ISLE OF ANGLESEY COUNTY COUNCIL	
COMMITTEE :	**Executive Committee/ Corporate Scrutiny Committee**
DATE:	**20th March 2017 13th March 2017**
SUBJECT:	**CSSIW Report on Inspection of Children's Services in November 2016**
PORTFOLIO HOLDER(S):	**Councilor Aled Morris Jones**
HEAD OF SERVICE :	**Llyr Bryn Roberts, Interim Head of Children's Services, (Operational) Leighton Rees, Interim Head of Strategic Services, Children's Services**
REPORT AUTHOR: Tel: E-mail:	**LeightonRees@ynysmon.gov.uk**

1.0 RECOMMENDATION

1.1 That Members note the outcomes of the Inspection that took place in November 2016.

1.2 That Members note confirm that the Recommendations are accepted.

1.3 That Members note that the Recommendations and action to address them have been incorporated in the Service Improvement Plan.

2.0 BACKGROUND

2.1 Care and Social Services Inspectorate Wales are the regulatory body for Social Services and Social Care Services.

2.2 They undertook an inspection of Children's Services in Anglesey in November 2016, looking closely at the quality of outcomes achieved for children in need of help, care and support, and protection. They focused specifically on quality of practice, decision making and multi-agency work in respect of the provision of information, advice and assistance and preventative services.

2.3 The Lead Inspector will provide a presentation to Members on the key findings. CSSIW recognised areas where they saw good practice, but also identified areas for improvement. The inspectors recognised that the focus of the inspection was significantly on the duties and responsibilities that were introduction in the Social Services and Wellbeing (Wales) Act 2014. This introduced from April 2016

substantial changes in the way Social Services are intended to operate, with a greatly enhanced focus on information, advice and assistance and prevention. Codes of Practice and Training for the new legislation were provided from the end of 2015/beginning of 2016 through to June 2016.

2.4 It was recognized in the Self-Assessment undertaken in preparation for the inspection that there were significant areas for improvement. The Inspection came to similar conclusions and made recommendations for improvement.

2.5 These recommendations have been taken forward in the Service Improvement Plan which is also being presented to this Scrutiny Committee. Management and Governance arrangements have been developed to ensure effective and timely delivery of the action proposed.

APPENDICES
CSSIW Letter CSSIW Inspection Report

Author: Leighton Rees
Job Title: Head of Strategic Services
Date: 23 February 2017

Appendix 1

Caroline Turner
Assistant Chief Executive (Director of Social Services)
Isle of Anglesey County Council
County Offices
Llangefni

Ein cyf / Our ref:

Eich cyf / Your ref: LL77 7TW

Dyddiad / Date: 9 February 2017

carolineturner@ynysmon.gov.uk

Dear Caroline

Thank you for meeting with the Inspectorate on 31st January. I appreciated the commitment expressed by the senior officers and representatives of the council.

In particular I noted:

1) That the council had itself identified serious problems with childcare services over a year ago and already has a comprehensive plan in place. It is on a journey of improvement. The council has been open with CSSIW about the difficulties it has been facing. The recent inspection has been welcomed by the council and has been a constructive exercise.

2) The re emergence of problems with children's services appears to have been the result of a combination of a number of factors: the loss of newly recruited staff once they gained experience, the challenge of meeting PLO targets and significantly the performance issues of key managerial staff which have been a distraction and taken time to resolve.

3) The very high priority officers and members are giving to children's social services and both in terms of financial commitments and the openness and scrutiny with which the problems in children's services are being discussed and considered.

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4) The action plan the council has in place already addresses a number of recommendations identified in our report. The introduction of a practice group structure appears to provide a solution to the problems you have with decision making, quality and confidence issues and should aid retention for newly qualified staff.

I also suggested you might consider:

1) Strengthening Anglesey's voice on the Regional Children's Safeguarding Board especially in relation to the problems identified in our report in respect of other agencies;

2) Ensuring the improvement plan is phased and realistic in terms of delivery. It is easy to try to do too much too quickly. You may also want to put in place a risk assessment and seek to mitigate any risks of serious failures in the interim. I am thinking of particular practitioners or safeguarding concerns where you might wish to have additional controls in place in order to provide assurance.

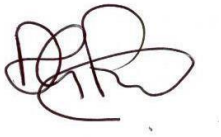
We discussed the next steps. CSSIW will present the report at scrutiny in early March after the report is published. It would be helpful if our two communications teams co-ordinated the handling of this and lines to take. We would wish to say that whilst problems are identified in the report progress is being made in Anglesey and a plan is in place.

Marc Roberts will meet with council representatives on a monthly basis to monitor progress of your action plan which could include involvement in overseeing any assurance activities. CSSIW will undertake a further inspection around in around twelve months time.

CSSIW will be writing to the chair of the Regional Children's Safeguarding Boards about the inter-agency issues identified in the report and will also be writing to the Police to advise them of some of its contents.

Thank you again for the very helpful and constructive approach Anglesey's officers and members have taken in response to the inspection.

Yours sincerely



David Francis

Assistant Chief Inspector
CSSIW – Care and Social Services Inspectorate Wales

cc Dr Gwynne Jones, Chief Executive gwynnejones@ynysmon.gov.uk

AGGCC
CSSIW

Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Inspection of *Children's* Services

Isle of Anglesey County Council

March 2017

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Contents

Introduction

Care and Social Services Inspectorate Wales (CSSIW) undertook an inspection of services for children in Anglesey County Council during November 2016. Inspectors looked closely at the quality of outcomes achieved for children in need of help, care and support and/or protection. We focussed specifically on the quality of practice, decision making and multi-agency work in respect of the authority's safeguarding, access and assessment arrangements; including arrangements for the provision of information, advice and assistance and preventive services. In addition inspectors evaluated what the local authority knew about its own performance and the difference it was making for the people it was seeking to help, care and support and/or protect.

The inspection was structured around people's pathway into care and support services, specifically access to preventive and statutory services and the interface between the two, as well as any safeguarding issues arising. We considered carefully the contributions made by social services in partnership with other agencies to achieving good outcomes for children and families and where relevant to protecting children from harm.

Inspectors read case files and interviewed staff, managers and professionals from partner agencies. Wherever possible, and as appropriate, they talked to children and their families[1].

The council were experiencing a significant period of change and at the time of this inspection including the requirement to implement the Social Services and Well-Being (Wales) Act 2014. Despite some bespoke focussed improvement activities the local authority acknowledged that there had been insufficient attention given to improving practice in children's services in recent years. Whilst, there has now been a greater investment, focus and attention to improving practice, particularly in the last nine months, these developments need to be embedded and sustained. We found that management oversight of safeguarding, access and assessment arrangements were insufficient and the pace of change in improving the provision of help, care and support and/or protection for children and families in Anglesey must be accelerated.

Inspectors were pleased to note that senior managers accept our findings and have committed themselves to achieving the necessary improvements.

The recommendations made on pages 8 and 9 of this report identify the key areas where post-inspection development work should be focused. They are intended to assist Anglesey council and its partners in their continuing improvement.

[1] All names have been changed in the practice examples in this report.

Next steps

CSSIW will expect the Anglesey County Council to produce an improvement plan in response to this report's recommendations within 20 days of the publication. The improvement plan will be monitored during our programme of inspection engagement and performance review throughout 2017/18.

Due to the significant concerns identified in this inspection consideration will be given to undertaking a re-inspection of Anglesey children's services within 12 – 18 months from the publication of this report.

Overview of findings

Access arrangements

We found that access arrangements to preventive and statutory services were established and offered bilingually. Eligibility criteria for team around the family services were well embedded and shared with partners. However, the local authority's information, advice and assistance services and prevention arrangements were insufficiently developed. The council was responsive where there was an immediate indication that a child was at risk but the understanding of thresholds between partners and children's services was inconsistent. Multi agency work to address this was urgently needed. Referral information received from partners was poor. Children's services were diligent in respect of collecting missing information but analysis of (re)referrals was variable and too often cases that should have progressed to an assessment did not do so. All staff were clearly committed to improving the lives of the children and families they worked with, but the duty & assessment team did not have sufficient capacity, experience or senior management support to effectively deliver good quality outcomes for children and families. Management oversight of decision making was insufficient.

