

# Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams

## Overview Inspection Report

August 2011

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## **1.0 Introduction**

- 1.1 Under the provisions of the Children (NI) Order 1995, the Regulation and Quality Improvement Authority (RQIA) has a statutory responsibility to register, inspect and regulate the living arrangements of looked after children (LAC). In 2004, it came to the attention of The Department of Health, Social Services and Public Safety (DHSSPS) that some LAC aged 16 and 17 years were living in alternative forms of supported accommodation in what became known as out of care placements. These placements included generic homeless hostels, bed and breakfast accommodation and houses of multiple occupancy. A number of these facilities were providing accommodation either solely or mainly to children and young people and were operating to all intents and purposes as unregulated children's homes, with no minimum standards, to which providers had to comply. This raised concerns as to the condition of the premises, the safeguarding of the young people residing in them and the quality of support they were receiving.

This report relates to care and other findings of a number of announced inspections of six selected supported accommodation projects in each of the five health and social care (HSC) trust areas for young adults aged between 16 and 21 and of services provided by the host trust's 16 plus transition teams. The inspections all took place in July and August 2010.

DHSSPS had expressed concern regarding the accommodation in which young people were living. DHSSPS had also wished to be assured that the services delivered by trusts to young people on the leaving and aftercare continuum was of an acceptable standard and complied with the relevant requirements of the Children (Leaving Care) Act (Northern Ireland) 2002. In February 2010, DHSSPS invited RQIA to undertake a series of pilot inspections using recently developed draft standards for Young Adults Supported Accommodation Projects In Northern Ireland (April 2010 Draft 10). The team developing the draft standards had also created a self-assessment framework (SAF). This framework was sent to the projects to be completed prior to the inspection. This gave each project an opportunity to assess its performance and compliance against the draft standards. It also afforded facilities an opportunity to provide written evidence to the inspection team as to how they complied with the standards. As part of the pilot inspection process six projects were identified within the five health and social care trusts. Whilst each of the facilities had been subject to independent assessment in respect of the provisions of the Supporting People standards, they had never been visited or inspected by RQIA. The projects were selected to ensure that all of the providers were involved in the pilot.

## 1.2 Context

In 2007, RQIA undertook a scoping exercise of various accommodation projects which had been used to accommodate young people aged 16 to 21 years. The subsequent report identified the type of accommodation which could safely deliver the necessary care and support for this group of young people.

Following this exercise the DHSSPS established interim joint commissioning arrangements (IJCA) between trusts, providers and supporting people within the Northern Ireland Housing Executive (NIHE). Interim joint commissioning arrangements ensured, for the first time, that providers accredited by supporting people could be commissioned by the HSC trusts. Under this agreement, trusts were required to identify their needs for the year and develop services level agreements (SLA) with providers, specifying in detail their expectations of the service.

These arrangements were to remain in place until minimum standards could be developed by DHSSPS.

Parallel with this, a working group was established by the Regional Implementation Team (RIT) for Leaving and Aftercare to develop accommodation standards for young people on the leaving care pathway, in order that HSC trusts could determine their suitability to accommodate this vulnerable group of young people.

In May 2009, RQIA received information expressing concern regarding the delivery of care in three projects offering young people accommodation. None of these projects were accredited under the IJCA. Consequently, a number of unannounced inspections were undertaken. Three of these projects were identified as operating to all intent and purposes as children's homes, as the majority of the young people being accommodated were either aged 16 or 17 years old.

Following the inspections, two of the projects ceased operation and one agreed to register as a children's home. The information arising from these inspections was shared at a meeting with the Health and Social Care Board (HSCB) and the trusts who placed the young people.

Two other complaints/whistle blowing incidents occurred one relating to an interim joint commissioning project and the other from the project which had agreed to register as a children's home. Investigations into these incidents highlighted areas of concern around safeguarding, care planning, referral arrangements, information sharing and record keeping. RQIA requested a meeting with HSCB and DHSSPS representatives to highlight concerns regarding the operation of these and similar projects.

