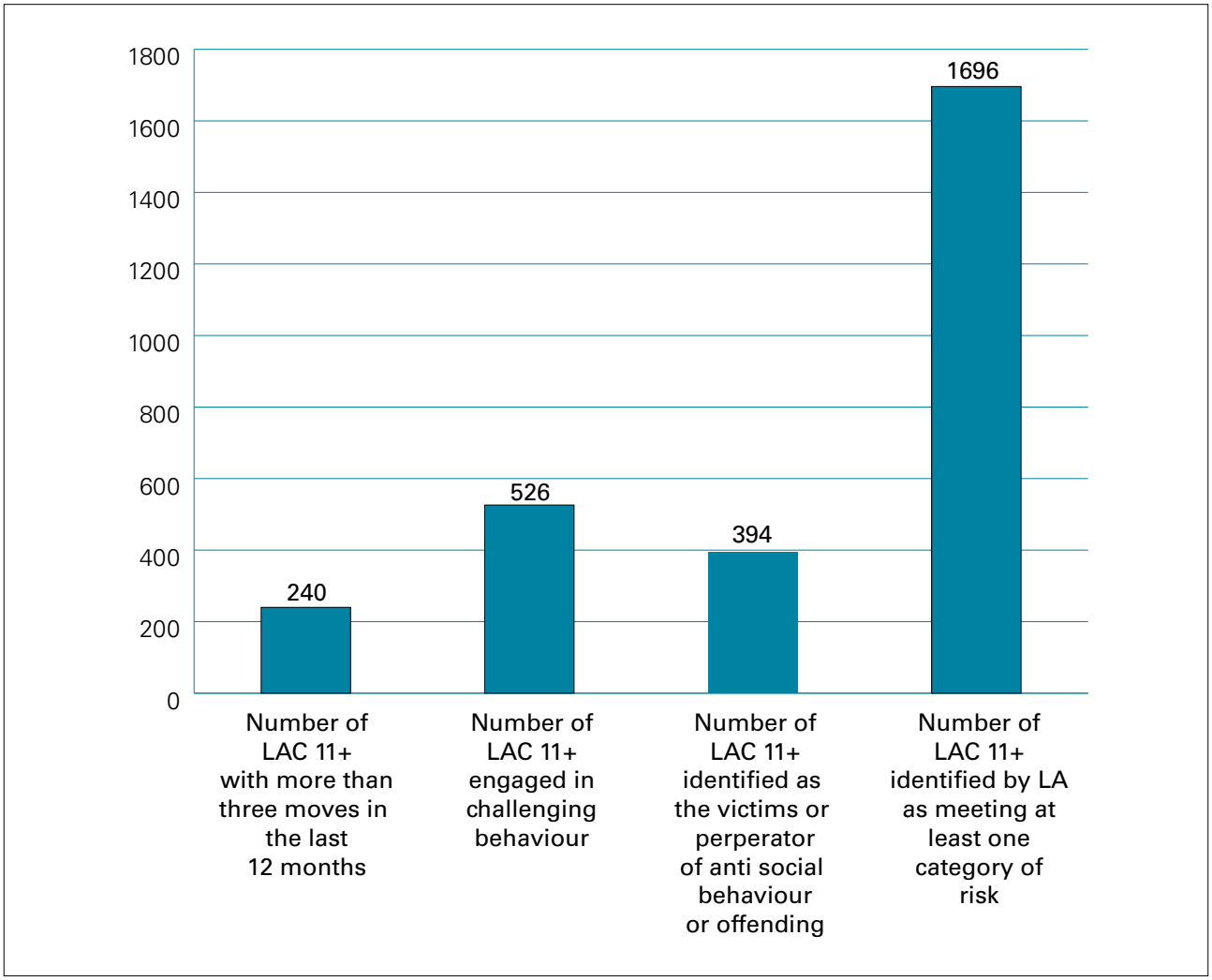


NB: The same child may have been counted in more than one sample group.

1,696 out of a possible population 3,005 10-18. (Excludes 10 year olds)
Source – not validated (direct from local authorities.)

