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Late Information for 15th March 2012 Scrutiny Board (Children and Families)

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Draft Scrutiny Inquiry report

**Services for children with
disabilities, special educational
needs and additional health needs –
Inquiry into service redesign**

2012



Introduction and Scope

Introduction

1. In March 2010 the Executive Board considered a review of the organisation of children's services delivery in Leeds, and agreed to create a single Integrated Children's Service within the council by 1 April 2011. This would bring Education Leeds back into the council.
2. The preparations for this structural change coincided with a period of severe financial challenge within the public sector, creating both the opportunity and the necessity to consider changes in the way services are provided to become more efficient.
3. In some areas of children's services this work has been extended beyond those services directly delivered by the council to include (for example) health provision.
4. In discussing areas of work for the coming year, the Children's Services Scrutiny Board agreed in June 2010 that it would carry out an inquiry into the proposed redesign of services, taking the provision of services for children with disabilities, special educational needs and additional health needs (and their families) as our focus.
5. However, whilst the economic climate and the change in council structure were important issues, our main motivation in undertaking this piece of work was to examine how a better integrated service could improve outcomes for children and their families locally.
6. Children with disabilities, special educational needs and additional health needs are some of our most vulnerable young people, and in many cases have complex needs which cut across service delivery boundaries.
7. The Scrutiny Board also maintained oversight of the progress of the overall programme to create an Integrated Children's Service as part of its performance management and accountability activity, but it made a more detailed study of this particular project.

Scope of the Inquiry

8. The purpose of the Inquiry was to make an assessment of and, where appropriate, make recommendations on:
 - The proposed range of services that will be provided in an integrated model
 - The balance of universal, targeted and specialist service provision for this group of children and their families
 - The potential benefits to children and families from the proposed redesign of services



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Anticipated Service Impact

9. Although this inquiry was carried out during 2010/11, our report was not finalised until spring 2012. At this point in time the new Complex Needs service is about to be launched as a result of the restructure of Children's Services.

Recommendation 1
That the Director of Children's Services brings us a progress report on the overall implementation of the new Complex Needs Service to accompany the formal response to our recommendations in this inquiry report in July 2012.

10. We hope that the Scrutiny Board's findings will contribute to shaping the emerging arrangements for the future delivery of services to children and families with complex needs.



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Transforming Children's Services in Leeds

11. We began our inquiry with a presentation from the newly appointed Director of Children's Services about his plans for transforming the provision of children's services in Leeds.
12. Underpinning the plans was a new aspiration for Leeds to become a 'child friendly city' adopting the Unicef model.
13. In addition the Director articulated three key messages:
 - Do the simple things better – often this makes the biggest difference to children and young people
 - The child is the client
 - Safeguarding and promoting the welfare of children must underpin everything we do
14. He set out a proposed new structure based around locally based teams of universal services, supported by both a local well-being team and a local child protection team. There would be two specialist services – for looked after children and for children with complex needs. Each of these specialist services would be provided by 3 area based teams.
15. Although these plans have since been refined, the part relevant to this inquiry, specifically the three area based complex needs teams, are still retained.
16. We were told that there was a specific strand of the children's services transformation programme relating to the integration of service delivery.

Originally this was organised into six key areas of work:

 - Leadership and governance
 - Disability/special educational needs/additional health needs
 - Looked after children
 - Safeguarding
 - Universal services
 - Well-being teams (locality based)
17. The disability/special educational needs/additional health needs programme was later combined with the universal services programme in order to ensure consistency, avoid duplication and ensure that the needs of the children and families were prioritised.
18. This had led to the development of two proposals – one linked to the improvement of universal settings, and the other linked to children with complex needs. This latter proposal would cover the 1,000 children and young people in Leeds with the most complex long-term needs, and their families. This is the proposal that we focused on in our inquiry.
19. We already know that most children with special educational needs and disabilities can have their needs met within mainstream services, so long as the appropriate support is in place within children's centres, schools and colleges, and with established routes for additional help when necessary.
20. However, for a small number of children with complex needs and life limiting illnesses the breadth, intensity and complexity of the support they and their families require means that it would be



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difficult for a mainstream setting to manage this on their behalf.

21. Parents of children with complex needs often have to interact with a wide range of services to co-ordinate all the support they need and the range of professionals involved in order to ensure that the needs of their child and family are met.
22. The main objective of the service redesign was to address this problem and provide families with a more joined-up response to their situation. This tallied with the key objective of our inquiry.