From this meeting the following decisions were agreed:

1. Inspections would be undertaken of six projects against draft accommodation standards
2. Inspections would be undertaken of the HSC trusts 16 plus Transition Teams' processes
3. RQIA would assess the applicability of the regulations and standards within an inspection process

## **2.0 Aims of the Inspection**

2.1 The aims of the inspection of the projects were:

- to examine the policies, practices and monitoring arrangements for the provision of support within the project
- to assess and determine the suitability of the accommodation provided
- to determine that the project was implementing the Children (Leaving Care) Act (Northern Ireland) 2002 and associated regulations
- to determine that the project was achieving the draft minimum standards for young adults in supported accommodation, April 2010
- to determine the extent to which the project's Statement of Purpose had been achieved

2.2 The aims of the inspections in the HSC trusts were:

- to examine the policies and procedures the trust has in place for the delivery of services
- to determine how the trust was implementing the Children (Leaving Care) Act (Northern Ireland) 2002 to determine if the trust was achieving the draft minimum service standards

2.3 The aims of the inspections for RQIA were:

- to assess suitability of standards for the purposes of inspection of accommodation projects
- to develop and evaluate an inspection methodology which included self assessment
- to develop inspection methodology
- to assess the suitability of standards for HSC trusts
- to identify any requirements for the future regulation of leaving and aftercare accommodation for young people aged 16 and 17 years

### **3.0 Standards Inspected**

3.1 The standards for accommodation projects are developed into four quality themes and the inspection focused on two of these themes:

- Theme 1: Quality of Care and Support
- Theme 3: Quality of Staffing, Management and Leadership

3.2 The standards for the trusts support high level outcomes for young people and the inspector focused on one of these standards:

- Standard 2: Planning, Preparation and Review

### **4.0 Inspection Process**

4.1 As well as inspecting for compliance with the requirements of the Children (Leaving Care) Act (Northern Ireland) 2002, the inspections were informed by the following:

- the completion and return of a provider comprehensive self assessment
- inspection of a selection of records required to be kept in accordance with the Children (Leaving Care) Act (Northern Ireland) 2002 and subsequent regulations
- inspection of duty rotas
- meetings/questionnaires/interviews with young people
- discussions with management and staff
- staff information forms
- questionnaires to visiting professionals
- confirmation of staff vetting forms
- inspection of premises
- observation of practice and interaction between staff and young people

The inspections examined the projects and trusts' management systems, procedures and documentation and validated these against legislation and standards of best practice.

## 5.0 Accommodation Projects

5.1 Six jointly commissioned projects were selected for this pilot, one from each of the five HSC trust areas, ensuring a regional approach. The projects inspected were:

Provider	HSC Trust	No. available Placements	Date of inspection
First Housing	Western HSC Trust	9	1 July 2010
Praxis	Western HSC Trust	6	29 June 2010
BCM	South Eastern HSC Trust	2	4 July 2010
BCM	Southern HSC Trust	4	21 July 2010
Barnardos	Northern HSC Trust	5	19 July 2010
MACS	Belfast HSC Trust	8	7 July 2010

## 5.2 Key Findings Arising from the Inspections

- There was notable engagement of the providers in the inspection process.
- There was an identifiable and proactive approach adopted by providers in attaining the standards examined.
- Most of the providers completed a comprehensive self-assessment framework prior to the inspection, indicating an evidenced based approach to meeting the standards.
- Some projects have developed robust policies and procedures as identified in the standards.
- The environment, in the majority of the projects, was maintained to a high standard.
- There was evidence that staff in the projects were familiar with the appropriate legislation.
- Support staff had appropriate training qualifications and/or experience.
- The majority of projects had achieved the minimum standards.
- All of the projects had achieved their statement of purpose.
- Most of the projects had clear referral and admissions procedures and demonstrated good sharing of information.
- The file audit evidenced well written young persons' information and support plans which had been linked to various forms of outcome based models.
- There was evidence of young people's involvement in the decision making process and there were some excellent examples of young people's involvement in the running of the projects.
- There were well produced risk assessments for the young people, which were subject to regular review.
- Some projects had well established working relationships with the trusts' transition teams and other relevant agencies.

- There was positive feedback from the young people regarding the quality of their accommodation and support, including the relationships with staff.