Chart 2

Looked after children aged 11+ with more than three moves in the 12 month period from January 2013 to the end of December 2013 compared with those engaged in challenging behaviour i.e. behaviour that results in potentially dangerous or frightening consequences for the individual and or for others; and those identified as the victims or perpetrators of anti social behaviour or offending in the last 12 months.

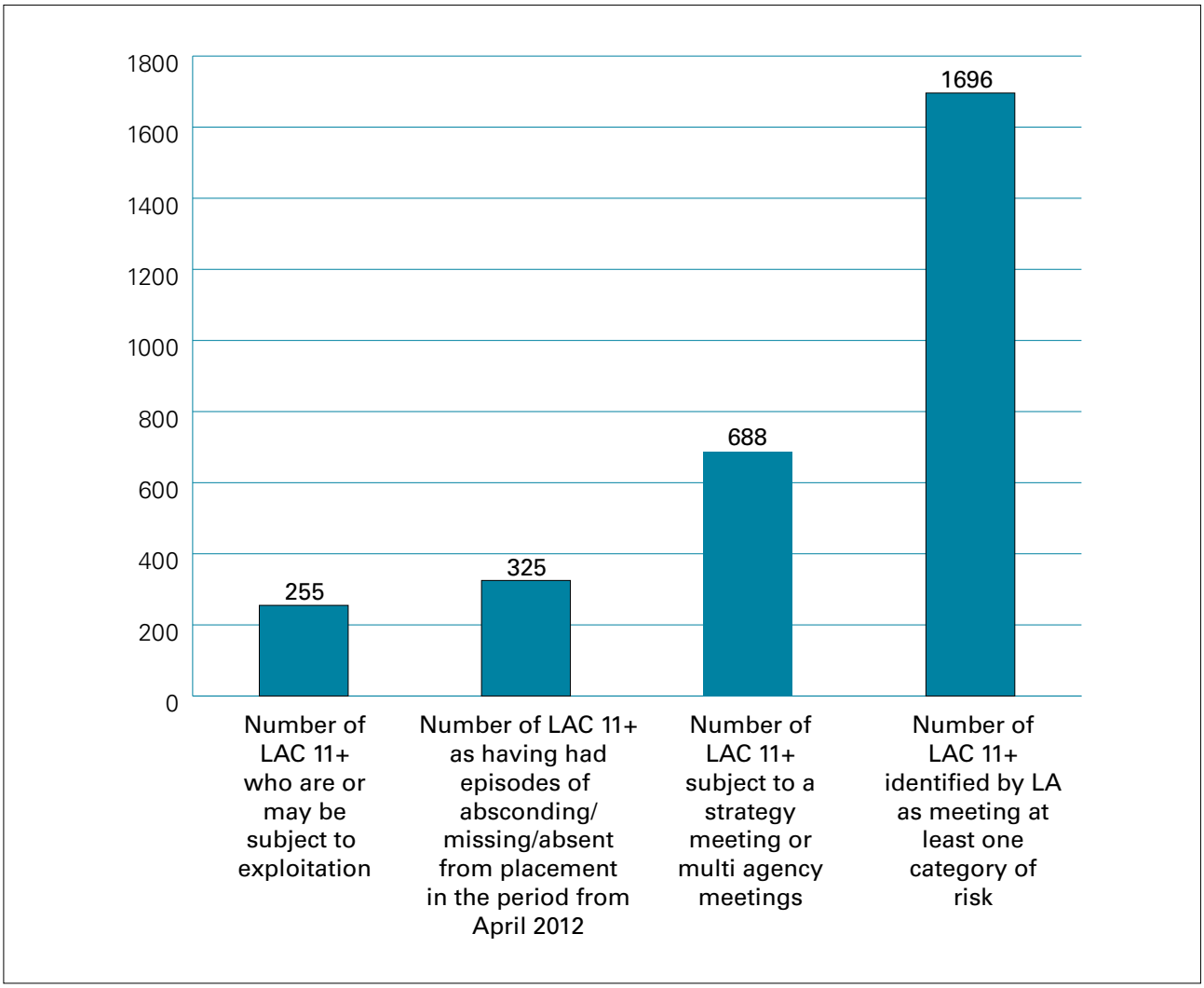


NB: The same child may have been counted in more than one sample group.