Principles

23. We applauded the key principles of the proposed new model of service delivery for children with complex needs:

- Child and family first
- Single point of contact
- Coordinated response
- Unified referral, assessment and planning process based on the common assessment framework (CAF)
- Named key worker
- Telling the story once
- Keeping the door open
- Planning ahead for the next stage (managing transition)

24. The new service would enable children and young people and their carers to make informed choices to lead as ordinary and successful a life as possible in the circumstances.

25. We strongly believe that this group of 1,000 children and young people have every right to enjoy every aspect of provision across the city.

26. We learned that the development of the proposals was also based on the following premises;

- All service design and function is premised on identifying and achieving enhanced outcomes for children and families.
- Families, early years providers, schools and colleges provide the key universal settings and focus for public service provision as the child grows and develops.
- Where the universal provider settings lack the capacity and resources to properly meet the needs of the child they will then work in partnership with external specialist agencies to
 - a) target work on the development of their own capacity and capability to meet the child's needs and where necessary
 - b) provide a base and/or focus for specialist intervention from external specialist agencies.
- Where targeted/specialist work with the child and family is carried out away from the universal setting (in, for example, a clinic, hospital, GP surgery) or is by nature an essential business support function (as in the case of SEN statutory assessment and statement functions) this work will always be clearly and simply communicated back to the universal setting in terms that are designed to enhance the work of that setting.



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- This partnership working will be 'person-centred' so that planning, delivery and review of the effectiveness of interventions always involves the child and family. No work will ever be done in isolation from this focus. Referral from one agency to another must always take the form of a structured conversation designed to build and enhance the effectiveness of the team working with the child and family.
- Support should always be delivered as close to the child and family as possible and appropriate to the child's needs and wishes.

27. All the above features should ensure that the child and family are clear about the purpose and intended outcomes of a planned intervention, what the child's and family's role is in delivery, who else is involved and their role and the intended period for the intervention.

Integrated Service Delivery

28. Under the new proposals existing services will be reconfigured to develop three area based teams of lead professionals operating locally. The complex needs service will not include all staff with a focus on inclusion – some of these will be located in Wellbeing Teams, e.g. attendance improvement officers, or in Settings Improvement. The service for children with complex needs will have close links with both these teams. The service will recognise the different phases of delivery of services and support in the life of the child and young person.

29. We heard that it was felt that the integrated 0-5 service for children with complex needs would be best focused on a Child Development Centre, of which there are three (North East and East, North West and West, and South). NHS Child Development Centres currently provide early assessment of young children's needs and development and they support interventions to aid their progress. An alternative setting would be one of the six resourced children's centres.

30. The 0-5 service would be likely to include:

- Specialist health visiting
- Hearing Impairment and Visual Impairment service
- Early Years Support Service
- Leeds Inclusion Support Service
- Portage
- Speech and language therapy, occupational therapy and physiotherapy.

31. The service will work with families and with the full range of early years settings. It will lead on the planning for the child's transition into statutory education. It will maintain relationships with key professionals including Child Health and Disabilities social workers (children with disabilities are regarded as children in need under section 17 of the Children Act 1989), paediatricians, acute services, and educational psychologists and others who may be based separately from the core team.

32. For children and young people from 5 to 14 with complex needs, the most appropriate setting for the service was seen to be a Specialist Inclusive Learning Centre (SILC) site or



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resourced or partnership school, although it was recognised that current accommodation may present constraints.

33. The 5-14 service for children with complex needs would be likely to include:

- Child Health and Disabilities social work
- Hearing Impairment and Visual Impairment service
- Leeds Inclusion Support Service
- Speech and language therapy, occupational therapy and physiotherapy
- SILC nursing

34. The service will work with families and with the full range of educational settings and with those colleagues who work in other services to improve the quality of provision in all settings. A key feature of this service will be the provision of a single point of contact for the families of children with complex needs, ensuring that families experience a seamless service from the point of diagnosis onward, through an identified co-ordinator or key worker.

35. The service will maintain relationships with key professionals including paediatricians, acute health services and educational psychologists. It will plan for and support the needs of the whole child and family. This will include access to and progression in education, access to leisure and enrichment opportunities, participation, care in the home, short breaks, relationship issues. It will also need to be responsive to a crisis or sudden change in families' circumstances e.g. arranging short term

emergency residential or other placement.

36. Young people from age 14 onwards will be supported by the same team of lead professionals, but in addition the team will be augmented by specialist Connexions workers. The focus will be on preparation for transition into post-16 learning and onwards into independent living where appropriate, supported by adult services. The integrated team for the area will be augmented by the Social Care Transitions Team, which will operate city-wide, with alignment to the three areas.