Safeguarding & assessment

The quality and timeliness of child protection enquiries was inconsistent. The process for organising strategy discussions was not effective and did not routinely include information from all relevant partners. New arrangements had been confirmed and urgent action was required to ensure that these were clearly understood, implemented consistently and that as a result unacceptable delays to child protection enquiries were avoided in future. Assessments were of a variable quality; where they were good there was evidence of utilising a range of information to inform the risk analysis. Social workers made persistent attempts to elicit the childrens' wishes and feelings and some good use was made of informal advocacy to support children to make best use of support offered. However, good social work practice reflected in the content of some assessments was undermined by the limited range of resources available to support work with children and families and lack of sufficiently experienced and stable operational management and staff across the long-term child care teams. Frequent changes in social worker resulted in a loss of impetus that impacted on engagement with families. Although most assessments were shared with children and families, lack of effective engagement resulted in them not being sufficiently clear about the purpose of the help, care and support and/or protection they received. The quality of recording throughout the assessment process was poor and consequently hampered those taking over a case from swiftly understanding the needs and risks associated with children and families. This was of particular significance given the high level of churn within the workforce. Management oversight of the quality of assessment was insufficiently robust in terms of challenge and quality control.

Leadership, management & governance

Senior leaders held a shared vision for improving safeguarding and for promoting services that supported children and families to achieve resilience and to lead independent lifestyles. They had sought to strengthen this commitment through increased investment in children's services. Strategic plans needed to be translated into a strategy for the delivery of good quality and well integrated preventive and statutory services. The strategy should be better disseminated throughout the workforce and more effectively shared with partners. The council needed to build-on the relationships it has with partner agencies to ensure a shared ownership of the strategic direction for children's services and also the operational drive needed to improve services and outcomes for children and families. Senior leaders acknowledged that their focus on services for children had been insufficient in the past and the pace of improvement too slow. In recognition of this the council was about to embark on an ambitious transformational change programme however concerns were identified about the lack of secure workforce capacity to deliver desired change against a backdrop of austerity and increased demand. More focussed, sustained and faster improvement was needed to effectively promote the safety and wellbeing of children and families.

An analysis of the ongoing risks and needs of communities did not inform planning for children's services. Performance management arrangements, quality assurance monitoring or strategies to ensure the authority sustained a culture of learning did not include the voices of children and families. Nor were they sufficiently well embedded to provide a thorough understanding of the difference that help, care and support and/or protection was making for children and families. Senior leaders needed to improve their knowledge about practice and performance to enable them to discharge their responsibilities more effectively.

The workforce was committed to achieving good outcomes for children and families and although fragile staff morale was apparently improving. However, services were not always delivered by a skilled, competent, suitably qualified and experienced workforce that had the capacity to consistently and effectively help, care and support and/or protect children and families. There was a particular vulnerability at team manager level. Managers, including senior managers, were seen as accessible and a good range and volume of training opportunities were available for staff. However there needed to be stronger oversight of practice, more frequent and better quality staff supervision and the prospects for leadership development needed to be strengthened to support the workforce to deliver services that result in positive outcomes for children and families.

Recommendations

As a priority:

1. The authority should progress its commitment to developing a framework for the provision of preventive work with children and families that will deliver an integrated service and provide early help and support that effectively delays the need for care and support.

2. Effective, multi-agency quality assurance systems and training arrangements should be established to ensure that thresholds for assessment to statutory children's services are understood by staff and partners and are consistently applied; this should include the development of a multi-agency child protection thresholds protocol incorporating recent Welsh Government guidance.

3. Senior leaders in social services and the police should continue to work proactively together to ensure improvements to the quality, consistency and timeliness of child protection enquiries.

4. The council should continue to support senior leaders to improve their knowledge and understanding of the complexities and risks involved in delivering children's services to assure themselves, partners, staff and communities that their responsibilities are discharged to maximum effect.

5. A robust workforce strategy should urgently be developed to include short, medium and long term aims for recruitment and retention of social workers.

6. Arrangements for team managers and senior practitioners should be reviewed to ensure capacity to effectively and consistently provide management oversight of decision making, challenge and direction for staff across the service; a leadership and development programme should be made available to build resilience.

7. Senior leaders should take steps to improve the frequency, consistency and quality of front line staff supervision; an assurance mechanism must be implemented to ensure compliance and quality.

Over the next 12 months:

8. Strong political and corporate support for children's services must continue to ensure the service improvements needed are prioritised and the pace of improvement accelerated and sustained.

9. Multi-agency arrangements should be established to strengthen operational plans to support effective co-ordination of statutory partners' completion of Joint Assessment Frameworks.

10. The quality of assessments and plans should be improved to ensure that they are consistently of a good quality, with a clear focus on the needs, risks and strengths of children and families, and that desired outcomes, timescales and accountabilities for actions are clear.

11. The quality and consistency of record keeping should be improved; all staff and managers should ensure that their records are of good quality, are up to date and are systematically stored.

12. The local authority and partners should work together to develop a cohesive approach to the collection and analysis of information about the needs of communities, that includes the voices of children and families. This should be used to inform the shaping of strategic plans to achieve effective alignment of service delivery between information, advice and assistance services, the preventive sector and statutory services.

13. Performance management and quality assurance arrangements, including scrutiny of service demand and routine auditing of the quality of practice, needs to be embedded so that managers at all levels have timely, relevant and accurate performance and quality assurance information to enable them to do their jobs effectively and to deliver improvements.

14. Caseloads and reports regarding the quality of workers' performance should be continuously monitored to ensure there is sufficient capacity for workers to engage effectively with children and their families.

Access arrangements

What we expect to see

All people have access to comprehensive information about Information Assistance & Advice services and get prompt advice and support, including information about their eligibility for care and support services. Preventive services are accessible and effective in delaying or preventing the need for care and support. Access arrangements to statutory social services provision are understood by partners and the people engaging with the service and are operating effectively.

Summary of findings

- Access arrangements to preventive and statutory services were established, respectful of peoples' rights and individuality and were available bilingually.
- Eligibility criteria for team around the family services were well embedded, shared with partners and quality assurance mechanisms ensured that thresholds were rigorously applied.
- The authority's arrangements for access to preventive services were insufficiently developed, impacting on the timeliness of early help and the effectiveness of delaying the need for care and support; more work with statutory partners in health and education was required to ensure that responsibility for completing Joint Assessment Frameworks was owned and shared.
- When contacts were received by children's services and there was an obvious indication of significant harm prompt and proportionate initial action was taken to protect children.
- Lack of stability, capacity and experience at operational manager/senior practitioner level in the duty & assessment team, coupled with lack of a quality assurance mechanism and insufficient senior management support had adversely impacted on the oversight of cases.
- The authority's policy on thresholds, screening decisions and managing referrals to children's services was not sufficiently shared with or understood by partners; the quality of referral information received from partners was poor.
- The quality of analysis of referral information, in particular in the case of repeat referrals, was insufficient; chronologies and genograms were not purposeful. Professionals were not kept sufficiently informed or engaged in the outcome of referrals they made to the authority.

- All staff were committed to improving the lives of the children and families they worked with.
- The quality assurance and senior management oversight of access arrangements were insufficient.

Explanation of findings

1.1 Anglesey county council had established referral routes for access to Information, Advice and Assistance (IAA) services for children, families and professionals: Family Information Services (FIS); Team around the Family (TAF); and children's services Duty & Assessment Team (DAT). In addition there were enhanced out-reach IAA arrangements specifically aimed at increasing the accessibility of services for disabled children that complimented other routes. Whilst the effectiveness of the authority's access arrangements was variable across these services all respected people's rights and individuality and all were offered in Welsh, English and translation to other languages if requested.

1.2. The FIS was a well established and important resource. It could be accessed by citizens and professionals either by 'drop-in' or telephone. A FIS website had previously been operational but was temporarily suspended while technical improvements were being undertaken. FIS staff were able to provide information and/or signpost people to universal childcare provision, preventative services and/or care and support services.

