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

National Inspection Safeguarding and Care Planning of looked after children and care leavers, who exhibit vulnerable or risky behaviours

Inspection of Caerphilly County Borough Council

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1.0. INTRODUCTION

1.1. This report provides an overview of inspection findings in respect of: Safeguarding and care planning of looked after children and care leavers who exhibit vulnerable or risky behaviour, within Caerphilly County Borough Council.

1.2. The inspection was carried out as part of Care and Social Services Inspectorate Wales (CSSIW) national thematic inspection programme. The methodology for the review included three and a half days fieldwork in each local authority across Wales, between January and May 2014.

1.3. The aim of the national inspection was to assess the quality of care planning across Wales and whether it effectively:

- Supports and protects looked after children and care leavers;
- Identifies and manages the vulnerabilities and risky behaviour of looked after children and care leavers;
- Promotes rights based practice and the voice of the child;
- Promotes improved outcomes for looked after children and care leavers;
- Promotes compliance with policy and guidance

1.4. Findings from the individual local authority inspections will inform a CSSIW national overview report to be published later this year.

2. THE INSPECTION

2.1 The inspection focused on the work undertaken with looked after children over eleven years of age and care leavers who were identified as being vulnerable and/or involved in risky behaviours, against defined criteria.

2.2 It is important to recognise that given this focus the case sample reviewed in each local authority encompassed some of the most challenging and complex case management issues and represented only a small cohort of each authority's wider looked after children and care leaving population.

2.3 As well as inspecting cases in respect of the assessment, care planning and review systems the inspection also considered the extent to which the corporate parenting, management and partnership arrangements acted to promote improved outcomes for looked after children and care leavers. Also how organisational structures including, workforce, resources, advocacy and quality assurance mechanisms impacted on the quality of care planning.

The inspection considered these areas against the following five questions.

A summary of our findings is presented below

QUESTION 1

Did the authority effectively discharge its corporate parenting roles and responsibilities promoting the stability, welfare and safety of looked after children and care leavers?

POSITIVES

- The corporate parenting arrangements in this authority were embedded. Members understood their roles and responsibilities and they demonstrated ambition for looked after children. This was evidenced by commitment to supporting academic achievement.

- Partnership arrangements facilitated gathering and sharing reliable information about many of the potential risks posed by looked after children and care leavers. The authority and strategic partners had both formal and informal mechanisms in place that enabled a good understanding of the immediate and individual needs of looked after children and care leavers engaged in risky behaviours, for example the multi-agency Vulnerable Young People and Complex Needs Panels.

- We heard that all managers were visible and accessible and that the authority had systems in place that supported active oversight of compliance in respect of its statutory responsibilities for looked after children and care leavers. These included, for example, the multi-agency Brighter Futures Panel, oversight of children and young people placed outside the county and/or those who were presenting specific concerns.

- The authority appeared to have a sufficient volume of suitably skilled and experienced staff working with looked after children and care leavers. Staff we spoke to conveyed commitment, enthusiasm and motivation to undertake the work they carried out.

- The regional South East Wales Safeguarding Children's board had been in place since April 2013 and had developed a comprehensive strategic plan. Priorities had been agreed with 'adolescents who exhibit harmful behaviours' planned as a focus for 2014/15.This development includes significant key actions which could be expanded to include risky behaviours in addition to those of child exploitation and missing young people.

- There were generally resilient and supportive relationships within social services and with partners to ensure looked after children and care leavers, including those who live away from their home authority, had access to services that met their needs. For example, cooperation between housing and social services departments with regard to this group of children and young people was good. The authority benefited from a

recent appointment of a young person's housing officer who had been effective in improving the service received by children and young people.

AREAS FOR IMPROVEMENT

- The local authority had not given sufficient regard at a corporate level to the importance of highlighting this group of most vulnerable children and young people. Neither was the profile of this group of children and young people collated and shared across partner agencies and so was not available to facilitate strategic service planning for this group of service users. We noted the recent development of the Children & Families Partnership Board, lead by health and attended by social services and education with the aim of planning future services as a strong indication of a commitment to redress this deficit.

- We did not see evidence of systems to evaluate the effectiveness of the authority's placement strategy. The placement strategy does not include a contemporary analysis of the needs of looked after children or care leavers nor does it outline what actions the authority has planned to manage future need. We noted the authority's commitment to addressing this deficit through the process of drafting a revised placement strategy.