37. Some functions will be most appropriately delivered via a centrally retained service aligned to the three areas. This includes SENSAP (Special Educational Needs Statutory Assessment and Provision service) and the Child Health and Disability Occupational Therapy (CHAD OT) Team. The city-wide roles within the Sensory Service e.g. audiologist, disability access officer will also operate across the city rather than be aligned to an area of the city. These services are too small to be able to work effectively if they were split to separate locality teams. They will work alongside Health teams e.g. the Children's Nursing Team, Dieticians, Children's Learning Disability Service, Continuing Care and Health Short Breaks which also operate as centrally retained Health services, aligned to areas.

38. The Special Educational Needs Statutory Assessment and Provision service and the Education Psychology Service, whilst sitting within the complex needs service, will work with children, young people and all settings across a broad range of needs. The Child Health



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and Disability Social work team (CHAD) will have a strong link with the 0-5 service on a locality basis.

39. Members asked about the engagement of the Child and Adolescent Mental Health Service (CAMHS) service with the proposals for a more integrated provision. They were informed by council officers that discussions with the CAMHS service had taken place later than with some other partners and that this was the reason CAMHS was not specifically mentioned in the diagrams, but that CAMHS had confirmed their support for the principles of the proposed new arrangements.
40. CAMHS will continue to operate as a centrally retained service, supporting settings, children and young people as appropriate.
41. This was verified in correspondence with CAMHS, who confirmed that they could see how they could and would interface with proposed model. They would need to understand the operational detail as the next stage of the development of the proposals. CAMHS were happy to deliver in local settings for better access to services.
42. We feel that it is vital, given the prevalence of mental health concerns, that the CAMHS service plays a full role in the new arrangements.
43. We also noted that in disability services children and young people keep the same social worker from assessment onwards up to the age of 18 unless the worker leaves. This is also an area with a relatively stable workforce when compared to other branches of the social work service.
44. Settings improvement work is crucial to ensure that all provider settings continue to develop their inclusive practice and that effective approaches are shared and adopted.
45. It is envisaged that settings improvement will be delivered via centrally-retained or commissioned services, aligned to the three areas. It is also important that there is a clear link between those providing advice and support on meeting individual needs, and those concerned with settings improvement so that practice is constantly reviewed, refreshed and enhanced in the light of experience.
46. As part of the new integrated service offer, it will be important to be clear about the sources of advice and support across the city, to ensure that provision is sufficient to meet need and is equitably distributed.
47. Management of the integrated service across the whole age range (0-5, 5-14 and 14+) is likely to be via three area managers who will be responsible for ensuring that the appropriate plans are in place to anticipate the needs of individual children and families, and for monitoring outcomes. They will need to work closely with the managers of the universal settings and with the Wellbeing and Child Protection teams in their area.

Recommendation 2
That the Director of Children's Services confirms how the CAMHS service will be delivered within the context of the redesigned service.



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48. The whole service, including the three area teams and the centrally-retained and aligned elements, will require a leader with complete oversight and accountability to ensure strategic vision, service development and consistency of delivery. Professional leadership will also need to be retained and this can be provided separately from the day to day operational management of the work of the area team.

Recommendation 3
That the Director of Children's Services explains how the service will ensure consistency of standards between the three areas of the city and also what monitoring of caseload will be in place to ensure an appropriate distribution of resources.

49. It was acknowledged that the new model would also need to take account of the outcomes of the national Spending Review, changes to national policy such as the schools white paper, and changes in health.

50. We know that the incompatibility of IT systems continues to present a considerable challenge for information sharing and joint case working.

51. One of the things that we were told that the service redesign plans to address is to improve information sharing by having a central hub that would know all the children in their geographical area.

52. The effectiveness of the integrated service will be measured by a range of indicators including:

- Educational progression of young people including attendance and attainment
- Participation including access to a range of cultural and leisure opportunities
- The extent to which needs can be met locally, without recourse to out-of-city placements
- Young people's perceptions of their progress, personal autonomy and the quality of their support
- Parents' perceptions of the quality and timeliness of the support they have received
- Staff perceptions of the effectiveness of integration and joint working
- Value for money

Visits and stakeholder meetings

53. Members of the Board carried out a series of visits and stakeholder meetings to explore various aspects of existing services to this group of children and young people and their families in more depth. Members were keen to learn about existing service provision, to hear about good practice and to discuss with front line staff how a more integrated service can lead to improved outcomes. We also took the opportunity to explore with practitioners some of the emerging themes from our full Board discussion.