A significant number young people who experienced more than three moves were also identified as being engaged in challenging behaviour. All local authorities consider the number of children and young people who had experienced three or more placement moves within a period of 12 months; however as annual data, this performance indicator does not reflect the true extent of this indication of vulnerability. The majority of authorities did not provide information on the additional number of placement moves children experienced over three per year. Young people were reporting they had moved twenty or even thirty times since they became looked after and this was reflected on case files. The information sharing and risk management arrangements between children's services and youth offending services across Wales were found to be effective.

Chart 3

Looked after children aged 11+ reported as absconding/missing/absent from placement compared with numbers of looked after children 11+ who are or may be subject to exploitation; and those subject to a strategy meeting or other relevant multi agency meeting including case conferences in the period from April 2012.

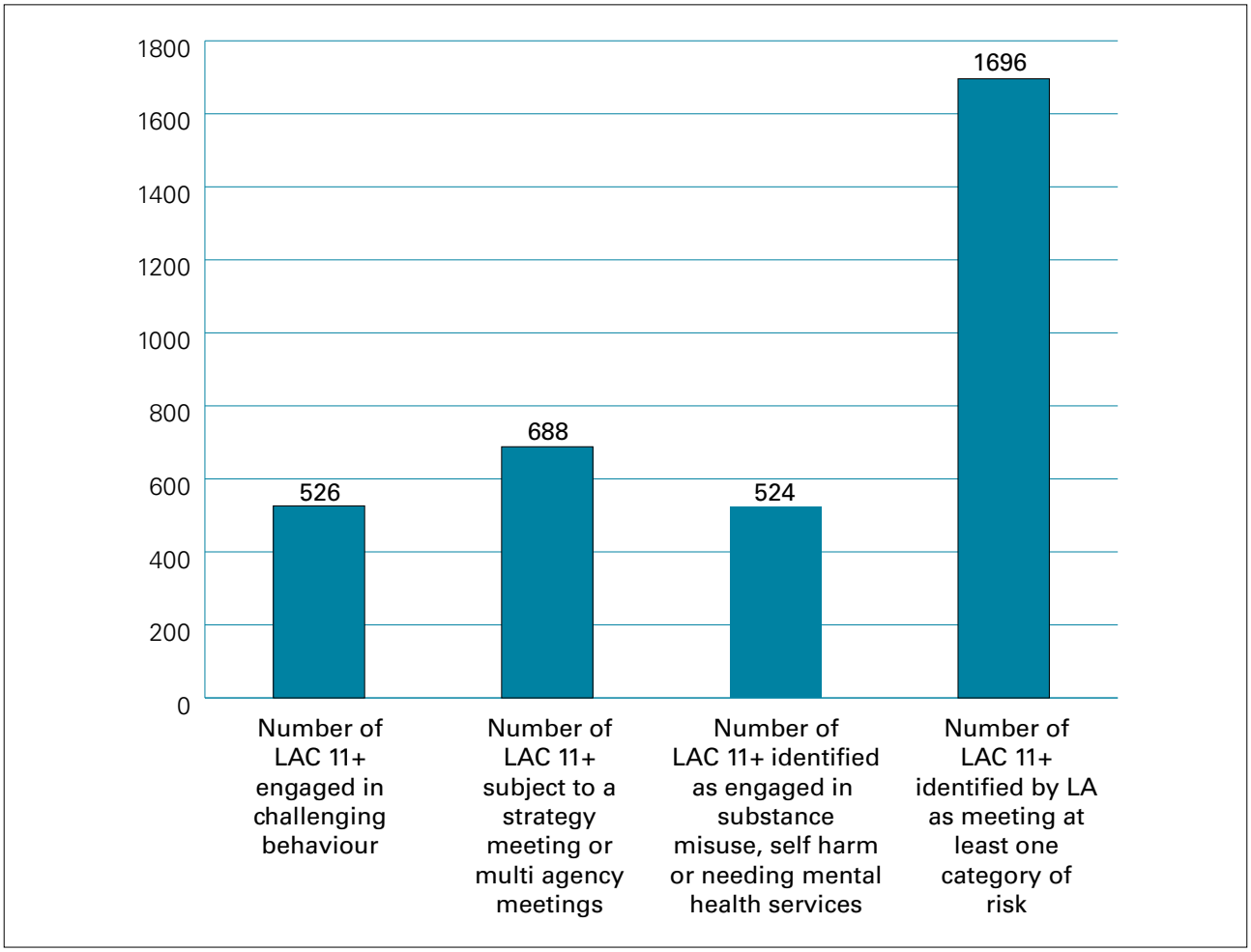


NB: The same child may have been counted in more than one sample group.

When requesting information we did not distinguish between 'unauthorised absence' and those who had been reported missing. All local authorities had a protocol in place to manage the latter situation and the reporting process to be used in either situation. As can be seen from the numbers illustrated more young people are reported missing than those believed to be at risk from child sexual exploitation.

Chart 4

Looked after children aged 11+ subject to a strategy meeting or other relevant multi agency meeting including case conferences compared with those engaged in challenging behaviour i.e. behaviour that results in potentially dangerous or frightening consequences for the individual and or for others; and those identified as engaged in substance misuse/self harm or needing mental health services.

