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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 Carmarthenshire County 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 Carmarthenshire County 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

- Children's services were recognised as a corporate priority. The authority had a corporate parenting strategy reflecting the principals of 'If This Were My Child'. The authority had an established corporate parenting board and there was a strong commitment to collaborative working. The corporate parenting panel met on a quarterly basis and had undertaken work to interrogate the fluctuations in its lac population and the impact of its gate keeping and prevention strategies on future demand.

- The authority had well developed systems that provided officers, members and partners with a general profile of the looked after children and care leavers' population. These systems also monitored compliance against such issues as young people not in education and employment (NEET). Senior officers were well informed about individual looked after children's vulnerability and systems such as a quarterly permanency panel supported officers and partners maintain oversight of placements. A multi agency complex needs panel managed out of authority placement arrangements. All out of county and agency placements needed the agreement of the Head of Children's services.

- The authority's structural arrangement locating children's services within a directorate for Education and Children was well embedded. Work had been undertaken across social services, education and with schools to ensure a greater shared focus on looked after children. The receptiveness of some individual schools to the admission of looked after children however remained an issue.

- The authority and health partners had developed a register of all looked after children placed in Carmarthenshire from other authorities. Information on the numbers and placing authority was presented to Corporate Parenting Panel on a quarterly basis. The Head of Service writes to all authorities that do not comply with the notification process.

- The Safeguarding Children's Board had developed a protocol and subgroup for managing young people who are 'difficult to engage'. Dyfed Powys Police and the Children's Safeguarding Board were actively introducing a Vulnerable Children Living Away from Home (Missing – Pre- Placement Risk Assessment).

- The children's social services workforce was described as being relatively stable and staff viewed caseloads as manageable and at a level that enabled planned direct work with young people.

AREAS FOR IMPROVEMENT

- Elected members had recognised the significance of both their safeguarding and corporate parenting role but needed to provide greater challenge to ensure that they are achieving best outcomes for looked after children and care leavers, including the most vulnerable and challenging. Members needed to assure themselves that strategic aims are effectively owned and translated into action across the local authority and by partner agencies.

- The authorities systems did not routinely capture a profile of the lac and care-leaving populations assessed needs or detailed thematic information regarding vulnerability and risk. This information is essential if the authority is to evaluate the effectiveness of its placement and permanency strategies and predict future resource needs.

- The authority promoted the ethos of family based care within the child's own community and was rightly concerned to maintain family, school and community links, seeking to minimise the use of external providers and manage unit costs. However, case examples were identified where maintaining the young person in the locality appeared to be the priority rather than meeting the young person's needs. In these cases young people experienced a significant number of predictable placement breakdowns.

- Children's services had a number of multi agency panels in place developed to prevent drift and determine access to targeted services. Although helpful there was concern that referral to the various panel delayed decision-making. The interrelationship between the panels needs greater clarity to ensure oversight of issues and the timely escalation of cases. The information presented to these panels could contribute to a more detailed profile of presenting need.

- Children's social services were working with the adult and housing directorate to strengthen young people's access to services. Although some progress had been made, for example the creation of a transition team, these developments mainly focused on young people who met the adult service criteria. The authority had commissioned supported lodging provision through supported people funding. However, the availability of appropriate move on accommodation for care leavers was identified as a gap in service by staff and service users. Given the age profile of the looked after children population this is an area that will require greater cross directorate focus.

- Despite good working engagement the resilience of the authority's relationship with health services remained overly dependent on children's social services providing funding and resources to assess and meet the therapeutic needs of looked after children and care leavers, including part funding of the looked after children nurse.

- The Safeguarding Children Board (SCB) was in the process of moving to a regional footprint. Both the authority and the new Mid and West Wales SCB will need to ensure that they have systems in place that gather and share reliable information, in respect of concerns about the welfare of looked after children including those resulting from the abuse, exploitation and the risky behaviors of the young person.

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

- Referral and information sharing processes between professionals were well embedded Operational relationships between teams including the Youth offending service and partner agencies support timely communication. Social workers and their managers had a good understanding of the young people they worked with including knowledge of presenting vulnerabilities and risky behaviours.

- The authority was focused on developing an early intervention prevention strategy whilst also acting to meet the needs of its current looked after children population. The authority had actively sought to increase the number of foster carers able to meet the complex needs of young people but this remained an area of significant challenge.