1.3. The TAF service had also been in place for some time. As well as directly assisting children and families TAF provided the gateway to a range of IAA and preventive services commissioned through Welsh Government "tackling poverty" grant schemes.

1.4. The TAF service received on average 12 referrals per month direct from families and/or from professionals. All referrals were screened by a multi-agency panel. This quality assurance mechanism ensured that thresholds were rigorously applied supporting the ethos of the team however it also meant that a three week delay could accrue before some referrals were put before the panel. Inspectors also found there were waiting lists for access to some of the commissioned services. The impact of these delays was that children and families referred to TAF did not always receive a sufficiently prompt service to help meet their needs. Nevertheless inspectors did see evidence of proactive work with children and families that supported their independence and improved wellbeing.

Practice example

Lewis* was a young person with severe health needs. His mum (Maggie) was struggling to cope with meeting Lewis's needs after a bereavement and as a result Lewis was not able to make the best of his education or his leisure time. Maggie was reluctant to accept help from statutory social services. A social worker was able to advice Maggie about the TAF services and she and Lewis requested an assessment. The TAF worker made considerable effort to engage individual family members and to explore with each of them what they wanted to achieve from TAF involvement. She worked with them at a pace they set to address a range of issues including: support to claim appropriate benefits; advocacy with the local health board; support for Lewis to independently attend appointments; liaison with school to address difficulties; and liaison with adult social services for transition services. As a result of these interventions the family were able to manage their finances more efficiently. Maggie had received bereavement counselling and was generally coping better. With support Lewis was regularly attending school, health appointments and was able to access leisure activities that had previously been unavailable. This family had clearly been empowered and Lewis was evidently striving toward greater resilience and independence.

1.5. Subsequent to the TAF panel children and families were either signposted to relevant single agency support; or if the family presented with more complex needs (falling short of a requirement for an assessment for care and support) a Joint Assessment Framework (JAF) was undertaken. Significantly more work was needed with partners in health and in particular with education, to ensure that responsibility for completing the JAF was suitably owned and shared by them.

1.6. Eligibility criteria for TAF services were well embedded and written protocols had been shared with staff and partners. It was disappointing that whilst the parameters for eligibility to TAF services encapsulated children and families in need of some extra help or support the range of available services were insufficient to meet the requirements of other children and families whose needs were more complex but who were not (yet) eligible for a care and support plan. The impact of this gap in provision meant some children and families were excluded from preventive services and that the likelihood of them requiring more complex, expensive and statutory provision in the future was increased. This significant threshold gap between TAF and statutory services also impacted negatively on the capacity for statutory child care teams to "step-down" cases when children and families continued to need support after making sufficient progress in relation to those needs that were eligible and required care and support plans.

Quote from staff survey
"Big gap between safeguarding services and preventative. Large number of families that are over threshold of preventative and do not meet threshold of safeguarding. Big issue."

1.7. At the time of the inspection fieldwork line management responsibility and accountability within the council for FIS and TAF rested with the head of lifelong learning. Staff and partners expressed frustration with the lack of a fully coordinated approach to the provision of early help for families as they believed that this would significantly benefit families and also mitigate the need for statutory services. The local authority had recognised this deficit in service provision and were in the process of developing plans as part of their transformation agenda to reconfigure services, including re-commissioning the suite of preventive services to better reflect the needs of children and families. A proposal to combine FIS and TAF services with DAT into a single IAA "hub" to be accountable to the head of children's services had been accepted by the council's executive in May 2016 and it was agreed that TAF and Families First services will be transferred to children's services from April 2017.In preparation for this operational TAF managers and staff had been co-located with DAT and all staff reported that communication between the services was enhanced as a consequence. Revised senior management arrangements to support this transfer of resources were still being debated.

1.8. Arrangements for access to children's services in Anglesey were organised through the DAT. Referrals were received by an experienced and competent duty officer who was not a qualified social worker. She was bilingual and confident in her ability to engage well with referrers, to provide information and to signpost both professionals and families to universal services and other appropriate resources, including FIS and TAF. The duty officer demonstrated a clear understanding of how and when to seek advice and/or to hand-over more complex referrals, particularly in relation to safeguarding issues, to qualified social work staff and/or managers. We found that screening decisions about contacts were timely. Where there was an obvious indication that a child or children were at risk of significant harm, prompt proportionate initial action was taken to protect them.

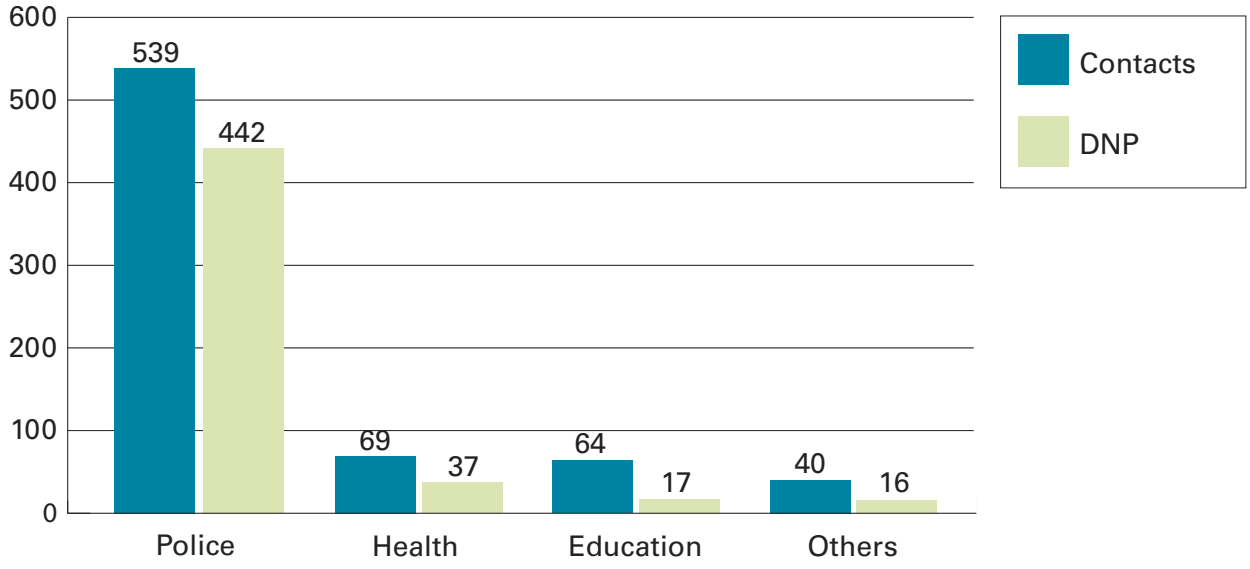
1.9. The duty officer was supported by a team of social workers, senior practitioner and team manager. All staff were clearly committed to improving the lives of the children and families they worked with.

Quote from social worker
"Workers care very deeply about the families, children and carers we work with and will advocate for them to receive the services and support they deserve."

1.10. Inspectors were concerned that DAT operational managers and staff were insufficiently well supported and that the team lacked longevity of experience. Of particular concern was the inadequate level of senior management support awarded to the recently promoted team manager who, to her credit, for a three month period managed the team as well as covering two senior practitioner vacancies. One of these vacancies has subsequently been filled on an interim basis. This deficiency in capacity and experience at the operational manger/senior practitioner level coupled with the lack of a quality assurance mechanism to support management oversight needs to be rectified as a high priority. Although staff stated that managers including service managers were accessible the gaps in management capacity could not be sufficiently absorbed from within the current establishment and this had adversely impacted on the oversight of cases.

1.11. The volume of referrals to children's services in Anglesey rose steeply between 2012/13 and 2014/15. Although this trend was reversed during 2015/16 data for 2016/17 shows that referral rates are rising again. Despite generally good working relationships with partner agencies, staff and managers reported that there was no shared common understanding of the threshold for an assessment for care and support. The volume of contacts (known as CID 16s) from the police reporting concerns and/or incidents has remained consistently high. Similar to other north Wales authorities, the practice of sharing all CID 16s without prior screening had created additional pressures for the duty team. In the period between April and June 2016/17 82% of police contacts did not proceed to referral/assessment. During the same period, contacts from other partners such as health, schools and third sector agencies similarly culminated in between 26% and 54% not proceeding to referral/assessment.

