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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 Neath Port Talbot 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 Neath Port Talbot 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

- A Corporate Parenting Panel was established with representation from looked after children and care leavers.

- We saw emerging partnership arrangements within social services and between partners that facilitated gathering and sharing information in respect of looked after children and care leavers engaged in risky behaviours. For example caseload information was shared between the Youth Offending Team and Children's Service. Also the Education Directorate had developed a Vulnerability Assessment Profile which included looked after children alongside other risk criteria.

- We noted that the development of a dedicated looked after children team had consolidated relevant staff skills and expertise to positive effect. The staff group conveyed commitment, enthusiasm and motivation to undertake the work they carried out.

- The Safeguarding Children Board (SCB) had moved to a regional footprint Western Bay Safeguarding Children Board (WBSCB). Although still relatively new the board had undertaken work to develop shared information and quality assurance systems. The board was live to the need for effective oversight of safeguarding practice in relation to looked after children and had recently completed a review of its arrangements for managing risky behaviors.

AREAS FOR IMPROVEMENT

- The corporate parenting panel did not provide sufficient challenge to ensure the best outcomes were achieved for looked after children and care leavers, including the most vulnerable and challenging. Nor were they sufficiently well assured that strategic aims in respect of this group of service users were effectively owned and translated into action across the authority or by partners.

- Mechanisms for understanding the profile of looked after children and care leavers engaged in risky behaviours were insufficiently well developed and did not therefore facilitate an accurate prediction of the level of resources required to meet future needs or to plan for these more strategically. Neither did we see evidence in this authority of mechanisms in place to seek the views and opinions of children and young people about their care with the purpose of informing service planning.

- We did not see clear systems in place to evaluate the effectiveness of the authority's permanency strategy or external/specialist placement protocol. We recognised the recently established Looked After Children Improvement Group, the purpose of which was to improve outcomes for children through a better understanding of placement breakdown, as commitment to addressing this deficit. However, representation on the multi-agency external/specialist placement panel is inadequate. Neither the authority nor its partners are represented by staff with sufficient seniority to make decisions or to commit funding. The impact of this is that decision making is delayed creating uncertainty for children and young people and their parents/carers.

- Despite good operational 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.

- We did not see a corporate approach or commitment to consultation with children's services staff, managers or partners in respect of commissioning arrangements for third sector specialist support services relevant to complex and vulnerable children and young people. This had led to staff confusion and uncertainty about the sustainability of some services.

- Evidence of systems to support active senior officer oversight of compliance with statutory responsibilities and/or specific concerns about the welfare of looked after children and care leavers was limited. There was no strategic representation from health on the Corporate Parenting Panel.

- Ineffective support and encouragement to access and sustain involvement with adult social services (where eligible) and/or universal services, exacerbated by gaps in service provision, particularly appropriate supported accommodation, hampered on-going engagement with young adults. We noted the recent Project Initiation Document 'Modernising Transition to Adulthood' which outlines plans for transition arrangements for young people to begin at age 14yrs as commitment to driving improvement in this area.

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

- In general information sharing arrangements between teams and between agencies were in place that facilitated timely referrals and prompt responses when issues concerning risky behaviours were raised.

- We saw evidence on case files of children and young people being supported by social services professionals to continue with their education despite obstacles such as frequent placement moves. Similarly it was apparent that

professionals within individual schools demonstrated on-going commitment to continuity of education for children even when they were (temporarily) placed out of county.

AREAS FOR IMPROVEMENT

- Care and pathway plans did not routinely include relevant *shared* assessments of need or robust analysis. Where more than one agency was involved with the same child or young person, planning for risk management was not co-ordinated well.

- 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 person's views nor had plans routinely been effectively shared with children and/or their families. We noted recent staff training in relation to care planning which demonstrated the authority's recognition of this issue and showed a commitment to drive improvements forward.

- The authority recognised that the range and choice of placements was insufficient to meet the assessed needs of vulnerable and complex children and young people as was the availability of housing and/or supported accommodation for care leavers. This deficit militated against the achievement of good outcomes for children and young people.

