

Adult placement Continuing Care Adult Placement Service

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Unannounced

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Clackmannanshire Council

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About the service

Adult placement and Continuing Care service is a linked registration to the Family Placement Team. It approves and supports carers looking after young people who remain with their caregiver families on a continuing care basis from ages 18 to 21.

About the inspection

This was a short notice inspection which took place from 20 September to 7 October 2022. The inspection was carried out by three inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we spoke with two young people using the service and their social workers and spoke with staff within the service.

Key messages

- Young people were aware of their rights and supported to access Continuing Care.
- The service needs to improve the relationship between carers and the service.
- The capacity of the service had impacted negatively on outcomes.
- Robust quality assurance processes are required to improve consistency of practice.
- Transitions for young people who turn 21 need to be planned for earlier.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	1 - Unsatisfactory
How good is our leadership?	2 - Weak
How good is our staff team?	2 - Weak
How well is our care and support planned?	2 - Weak

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing?

1 - Unsatisfactory

We have graded this key question as unsatisfactory with major weaknesses in critical aspects of performance that require immediate remedial action to improve experiences and outcomes for people.

Young people in the service did experience nurturing care from committed carers and were treated with dignity and respect. Young people benefitted from access to advocacy services and a wider participation review was underway to support young people to become more involved in their care planning and promote positive outcomes. We saw that young people were able to be active members of their communities and there were positive examples of sibling groups being placed together within the service.

There were examples of positive collaboration within the authority between the educational psychology service and the family placement team to deliver training and consultancy to carers which was well received by carers and supported their understanding of trauma informed practice.

Staffing issues and workload pressures had impacted on the quality of support provided to carers, which in turn impacted on the quality of care provided to young people. Carers were not benefitting from regular contact from the service which impacted on care planning and the outcomes for young people using the service. Relationships between the carers and the service were fractured. One carer spoke of a "systemic failure of the system", another carer told us that "the service in clacks have a lot of work to do to regain the goodwill of it's foster carers". The service needs to address the concerns of carers to build supportive

relationships. This will form a requirement (see requirement 1).

Support to carers was crisis driven and the carers were not supported via routine supervision. This meant it was difficult for the service to anticipate need and identify support or learning needs for carers which impacted on outcomes for young people. Carer training was resource led rather than needs led and carers did not have individual training plans to meet learning needs. Improvements are needed in the quality of support provided to carers and this will form a requirement (see requirement 2).

Whilst there were positive examples of young people living together with brothers and sisters, there were some young people who had siblings they did not know about. In some cases where young people were living separately from brothers and sisters we did not see examples of evidence based sibling assessments to evaluate the quality of these relationships to inform future planning and there were delays in reuniting siblings who had been placed separately. The service should review how sibling relationships are assessed and promoted, this will form a requirement (see requirement 3).

Staff had been trained in life story work and we saw an excellent example of life story work being completed but this was not consistent for all young people in the service which meant that some young people did not have a full understanding of their life history. The service should improve consistency of life story work to ensure all young people have a full understanding of their identity. This will form an area for improvement (see area for improvement 1).

When young people were moving to live with caregiver families there was not a consistent approach to matching their needs to carer skills or the needs of other young people within the household or carers not having sufficient information about young people before they came to live with them. This led to negative outcomes with young people moving on an unplanned basis due to issues with the matching process. The service should ensure that when young people are moving to live with caregiver families that this is robustly assessed. This will form a requirement (see requirement 4).

We saw positive examples of young people having access to continuing care and understanding their rights. The service should improve pathways planning and information for carers around support from the service when young people turn 21 to improve transitions, this will form an area for improvement (see area for improvement 2).

Requirements

1. By 31 January 2023 the provider must improve the quality of support offered to caregiver families in the service.

To do this the provider must as a minimum:

- a) undertake work to repair working relationships and restore the confidence of caregiver families in the service.
- b) ensure that caregiver families receive a responsive service that includes regular home visits to support them in their caring role.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which

state that:

"My care and support meets my needs and is right for me" (HSCS 1.19).

2. By 31 January 2023 the provider must ensure the early identification of vulnerabilities within caring households and timeous implementation of supports in order to mitigate risks which contribute to poor outcomes.

To do this the provider must as a minimum:

- a) review the support needs of foster carers as per their fostering agreement of fostering handbook
- b) establish regular supervision of carers
- c) Further promote engagement with carer support groups.

This is to comply with Regulation 24 (6)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards which state that:

'I am confident that people respond promptly, including when I ask for help.' (HSCS 3.17); and 'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty' (HSCS 3.18).

3. By 31 January 2023 the provider must ensure that sibling relationships are thoroughly assessed, in particular if they are placed with separate caregiver families.