Contacts that did not proceed (DNP) to assessment Quarter 1 2016/17



1.12. Despite reported confidence in children's services, partners identified that they often lacked clarity regarding how threshold decisions on new cases were determined. Additionally inspectors were told that partners sometimes had to challenge social services threshold decisions and on occasions had convened their own meetings to collate information in order to re-present their case to social services. Partners also reported they were not kept sufficiently informed regarding the outcomes of referrals including when cases were closed.

1.13. Inspectors noted the absence of a multi-agency threshold protocol. This was needed to support partners to make appropriate and more targeted referrals. It was also concerning that no multi-agency quality assurance mechanisms were in place to review thresholds or the quality of referrals. We recognised that recent work initiated by children's services to revise threshold guidance for staff in response to the introduction of the Social Services & Well-being (Wales) Act 2014 (SSWBA) could form the foundation of improvement work in this area. However, attempts to meaningfully engage partners in these developments or for partners to seek such engagement were not yet evident. Rapid multi-agency work to update protocols and improve consistency of thresholds and for partners to engage more effectively with each other and staff to secure ownership needs to be a priority.

1.14. Staff and managers reported that the quality of referrals to children's services from partners was often poor and although a multi-agency referral form (MARF) existed this was not universally used. Inspectors found evidence from our review of referrals that supported this perspective. The quality of the referrals seen was very variable. Duty staff made relevant background checks although inspectors often found these were not easily identifiable on the electronic record. To their credit duty staff were also diligent in verifying/clarifying and chasing up missing information, however, due to volume, the excessive time involved in doing this militated against their capacity to undertake other key activities more directly aimed at supporting children and families.

1.15. The cumulative impact of increasing volume and limited staff capacity was to narrow the scope of engagement of the DAT with children and families. This was reflected in some of the cases inspectors reviewed. We saw examples of cases being closed where there was a clear indication that children and families were in need of help and support, albeit with no obvious indication that the level of need met the threshold for significant harm. Nevertheless, these cases clearly should have progressed to an assessment prior to deciding how and by whom support could most effectively be provided.

1.16. Cumbersome administrative and technological arrangements in place for duty staff to record referral information and decision making as well as poor recording practice hampered achieving a clear account of events leading to (re)referrals. Evidence from some case files reviewed showed a lack of analysis of referral information; the reason for referral was often unclear and in the case of multiple referrals a clear cohesive account of the cumulative needs/risks was too often absent. The failure of the authority to develop an

effective system of chronologies and genograms that could support the oversight of the case also contributed to significant information not being appropriately considered as part of determining risk.

Practice example

Janice* was a young woman with a diagnosis of autism and possible attention deficit disorder who had been pushing boundaries. Since 2014 there had been fifteen referrals to children's services; five of these during 2016. Referrals had related to various incidents, including: running away from home and refusing to return; violent arguments and criminal damage to the home that frightened herself, her mum and her younger sister; concerns about sexual activities and possible child sexual exploitation (CSE); misuse of substances; and self-harm. Subsequent to some of these referrals there had been an initial assessment followed by case closure. Many others had resulted in no further action. To date each of these incidents had been viewed in isolation thus failing to take account of the cumulative impact of these behaviours on Janice and her family. Following a recent referral a strategy discussion had been convened and a more thorough risk assessment taking into account the history and recent events was now underway.

1.17. Management oversight of access arrangements was clearly insufficient in terms of challenge and quality control. Cases referred to DAT did not receive the management oversight needed to assure the authority that children were appropriately safeguarded and that families received the timely support they required. Senior managers did not routinely audit case file records in respect of this work and so did not secure an accurate view of the quality of practice. Inspectors did see evidence of management sign off but neither management capacity nor quality assurance systems were sufficiently robust to positively oversee the quality of work.

Conclusion

We found that access arrangements to preventive and statutory services were established and offered bilingually. Eligibility criteria for team around the family services were well embedded and shared with partners. However, the local authority's information, advice and assistance services and prevention arrangements were insufficiently developed. The council was responsive where there was an immediate indication that a child was at risk but the understanding of thresholds between partners and children's services was inconsistent. Multi agency work to address this was urgently needed. Referral information received from partners was poor. Children's services were diligent in respect of collecting missing information but analysis of (re)referrals was variable and too often cases that should have progressed to an assessment did not do so. All staff were clearly committed to improving the lives of the children and families they worked with, but the duty & assessment team did not have sufficient capacity, experience or senior management support to effectively deliver good quality outcomes for children and families. Management oversight of decision making was insufficient.

Safeguarding & assessment

What we expect to see

Effective local safeguarding strategies combine both preventative and protective elements. Where people are experiencing or are at risk of abuse neglect or harm, they receive prompt, well-coordinated multi-agency responses. People experience a timely assessment of their needs and risks which promotes their safety, well-being and independence. Assessments have regard to personal outcomes, views, wishes and feelings of the person subject of the assessment and that of relevant others including those with parental responsibility. Assessments provide a clear understanding of what will happen next.

Summary of findings

- The quality and timeliness of child protection enquiries was inconsistent and would have benefitted from more proactive engagement from the police.
- Strategy discussions were insufficiently timely and did not include information sharing with key agencies.
- Assessments did not always ensure a holistic analysis of need/risk from the outset impacting adversely on the timeliness of help offered to families; the quality of recording of decision making was poor.
- Workers lacked capacity to sustain short focussed interventions with children and families and the range of services available to support the assessment process was inadequate.
- Good social work practice, including effective use of the Gwynedd/Thornton Risk Model was reflected in the content of some assessments; assessments underpinning applications to court provided clear direction.
- Social workers needed to be more robust and confident in working with families and setting out their professional analysis of risk and needs.
- Social workers were persistent in their attempts to elicit childrens' wishes and feelings and some good use was made of informal advocacy to support children to make best use of support offered; this was not always reflected well in the record of assessment and/or planning.
- Management oversight of safeguarding and assessment was insufficiently robust in terms of challenge and quality control.

Explanation of findings

2.1. Not all child protection enquiries seen were thorough and/or timely. Whilst most were informed by decisions made at strategy discussions not all strategy discussions were timely and in a minority of cases a delay of several days was completely unacceptable. We found that the process in place, at the time of inspection, for organising strategy discussions/meetings was not effective. Staff, managers and partners reported that meetings/discussions were often cancelled and/or re-arranged. Police and children's services staff reported that key decision makers in both agencies were sometimes unavailable and that this could lead to delays in making arrangements. The impact on professionals was frustration and uncertainty about the extent of the risks posed and how these might be managed. More importantly, the impact on children and families was to delay help, care and support and/or protection and to create high levels of discomfort, stress and anxiety.

2.2. Inspectors were informed that new arrangements for convening strategy discussions had now been implemented by the North Wales Police. Urgent action was required to ensure that the new arrangements were clearly understood by staff, managers and other partners; that they were implemented consistently; and as a result unacceptable delays to child protection enquiries were avoided in future.

2.3. Strategy meetings had mainly been displaced in favour of strategy discussions. The majority of strategy discussions were held between police and children's services and did not routinely involve other partners who, despite having significant intelligence about a family, were not able to effectively contribute to this key decision making process. Inspectors recognised the resource implications and logistical difficulties associated with multi-agency discussions/meetings. Nevertheless not involving partners particularly health and education early enough limited the range and volume of information obtained/shared resulting in a negative impact on the quality and breadth of risk assessment. Neither was the use of outcome strategy discussions/meetings always evident. This contributed to partner assertions that they were not kept sufficiently informed of the outcome of referrals.