- 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 Children & Adolescent Mental Health Services (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.

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

- We recognised the enthusiasm, commitment and developing skills and knowledge of staff at all levels. Many of the social work staff we interviewed had an understanding of the needs and vulnerabilities of looked after children and care leavers.

- Workforce arrangements supported the recruitment and retention of qualified social workers. Recent improvement was demonstrated by fewer changes of social worker for looked after children and care leavers over the last 12 months. Greater consistency and stability of workforce was also noted by partner agencies.

- We heard from staff that principle officers and head of service were accessible. Staff also told us that they received regular formal supervision and that managers were always 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

- The local authority had invested in it's workforce, however workload demands meant that social workers sometimes found it challenging to engage children and young people fully in care planning and risk assessment.

- We saw evidence from case reviews and interviews with professionals that not all staff were fully aware of risk management policies and procedures. This led to confusion and on occasions the duplication of work. There was insufficient awareness by some social workers of the risks to children and young people of child sexual exploitation.

- 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. We noted that new arrangements for the provision of constructive feedback between IRO and social workers were becoming embedded and that the effectiveness of working relationships was enhanced as a result.

- Reviews took place in a timely manner and were well attended by other professionals and families. We also saw evidence of the authority's

commitment to sustaining consistency of IRO for individual children and young people.

- All of the children and young people we spoke to knew who their IRO was and could tell us the purpose of a looked after children review meeting. Children and young people were aware they could attend reviews. All of the children and young people we spoke to said that they completed the consultation booklet prior to the meeting.

- We saw evidence of performance monitoring arrangements that helped to maintain an effective oversight on practice and drive improvement such as monthly team manager case-file quality audits. We also heard that the IRO team had raised the profile of their quality assurance/improvement role and were regular contributors to the audit process.

AREAS FOR IMPROVEMENT

- We did not see enough evidence from case files that the IRO had been sufficiently challenging to ensure early intervention to counter drift in care plans or to remove blockages hampering the achievement of objectives in the plan. We noted recent positive changes in IRO practices that were aimed at creating greater clarity about accountability for delivery of the care plan and for more routine follow-up of agreed actions.

- The level and extent of consultation with children, young people and their families prior to reviews was inconsistent as was the amount of feed-back/follow-up post meeting. Many children and young people preferred not to attend review meetings. The reasons for this were often linked to number of professionals attending the meeting and a perception that although they were invited to express their views these contributions weren't valued. Children and young people told us they found it "totally embarrassing" to hear their words from the consultation booklet read out in the meeting and did not feel this was necessary. Notes of meetings were not routinely effectively shared with families.

- 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 were committed to helping children and young people understand their lives in this authority. We learned from discussions with children and young people that they experienced professionals as persistent in their efforts to engage them and that problems were resolved satisfactory. They thought that social workers had their “best interests at heart”.

- 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.

- All of the children and young people we spoke with were aware of the advocacy service and could articulate for us what the role of an advocate was.

AREAS FOR IMPROVEMENT

- It was the perception of the social workers we spoke to that they lacked the capacity to carry out meaningful or sustained direct work with children and young people. We saw some evidence on case files of social workers attempting to ensure direct work was undertaken through others; often this was achieved through family support workers and/or personal advisors. When such work was undertaken it was of good quality. However the approach was piece-meal and inconsistent.

- Limitation of placement choice, including appropriate move-on accommodation for care leavers, for the most challenging and complex looked after children and young people, frequently militated against simultaneously meeting the child or young person’s wishes and feelings and keeping them safe.

- The Advocacy Service was oversubscribed and as a result a waiting list of several weeks had accumulated. The future of the service was unclear. The current provider, managers and workers had not been informed whether or not the provision was to continue despite the current contract having only a few weeks left to run. Whilst senior managers assured us of an on-going commitment to advocacy it was not clear how this was going to be achieved.

- Care and pathway planning did not always ensure children/young people were engaged in a wide range of cultural, sporting or other community based activities.