To do this the provider must as a minimum:

- a) review practice in relation to sibling assessments and identify knowledge gaps amongst staff
- b) ensure that sibling assessments are evidence based and undertaken according to best practice guidance
- c) review the quality of relationships between sibling groups who live apart to with the aim of promoting positive relationships where this is assessed as in the child's interest.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

"I am supported to manage my relationships with my family, friends, or partner in a way that suits my wellbeing" (HSCS 2.18).

4. By 31 January 2023 the provider must ensure that there is a clear identification of a fostering family's ability to meet the needs of a child before the child joins this family.

To do this the provider must as a minimum:

- a) have clear a clear referral process which outlines the needs of children needing alternative care from fostering families
- b) identify carer strengths and vulnerabilities in relation to meeting the needs of a specific child and outlining any additional support required to ensure that children's needs are fully met
- c) ensure planning meetings take place when children join fostering families to review children's needs
- d) ensure that this process fully considers the needs of existing children in the fostering family.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland

(Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'My care and support meets my needs and is right for me' (HSCS 1.19).

Areas for improvement

1. To ensure all children have a clear understanding of their past the provider should improve its approach to life story work.

This should include but is not limited to, implementing a consistent approach to gathering and storing important life story information and providing specific training to staff and carers about how life story work should be approached.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am supported to be emotionally resilient, have a strong sense of my own identity and wellbeing, and address any experiences of trauma or neglect' (HSCS, 1.29).

2. To ensure that young people experience a positive transition from continuing care, the service should improve pathways planning and information available to carers in relation to post 21 support options.

This should include but is not limited developing a transition policy and ensuring pathways planning occurs timeously so young people are aware of their rights.

This is to ensure that care and support is consistent with the health and social care standards (HSCS) which state that: "My future care and support needs are anticipated as part of my assessment" (HSCS 1.14).

How good is our leadership?

2 - Weak

We have graded this key question as weak where there are strengths but these are outweighed by significant weaknesses.

The service had undertaken a thorough internal review and a safeguarding review since the last inspection with the aim of improving practice which were positive initiatives however it was not clear how either of these reviews had led to systematic change or practice development.

Some quality assurance measures were in place to support positive outcomes for young people, a new file audit template was in use and a tracker was in place to monitor carer reviews within the service. A new experienced independent panel chair had been appointed since the last inspection and panel benefitted from a committed and experienced membership. Improvements to permanence processes such as the creation of a dedicated permanence team within young people's social work and new Permanence Advice meetings ensured practice in relation to permanence was reviewed at an early stage to reduce drift and delay.

The service had a development plan which had evolved through the work of previous service managers and was a very large document with a high number of action points. To ensure that improvement can be effectively targeted, a more focused SMART (Specific, Measurable, Realistic, Time-bound) plan should be devised. This will form an area for improvement (see area for improvement 1).

Weaknesses in quality assurance processes had the potential to impact on the consistency of practice and outcomes for young people in the service. The service had no mechanism for tracking unplanned moves for young people with interim carers or any ability to take learning from these to improve practice. We noted that some young people had experienced high numbers of moves and the service had no overview of the reasons for this. Unplanned endings that did take place did not identify clear learning points for the service overall. The service should improve how it learns from any unplanned endings this will form a requirement (see requirement 1).

The service had no systems in place for monitoring the consistency of practice and support for carers and ensuring key elements of practice to safeguard welfare were undertaken, for example carer checks, unannounced visits and carer supervision. Quality assurance systems should be made more robust to ensure consistency of practice and improve outcomes, this will form a requirement (see requirement 2).

Deficits in quality assurance processes also meant that the service was not complying with its statutory duty to notify the Care Inspectorate of key events. This has been noted in two previous inspection reports as a practice issue and will form a requirement (see requirement 3).

There was not a consistent process for panel reviewing instances where carers were given temporary approval to exceed their registration as carers. This meant that there was not external oversight of the impact of these interim decisions. The role of panel in quality assurance in this area should be strengthened, this will form a requirement (see requirement 4).

Requirements

1. By 31 January 2023, the provider must ensure that there is reflection and clear learning points identified if an unplanned ending occurs within the service.

To do this the service the provider must as a minimum:

- a) hold reflective meetings in all cases when children are moved between caregiver families on an unplanned basis. These meetings should identify clear learning points for the service to improve future outcomes
- b) undertake an audit of practice where young people using the service have experienced multiple moves. Use this information to drive improvement and improve stability children experience in caregiver families.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

"I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

2. By 31 January 2023 the provider must ensure that there are robust quality assurance measures in place to support positive outcomes for young people in caregiver families.

To do this the provider must as a minimum:

- a) embed quality assurance systems across the service to ensure carers receive a consistent service
- b) ensure statutory checks are completed within timescales.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

"I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

3. By 31 January 2023 the provider must ensure that all notifiable incidents are appropriately reported to the Care Inspectorate.

To do this the provider must as a minimum:

- a) comply fully with statutory requirements in accordance with "Records that all registered services (except childminding) must keep and guidance on notification reporting".