- The range and choice of placements able to meet the assessed needs and promote good outcomes for looked after children and care leavers involved in risky behaviours was not sufficiently comprehensive; as evidenced by the numerous placement moves experienced by some children and young people.

- Despite good working engagement the resilience of the authority's relationship with health services remain overtly 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 many cases.

- Ineffective support and encouragement to access and sustain commitment to available universal services and gaps in provision, particularly supported accommodation, hampered on-going engagement with young adults. We noted the authority's Transitions Operational Group which emphasised early engagement with young people with disabilities likely to require statutory adult social services interventions, as a prospective model for driving improvement in this area.

- Although the authority had some mechanisms in place to seek the views and opinions of children/young people about their care, for example through the advocacy services and the Shout Out (care leavers) group, we saw little evidence of how this feedback was used to plan and develop future services.

QUESTION 2

Were care and pathway plans informed by relevant assessments, including explicit risk assessments, which supported a comprehensive response to the needs and experiences of children and young people?

POSITIVES

- Information sharing arrangements were effective in this authority between teams, including the Youth Offending Team and between agencies. There was a clear shared understanding and commitment from all professionals to safeguard children and young people and to improve outcomes for them. Further evidence of good multi-agency working in relation to this group of children and young people was evidenced by the authority's contributions to and utilisation of pan-Gwent intelligence and information sharing initiatives such as the Missing Persons Project (MISPER) and Operation Artemis (child sexual exploitation).

- There was a culture of shared professional assessment and care planning and documentation often included contributions from other agencies, such a Personal Education and Health Plans, in support of the overall plan for the child or young person. The co-location of the Looked After Children Education Service (LACES) alongside social workers; shared access to ICT; and a protocol for professional challenge, reported to prompt healthy debate and challenge which was viewed as a constructive tool was further evidence of an effective shared approach to joint work with the aim of improving outcomes for this service user group.

- We observed that intervention from the authority's Immediate Response Team and the pan-Gwent Skills for Life service were in some cases able to compensate for lack of Child & Adolescent Mental Health Services (CAMHS) provision.

- Recent restructuring to introduce a 16+ team appears to have improved the focus on work with care leavers who spoke positively about their involvement in Pathway Planning and about their relationships with Personal Advisors.

- Care leavers were valued and empowered to have a voice and to engage meaningfully in decisions that influenced their lives. Pathway planning was evidently a dynamic process involving the young person from the outset in determining relevant objectives and taking ownership for delivering on some of these.

AREAS FOR IMPROVEMENT

- It was acknowledged that despite the range of foster placements available both within and outside of authority boundaries, carers did not always have the skills to effectively safeguard the most complex and vulnerable children and young people nor was there a sufficient level of support for them to achieve this.

- There was a significant gap in appropriate services to meet the emotional and psychological health and development needs of some children and young people, including those associated with risky behaviours thus creating an over-reliance on social services. Specifically there is a recognised longstanding disconnect between the access threshold applied by CAMHS and the presenting emotional resilience needs of looked after children and care leavers. We saw extensive waiting lists for CAMHS with some children and young people not receiving a service to address an assessed therapeutic need at all.

- The quality of care plans was variable. Most plans clearly articulated overarching objectives but very few of these were outcome focussed or clear about how risk was to be managed, within what timescales or by whom. The care plans of those children and young people who were looked after for long periods were often reliant on informal information exchange between professionals rather than updated written assessments; this was even in circumstances where there had been significant change. Very few care plans explicitly included the child or young persons views nor had plans routinely been effectively shared with children and/or their families.

QUESTION 3

Were operational systems and procedures in place that ensured responsive coordinated action was taken to mitigate risk and achieve safe continuity of care?

POSITIVES

- There was a stable workforce in place and we recognised the commitment, skills and knowledge of staff at all levels. Most of the social work staff we interviewed had a good understanding of the needs and vulnerabilities of looked after children and care leavers.

- Workers were clear that safeguarding was a priority. We saw evidence from case reviews and interviews with professionals that staff were aware of their statutory responsibilities and of risk management policies and procedures, such as strategy meetings, multi-agency panels, case conferences and return to placement checks and that these mechanisms were utilised promptly and appropriately to co-ordinate relevant safeguarding strategies.