Practice example

Laura* alongside her brother and sister were at the centre of a single agency section 47 enquiry concerning matters of parental conflict. During the course of the enquiry Laura's sister disclosed to the social worker and a teacher concerns about Laura's contact with an ex- offender. When the social worker attempted to re-convene the strategy discussion her manager was unavailable and as a result the enquiry was not completed until the following day when the social worker visited the family alone. The result of this was that the Laura's sister was anxious and worried overnight since she did not know what the consequences would be for herself or for Laura of making the disclosure. An outcome strategy discussion was not convened. Partners were not effectively engaged in managing the risks nor fully informed about the outcome of the enquiry.

2.4. Whilst not undermining the effectiveness of multi-agency work when it took place, the authority reported a growth in single agency (social services) led section 47 enquiries and fewer opportunities for joint social services/police enquires. This was partly attributed to the perceived reduced availability of the police but there was also a perception that police focus was more on the potential for prosecution rather than on wider safeguarding. The police also noted a reduction in joint enquiries but attributed this to their more rigorous approach to ensuring appropriate application of All Wales Child Protection Procedures (AWCPP) for their involvement. We found little evidence from our review of case files that consideration was given to undertaking joint enquiries with only limited challenge between partners regarding how cases could most effectively be progressed. Inspectors identified a minority of cases where more proactive police engagement would have been appropriate and ensured a more robust enquiry given the complexity of the presenting issues. We also saw evidence of delays in completing section 47 enquiries due to police and social services staff capacity issues. In a significant minority of the cases we reviewed this led to high levels of distress for children and families as a result of not being clear about what was expected of them or likely to happen next.

Practice example

A referral was received from a health visitor expressing concerns about domestic abuse and substance misuse in the home of Joseph*, a baby boy. In the course of a (single agency) section 47 enquiry it was found that there was a history of similar incidents and that Joseph's step sister Mari had joined the household. Her dad, Lee was refusing to allow Mari to return home after he made allegations against her mother. Lee was aggressive toward social services and health staff and declined all support offered leaving Joseph's mum, Louise, vulnerable to repeat incidents of abuse. Some good work was undertaken by the social worker to engage Lee, support was provided with housing needs and the issue of Mari's residency was dealt with through family court. However the participation of the police in a joint investigation could have facilitated a better understanding of the level of presenting risk and a more robust safety plan for Louise and the children.

2.5. Records of strategy discussions and section 47 enquiries varied too much in quality. Although the authority generally demonstrated clear initial decision making when moving into child protection proceedings too many records lacked detailed planning arrangements concerning roles, responsibilities and timescales for future action. In the cases reviewed, inspectors did not see any examples of children and families being subject to child protection investigations unnecessarily.

2.6. At the time of the inspection Anglesey children's services was yet to harmonise assessment practices with the new requirements of the SSWBA. The consequence of this was that staff were still undertaking initial and core assessments commensurate with previous guidance and as a result our case sample did not include any practice examples of the new approach to proportionate assessment.

2.7. Templates for recording proportionate assessments and corresponding guidance had been developed but implementation was delayed until December 2016 in order to introduce the new arrangements on a regional basis. The authority had not sufficiently engaged partners in the development of these tools. The authority recognised that the delay in introducing the new tools indicated a lack of preparedness for the implementation of the Act and that a significant opportunity to more effectively engage partners had been missed. Nevertheless, staff and managers we interviewed demonstrated a good awareness of the changes to practice required by the SSWBA and examples of new documentation had been shared with them. All staff we spoke to had attended training about the new Act.

2.8. Most of the initial assessments we reviewed had been completed in a timely manner. However, the objective of assessment was too often to gather more information and to close the case. Early opportunities to intervene were therefore often not reflected and were being missed. In many of the cases we reviewed we saw multiple initial assessments, the quality of which was variable, followed by closure. Some of these assessments were functional but failed to provide a cohesive holistic analysis of risk. The result of this episodic approach was that the importance of professionals' shared understanding of issues that mattered to the family and were necessary to promote their well-being, combined with their risk assessment and how childrens' safety might be assured, was undermined for families.

2.9. Evidence in the cases reviewed included examples of staff signposting families to other services, including joint visits with TAF colleagues, to assist families to appreciate the potential value of a voluntary intervention. In a few cases social workers undertook a short piece of direct work themselves. However in too many cases, social workers and managers appeared to conceptualise this activity as a mechanism for completing an assessment and early closure of the case and in so doing underestimated the significance of some of the information gathered and the value of their own work as a preventive service in itself. Many staff and managers we interviewed expressed frustration regarding the inconsistent application of thresholds and about their limited capacity to undertake short focussed interventions aimed at assisting families to sustain independence and resilience and to alleviate their need for subsequent more complex interventions.

Practice example

Maxim* made allegations of abuse against his mum, Irene. During the course of the investigation Irene made allegations of abuse against Maxim's dad Joe. Joe was required to leave the family home and bail conditions then prevented his contact with Irene but did not extend to Maxim; he and Joe continued to see each other. The allegations Maxim made were not substantiated. Nevertheless given the complexity of presenting issues this family met the threshold for an assessment for care and support. The social worker recognised that the family needed immediate support and quickly convened a multi-agency meeting to identify and confirm support arrangements for the family during the assessment period. The main purpose of the (interim) plan was to ensure that the negative impact of his parent's separation was militated for Maxim and that the strengths in his relationship with Irene were supported. It is likely that this early intervention promoted Maxim's safety and prevented further deterioration in his relationships with both parents.

2.10. Family support services were available to support assessment and/or to provide direct work with children and families. Examples included parenting work and preventive interventions provided by the youth offending service (YJS). But overall the scope of available services was very limited and staff were frustrated by the inadequate range and/or inaccessibility of resources on behalf of the children and families who potentially could have benefitted from them. The reasons for limited accessibility/ineligibility were various but included: constraints imposed by grant funding arrangements (Families First and Flying Start); tight eligibility criteria associated with specialist provision (Community Mental Health Services (CAMHS) and Intensive Family Support Services (IFSS)); long-term staff vacancy (Family Group Conferencing (FGC)); and insufficient capacity and waiting lists (Child Support Services, Keeping Learners on TRAC and the emotional well-being project).

Quote from staff survey

"There needs to be more resources available to access services for my service users."

2.11. The local authority had invested in a whole service risk assessment model (Gwynedd/Thornton Risk Model) to support social workers to identify and analyse potential risk factors. Most staff told us they found the model helpful and inspectors saw some good examples of its use to inform wider assessment. However, in practice this tool was used independently of the existing core assessment process and as a consequence assessments were duplicated and/or became fragmented and/or protracted.

2.12. The quality of assessments was variable. In too many cases the context of assessment was too narrowly applied and reliant on self-report. Too many assessments did not address all aspects of the referral; some failed to take sufficient account of the

on-going impact of significant events such as repeat episodes of domestic abuse or significant changes in circumstances for instance the introduction of an ex-offender to the household. Others failed to take a sufficiently rigorous approach to tackling chronic issues such as neglect and failure to thrive. An exploration of the impact of adult behaviours in relation to their caring responsibilities was insufficient in many cases. Assessments did not therefore provide a learning context for the family to reflect on how they might do things differently or better. Nor did they underpin an effective basis for the resulting outcome of the case.

2.13. The core assessments undertaken mainly resulted where the threshold for child protection had been reached. Some assessments failed to capture a holistic view of the risks and needs that then informed a robust child protection plan. The plans seen were not written in clear language that spelt out what had to change and how it would be measured. Social workers needed to be more robust and confident in working with families and setting out their professional analysis of risk and needs. The failure to ensure an appropriate holistic and coherent analysis of need and risk from the outset was to the detriment of achieving transparency with families when setting out clearly what change was required of them and/or the potential consequences of failing to make these.

> **Quote from a parent**
> "I get on well with my social worker now and this one is good and reliable. But I did not feel that the assessment was done properly. That social worker just saw and heard what she wanted and didn't investigate matters or check out how things really affected me and my children. Although I was trying to co-operate I didn't really know what I was supposed to do."

2.14. The best quality assessments seen were those that subsequently went into court when clear direction was then provided. It was noted that current managers were applying a firmer threshold approach to the Public Law Outline (PLO). Some of Anglesey's increase in children looked after figures may be attributed to the fact that cases had not been well-managed in the past and issues had been left to drift. Further improvements could be achieved through a combination of the changes resulting from the SSWBA, greater clarity of eligibility and thresholds, more effective use of PLO and a resolution on historic cases. However, this will not be achieved unless the current approach is sustained along with greater consistency in the quality of assessments resulting from a well trained stable staff and management group and an effective quality assurance mechanism.