Ralph Thoresby School Resourced Unit

54. We visited Ralph Thoresby High School which has recently been rebuilt under a Private Finance Initiative (PFI)



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scheme, including a resourced unit. The new building includes good facilities such as community physiotherapy, a hydrotherapy pool, an activity base and treatment room, as well as accessible facilities throughout the school. There is a school nurse on site full time.

55. There is an on site visual impairment unit with eight pupils who have a range of needs. The school can take roughly 20-25 pupils with medical or mobility needs. We were told that pupils receive most, if not all, of their support on site.
56. The philosophy of the school is for it to be a mainstream school where children with medical or mobility needs are offered a care package so that they can access education with peers.
57. The school has also had a Cope Team for several years, which is a specialised team trained to cater for the welfare needs of young people that have mobility or medical issues.
58. Pupils with medical or mobility needs that come to Ralph Thoresby's resourced provision have to go through the education statementing procedure. They would usually have already been through this procedure to assess their needs at pre-school and primary school.
59. Annual reviews and transition reviews (Year 5) are held once a child attends school. These will include educational psychologists, the head teacher, SENCO, any health specialist necessary and the parents/family.
60. Some of the issues raised with us in discussion at the school were:
 - concerns about access to educational psychologist time – there was one EP for the cluster of schools that Ralph

Thoresby belongs to. An EP will be involved approximately once a week and it is rare for them to work one to one with a pupil;

- transport is not always paid for by the authority, dependent on whether or not a pupil meets the criteria;
- difficulties accessing CAMHS due to the workload of the service;
- staff would like access to a social worker based in the school or the cluster to provide advice;
- it would help if there were support staff available to help children and young people access after school activities;
- the perennial issue of short-term funding was raised;
- staff were very supportive of the key worker proposals.

Rainbow House

61. Rainbow House opened in February 2010 as a purpose built facility offering short term respite care for up to 12 young people. It offers short breaks for 35 days per year, spread over the year. The unit includes a small self help unit for 3 young people. It can accommodate children and young people from 6 to 18 years of age. Young people are referred via Social Care.
62. The facilities are used predominantly outside the school day as children continue with their normal daily routine when at Rainbow House. Children do make use of the facilities during the day on training days and during the school holidays.
63. We were impressed by the facilities but felt that they were under-used during



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the day. We felt that the possibility of further use being made of the facility at Rainbow House during the school day should be explored.

Recommendation 4
That the Director of Children's Services reports back to us on how more use can be made of Rainbow House during the day.

Child Development Centres (CDCs)

64. We visited two of the three Child Development Centres (CDCs), which are expected to host the 0-5 integrated service.
65. The function of a CDC is to provide specialist assessments and timely coordinated interventions for pre-school children with complex developmental needs (eg Down's syndrome, cerebral palsy, autistic spectrum conditions, language or feeding problems, sensory impairments and severe physical or learning difficulties).
66. The CDCs aim to provide a child and family centred service which focuses on enabling children with complex needs to reach their full potential and participate in society.
67. The CDC at St James's Hospital covers the East and North East areas of the city and the Wortley Beck Centre covers the West and North West. A third centre – St George's – covers the south of the city and operates on the same model as Wortley Beck. The CDC at St James was under a split management arrangement, although we understood that the intention was for it to move to the same management arrangements as the other CDCs shortly.
68. The staff teams include paediatricians, physiotherapists, occupational therapists, speech and language therapists (including feeding issues), play therapists, psychologist support and also audiology and eye clinic services, as well as administration support. The on-site teams work closely with wider partners including Leeds Inclusion Support Service (LISS), early years, Education Leeds, Child and Adolescent Mental Health Service (CAMHS), other health services and SILCs.
69. There are established pathways for dealing with the majority of cases, based on how complex the child's needs are. However, staff were keen to emphasise that 'one size doesn't fit all' and services are adapted accordingly.
70. The initial multi-disciplinary team assessment of a child's needs is likely to be quite a lengthy appointment, and may involve several professionals or the full team. This is followed by verbal feedback supplemented by a comprehensive intervention/support plan shared and agreed with the family.
71. Following the initial assessment (which in some cases also includes a home and/or nursery setting visit), the child may need to be seen by one or more professionals at varying intervals until they start school.
72. Staff work closely with families to build a rapport and to help them come to terms with their child's needs over a period of time. The role of the Specialist Health Visitor is often key in such instances.



