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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 Rhondda Cynon Taf 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 Rhondda Cynon Taf 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 well embedded. Members understood their roles and responsibilities. Looked after children and care leavers had been identified as a corporate priority. Both members and senior officers' demonstrated ambition for looked after children evidenced by their commitment to supporting them to achieve academically and vocationally to the best of their ability.

- The authority had some partnership arrangements in place that facilitated gathering and sharing information in respect of looked after children and care leavers engaged in risky behaviours and for appraisal of their permanency policy. For example, the (multi-agency) Looked After Children Outcomes Board and monthly Placement Panel.

- Senior Officers and partners had systems in place that supported active oversight of compliance in respect of the authority's statutory responsibilities for looked after children and care leavers. These included arrangements for oversight of children and young people placed outside the authority and/or those who were presenting specific concerns; for example the multi-agency team supporting vulnerable children and young people in education.

- The Cwm Taff Children's Safeguarding Board had a range of systems in place to gather and share information including in respect of looked after children and care leavers which underpin multi-agency working. Specifically the Board had developed/reviewed a range of joint protocols/policies with a view to streamlining these into a Risky Behaviours Protocol and had recently established Risky Behaviours Task and Finish Group that was developing multi-agency risk assessments and plans.

- There were generally resilient and supportive relationships within social services and between agencies 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.

AREAS FOR IMPROVEMENT

- Members 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.

- Established systems for enabling an understanding of the profile of looked after children and care leavers engaged in risky behaviours were limited and did not facilitate a comprehensive prediction of the level of resources required to meet their future needs or to plan for them strategically. We did however recognise the work of the Looked After Children's Action Plan Group, which comprised senior officers from children's services and finance and the Accommodation Group a joint planning fora between children's services and housing as contributing to strategic planning. We did not see evidence 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.

- 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. This was evidenced by the numerous placement moves experienced by some children and young people. We recognised the work undertaken through the Regional Commissioning Consortium Cymru, hosted by this authority, to improve placement choice as commitment to improving outcomes for looked after children.

- The authority did not appear have a sufficient volume of suitably skilled and experienced staff working with looked after children and care leavers. The authority had recognised this shortfall and was pro-actively taking steps through a comprehensive Workforce Review programme to address the situation.

- 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.

- Lack of clear strategic arrangements, combined with gaps in provision, particularly appropriate supported accommodation, did not facilitate a clear pathway for care leavers to access and/or sustain commitment to universal (adult) services. This hampered on-going engagement with young adults. We noted the authorities recognition of this deficit and saw it's willingness to participate as a pioneer authority in the Welsh Government's "When I am Ready" Scheme as well as construction of a short stay supported accommodation provision for care leavers as positive commitment toward improving the life chances for care leavers in future.

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 between teams, including the Youth Offending Team and between agencies were robust in this authority. Interviews with staff and case file reviews evidenced that information sharing, both formal and informal between professionals, in particular concerning risk issues, was generally timely and that responses were prompt.

- The authority was ambitious for looked after children and care leavers in terms of education/training. We saw examples of young people being supported in education despite placement moves and other significant obstacles and of care leavers being supported to access training opportunities to develop their employment related skills, for example driving lessons.

- We observed that interventions from the authority's Miskin Service, a project able to undertake direct work with looked after children and care leavers, was in some cases able to compensate for lack of Child & Adolescent Mental Health Services (CAMHS) provision.

- 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

- 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 emerging use of the Live Case Analysis Learning Tool did however provide evidence of commitment to improving the effectiveness of multi-agency working.

- 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 had been effectively shared with children and/or their families.

- There was an insufficient suitable supply of appropriate placements within this authority's boundaries to meet the demands of children and young people identified as having emotional or psychological health needs, including those associated with risky behaviours. This led to many looked after children being placed some distance from home thus militating against the maintenance of significant relationships within their home authority. The authority recognised this challenge and was working with other local authorities to develop a commissioning strategy to create placement capacity within the south east Wales region.

- 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 situation was exacerbated for those children and young people placed out of county.

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

- The authority had invested in staff training, including sexual exploitation and sexually harmful behaviour, to promote the competency of staff working with looked after children and care leavers. Training arrangements appeared to be well organised and consistently delivered, incorporating practitioner learning events and learning from child practice reviews. Specifically most of the social work staff we interviewed had a good understanding of the needs and vulnerabilities of looked after children and care leavers.

- The authority has promoted a strong focus on risk assessment and management for looked after children and care leavers. 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.

- We heard from staff that all managers were visible and accessible. Staff also told us that they received regular formal supervision and 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

- 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.

- Whilst recognising the commitment, skills and knowledge of the workforce, staffing capacity had not kept pace with the demands of looked after children and care leavers. This resulted in some cases being allocated to unqualified staff or in a small number of cases not allocated at all. There was a strong perception amongst some staff and managers who speculated that current pay and grading arrangements did not support the recruitment and retention of experienced social workers.

- Children and young people reported frequent changes in social worker and said that social workers were often late for appointments and/or difficult to contact; they cited pressure of social worker workload as the reason for this. This hampered the opportunity for children/young people to form good working relationships with social workers.

QUESTION 4

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

POSITIVES

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

- Almost all looked after children review meetings took place in a timely manner and were routinely well attended by other professionals and families.

- IROs told us they were confident to challenge and a disputes resolution policy was in place. Social workers and team managers experienced review meetings as challenging; they reported that care plans were rigorously reviewed and that they were held to account for any changes. (This was not supported by evidence in records.)

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

AREAS FOR IMPROVEMENT

- We heard from IRT that despite a clear escalation policy, sometimes the process was hampered by the complexity of the multi-layered, matrix management organisational structure within the children's services directorate.

- We saw some evidence of consultation with children and young people and families prior to reviews albeit the level and extent of consultation was inconsistent as was the amount of feed-back/follow-up post meeting. Some children and young people attended reviews but most of those we spoke to reported discomfort and/or embarrassment and preferred not to go. 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.

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

- We saw only limited evidence of performance monitoring arrangements that helped to maintain an effective oversight on practice and drive improvement in respect of looked after children and care leavers. However, we recognised the benefits of recent work undertaken by head of service in respect of disseminating learning from youth justice thematic reviews.

- 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. The authority recognised this challenge and was working with other local authorities to improve children's services commissioning arrangements, including outcomes based approaches.

QUESTION 5

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

POSITIVES

- Professionals, including contributors from the 3rd sector, were committed to helping children and young people understand their lives, including the impact of their journey through the care system, including in some cases that of their siblings too. 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 interventions of the Miskin Project as providing flexible and imaginative support to children and young people. We also recognised the resource constraints within which staff were attempting to deliver such interventions.

- 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. We learned from discussions with children and young people that generally they experienced professionals as persistent in their efforts to engage them and to ensure their voices were heard and that problems were resolved satisfactory.

- The authority had developed formal advocacy arrangements that ensured looked after children had access to appropriate support and had an effective voice. 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). Most of the children and young people we spoke to knew about the advocacy service and about how to access it. Children and young people were routinely given a leaflet about the advocacy service and it was always mentioned in review meetings. The authority had mechanisms in place to monitor delivery of the advocacy service through a series of quarterly reporting arrangements.

AREAS FOR IMPROVEMENT

- Limitations on placement choice, including appropriate move-on accommodation for care leavers, for looked after 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. We also saw examples of opportunities offered but these not being taken up.