2.15. Although in many cases completed assessments were effectively shared with children and/or families, the extent to which they were proactively engaged in producing their assessments was inconsistent. Given the lack of progress in adopting the principles of the SSWBA we saw only limited evidence of the use of "what matters conversations" the consequence being that some children and families perceived social work intervention as oppressive rather than helpful or supportive. Some families told us that they had not

been clear about the purpose of children's services involvement in their lives. In a minority of cases this directly impacted on the experience of the family and their ability/willingness to engage in a process that they did not understand.

Composite quote from a parent

"I thought social services were supposed to help me but I know I'm depressed and have high levels of anxiety but I'm scared to go to my GP in case she (the social worker) uses this against me. I feel she has a vendetta against me. My kids can't stand her and won't tell her anything. I was given a list of do's and don'ts but she keeps changing these and even though she says she'll write out an updated list she never does. I never know where I am or what to do next. I just do my best and try to keep her off my back."

2.16. We did not see use of formal advocacy during the assessment phase though it was clear that some children were offered advocacy to help them make best use of services. Some good practice was identified: in their interviews with inspectors, social workers were often able to describe the persistent efforts they had made to gain children's wishes and feelings. It was disappointing that despite the importance attributed by staff to seeking children's wishes and feelings assessment analysis and resulting plans often lacked a sufficient focus on promoting best outcomes for the child.

Practice example

Lucy* was in need of support due to her mum's alcohol dependency. Without parental boundaries she was starting to make poor choices and her education and health were suffering. At first Lucy was not able to articulate how she might benefit from support. The social worker helped her to think about some-one in whom she could trust to help her express her views. Lucy identified a close family member as a source of support and as a result has been able to work out a safety and support plan that she and her mum understand and agree to; including a safe place for Lucy to go if things go wrong. Lucy had resumed good attendance at school and was no longer staying out late. Her "advocate" continues to offer support.

2.17. Although some of the assessments seen, including complex assessments, were of a sufficient quality that utilised a range of information, including from partners and families to inform the analysis, evidence of good quality of social work practice elicited by inspectors through interviews with staff was not always well reflected in the case recording. Neither did the electronic information system support an accessible overview of social services engagement with families. In many cases records did not reflect the work undertaken with individual children in families. The impact of poor recording practice was to prevent new workers or those taking over a case when the allocated worker was

absent, as well as managers, from swiftly understanding the needs and risks associated with children and families. This was of particular significance in this authority at this time given the current high staff turnover of social workers and operational managers.

2.18. Workflow arrangements for the transition of cases out of the DAT to long term childcare teams and between long term teams were theoretically agreed and understood. However, the workforce capacity issues in DAT were replicated in both the Family Intervention Team (FIT) and the Looked After Children (LAC) Team. Neither FIT nor LAC team had a substantive team manager and there were vacancies and interim appointments at senior practitioner level in both teams. These arrangements were very fragile and compounded by the short-term nature (three month) of the agency staff contracts and the lack of adequate business support arrangements for all the teams. This meant that in practice the transition of case work between teams was reliant on workforce capacity rather than the allocation policy. Consequently, cases were sometimes held back in DAT pending availability in FIT or LAC team thus further intensifying the pressure on access services. Similarly the long term child care teams frequently used capacity criteria to manage the influx of work rather than the best experience or expertise of workers to accept cases. This situation was exacerbated by the high turnover of staff and managers in these teams.

2.19. The authority had recognised these pressures and had attempted to mitigate by investing in agency workers to fill all vacancies as soon as they arose despite the high dependency this created. There had also been a relaxation in the distinct allocation criteria for FIT and LAC team, effectively creating a more generic allocation process across both teams. This latter tactic had not been well communicated to staff, many of whom told us they felt their specialist skills or preferred areas of work were undermined and that this practice was increasing the complexity of their already only "just manageable" caseloads.

> **Quote from staff survey**
> "One week we are a LAC team, then the next we are a generic team. It is so difficult to have a mixed case load – court work and child protection work is always priority, I feel bad that I cannot give the time and commitment to the looked after children, no time to do life story work etc. It feels that duty team cannot wait for cases to be transferred and when cases are transferred it is never seamless."

2.20. The effect of the workforce instability for many children and families was that they experienced frequent changes of social worker often at short notice. This had impacted negatively on the quality of casework and relationships between children, families and staff. In a significant minority of cases the quality of social work support was poor, with an overall lack of purpose, leading to slow progress against the care and support plan.

2.21. Inspectors saw evidence on the files that managers sign off assessments and provide comment. It was positive that this process was timely. Most of the manager's comments regarding assessments related to next process steps rather than a reflection on the content, the quality of the assessment and the resulting plan. As with access arrangements, senior management oversight of the quality of assessments required significant strengthening.

Conclusion

The quality and timeliness of child protection enquiries was inconsistent. The process for organising strategy discussions was not effective and did not routinely include information from all relevant partners. New arrangements had been confirmed and urgent action was required to ensure that these were clearly understood, implemented consistently and that as a result unacceptable delays to child protection enquiries were avoided in future. Assessments were of a variable quality; where they were good there was evidence of utilising a range of information to inform the risk analysis. Social workers made persistent attempts to elicit the childrens' wishes and feelings and some good use was made of informal advocacy to support children to make best use of support offered. However, good social work practice reflected in the content of some assessments was undermined by the limited range of resources available to support work with children and families and lack of sufficiently experienced and stable operational management and staff across the long-term child care teams. Frequent changes in social worker resulted in a loss of impetus that impacted on engagement with families. Although most assessments were shared with children and families, lack of effective engagement resulted in them not being sufficiently clear about the purpose of the help, care and support and/or protection they received. The quality of recording throughout the assessment process was poor and consequently hampered those taking over a case from swiftly understanding the needs and risks associated with children and families. This was of particular significance given the high level of churn within the workforce. Management oversight of the quality of assessment was insufficiently robust in terms of challenge and quality control.

Leadership, management & governance

What we expect to see

Leadership, management and governance arrangements together establish an effective strategy for the delivery of good quality services and outcomes for people. The authority works with partners to commission and deliver help, care and support for people. Leaders, managers and elected members have a comprehensive knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively. Services are delivered by a suitably qualified, experienced and competent workforce that is able to recognise and respond to need in a timely and effective way.

Summary of findings

- The council had determined the principle that vulnerable children and families should be safeguarded and supported and all staff and managers expressed commitment to promoting the safety and well-being of the children and families they worked with; there was a good level of political support for the council's strategic direction for services for children.
- The council's strategic direction needed to be translated into a strategy for delivering children's services that is effectively communicated to staff, partners and service users.
- Senior leaders recognised that the pace of improvement needed to accelerate for the authority to be assured that arrangements for delivering good quality services and outcomes for children and families are effective; recent increased investment in services for children provided evidence of the council's commitment to promoting improvement.
- Elected members' ability to challenge performance needed to be strengthened by improved information about the quality of services and the experiences of children and families receiving these.
- Senior leaders were committed to improving children's services but did not have a comprehensive knowledge and understanding about the complexities and risks involved in delivering children's services; nor about practice and performance to enable them to discharge their responsibilities effectively.

- Senior leaders recognised the significant challenges they faced to achieve delivery of the planned transformation agenda at an appropriate pace to assure rapid improvement to services whilst ensuring that staff, service users and partners were effectively engaged in the process.
- Commissioning arrangements and resource allocation to services for children and families was not being used effectively to promote the most positive impact on outcomes for children and families; the voices of children and families were not sufficiently captured or used to shape service development.
- Performance information and quality assurance monitoring did not effectively drive continuous improvement; quality assurance arrangements did not include sufficient feedback from children and families.
- The local authority expressed a strong commitment to learning and development; despite capacity issues staff were positive about the range and volume of training and development opportunities available.
- Caseloads were becoming increasingly pressurised both in terms of volume and complexity across all teams; this impacted on the quality and consistency of work undertaken with children and families.
- A robust strategy for recruitment and retention of the full range of social work and support staff, including a workforce succession plan, needed to be developed and implemented urgently.
- Staff supervision was insufficiently frequent and often of poor quality; there was a significant vulnerability at team manager and senior practitioner level across the service.