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73. Prior to the child reaching school age the service send a 'HEN' form which triggers a visit by an Educational Psychologist to discuss options for school and process for statutory assessment.
74. We talked about the transition to primary school. This can be a hard time for the family as they move from intensive personal support and contact with CDC professionals to new community team members and adapt to a new education setting.
75. The Specialist Health Visitor can continue to work with the family until the child is five, but after this the school nurse is the closest thing to a replacement. We discussed the importance of finding ways of keeping parents informed and empowered in relation to their child's needs.
76. If the child requires Clinical Psychology input past the age of five they would be referred to CAMHS.
77. The paediatrician will continue to have contact with the child until they are 19, but this is infrequent and does not resemble a 'key worker' role. We were told that it is rare to be able to discharge a child from the service, as GPs and the local paediatric clinics find it generally challenging to be able to manage the long term needs of children with neurodevelopmental problems.
78. Our parent governor representative for special educational needs confirmed this from her own experience of her GP's reluctance to deal with apparently straightforward issues with her child.
79. The following points were raised during the visits and discussions at the CDCs.
80. It was stressed that it was important to avoid the CAF becoming additional bureaucracy over and above the assessment process. Mention was made of a 'deemed CAF', allowing the assessment process to feed directly into the CAF assessment rather than duplicating work.
81. Staff emphasised the added value of the team approach, as they could achieve more by joint working with a child and family.
82. It was suggested that joint funding was key to success as the current separation of funding was a barrier, for example in agreeing who will fund what equipment for a child.
83. They also emphasised the importance of empowering parents, and creating opportunities for parents to share experiences and knowledge with others in a similar situation.
84. The team at St James's told us that they would like to provide more joint clinics in order to provide a one stop service for families where possible. Medical follow-up at the other CDCs is offered more on an outreach basis. Both approaches are in line with the aim of the review to make services more accessible to families.
85. We learned that staff have regular joint meetings with certain partners, as well as providing regular training opportunities for doctors and therapists. They are trying to work more closely with generic health visitors and the wider primary care team. The Speech



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and Language Therapy training programme for mainstream staff was quoted as an example of best practice.

86. We were told that regular meetings include the sharing of best practice and the use of case studies. In addition the centre has access to specialist advice, for example from a specialist clinic in London, when a child's condition is particularly complex or rare.
87. St James's CDC would like to offer a toy, equipment and information library for families. They would also like space to offer to parents to run a support group.
88. St James CDC had particularly felt the impact of losing admin staff and also delays in recruiting to vacant posts. There were significant waiting lists for some services especially psychology. There were also current waiting time discrepancy between referrals received from GPs and other health professionals. We were told that commissioners were looking at strategies to reduce waiting times.
89. The case load figures provided by the CDC and LISS both showed that the area covered by St James's CDC has about 1/2 the total cases for the city. The challenge that this creates is exacerbated by the number of families requiring interpreters, high levels of deprivation and the number of children with social care involvement, as well as families who take regular trips out of the country or those who are reluctant to admit their child's disability.
90. Such cases often mean that appointments have to be re-arranged, and delays can mean children have to have more treatment, which impacts on the service available to others.
91. We asked about safeguarding issues where parents are in denial about the level of their child's needs and CDC staff confirmed that this would be considered if appropriate. The CDC used to have the support of a Social Worker based in the centre and would like to have this type of on hand advice about individual cases again, especially those involving families 'on the edge' of social care intervention.
92. The team were supportive of the proposed model for service integration. They also felt the potential role of a key worker in helping to co-ordinate appointments for a family would be very helpful, especially if they had more than one child with complex needs.
93. There was felt to be a need to improve links with adult services when parents have mental health needs which impact on their ability to support their children.
94. One of the case studies presented to us by the CDCs included lots of missed appointments leading to delays in diagnosis and treating the child's condition, as well as more treatment required. Parents had their own problems and a chaotic lifestyle. The role of the key worker could make a real difference here.
95. Concern was also expressed about the variability of educational psychologist input due to the capacity of the service to meet demand.
96. The CDC saw opportunities for better integration with the Leeds Inclusion Support Service (LISS). They had also heard of plans to enhance provision at



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some children's centres, to enable them to become more inclusive, but they were unsure how this was progressing – possibly due to training issues.

97. Notwithstanding some of the issues of detail raised during our visits, overall the CDC staff saw lots of areas of opportunity in the transformation programme for further improved integration.