## **5.2 Statement of Purpose**

Most of the providers had statements of purpose in place. However there were variances in the quality of the statements. Although most statements had been produced to a high standard, some reflected the ethos of the provider organisation and required greater emphasis on the specific project. There were also some very good examples in the production of information for the young people and referrers.

## **5.3 Referral and Admissions Arrangements**

With the exception of one, the providers had in place robust procedures and referral arrangements to the projects. This included information gathering and appropriate sharing of completed referrals and assessments. As part of the referral and admissions process, young people visited the projects and met with staff and other young people. Referral arrangements were most successful where the trusts played a central role in the organisation and management of the referral process. In the main, there was evidence that young people were involved in the decision making processes of choosing their accommodation. However, due to a shortage of appropriate accommodation, some young people felt they had fairly limited choices.

## **5.4 Self-Assessment Framework**

As part of the inspection, providers were asked to complete a self-assessment framework (SAF). This tool had been developed to enable providers to self-assess against the draft standards, demonstrating their level of compliance. Four of the six providers had completed this in detail. Most providers were able to cite evidence and examples of how they had met the standards, or what actions they had planned to take to ensure future compliance, within an agreed timeline.

## **5.5 Policies and Procedures**

### **5.5.1 Safeguarding**

All of the providers had robust policies and procedures in place for the safeguarding of children and young people. The providers had designated child protection officers, and staff in the projects were aware of the reporting and recording of incidents of a child protection nature. Other incidents were also well recorded and the projects were able to evidence good liaison and communication with respective trusts.

### **5.5.2 Support Planning and Risk Assessment**

All of the young people had risk assessments in place and these were reviewed on a regular basis. Risk meetings were arranged when the level of risk surrounding the young people had changed. There was a good standard of practice in the projects relating to the development and review of support plans. However, some of the projects were better than others in demonstrating the involvement and participation of the young people in the development of support plans. Some were linked strongly to the young person's pathway plans whilst others appeared to have been developed with little reference to the pathway plan or assessment. This was often directly linked to the level of social worker/trust involvement.

There was a direct correlation between effective partnership working between projects and trusts and better outcomes for the young people. All of the projects had developed outcome focused support plans which were linked to the high level outcomes for young people, and this practice was commended.

### **5.5.3 Young People's Participation**

Each of the providers had developed models and strategies around young people's involvement in their projects. There were excellent examples of user participation in the wider provider organisations. All of the young people attended group meetings within their projects and had opportunities to share their views at individual meetings with their support workers. One organisation had young people present on the management board and another had young people sitting on interview panels for staff appointments. Both of these examples of good practice should be replicated by other providers.

A number of the projects had no exit questionnaires. This information is invaluable for the strategic improvement to the service and a recommendation was made for these to be introduced. Some projects had age and risk appropriate rules in relation to the accommodation including visiting policies and policies relating to overnight stays. Others were more stringent and did not consider the individual young people or their ability to manage risk.

This often caused difficulty for young people and staff and it was recommended that staff should openly discuss this matter with young people and explain why certain decisions are made.

### **5.5.4 Young Peoples Reported Experience**

The inspectors successfully engaged with the young people throughout the inspection process by use of questionnaires, individual and group meetings. The inspectors received positive feedback from the young people.

The young people confirmed their involvement in the decision making process and spoke warmly of the relationships they had with staff. They spoke positively about the support they received from staff, which was described by some as invaluable. They appreciated being treated as young adults and enjoyed the greater freedom they experienced in comparison to living in children's homes or with foster families.

In one project, young people expressed the view that, at times, due to insufficient staffing and the mix of young people, they did not feel safe. This project has now begun to review its staffing arrangements to ensure that the young people feel safe. In other projects, young people commented that staff were too intense in their engagement and they subsequently felt overly scrutinised. This was often a feature in the smaller projects, as opposed to the self contained accommodation.

Some young people expressed concern about the shortage of suitable alternative accommodation. Often social housing is not available and young people have no other recourse but to the private rented sector, where they do not have the same degree of security of tenure that social housing offers. Rents are higher and the young people struggle financially, often finding themselves at a later date within the homeless sector. Some of the providers have developed 'move on' and 'out reach' support for the young people and the young people spoke positively of this support.