Explanation of findings

3.1. The council had determined the principle that Anglesey's vulnerable children and families should be safeguarded and supported to build resilient and independent lifestyles. This vision was shared and understood at the most strategic level within the council and all managers and staff interviewed expressed commitment to improving wellbeing and safety outcomes for children and families. But the strategic direction for children's services had not yet been translated into a strategy for delivering services that had been effectively disseminated to the workforce or shared with key partners. Specifically we found that there was not a common understanding amongst staff or partner agencies about the approach being taken by the local authority to redefine and further develop IAA and preventive services or to promote improvement. The disconnect between strategic planning and a clear focussed framework for delivery of children's services militated against staff, operational managers and partners understanding what was expected of them.

Quote from staff survey
"I am unsure of what the performance indicators are. I am aware that there is a business plan, but they don't really provide us with a clear direction."

3.2. The impact of this was confusion about future operational arrangements including the proposed routes into preventive services and pathways between these and the statutory sector. Also staff and partners at all levels expressed concern regarding the capacity of the service to promote the level of sustained improvement needed, in the face of increased demand, to promote the wellbeing of children and families.

3.3. Inspectors found a good level of political support for the council's strategic direction for children's services. A cross-party panel of elected members had been convened to meet monthly to oversee the delivery of the children's services improvement plan and the implementation of the SSWBA. There was a consensus amongst the panel that they were clear about the improvements needed in children's services and that they were committed to supporting and holding officials to account to achieve these. Members had also attended training on the SSWBA so were aware of the implications of the Act on the service and the authority. It was disappointing that despite the high levels of commitment expressed the pace of improvement and of implementation of the SSWBA had to date been too slow.

Composite quote from panel interview
"As you know we're committed to preventive services and information, advice and assistance; to keeping children out of care through providing care and support to tackle issues early enough. We see the importance of this work as an investment in helping families become more resilient and giving children the best start. This is our vision."

3.4. The scrutiny arrangements undertaken through the Executive and the Corporate Scrutiny Committee were well established. Committee members understood their challenge role and could provide some positive examples of how they discharged their responsibilities in monitoring the council's performance. Inspectors found that the reports provided to scrutiny did not always include a sufficiently robust analysis and believed that elected members' ability to understand and challenge performance could be strengthened by improved information regarding the quality of services and the experience of people receiving these. A greater emphasis on eliciting feedback from children and families about their experiences and a more thorough interrogation of information about emerging trends arising from the impact of the preventive sector and that inter-relationship with statutory provision was needed to provide greater assurance that outcomes for children and families were improving.

3.5. Leadership, management and governance arrangements were in place that complied with statutory guidance. We observed appropriate accountability and reporting links between the chief executive officer (CEO); the director of social services (DSS); the leader of the council; and the portfolio holder for children. This group, although confident in its ambition, was only recently established and was still developing its knowledge, working relationships and accountabilities. We found that senior leaders did not have a comprehensive knowledge of the complexities and risks involved in delivering children's services; nor about practice and performance to enable them to discharge their responsibilities effectively. We noted that formal mentoring arrangements were established for the DSS. The DSS was pro-active about facilitating her own learning and met regularly with the head of children's services to review progress. It was also positive that elected members undertook regular visits to front line staff to directly hear their views.

Quote from staff survey

"Decision making processes need to be streamlined – less bureaucracy. Need to cut down on the processes to get an outcome. Getting a Special Guardianship Order is excruciatingly long winded. Revocation of care orders is also process driven rather than dealing with the issue and getting it into court. Everything takes too long. Senior managers need to make decision processes quicker – too many panels. Senior management need to be more flexible so that cases can be heard not just throw them out and delay and put children at risk just because paperwork was in a little late. If they are not up to assessing risk in a short timescale they should not be in the job."

3.6. We were assured by the senior leadership team (SLT) that arrangements were in place, through departmental safeguarding targets and regular inter-departmental meetings to ensure that children's services and wider safeguarding issues were visible across the council. Despite positive working relationships with children's services heads of departments recognised that this did not always sufficiently ensure that children and families received a fully 'joined-up' service. More work was needed to better integrate cross-directorate working to reduce duplication and to improve outcomes for children and families.

Quote from senior manager

"We do work closely with children's services at times, but don't have a clear profile of their needs. There is silo working here, but we are trying to close those silos. Housing/education services will do all they can to support families to prevent homelessness/educational breakdown but this happens more informally than formally."

3.7. SLT reported good working relationships with partners and this view was reciprocated by the third sector and statutory partner agencies we interviewed. We noted the recent appointment of a strategic lead for children within the local health board and we were made aware of some initial multi-agency work to develop new processes and revised documentation required by the SSWBA. A regional Partnership Board has been set-up and Anglesey council's contribution to this, to the regional Safeguarding Children's Board (SCB) and to the Prevent agenda was apparent. However, evidence from case reviews as well as interviews with staff, managers and partners indicated that partnership arrangements fell short of an effective, integrated approach to developing/delivering services to children and families. We found that agencies worked harmoniously alongside each other rather than genuinely holding each other to account for their contributions to wider safeguarding arrangements.

Quote from staff survey

"Partnerships with other agencies are forged through personal knowledge and relationships and the motivation of individual social workers. There is no corporate response to partnership working and accessing resources for service users."

3.8. At the time of this inspection, Anglesey children's services was facing continued ongoing challenges associated with stabilising the workforce, implementing new legislation and re-organising provision to more effectively deliver IAA and preventive work as well as statutory services to children and families, all against the backdrop of austerity and increased demand. The temporary absence of the longstanding head of service had also resulted in a loss of local knowledge and expertise. The SLT and elected members recognised these challenges and had developed an improvement plan for the service.

3.9. Senior leaders acknowledged a lack of sustained management focus in the past; also that delivery of progress against the improvement plan had been too slow. Inspectors noted the authority's improved focus on children's services through increased investment both to baseline budget and for improvement projects and we welcomed the council's programme of transformational change. Alongside the wider implementation of requirements arising from the SSWBA this included: the development of an IAA hub; setting up a resilient families team; and the more effective alignment of IAA and preventive services with the statutory sector. It was also essential to determine how preventative and statutory services could work better together to produce proportionate assessments and to concurrently address eligible and non-eligible needs; this aspect needed to be incorporated into the agenda for change.

3.10. The authority had recruited additional management capacity to support the transformational change programme. This was led by an experienced seconded children's services senior manager and overseen by a panel of elected members. Inspectors had serious reservations about the pace with which these plans had progressed. The main

concern identified was the lack of secure workforce capacity to consecutively achieve desired changes to preventive provision, implement the SSWBA and to secure the improvement needed in meeting statutory responsibilities. Despite some high level proposals such as the intention to transition TAF services from lifelong learning to children's services, there was as yet no clear 'road map' for how these changes were to be achieved. The SLT and elected members fully acknowledged that they still had much to do to shape their improvement aspirations into a focussed holistic framework for delivery of services to children and families. It was recognised that the focus had to date been too much on the project plan and not enough on engagement or action. The authority needed to be more proactive to ensure that the speed of change is accelerated and is undertaken in a way that takes staff with them and supports the meaningful engagement of partners and service users.

3.11. We found that commissioning arrangements and resource allocation to services for children and families were not being used effectively to promote the most positive impact on outcomes for children and families. Inspectors found insufficient evidence that the authority had used detailed knowledge of its population to inform its commissioning arrangements. Also that they had been too slow to engage with children and families to ensure their voices were sufficiently captured to contribute to shaping service delivery. We noted the intention to make use of local data collected for the regional population assessment and of the national well-being outcome indicators in future. However, the authority, together with partners, rapidly needs to develop a cohesive approach to the collection and analysis of information about the needs of local communities, as well as performance information, particularly at the interface between preventive and statutory services, to create a robust evidence base to support their strategic plans. Also to gain an understanding of the potential impact of IAA and preventive services on mitigating the need for children and families to (re)enter statutory provision.