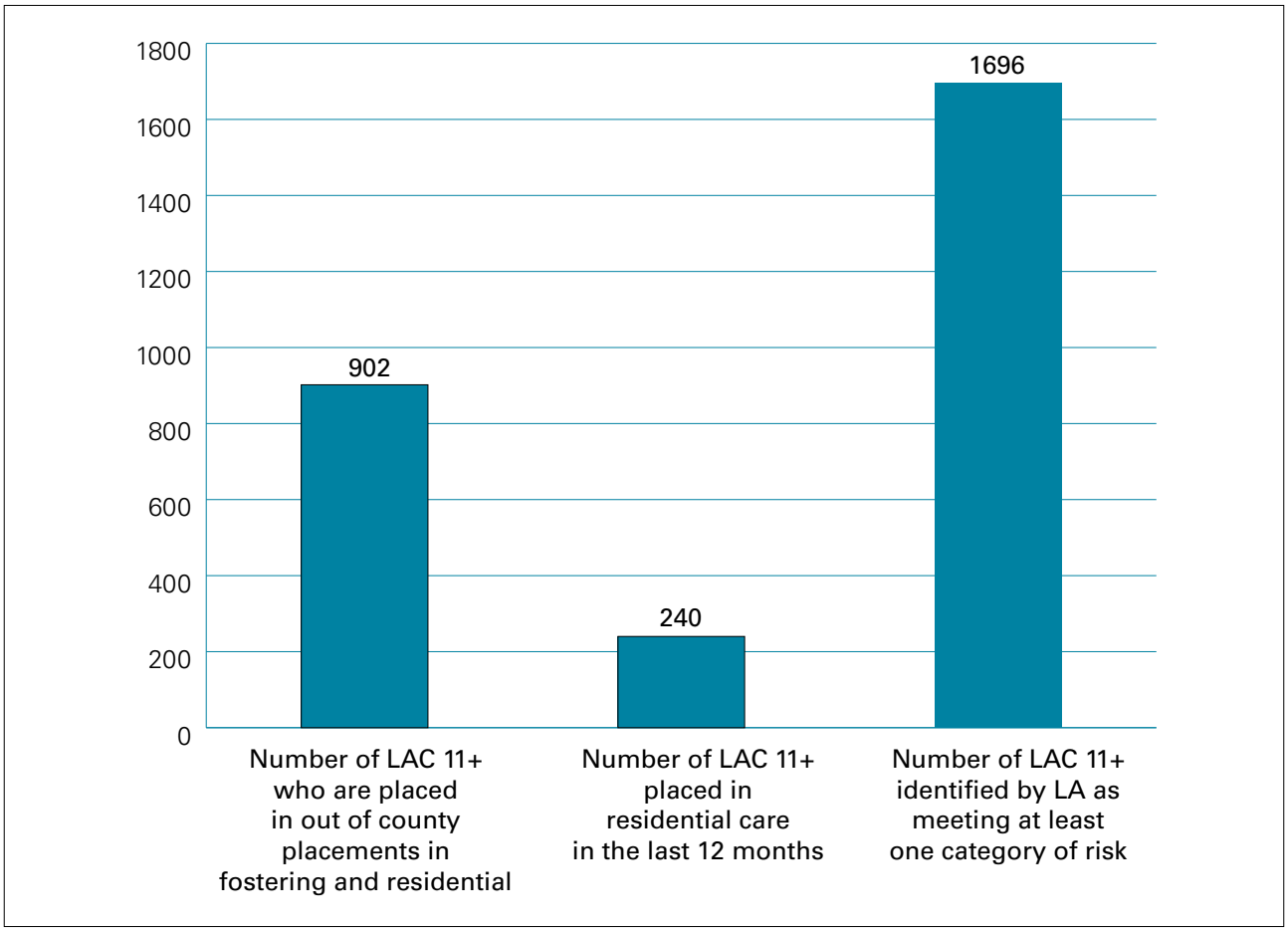


It was not clear that every local authority considered safeguarding data in respect of looked after children separately, but this could be used to cross reference with other data on vulnerability and risk to better monitor compliance with procedures and whether this led to better outcomes. Although the numbers of strategy meetings held in each local authority varied, it was evident from the field work that child protection procedures were being used appropriately to manage the safeguarding concerns in respect of looked after young people aged 11 years and over. Some authorities used multi-agency meetings to co-ordinate arrangements to manage risks, but these were not recorded on the electronic system so the data was not available.

Most authorities had put arrangements in place to support placements because of the lack of availability of CAMHS, or a primary mental health service. The most successful of these included direct work for the young person; behaviour management and practical support for the carers and consultation for social workers. The quality of the support carers were able to provide was an extremely significant factor in influencing the outcomes for the young people in the cases reviewed.

Chart 5

Looked after children aged 11+ who are in out of county placements/placed across borders compared with those placed in residential care in period from January 2013 – January 2014.