- There was recognition of a long standing disconnect between the access threshold applied by the CAMHS service and the presenting emotional resilience needs of looked after children and care leavers. The authority had been proactive in trying to compensate for the shortfall in the availability of therapeutic services by establishing and funding in house therapeutic provision that included access to psychologists and play therapy. Staff described these services as positive.

- The authority had developed a corporate parenting team reporting to the head of children's services, to provide a stronger focus on individual planning and outcomes. Personal Education Plans had been identified as an area of improvement and the authority had recently piloted a person centred education plan seeking to engage young people and their carers more effectively. School stability was seen as a priority and considerable efforts were made to maintain school placements. The use of school nurses to undertake health assessments, for older looked after children was seen as a means of improving ease of access, to health advice and lessening young peoples anxieties about being identified as 'different'.

AREAS FOR IMPROVEMENT

- From the cases reviewed it was identified that the care plans of those young people who remain looked after for longer periods were not routinely informed by a relevant shared written assessment, despite considerable changes in circumstances. Significant reliance was often placed on-going informal information sharing between the workers involved and on the social work report, prepared as part of the statutory review to capture updated information.

- Staff recognised and were active in relation to identifying risk however, such issues often appeared to be managed as separate episodes, risk assessments and resulting actions were not clearly recorded or shared. The resulting impact of the actions taken was not well reflected within the lac review and care planning process.

- The quality of care plans seen was variable. Most included broad overarching statements but did not routinely articulate the objectives and how the desired outcomes for the young person were to be achieved. There was little evidence that assessments and care plans were consistently shared with young people or their families and some young people had no awareness of them.

- The quality of pathway plans seen was found to be inconsistent and the pathway plan template itself was not 'young people friendly'. Pathway plans were not routinely informed or owned by the young person. Care leavers experienced the response they got from staff particularly in relation to financial and resource decision as slow and inconsistent. The virtual nature of the leaving care team (next steps) embeds individual Leaving Care workers within the childcare teams. While this structure may have benefits, clarity is needed regarding the interface between the 'next steps' team management arrangements and that of decision-making and resource allocation on individual case. It is important that training and development opportunities are made available to ensure Leaving Care workers are confident in their 'specialist' role. Also that there is a clear understand of the respective responsibilities of the Leaving Care worker and that of the Personal Advisor.

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

- Staff had access to key policies and there were well-developed information systems in place to support oversight of compliance in respect of statutory child protection procedures. The authority's structural arrangements ensured a level of consistency as all child protection referrals, including those on open cases,

are initially managed through one team.

- The authority and the Safeguarding Children Board had acted to heightened awareness of the vulnerabilities of looked after children and care leavers, including children missing from placement. Training in respect of a sexual exploitation risk assessment framework (seraf) and sexually harmful behaviours had been provided and was available as part of an on-going programme. Staff valued and appeared to use aspect of the seraf risk assessment effectively.

- The authority had invested in and piloted its own multi agency backed therapeutic service for sexually harmful behaviour (TISSH-B) the impact of which was subject to evaluation.

- All looked after children were allocated to a qualified social worker. The authority had a strong commitment to training and this formed an important part of their workforce retention strategy along with the principal of maintaining caseloads at a manageable level. Staff reported that they felt confident of their role and responsibilities in relation to child protection and safeguarding including where the risks resulted from the young persons own “risky behaviour.

- The frequency of supervision was formally monitored through performance management systems. Managers were described as approachable and staff reported that there was oversight of cases within the service. The mixed level of experience within teams was viewed as a positive that encouraged learning and helped build confidence and skill development. The authority had acted to effectively support newly qualified staff in their early years of practice.

AREAS FOR IMPROVEMENT

- Although statutory child protection procedures and thresholds were generally well understood the management pathway for looked after young people and care leavers exhibiting ‘risky’ behaviours needed greater clarity.

- 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. The progress made in mitigating risk was not always well, evaluated or recorded. It was not apparent the extent to which that young people were directly involved in the process.

- Despite knowledge of presenting issues contingency planning in relation to managing risk was not well evidenced and in some cases the over reliance by staff on panel processes resulted in avoidable delay in decision making for the child.