## **5.6 Staffing Arrangements**

Staffing arrangements varied between the projects. Staffing levels were closely linked to the statement of purpose, ethos and assessed needs of the young people. Most facilities provide 24 hour cover, usually in the form of a combination of day shifts and sleep-in staff at night. All projects require this level of cover, given the high levels of assessed need of young tenants. Where this level of support was not present, recommendations have been made to increase staffing. RQIA has subsequently been advised that the necessary changes are being addressed.

All of the providers demonstrated robust recruitment procedures and had well established staff induction in place. The providers had a wide variety of training opportunities for staff, including mandatory child protection training and health and safety training. All the managers demonstrated evidence of having undertaken relevant professional qualifications or management training. The majority of staff had National Vocational Qualification (NVQ) level 3 or were in the process of obtaining this as a minimum qualification. There were significant numbers of staff with relevant third level degrees and a range of professional qualifications including: social work; teaching; nursing; and youth and community work.

Some of the projects had successfully registered their staff as social care workers with the Northern Ireland Social Care Council (NISCC) and it is recommended that providers, which have not already done so, should ensure that all staff complete the registration process.

## **5.7 Environment**

The projects differed considerably from group living accommodation to self-contained flats. The latter accommodation type appeared to be the most successful. This arrangement afforded the young people the independence and privacy appropriate to their age, and addressed their risk taking behaviours.

In these schemes young people were given the opportunity of developing the skills required for independence, including, maintaining their accommodation, budgeting, paying service charges, cooking and gatekeeping their own front door. This model offered the young people the balance between maintaining their own space whilst being able to seek help and support when needed. These flats were generally one bedroom accommodation with an open plan kitchen living area and bathroom facilities. The young people had personalised their accommodation and most were presented as comfortable and well looked after.

The inspectors felt that there is an identified need for group living as some young people are unable to move directly into supervised independent living, as outlined above. However, the standard of this type of accommodation was not as good; living space tended to be smaller, with little room for personal space or privacy. Some young people felt that staff were always in close proximity. Whilst this was not perceived as a criticism, the young people felt that it compromised opportunities for independence. It was evident that some young people desired to leave these projects sooner and had not developed the necessary skills for independent living. This resulted in poorer outcomes for this group.

## **5.8 Feedback**

As part of the inspection process, feedback on the findings from each inspection was provided to project managers and, in some instances, to senior managers not directly involved in the daily operation of the schemes. Since the inspections took place, feedback meetings have been held with the NIHE, Supporting People and the Provider's Forum to present the findings. All stakeholders were receptive and responsive to the inspections and efforts have already been made to comply fully with the recommendations.

## 6.0 Recommendations for Projects

- Where highlighted, projects are required to modify the content/detail of the statements of purpose.
- Exit questionnaires should be developed for the young people.
- Best practice would advocate that staff teams are registered with NISSC.
- Record keeping in respect of incidents relating to safeguarding and Police Service of Northern Ireland (PSNI) involvement should be maintained in line with legislative requirements and the minimum standards.
- One project is required to undertake a review of staffing arrangements in order to improve the safeguarding arrangements of the young people.
- Each project should maintain a copy of the Service Level Agreements with the host trust.
- Some projects were advised to keep a record of all referrals and their outcomes in order to identify trends and unmet needs.
- Trusts should ensure that adequate exit arrangements and post placement support for young people is included in their pathway plans.
- One provider is required to undertake comprehensive work relating to policies on recording systems.
- The provider forum, which had been created for the development of standards, should remain in place as a practice forum for providers.

6.1 In the main, the inspectors were very satisfied with the progress the accommodation projects have made since their initial engagement in the process of inspection. The providers have been closely involved in the development of the standards and have been proactive in taking measures within their projects to improve the experience and outcomes for the young people. This has resulted in several very positive findings identified in most of the projects. However deficits were clearly identified in respect of one provider in the development of its accommodation, the policies and procedures which would have been expected to be in place prior to the inspection. This provider has fully accepted the recommendations and has already commenced the implementation of the quality improvement plan.