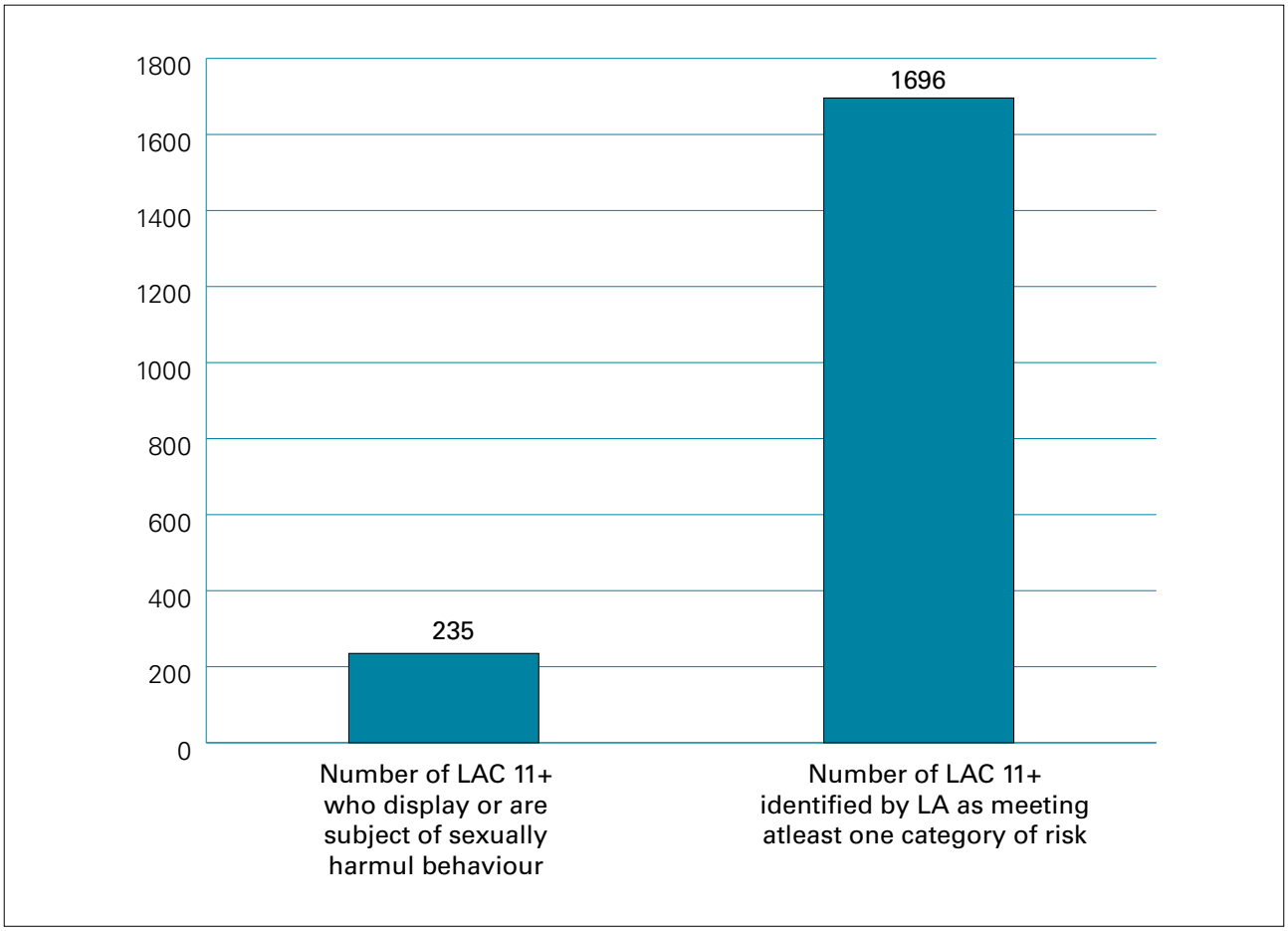


NB: The same child may have been counted in more than one sample group.

The lack of good quality residential units which are locally based was seen to influence decision making when a young person's behaviour was becoming too challenging for a foster placement. The lack of early therapeutic intervention could be a significant factor in the reasons for some young people experiencing multiple placement breakdowns.

Chart 6

Looked after children aged 11+ who display or are subject to sexually harmful activity compared with numbers identified by each local authority as meeting any one of the vulnerability / risk categories.



NB: The same child may have been counted in more than one sample group.

Most authorities had good access to assessment for young people who display or are subject to sexually harmful behaviour; however there was a lack of appropriate services to support them. The transition arrangements for managing risk for those young people approaching 18 years of age were not well managed.

Appendix 3

Acknowledgements

CSSIW would like to thank the children, young people, as well as their family and carers who shared their experiences with us. The inspectorate would also like to thank the social workers, managers, senior officers, members and partners listed below who took part in the fieldwork for all their help and co-operation with this inspection.

- The cabinet member holding the children's social services portfolio.
- The chair of the scrutiny board/committee for children's social services.
- Chair of the corporate parenting board or equivalent.
- Chair of safeguarding children board reflecting regional and local arrangements.
- Chief executive officer.
- The statutory director of social services.
- Director of education.
- Director of housing.
- The head of children's services.
- Head of adult services.
- Child protection co-ordinator and or the children's quality assurance officer or equivalent.
- Commissioners.
- Independent reviewing officers.
- Children's services – service managers.
- Children's services – team managers.
- Children's services – social workers.
- Personal advisors.
- Youth offending service.

Representatives from the police, health, probation and local authority education services

- Service providers
- Advocacy providers.

The CSSIW inspection team included inspectors from the regional teams and the strategy team. Lead inspectors were Katy Young, Pam Clutton and Bobbie Jones.