Wiltshire Council

National Review into Safeguarding Children with Disabilities and Complex Health Needs in Residential Settings

Wiltshire Council - Outcome of Review

Purpose of Report

1. This report contains the outcomes and recommendations of the Quality and Safety Reviews of 10 Wiltshire children and young people with disabilities and complex needs requested by the Child Safeguarding Practice Review Panel to all Directors for Children's Services (DCS) on 23 August 2022.

Background

2. On 23 August 2022, the Child Safeguarding Practice Review Panel issued a letter to all Directors of Children's Services (DCS) requesting two actions be completed. These actions were to provide further assurances in relation to a national review that has been considering the experiences of children placed in three specialist independent residential settings located in the Doncaster area subject to allegations of widespread abuse.

3. Due to the findings in the national review, it was recommended that additional assurance was needed immediately for children in similar placements to ensure that they remain safe and are receiving the most appropriate and high-quality care.

4. The actions requested of the DCS to be carried out by 23 November 2022 were as follows:

    - Action one - Carry out Quality and Safety Reviews for all children with complex needs and disabilities currently living in residential specialist schools registered as children's homes (those who are resident for part of the year as well as those who are resident all year)
    - Action two - In relation to the same group of people, the host authority LADO for each individual establishment is to review all information on any referrals, complaints and concerns over the past 3 years relating to the workforce to ensure they have been appropriately and actioned. Also, to contact any local authorities who currently have children placed in the establishments in their area if there are any outstanding enquiries being carried out regarding staff employed at the home

5. Following completion of the actions, a report of the findings was requested to be compiled and shared with safeguarding partners, local parenting boards and the Regional Improvement Support Lead within the Department for Education by 23 December 2022.

Action One:

6. A multi agency review of the 10 children (10-17 years old) has been undertaken as requested by 23 November 2022. Of these 10 children, 7 are children in care, 1 child in need, 1 subject of a Single Assessment under S17 and 1 not open to children's social care. The average distance between the child's home and placement address is 54 miles.

7. Of the 6 establishments these children are placed within, the Ofsted judgements are: 2 Outstanding, 3 Good and 1 Requires Improvement (RI).

8. All children were seen in both their school and home setting.

9. No immediate or significant concerns have been raised as part of these reviews. Any matters requiring improvement were already subject to additional monitoring and assurance with the providers. The decision for children to remain in establishments judged RI is taken on a risk assessed, needs led basis. Therefore, this was completed prior to the review as per procedures for the 1 child placed in the RI establishment.

10. The review has highlighted areas of good practice as well as identifying areas that would strengthen practice.

11. In 100% of cases the Communication Plan was in place, up to date; with supporting evidence of how it was being used effectively.

12. In 100% of cases the most recent Positive Behaviour Support Plan was being used and was up to date. In all settings training was in place and staff supported in the implementation of these plans.

13. In 2 cases there were incidents that related to medication not being administered sufficiently well that resulted in discussion about how this would be prevented and monitored more robustly in the future.

14. All children are registered with the GP, Dentist and Optician/Specialist and have a Statutory Health Assessment in place where applicable, all actions have been completed, except for one child whose assessment is currently being updated as it is overdue.

15. All reviews identified a good level of understanding of the mental health and well-being needs of the children. Examples of this included use of PACE, music therapy and psychology/psychiatrist appointments, family therapy, speech and language support, interests being catered for and personalised communication approaches and strategies.

16. All of the children subject to this review are engaged in education. Attendance ranges between 79-100%, with lower attendance attributed to the needs of the child rather than a concern about the providers/practitioners role in supporting this. All the children have clear progress targets for their education, and these are quite often termly targets which are regularly reviewed.

17. Each establishment had their own method for maximising contact with the significant people in these children's lives. Examples included video calls, sharing of photographs, 'open door' policy around time with family and weekend visits to grandparents. There was a very strong emphasis on this family time with a variety of methods of frequencies employed that met the child's and family's needs.

18. There was evidence the child's voice was heard and their lived experience understood, with quotes used to describe in children's own words. This was harder to achieve in one instance due to how the child was feeling on that day, which is why rounded methods of understanding 'voice' is key as children may not feel able or want to speak with their lead practitioner when they visit for example. There were ample examples of how other professionals could recognise the positive impact of the care upon the child's wider outcomes. Strong relationships were a theme, as well as consistency of staffing. There was also evidence of issues being raised and challenge given where dissatisfaction existed.

19. Feedback from parents and carers highted very positive views of care, as well as some frustrations they appeared 'stuck' with resolving. For example, a parent's request for their child to receive the covid vaccination not being met. It is important all parents feel able, and are asked routinely, about their views on care in order for practitioners to support them in resolving matters if this isn't being achieved through their own liaison with the home.

20. Safeguarding concerns were raised for 4/10 children. Three of these did not raise any concerns and evidenced the safeguarding practice was robust. In another, there was agreement that the provider should have alerted the social worker to the incident sooner, but their practice did not give rise to on-going safeguarding concerns. Liberty Protection Safeguards are in place for all relevant children.

21. The multi agency group reviewed staffing records against the required level of staffing and found them to be satisfactory excluding any incidents already referenced above within the safeguarding section. For most individuals support is provided as 1:1 during the day, 2:1 in the community, and shared support overnight.

22. Where children and young people are eligible for an Annual Review, actions from the latest reviews have been checked and where actions are still outstanding there is either a plan to complete those actions or they are due to be completed at a date specified into 2023.

23. Areas of consideration:

Quality Assurance

- Regulation 44 reports are not routinely received by the Children's Commissioning team, the review enabled these to be requested. This has highlighted that there are sometimes incidents in these reports that may not have been previously flagged to commissioners or the relevant case holding team that builds a bigger picture of the child's lived experience.
- How providers ensure regulation 44 visits remain independent and provide the necessary scrutiny is a consideration.
- A routine sharing of information meeting led by commissioning to inform the on-going overall and assurance of a provider.

Providers

- The review highlighted some good practice examples with providers following processes robustly but also some where incidents are not notified to the relevant workers as quickly as they should be.
- Although most staff have been trained in Positive Behaviour Support and use the plans, there were a couple of instances where holds were used that were not written into the plans and had been classed as 'emergency' holds.

Action Two:

24. As Wiltshire has no current establishments meeting the criteria of the review there were no actions for the DOFA (Wiltshire LADO) to undertake.

Recommendations

25. The multi agency review group have reviewed all assessments and findings and identified some recommendations to strengthen the oversight of children and young people in these types of placement:

    - Commissioning will lead in establishing further quality assurance mechanisms with providers, to include that all Regulation 44 visits will be routinely requested and reviewed by commissioning where there are concerns expressed about a provider, or where their Ofsted rating is requires improvement, or inadequate.
    - Improve communication between commissioning and practitioners involved in these children's lives through additional meetings and engagement; ensuring a comprehensive view of the care children are receiving and that it remains the most appropriate and high quality.
    - That all staff working with these children continue to be alert to the on-going consideration that these are some of our most vulnerable children, living at distance. Ensuring everyone understands their individual role in assuring themselves around the care children receive from these providers is paramount.

26. We have determined it is important to undertake a further phase of work in early 2023 to review similar residential placements for children and young people not in dual registered establishments. This will ensure that the same rigor and assurance process has been carried for all children with similar vulnerabilities and consider any additional learning.