## **7.0 Key Findings from the HSC Trusts' 16 Plus Transition Teams**

### **7.1 Context**

Each inspection undertaken to a project in a trust area was followed with an inspection of the host trust's 16 plus transition team. The purpose of the inspection was to determine the implementation of the Children (Leaving Care) Act (Northern Ireland) 2002 against the draft standards for leaving and aftercare services. The Act covers all aspects of a young person's life and places a statutory obligation on trusts to ensure that pathway planning is in place which considers: education; training and employment; contact with families; financial arrangements; health and wellbeing; and providing suitable accommodation. This legislation is intended to ensure that young people who have been previously looked after by trusts, receive their entitlements as prescribed by the legislation.

Ultimately it is expected that through this legislation, the overall outcomes for young people will be improved and that young care leavers reach their full potential. The Regional Implementation Team for leaving and after care was formed to assist trusts to implement the Children (Leaving Care) Act (Northern Ireland) 2002. This team agreed that as well as developing standards for accommodation it would be beneficial to also provide standards to measure how well the services were being delivered by the 16 plus transition teams.

Regional restructuring also took place to create these explicit teams in each of the trust areas and senior management in each trust was involved in drafting the standards.

### **7.2 16 Plus Team Structure**

Senior management in each trust had the flexibility to agree the configuration of their 16 plus teams, consequently some variations in structure were identified. All teams had social workers and personal advisors, some had discreet employability or tenancy support workers, some had their own office accommodation and drop in facilities for the young people, whilst others were integrated into mainstream social work offices. Some of the trust teams clearly evidenced joined-up working with other agencies and accommodation staff. Where this principle was better established, the teams demonstrated better outcomes for the young people.

## 8.0 Key Findings

The inspections of trusts demonstrated a wide variance in how each trust implements the relevant legislation, accordingly there were differences in the delivery of services to young people.

The Western Health and Social Care Trust (WHSCT) in particular presented the inspection team with exemplar models of practice in user participation, partnership working, young person centred practice, support, communication and record keeping. This trust's leaving and aftercare team had been established much longer than the teams in the other trusts. The WHSCT had a clear ethos of working with the young people within a holistic framework. The staff team was creative, enthusiastic and committed to the task of improving outcomes for the young people. They confirmed they felt the benefit of strong and supportive management. They were clear about their own role and the roles of the other professionals involved in the young persons life. This allowed the creation of person centred pathway plans, which were reviewed regularly and mapped the young person's achievements of identified goals. This trust had also well established networks within its own area and this partnership working had a positive impact on the success of young persons' plans.

Further examples of good practice within this trust area included:

- the development of policies for the leaving and after care services and the launch of protocols for the transfer of young people with a disability into adult services
- well utilised drop-in facilities for the young people which were located in the office accommodation of the 16 plus team
- the personal advisors had devolved budgets for undertaking work and engaging with the young people in a meaningful manner
- the young people were strongly encouraged to be involved in programmes which generated discussion and review of services and their improvement, these included residential events for staff and young people
- individual pathway plans demonstrated participation of young people and significant others and were regularly reviewed
- excellent working relationships with residential staff, project staff, PSNI, Youth Justice Agency (YJA), education and community links
- exit arrangements and move-on supports were in place

8.1 Within other trusts areas, examples of good practice were identified. These included:

- the introduction of employability schemes providing young people with jobs opportunities within the trust's work force (South Eastern HSC Trust)
- excellent examples of recording within trust files (Southern HSC Trust)
- flexible working arrangements for the personal advisor services which facilitated good engagement with young people outside of normal office hours (Northern HSC Trust)
- well resourced transition teams (Belfast HSC Trust)

## **9.0 Role Clarification**

There was evidence that each of the trusts' transition teams had made progress with the implementation of the Children (Leaving Care) Act (Northern Ireland) 2002 since the establishment of the Regional Implementation Team. However, there were also areas which the inspectors had identified as needing further improvement to ensure compliance.