Leeds Inclusion Support Service (LISS)

98. LISS is a commissioned service provided through the Pre-School Learning Alliance and the current contract ends in March 2011. There is a team of 3 Inclusion Development workers (one linked to each CDC) plus a case-holding manager.
99. The service provides signposting for families (and professionals) and also undertakes CAFs. LISS administers the budget for funding inclusion to enable children to attend private and voluntary sector early years settings, using the same funding criteria as local authority settings. They also fund inclusion in out of school activities including short break respite care.
100. The services helps professionals in settings to support children with complex needs and they also provide advice on grants.

Headteachers' Forum Meeting

101. We met with representatives of the Headteachers' Forum to hear their perspective. The representatives we met were from the primary sector. They told us that the number of

support staff in school has grown over the years, including the support for social, emotional and physical issues.

102. The head of Queensway Primary School told us that her school usually funds more than it receives in terms of the Funding for Inclusion (FFI) money from the Local Authority. There is a care suite on site.
103. The heads noted that there are an increasing number of children suffering from mental health, social or emotional issues, or with parents or siblings with such issues. Also parents and families that are unable to cope with the behaviours that their child displays.
104. The level and quality of information given to a school before a child attends, in regards to SEN or disabilities sometimes is not good. As a result schools are less prepared to support their needs than they could be.
105. Once again we heard that there is one educational psychologist per cluster usually, and that this raises capacity problems.
106. We specifically asked about the level of awareness in schools about the proposed changes. We were told that there has been a limited response from headteachers unless they are directly involved in the development of the proposals. A lot of schools are waiting until a decision has been made before they start changing. The schools need to be involved in the redesign of the service.
107. Concern was expressed that there are not enough Headteacher meetings to



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filter down the information on what is happening to the services in Leeds in regards to the redesign. There have been mixed messages so far. The twice a term regular meeting is not enough time to get the message across.

Recommendation 5
That the Director of Children's Services investigates how information relating to service redesign better communicated to Headteachers.

108. Nevertheless, the heads felt that there are excellent services in Leeds, and it would be good if they could come together in one place for people to access, in locality based teams. Services need to be co-ordinated through a single point of contact.
109. Resource need to go in as early as possible. It was suggested that it may be worthwhile to evaluate whether the children's centres are able to target the people they need to get to well enough.
110. The schools drive the clusters forward. Partners need to be convinced of the benefits of a locality model so that other organisations participate fully in these meetings and put money in.
111. They also confirmed that schools have data and so do ward councillors, it is just about using that data to identify families and looking at how to involve them appropriately.
112. As always with our inquiries, we were keen to meet hear the views of children and young people. Some of us met with a small group of young people from Aim Higher and People in Action, with disabilities ranging from mental health and learning difficulties to visual impairments and physical disabilities. All were aged 14 or over.
113. They told us that medical staff, teachers and the general public tend to speak to their parents, or whoever they are with, rather than the actual child or young person. This can be deemed as ignorant, patronising or just down right rude.
114. They also said that they found it hard to speak out about courses they actually want to do. Instead they are just told what they should be doing, instead of being asked or listened to.
115. On some courses there are not enough support staff to enable them to successfully access the course..
116. They also found a huge gap for people with disabilities in terms of places to go to help them find work. They felt that there needs to be a way to tie together current schemes and offer more creative opportunities for people with disabilities, for example apprenticeships, work-place training and college courses.
117. Though there is an access bus, the young people told us that there was not enough support in terms of staff or volunteers who could help them with evening and weekend activities, for example walking around town or accessing universal services. There also needs to be more focus on social inclusion and widening the

Aim Higher and People in Action



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range of services and activities available.

118. It was also difficult for their parents and carers to understand the range of financial support available and access their full entitlements.
119. They agreed that a Social Worker can only help so much. They suggested that there needs to be someone else in-between who will be focused on specific outcomes, who can support them to access funding and deal with their anxiety and the care that a person requires.
120. They argued that if there is short-lived intensive money spent (for example in helping a young person to become mobile, thus independent) then there will be no further resources used after independence is gained.
121. The young people were concerned about a lack of support during transition and in relation to direct payments. Only one of the young people we met had a Connexions Personal Adviser. 4 had no Social Worker assigned to support them.

Recommendation 6
That the Director of Children's Services ensures that all children reaching the transition phase to Adult Services have the opportunity of access to a Social Worker and/or Personal Adviser to support them.

122. In terms of transition to adult services, for some it seems there is a lot of help in terms of careers advisers, transport to and from school provided by the local authority, and carers at the weekend.

