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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 Torfaen 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 Torfaen 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

- Children's services were recognised as a corporate priority. The corporate parenting arrangements were embedded and elected members were well informed. A strong commitment to support looked after children and young people, as well as care leavers was evidenced by continued investment in multi-agency projects such as the Multi Intervention Service Torfaen (MIST) and the Torfaen Young People's Support Service (TYPSS). Additionally, more recently new funding arrangements for a pilot prevention project, Family Focus. Members understood their roles and responsibilities and they demonstrated ambition for looked after children.

- Partnership arrangements facilitated gathering and sharing information about many of the potential risks posed by looked after children and care leavers. Senior officers were well informed about individual looked after children's vulnerability and risky behaviours and could direct resources accordingly. There were systems in place to share information across partner agencies for example the multi-agency Complex Case Panel and MIST partnership meetings.

- We saw clear leadership and a positive culture within the management team that modelled working together, transparency and learning. 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.

- The authority appeared to have a sufficient volume of suitably skilled and experienced staff working with looked after children and care leavers. Staff and managers 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, had access to services that met their needs. Specifically, arrangements were in place to ensure that looked

after children had access to education and primary health services as well as access to more specialist therapeutic provision through the MIST arrangements when needed. There was also to a wide range of community support from TYPSS for those aged over 16 years.

AREAS FOR IMPROVEMENT

- The effectiveness of service planning and identification of gaps in service provision could have benefited from a more cohesive collated profile of children and young people presenting with risky behaviours and/or complex and challenging needs being shared across partner agencies.

- We did not see evidence of systems to evaluate the effectiveness of the authority's permanency policy or commissioning strategy. Current documentation did not include a contemporary analysis of the needs of looked after children or care leavers nor did it outline what actions the authority had planned to manage future need. We noted however the more recently developed Market Position Statement for Children & Family Services in Torfaen as a positive step towards addressing this deficit.

- Although the authority had some good mechanisms in place to seek the views and opinions of children and young people about their care, for example the Leaving Care Forum and LAC review consultation booklets 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

- Referral and information sharing arrangements were effective. Operational relationships between teams including MIST and Family Focus supported communication. There was a clear shared understanding and commitment from all professionals to safeguard children and young people and to improve outcomes for them.

- We noted arrangements in place for the transfer of looked after children and young people to the 16+ team included early introduction to Personal Advisors who engaged them in "My Plan" work. This helped to prepare young people to proactively contribute to pathway planning. The authority had also expanded the multi-agency nature of its specialist post 16 years support. TYPSS provided access to mental health, employment and housing support/advice. This service complimented the work of the 16+ team and was highly valued by many of the staff and the children and young people we spoke to.

- It was acknowledged that limited appropriate placement provision could be problematic for some children and young people leading to disruption. However, there was a strong

focus on improving placement stability through extensive and on-going multi-agency investment in MIST. This project aimed to prevent children and young people from reaching out of county placements for reasons principally associated with their therapeutic needs. The main operational focus of MIST was provision of an intensive therapeutic support and intervention service, whether through direct work with the child or young person, family members or foster carers, in support of placement stability. This approach did not detract from the use of either residential or out of county provision where there was a clear assessed need for such a placement.

- We observed that intervention from MIST were in some cases able to compensate for lack of Child & Adolescent Mental Health Services (CAMHS) provision.

- The work of the looked after children and education support service (LACES) was valued. Educational attainment was promoted. For example university entry for care leavers who had achieved the relevant qualifications from a very low base as well as support to access more vocational opportunities such as motor mechanic courses.

AREAS FOR IMPROVEMENT

- There was a gap in appropriate services to meet the emotional, psychological health or 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.

- 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 over-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. Recording of this critical information could usefully be more explicitly prioritised by senior managers.

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 including more frequently than standards prescribe if required; this ensured that care plans were updated. Reviews were generally well attended by other professionals and families.

- Well established performance monitoring arrangements were in place as were reporting pathways to the senior management team in respect of key performance indicators relating to looked after children and care leavers. We also saw some evidence of performance management and quality assurance that helped to maintain an effective oversight on practice; such activity included quarterly case-file and supervision audits.

AREAS FOR IMPROVEMENT

- Independently contracted IRO did not appear to be formally supervised within the authority and it was not clear how their work was quality assured.

- 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 or from discussions with social workers.

- Independently contracted IRO did not have access to the DRAIG system; this significantly impeded their ability to prepare for reviews in a timely manner. They were reliant on hard copy reports from professionals on the day of meetings. This practice detracted from IRO capacity to routinely speak children and families immediately prior to review meetings. IRO capability to follow-up progress was also hampered by lack of access to ICT.

- 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 some 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.

- 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 specifically recognised the interventions of MIST and the 16+ team including the contributions made from TYPSS.

- The authority's permanency policy 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. Moreover, most of the children and young people we spoke to said they felt respected and treated fairly by their social workers.

- The authority had well developed formal advocacy arrangements that ensured looked after children had access to appropriate support and had an effective voice. 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).

AREAS FOR IMPROVEMENT

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

- Despite good relationships with current social workers, too many children and young people raised the significant impact that changes of social workers and placements had on their ability to form trusting relationships.