Some teams had recently restructured and as a result the morale in one team was low. This was particularly the case in the South Eastern HSC Trust which had recently moved an entire team which had previously been part of a voluntary organisation into the trust's structure. The management structure of the trust was quite different to that of other trusts e.g. the personal advisors (PAs) were line managed by a nurse manager rather than a social worker. The personal advisors did not have a devolved budget and they felt this prevented them from engaging creatively with the young people, for example, over lunch or a cup of coffee. The PAs viewed their role as office based and often made contact with the young people via text. This was very different to how PAs worked in other trusts and the inspectors felt that their role required to be expanded and made clearer.

Communication was not clear between the social workers and personal advisers. This resulted in planning drift in respect of some young people. Effective communication is essential to ensure clarity of roles and responsibilities and prevent young people feeling confused about the roles of different professionals.

### **9.1 Pathway Plans**

There were wide variations within trusts in the completion of pathway plans. Within the legislation each young person should have their own plan which they compile with the assistance of their social worker or personal advisor.

These plans cover specific areas including: education; work and employment; participation in society; health and lifestyle information; independent living skills; and financial arrangements.

The inspectors examined numerous plans and identified a wide variation between trusts in respect of their completeness. Some plans were poorly completed and had little detail relating to identified goals and how these were to be achieved. Others were written by social workers which resulted in young people having no ownership of the plans. There was also evidence of some poor review arrangements. Some social work staff stated that they had high caseloads of looked after children resulting in pathway planning having a lower priority.

There were also some excellent examples of pathway plans which were individually constructed and regularly reviewed. These plans demonstrated the achieved outcomes for the young people in each area of their plan.

## **9.2 Financial Arrangements**

There were different financial arrangements in place between the trusts, despite specific regional guidance in this regard. For example, some young people continued to receive food vouchers for supermarkets and travel warrants for public transport, which clearly identified them as looked after children. RQIA would recommend that these practices should be replaced with alternative arrangements more fitting to their status as young adults, which will help to develop the financial management skills they require. The young people were receiving different weekly allowances and often had to make repeat requests for payment of these allowances. This was a source of tension in relationships between young people and staff. Recommendations were made in respect of financial arrangements and policies linked to the regional guidance.

## **9.3 Partnership Arrangements**

Some trusts had forged excellent working relationships with project staff. In those trusts where strong relationships did not exist, information sharing and communication were compromised which caused drift in the young people's pathway plans. In these cases, project staff held the major responsibility for the young persons care. It was also clear that trust staff should engage with a wide range of other agencies in order to implement the young person's pathway plan. Some trusts have daily contact with the projects whilst others reported difficulty in obtaining this information, resulting in confusion for the staff and young people.

All of the trusts are operating with a level of unmet need regarding the commissioning of accommodation for these young people. There also appeared to be a lack of strategic planning around how meeting future needs will be addressed. This will become increasingly important as trusts will be expected to undertake needs assessments and complete an Understanding the Needs of Children in Northern Ireland (UNOCINI) proforma for all young people (under 18 years) who report to trusts or the NIHE as homeless. If these young people are assessed as children in need they will require to be accommodated by the trust.

Staff in each of the trust teams shared a concern regarding the large volume of work they had to undertake, as many of the young people they work with remained looked after. As a result, all the statutory arrangements/timeframes in place for these young people had to be implemented. This resulted in the leaving care arrangements not being seen as a priority i.e. reviewing of pathway plans etc. The inspectors empathised with these pressures but felt that role clarity and demarcation of duties between project staff and other agencies could go some way to addressing this difficulty and improving the outcomes for the young people.

#### **9.4 File Audit**

The inspectors undertook an audit of files held by the trusts which related to young people living in the projects being inspected. The trusts had notice of the file audit and had prepared well for the inspection. In the main, records were presented as well structured and included evidence of internal audit and case supervision. Whilst most files contained the statutory forms, there were variations in the quality of recording and detail of the information on the records. Only the Western HSC Trust maintained one file for all information relating to a young person, including the work undertaken by the personal advisors. The remaining trusts had two separate files for a young person; this often resulted in the duplication of information. The Belfast HSC Trust maintained a personal advisor file and a social worker file and whilst the social worker had access to all files the personal advisor did not have access to the social worker file. The inspectors did not receive a satisfactory explanation for this practice and suggested that the trust should review its recording system. The audit of files confirmed that where a young person remained looked after, more intervention with the young person was evidenced than for those young people who had turned 18 years.