123. There needs to be more information given out so people can access the services that are available to them. Support workers and social workers need to be more consistent in the provision of information.
124. Young people have quite rightly told us that they want independent supported living, a social life, work, just like their peers. We are pleased that the service redesign supports access to universal services. However it is important that young people receive the right support to grow their independence and enjoy these opportunities.
125. There is a danger that the institutional and specialist services world can be all a family knows, so we need to develop a conversation with the local partnership around whether the needs of those children can actually be met by making some reasonable adjustments to out of hours activity in the area, housing in the area, and those sorts of enhancements to universal services.
126. The overall message from the young people was that there needs to be more communication with young people with disabilities, in regards to the services on offer and the changes within the support services that they can access.

Recommendation 7
That the Director of Children's Services reports back to us on some of the service improvement initiatives which will improve this group of children and young people's access to universal services and opportunities to enjoy fun activities.



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Self Directed Support

127. We also received a briefing on the self-directed support project. The Children's Self Directed Support project in Leeds originally sought to develop a pilot with 12 families whose disabled young person was entering transition to adulthood and had a package of Social Care.
128. Unfortunately, in late August 2010, due to the financial situation, difficulties were encountered with Children and Young People's Social Care in accepting any financial risk from this transformational programme.
129. This led to a delay in implementation. The task was now to look at financial methods of delivering flexible access to services through a redesign of Direct Payments to enable Self Directed Support, linking to the Person Centred Planning being developed within the Transition Team, and using the learning from the earlier Budget Holding Lead Professional project.

Recommendation 8
That the Director of Children's Services provides us with an updated position in relation to the development of Direct Payments to families or its equivalent.

Scrutiny inquiry on transitions service

130. In addition we reviewed a piece of work previously undertaken by the

Adult Social Care Scrutiny Board on transition services. We were advised that the Transitions Service acts as a bridge, pulling young people from Children's Services into Adult Services whilst working alongside the mainstream services.

131. We were advised that the transitional period for young people is now between the ages of 14-25. This enables continuity of care and support throughout the particularly difficult age threshold of 18 when potentially children lose a number of support functions.
132. All 14 to 25 year olds with complex needs will be referred to the transitions team in Adult Services. The service specifically works with young people who would meet the eligibility criteria for Adult Social Services as well as Children's Services and require complex care packages.
133. Adult Social Services threshold for eligibility in Leeds is set at substantial or critical needs. A different set of criteria is applied in Children's Services and eligibility is set from moderate to severe needs. One of the main advantages of the Transitions Service is to bridge and manage this dislocation.
134. For those that fall below the Adult Social Care threshold, we heard that signposting information has been developed and put on the Family Hub as an ongoing process.
135. It is important that we ensure that the transition to adult services works well for these young people and their families.



Conclusions and Recommendations

136. This can be a particular concern for ageing parents. It also means that everything that has gone before is a waste if there is no good plan for adult life. However we also need to avoid institutionalising people.
137. When the young people get to 18, families need to know what options are available if they do not continue in education.

Key findings

Assessment and advocacy

138. It is important that the CAF process is not over-complicated and that CAFs are of a consistent quality.
139. All agencies need to be engaged with the assessment process, both in terms of commitment and timeliness.
140. We particularly welcome the notion of a basic assessment process that will act as a 'spine' to avoid unnecessary bureaucracy and duplication. We also strongly support the CAF aspiration that families should only have to tell their story once.
141. A sensible and proportionate assessment process will support children, families and professionals to focus on the actual work that they want to do together.
142. We strongly support the aspiration that families should only have to tell their story once, and that the information will then be shared appropriately as they come into contact with further services. We heard examples of families receiving excellent support, but facing the frustration of having to repeat their

history over and over again with each new contact.

143. However, we also acknowledge that families may not initially present the full picture. This has implications at the start and as involvement goes on.

Recommendation 9
That the Director of Children's Services reports to us on how the revised assessment process will ensure that parents only have to tell their story once.

144. We encountered very strong support for the key worker concept - based on an advocacy model that the service will provide one point of contact for the family - and the benefits that this could provide to more effective working from the perspective of both families and support services. Families can expend a great deal of time and energy chasing their entitlements and seeking out access to services that key workers should be able to arrange or signpost routinely.
145. However, we are concerned that proper recognition of the workload associated with this role should be built into the service redesign from the outset. We were particularly conscious of some of the issues associated with take-up of the CAF assessment service due to the capacity of staff to take on the lead professional role, and are keen that this new development learns from that experience.