- Looked after young people and care leavers told us that they were unhappy about the significant number of changes in social workers they had experienced over the period of being in care. They expressed mixed but often-negative

views regarding the accessibility and reliability of their social worker and personal advisor. Social workers were described as mainly being visible during periods of crisis. The authority was working to ensure sufficient priority is given to relationship building and planned direct work with young people.

QUESTION 4

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

POSITIVES

- The authority's independent reviewing arrangements were compliant with guidance. Reviews were timely and convened as needed to reflect the presenting circumstances of the young person.

- The authority had a well-established experienced Independent Reviewing Officer (IRO) team who maintained responsibility for the same cases. IROs routinely met the young people prior to review. The IROs were confidant that the significance of their role was understood and that they were made aware of any significant events potentially impacting on the relevance of the care plan. IROs attended strategy meetings and were represented on both the authority's permanency panel and the emotional needs panel. This helped them to maintain oversight of progress against review recommendations.

- The IROs complete feedback forms following reviews, these contributed to the authority's performance monitoring arrangements and reports to the corporate parenting panel. However, the information collected captured compliance issues rather than quality of service.

- Young people were encouraged to attend their reviews and there was good evidence that advocates were available to attend with or represent the young person's views at such meetings. The IRO team had undertaken participation events with young people to help them better understand the statutory mechanisms and raise awareness of advocacy.

AREAS FOR IMPROVEMENT

- Looked after children reviews generally appeared overly focused on the immediate needs of the young person and gave insufficient weight to securing better outcomes over the longer term.

- Although IROs were confident in their abilities to provide effective challenge this was not always evident. Lack of progress against the care plan, even in the most complex cases, needs to be effectively challenged and blockages to care plan objectives particularly in relation to placement stability and also leaving care arrangements should be pro actively monitored and escalated if they cannot be resolved within appropriate timescales.

- Health assessments, although available for the review, were not routinely translated into action within the plan and the decision of when to invite health professionals to the review was unclear.
- The IROs ability to track cases was not supported by the authority's electronic systems.
- Young people, even when provided with the support of an advocate, often-experienced reviews negatively describing the process as repetitive, embarrassing and acting to reinforce that they were 'different'
- The authorities understanding and oversight of its lac population would benefit from strengthening and better coordinated of its quality assurance systems.
- The commissioning arrangements for children's services appeared fragmented and monitoring arrangements were overly confined to contractual rather then quality assurance matters.

QUESTION 5

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

POSITIVES

- The corporate parenting strategy included a charter for looked after children that set the standards that Carmarthenshire, as a council would aim to deliver for looked after children.
- The authority's fostering and in house services were developing mechanisms to help improve the resilience of placements and enable young people to form and maintain more secure attachments with the adults caring for them.
- The authority had developed work placement schemes and traineeships for care leavers aimed at improving opportunities for employment and financial independence. Further support for young people who are not yet 'work ready 'was also available. Part of the corporate ambition was identified as breaking the cycle of care.
- Although formal advocacy arrangements were in place, the authority had recognised that its independence was potentially compromised due to its structural links with corporate parenting team. The authority had acted on this and awarded the advocacy and participation service contract to a new external provider as from April 2014. Although young people did not always understand the term 'advocacy' they were generally positive about the availability and help provided by individual workers in the service.

AREAS FOR IMPROVEMENT

- Although findings from files and interviews gave a mixed picture generally looked

after children and care leavers described a lack of proactive social work and personal advisor support with complaints about missed appointments and poor timekeeping.

- Looked after children and care leavers said that they had little choice or ability to exert influence around placements. Although these views need to be balanced against the authority's child protection responsibilities to take protective action.

- Young people highlighted the importance of ensuring consultation is meaningful and expressed exasperation about repeatedly being asked about 'wishes and feelings' but not feeling listened to.

- Care leavers described feeling socially isolated and unprepared for independence and some said they would welcome opportunity to meet together to share views and offer support to each other.

- Planning in relation to young peoples involvement in sporting and leisure activities was inconsistent but included examples of young people being proactively supported in their interests, also young people being offered opportunities that they then did not to take up.

- Referral to the advocacy service varied across teams and to an extent appeared dependent on workers own views and experiences of the service. Staff viewed themselves as strong advocates for young people and were concerned that young people could be overwhelmed by the number of people involved with them. The new advocacy and participation service will need to proactively promote the value and benefits of the new service for young people.