## **10.0 Recommendations for Transition Teams**

- Those trusts that did not have the necessary policies and procedures in place were advised to prepare and implement these, using regional guidance where appropriate.
- Representatives from the trust teams should meet together as a regional forum to ensure the sharing of creative ideas and new initiatives.
- Trusts should ensure that greater emphasis is placed on the completion and review of pathway plans which ensures young people's participation in the decision making process.
- Protocols should be put in place for the sharing of information and communication between trust and project staff.
- Trusts should work to ensure role clarification, responsibility and expectations between social workers and personal advisors is well defined and clearly understood.
- The South Eastern HSC Trust should ensure personal advisors receive a delegated budget to assist in their work with the young people.
- Trusts should develop participation strategies to ensure that young people are involved in the development of the service.
- Trusts to ensure that measures are introduced to identify and meet all of the identified needs of this age group. This is particularly important in identifying new accommodation; ensuring that the legislation can be implemented fully and that homeless young people are assessed and accommodated.
- Information relating to young people's financial arrangements should be drafted and made available to the young people.
- The practice of using shopping vouchers and travel warrants should cease.

## **11.0 The Draft Standards**

From the outset the DHSSPS had agreed that two sets of standards should be developed. One set was for the HSC trusts to assist them to ensure that they were fully compliant with their statutory duties and responsibilities. The second set of standards was developed to help accommodation projects to realise measurable improvements in the delivery of support for young people.

The core objectives of the standards were to develop a regional framework which would help in the implementation of the leaving care legislation and ensure that young people received the necessary entitlements, support and guidance required to assist them to reach their full potential.

The service standards were arranged into themes which were linked to the high level outcome statements contained within the ten year strategy for children and young people - Our Children and Young People Our Pledge. A further two standards were added around the themes of parental responsibility and care planning arrangements.

The accommodation standards were developed around four quality themes and is underpinned by a number of standards statements, criteria and potential sources of evidence.

The inspectors found the standards to be fit for purpose, well written and measurable. Stating potential sources of evidence was a beneficial tool for the providers to demonstrate how they were reaching the standards or assist them to identify gaps in provision. The service standards assist trusts to ensure that they are implementing the relevant legislation appropriately and in taking corrective action in areas where weaknesses were identified.

RQIA would commend these standards for future use in the regulation and inspection of leaving and after care services and accommodation.

RQIA's independent inspection regime will provide continuous assurance that young people involved in the leaving and after care continuum are appropriately accommodated and receive services as defined in their pathway plans.

Independent governance reviews of HSC trusts will provide evidence of the extent to which trusts are fulfilling their statutory functions as defined in the Children (Leaving Care) Act (Northern Ireland) 2002.

## **12.0 SUMMARY AND CONCLUSIONS**

To support positive outcomes for care leavers and build their resilience, the care system must provide these young people with the necessary skills to make the transition to independence. Maintaining links with the care leaving team, foster carers, and family members can provide young people with an important source of practical and emotional support.

Stable housing in particular is a critical element for a successful transition from care, combined with stability and maintenance of attachments with appropriate adults.

Supported living accommodation for young people within the leaving care continuum should be regulated by RQIA. Previous unannounced inspections of unregulated accommodation by RQIA found some facilities unsuitable and ill equipped to meet the complex needs of young people in a safe and effective manner.

- The DHSSPS should review the legislative framework and publish the minimum standards required to ensure that the regulation of these projects is appropriately maintained.
- The Health and Social Care Board should make sure that HSC trusts continue to fulfil their obligations as corporate parents in respect of young people who are looked after and residing in these projects.
- RQIA would recommend that these projects become part of a formal system of regulation and be inspected annually.
- RQIA recommends that information sharing protocols or a memorandum of understanding is drafted between RQIA and NIHE Supporting People regarding, the sharing of information and the facilitation of joint inspections of these projects.
- RQIA recommends that the work of the HSC trusts' transition teams is included in future thematic reviews of children's services to determine how effectively HSC trusts are delivering their statutory responsibilities in respect of this vulnerable group of young people.

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