Conclusions and Recommendations

Recommendation 10
That the Director of Children's Services reports to us on how the key worker system will operate and in particular how it will take on board the learning from the CAF process with regard to the capacity of staff to fulfil the role.

Partnership working

146. We recognise that there are challenges associated with joint partnership working, especially in view of the proposed changes to health services and the role of GPs. Nevertheless we were pleased at the level of enthusiasm and support that we encountered across services for the principles of this service redesign programme. We were also told by officers that discussions with GPs (who we did not speak to directly) were supportive of the proposals to date.
147. Service models focussed primarily on improving the coordination of existing services can only be better for the children and families who require such specialist support in able to enhance their quality of life.
148. The current proposals envisage that some services will be co-located, where this is possible and practical. Where this is not possible staff will operate as a 'virtual' team, working closely together on a regular basis.
149. Some services will be retained centrally for size or process reasons, but these will also be aligned to areas in order that staff can build relationships. We were particularly concerned that careful consideration be given to whether services such as

the deaf and visually impaired services would have sufficient capacity to operate on a decentralised basis.

150. A number of the partners that we spoke to raised questions about insufficient provision of Educational Psychologists, although officers assured us that the situation with recruitment was improving.

Recommendation 11
That the Director of Children's Services confirms the current position with regard to the availability of Educational Psychology services and how any shortfall is being addressed.

151. We also noted the important contribution that voluntary, community and faith sector organisations can play in supporting the new model of service delivery at a local level.
152. The issue of consistency between the three areas will be an important consideration for senior managers, as will the ability of services to adapt to changing patterns of need.
153. We noted that integration of services and alignment of budgets is the next step on from partnership provision in the longer term.

Conclusion

154. Members were very impressed with the services they visited during this inquiry, and by the passion and dedication shown by the staff they spoke to.
155. We look forward to seeing the development of an improved



Conclusions and Recommendations

integrated service for children with complex needs.

156. We would like to conclude our report by thanking all our witnesses for their co-operation with our work.

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Evidence

Monitoring arrangements

Standard arrangements for monitoring the outcome of the Board's recommendations will apply.

The decision-makers to whom the recommendations are addressed will be asked to submit a formal response to the recommendations, including an action plan and timetable, normally within two months.

Following this the Scrutiny Board will determine any further detailed monitoring, over and above the standard quarterly monitoring of all scrutiny recommendations.

Reports and Publications Submitted

- Report of the Director of Children's Services – Model for the Integrated Service for Children with Complex Needs – October 2010
- Transforming Children's Services in Leeds – presentation by the Director of Children's Services – October 2010
- Report of the Director of Children's Services – Model for the Integrated Service for Children with Complex Needs – Paper 2 - November 2010
- Scrutiny Inquiry Report – Transitional Arrangements for Disabled Young People into Adult Social Care – May 2010
- Recommendation tracking progress report September 2010 - Transitional Arrangements for Disabled Young People into Adult Social Care
- Briefing for councillors on Self Directed Support

Witnesses Heard

Councillor Blake, Executive Member, Children's Services
Councillor Dowson, Advisory Member, Children's Services
Nigel Richardson, Director of Children's Services
Barbara Newton, Strategic Leader, Partnership and Participation, Children's Services
Susan Rautenburg, NHS Leeds
David Dickinson, Deputy Chief Executive, Education Leeds
Barbara Shaw, Interim Head of Disability Services, Children's Services
Ken Morton, Locality Enabler, Children's Services
Linda Randall, Team Manager, Adult Social Care



Evidence

Dates of Scrutiny

21 October 2010 – Scrutiny Board meeting

2 November 2010 – Visit to Ralph Thoresby School and Resourced Unit – Cllr Chapman, Cllr Morgan, Cllr P Latty, Cllr Lamb and Mr Granger

4 November 2010 – Visit to Rainbow House – Cllr Chapman and Mr Granger

8 November 2010 – Visit to Children’s Development Centre at St James’ Hospital and Leeds Inclusion Support Service (LISS) – Cllr P Latty and Cllr Morgan

9 November 2010 – Meeting with representatives of Head Teacher’s Forum – Cllr Chapman, Cllr P Latty, Cllr Lamb and Mr Granger

12 November 2010 – Visit to the West/North West Children’s Development Centre at Wortley Beck Health Centre – Cllr Coulson and Mr Granger

16 November 2010 – Higher Aspirations Group – Cllr Chapman and Cllr Coulson

18 November 2010 – Scrutiny Board meeting

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**Scrutiny Board (Children and Families)
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