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

4. By 31 January 2023, the provider must ensure that there is clear panel oversight if care arrangements for children are outside of carers approval.

To do this the provider must as a minimum:

- a) ensure that the fostering/adult placement panel are appropriately notified if care arrangements are made that are outside of carers approval and that reviews are held timeously when required.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

"I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11).

Areas for improvement

1. To promote positive change within the organisation, the service should review it's current development plan in line with SMART (Specific, Measurable, Achievable, Realistic, Time-Bound) principles.

This should include but is not limited to a review of the current development plan to create a more streamlined document to make it easier to evaluate progress toward outcomes. "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

How good is our staff team?

2 - Weak

We have graded this key question as weak where there are strengths but these are outweighed by significant weaknesses.

Staff in the service were experienced and were knowledgeable about trauma informed practice. Staff had regular informal supervision and support to manage work tasks but these were often crisis driven and there were deficits in the quality of regular formal supervision. Where specific training had been invested in, staff were not confident there would be opportunities to fully implement their learning due to competing work pressures. Staff had limited ability to engage in team development and reflection of practice. One staff member told us "Due to poor staffing levels it is difficult to make time for development and to attend meetings or to provide the best care for our children and young people" The service should create a supportive learning culture to promote positive practice. This will form an area for improvement (see area for improvement 1).

At the time of the inspection, the service was experiencing staffing issues with staff absence. This was linked in part to the impact of Covid-19 which created additional pressures for the service. This compounded issues with what staff described as an unmanageable workload within the service due to pressures of duty tasks and family finding for children in need of resources external to Clackmannanshire Council provision.

Staff reported that they were working excessive hours and were on a daily basis being directed to undertake the most urgent tasks. One staff member told us "Everyone is driven to provide high standards of care but systemic issues are cause for staffing issues. There is real unrest which is impacting on drift and outcomes for children." The service should undertake an audit of the workload of the family support team and review staffing capacity and this will form a requirement (see requirement 1).

1. By 31 January 2023, the provider must ensure caregivers and young people are kept safe and that the quality of support offered by undertake an audit of staff capacity to review the ability of the team to ensure that each service is able to fulfil their legal responsibilities and complete the core functions of the service.

These will include, but is not limited to recruitment and assessment of care givers, supervision of care givers and training of care givers.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SS1 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state that:

'I have confidence in people because they are trained, competent and skilled, and are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14); and 'My needs are met by the right number of people' (HSCS 3.15).

1. To support care giver and children's wellbeing, learning and development, the provider should ensure that all staff are sufficiently confident, supported and enabled to develop a team culture. This should include, but is not limited to:

- a) provision of regular opportunities for good quality supervision in line with their policy
- b) ensure that staff have opportunities for team reflection and support through regular team meetings
- c) implementation of systems of staff appraisal for all staff.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).

This is to ensure that care and support is consistent with the SSSC's Code of Practice for Employers of Social Service Workers, which state that the employer will: 'provide effective, regular supervision to social service workers to support them to develop and improve through reflective practice' (3.5).

How well is our care and support planned?

2 - Weak

Young People had access to advocacy services and were able to become involved in care planning. The service is developing a participation strategy with funding from "The Promise" to further promote the engagement of children in their care planning and service improvement.

Young people were able to express their views and welfare assessments captured their voice and informed planning but these were not seen for all young people. Pathways planning and reviews were being undertaken but there was some drift in planning for transitions for young people post 21 (see area for improvement in key question 1).

Carers had family policies in place which outlined their approach to safer caring within their households. The service should develop its approach to safer caring through the use of individual safer caring plans and risk assessments to ensure that support needs are documented and there is shared understanding between carers and the service in relation to the management of risk. There should also be a consideration as to how these plans need to evolve in continuing care. This will form a requirement (see requirement 1).

Requirements

1. By 31 January 2023 the provider must ensure that robust plans are in place to support young people in caregiver families.

To do this the provider must as a minimum:

- a) ensure that individual safer caring plans are in place for all children
- b) ensure that risk assessments are in place and that these are regularly reviewed when circumstances change
- c) discuss with carers how safer caring plans need to evolve when young people enter continuing care.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

"My personal plan (sometimes referred to as my care plan) is right for me because it sets out how my needs will be met as well as my choices and wishes" (HSCS 1.15).

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	1 - Unsatisfactory
1.1 Children, young people, adults and their caregiver families experience compassion, dignity and respect	1 - Unsatisfactory
1.2 Children, young people and adults get the most out of life	1 - Unsatisfactory
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience	2 - Weak
1.4 Children, young people, adults and their caregiver families get the service that is right for them	3 - Adequate

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement are led well	2 - Weak

How good is our staff team?	2 - Weak
3.2 Staff have the right knowledge, competence and development to support children, young people, adults and their caregiver families	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	2 - Weak

How well is our care and support planned?	2 - Weak
5.2 Parents, carers and family members are involved	2 - Weak

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