- Staff also told us that they received regular formal supervision and had access to training to support their practice; specifically in relation to this group of children and young people many staff had completed Sexual Exploitation Risk Assessment Framework (SERAF) training. We noted that managers were available for informal discussion and/or consultation/decision making regarding safeguarding issues. Supervision was reported to be of sufficient quality with a good balance between reflective practice and personal/professional development being achieved.

AREAS FOR IMPROVEMENT

- Risk assessments and on-going risk management arrangements, particularly when more than one agency was involved, needed to be more effectively recorded, shared and coordinated.

- Discussion with staff and team managers suggested casework consultation about risk issues, including decision-making took place however we saw very little evidence on case files to support this.

QUESTION 4

Did Independent Reviews and quality assurance arrangements promote safe care and best outcomes for young people?

POSITIVES

- The authority's arrangements for Independent Reviewing Officers (IRO) were compliant with statutory guidance. Communications between team managers, social workers and IRO appeared constructive.

- Looked after children review meetings took place in a timely manner, were well attended by other professionals and families and ensured that care plans were updated.

- Well established performance monitoring arrangements were in place as were reporting pathways to the Corporate Parenting Board in respect of key performance indicators relating to looked after children and care leavers.

AREAS FOR IMPROVEMENT

- IRO told us they were confident to challenge arrangements for children and young people although this was difficult to evidence from the case files we reviewed. We noted recent work by the IRO manager to improve the quality of review records as a commitment to driving improvement in this area.

- The frequency of tracking between review meetings by IRO was insufficient to ensure actions were completed and as such did not enhance the review process or help counter drift.

- We saw evidence of the authority's commitment to consultation prior to review meetings but children and young people's response to the offer of consultation was poor. The children and young people we spoke to told us that they preferred not to attend their reviews as these meetings made them feel embarrassed and uncomfortable. The reasons for this were often linked to the number of professionals attending the meeting and a perception that although they were invited to express their views these contributions weren't valued. IRO were surprised by this and divulged that they had not

themselves ever sought feedback from children and young people about the review process.

- There were quality assurance arrangements in place but these were insufficiently cohesive to fully capture learning from the review process. A recent lack of capacity had impacted on the effectiveness of the system to influence improvement.

- Commissioning arrangements for children's services were underdeveloped. Where services had been commissioned, monitoring arrangements were generally confined to contractual matters rather than focussed on broader quality assurance metrics based around outcomes for children and young people.

QUESTION 5

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

POSITIVES

- Professionals within this authority were committed to helping children and young people understand their lives, including the impact of their journey through the care system. We saw evidence in case files of direct work being undertaken with children and young people to help them understand their identity and the changes they have experienced. We particularly recognised the positive interventions of the 16+ team. Young people told us about the work of their Personal Advisors (PA). They said that PA were able to get alongside care leavers to support them to deal with a range of issues, from early life experiences to, for example current substance mis-use problems as well as encouraging learning and the development of independent living skills.

- The authority's permanency strategy recognised the importance of helping looked after children and care leavers to maintain secure attachments. We saw evidence from case files of commitment to arranging and sustaining contact between families sometimes in the face of significant obstacles.

- The authority had developed formal advocacy arrangements that ensured looked after children had access to appropriate support and had an effective voice. This was monitored and reported annually to scrutiny and to the corporate parenting board. The children and young people we spoke to knew about the advocacy service and about how to access it. We heard that where the service was used that it was highly valued by staff as well as children and young people (although this was rarely evident on case file recording).

- The advocacy service provider also ran the care leavers participation group Shout Out alongside staff from the 16 + team. Care leavers told us that they felt they were listened to and treated with respect within this group.

AREAS FOR IMPROVEMENT

- Limitations on placement choice, including appropriate move-on accommodation for care leavers, for children and young people with the most challenging and complex needs, frequently militated against meeting the child or young person's wishes and feelings and simultaneously keeping them safe.

- Planning in relation to involvement in sporting leisure and/or other community based activities was inconsistent but did include some good examples of children and young people being pro-actively supported to pursue their interests, particularly by the 16 + team. We also saw examples of opportunities offered but these not being taken up.