3.12. Managers had access to performance data through the corporate performance officer and information was being used to measure some aspects of performance. We noted the constructive use the head of children's services had made of performance data to support the business cases for greater investment in children's services and the IAA hub. Although information systems supported the development of bespoke reports management information was not systematically used to challenge performance or to improve the quality of services for children and families. Inspectors were concerned that although routinely captured, performance information such as that relating to repeat contacts, re-referrals and assessments was not used to constructively challenge the authority's and/or their partners practices.

3.13. Managers recognised that overall quality assurance mechanisms required improvement. A safeguarding and quality assurance unit had been established and a quality assurance and performance reporting framework was in place. However, this was significantly underdeveloped and did not have the capacity to monitor progress against the children's services improvement plan. We found the work of the unit focussed mainly on the assurance of looked after children reports and on statutory child protection

processes. Routine auditing of cases by managers more broadly across children's services had not been embedded into core business. Nor did performance monitoring and quality assurance arrangements include: a multi-agency approach to monitoring thresholds; information gained from a sufficiently wide range of sources, including user feedback; or direct consultations with staff. We noted that the outcomes of complaints and compliments were shared with service managers and discussed at a quarterly panel but there was no consistent mechanism for highlighting learning points or for effectively disseminating these to inform service improvement. We found that reporting on performance and quality had not yet routinely or effectively been collected and collated in a way that was sufficiently meaningful to better inform analysis of service efficacy in respect of improving outcomes for children and families. Consequently, the use of performance information and quality assurance monitoring to drive continuous improvement was not consistently effective.

3.14. The local authority was aware of a long-standing requirement to improve services for children and families in Anglesey and acknowledged that, despite some improvements to practice, progress to date had not kept pace. However the CEO, senior managers and elected members gave a strong commitment to ensuring a service culture that welcomed constructive feedback in support of learning, development and sustaining improvements. Most staff we interviewed, despite capacity issues, were positive about the availability/accessibility of training and development opportunities. All staff had attended SSWBA training, were enthusiastic, and demonstrated a good level of understanding about the principles of the Act and the changes in practice implementation would require of them.

> **Quote from social worker**
> "Coming through a difficult period and the new Act is an opportunity to look at prevention and practice so hope for improvement."

3.15. However following training progress had paused in implementation and the important enthusiasm of staff was beginning to wane. There was limited confidence in what the future structure would look like and how it would be staffed. Systematic arrangements were not sufficiently well-established across the service to capture and disseminate wider learning from social work practice or service user feedback. This coupled with lack of capacity and ineffective management oversight identified through the cases we reviewed inhibited professional development.

3.16. Impediments to recruitment and retention of a skilled, competent, suitably qualified and experienced workforce had negatively impacted on performance in children's services. High sickness/absence rates had exacerbated this problem. There was a particular vulnerability at team manager level. Reliance on short-term contracts for agency staff, whilst a constructive tactic to alleviate pressure of work, had compounded inconsistencies in practice and decision making to the detriment of children and families receiving services. Many of the complaints seen by inspectors echoed concerns around frequent

changes of social worker and lack of or poor communication. Strategies for recruitment and retention of the full range of social work and support staff, including a workforce succession plan, needed to be developed and implemented urgently if the authority is to deliver the changes necessary to improve outcomes for children and families.

> **Quote from social worker**
> "A service user threw in my face you're the seventh social worker – how long will you be around? Now due to a change in role this person will have another change. This makes me feel terrible."

3.17. The majority of staff and operational managers we interviewed told us that they were proud to work for Anglesey children's services and that on the whole they felt the work they did was valued. However, whilst workloads were "just manageable" they were becoming increasingly pressured, both in terms of volume and complexity. Partners also raised concerns that social workers and managers taking on transferred cases did not always have sufficient time to read or understand the history and context of the case. Furthermore, staff were frustrated and concerned about how lack of social worker capacity and inadequate levels of business support hindered them from forming effective working relationships with children and families; this alongside and an unwieldy electronic recording system was the cause of some stress and anxiety amongst the workforce.

3.18. We noted the completion of the job evaluation scheme had the potential to improve the prospects of recruiting and retaining social workers but inspectors were not confident that a pay award in itself supported retention or that the outcome of the job evaluation scheme would have a positive impact on the recruitment of business support staff.

3.19. It was apparent, in general, that staff morale had improved recently, and responses to the staff survey we administered supported this. However, varying levels of concern were expressed about the potential impact of forthcoming change, in particular about flexible and agile working. It was also positive that social workers generally experienced all managers across the service as equally approachable and responsive and that they were helped to manage their work demands. We found that staff morale whilst improving remained fragile.

3.20. Many staff told us that they did not have regular supervision and that there was no structured induction for agency staff or enhanced provision for newly qualified workers. This was a significant deficit particularly in an authority currently vulnerable to staff leaving, fragile morale and so heavily reliant on agency staff.

Quote from staff survey
"I was given no induction and was given a caseload on my second day, therefore I am only now in the process of familiarising myself with what support is available to families locally. This puts me under even more pressure."

3.21. Evidence obtained from our review of supervision and appraisal records demonstrated that staff supervision was insufficiently frequent and often of poor quality. Supervision records lacked reflective supervision and did not consider welfare or training needs. Records we saw mainly reflected task centred case discussion. None of the appraisal documentation we reviewed included reference to social work competencies or continuous professional development for social workers. Nor did we see clear performance objective setting for either personal or professional development.

3.22. There was significant vulnerability identified at team manager and senior practitioner level across all of the teams. The supervision received by team managers and senior practitioners was less regular and often said to be vulnerable due to competing demands. There was also no proactive induction or training programme for staff moving into the management role. Managers and staff expressed growing anxiety that the inconsistencies of both management time and experience was increasingly impacting on the resilience and safety of the service as well as on the quality of services received by children and families.

Conclusion

Senior leaders held a shared vision for improving safeguarding and for promoting services that supported children and families to achieve resilience and to lead independent lifestyles. They had sought to strengthen this commitment through increased investment in children's services. Strategic plans needed to be translated into a strategy for the delivery of good quality and well integrated preventive and statutory services. The strategy should be better disseminated throughout the workforce and more effectively shared with partners. The council needed to build-on the relationships it has with partner agencies to ensure a shared ownership of the strategic direction for children's services and also the operational drive needed to improve services and outcomes for children and families. Senior leaders acknowledged that their focus on services for children had been insufficient in the past and the pace of improvement too slow. In recognition of this the council was about to embark on an ambitious transformational change programme however concerns were identified about the lack of secure workforce capacity to deliver desired change against a backdrop of austerity and increased demand. More focussed, sustained and faster improvement was needed to effectively promote the safety and wellbeing of children and families.

An analysis of the ongoing risks and needs of communities did not inform planning for children's services. Performance management arrangements, quality assurance monitoring or strategies to ensure the authority sustained a culture of learning did not include the voices of children and families. Nor were they sufficiently well embedded to provide a thorough understanding of the difference that help, care and support and/or protection was making for children and families. Senior leaders needed to improve their knowledge about practice and performance to enable them to discharge their responsibilities more effectively.

The workforce was committed to achieving good outcomes for children and families and although, fragile staff morale was apparently improving. However, services were not always delivered by a skilled, competent, suitably qualified and experienced workforce that had the capacity to consistently and effectively help, care and support and/or protect children and families. There was a particular vulnerability at team manager level. Managers, including senior managers, were seen as accessible and a good range and volume of training opportunities were available for staff. But there needed to be stronger oversight of practice, more frequent and better quality staff supervision and the prospects for leadership development needed to be strengthened to support the workforce to deliver services that result in positive outcomes for children and families.

Appendix 1

Methodology

Pre-fieldwork

The authority completed a self assessment and provided CSSIW with documentation and performance information relating to the focus of the inspection. The information provided was reviewed and used to shape the detailed lines of enquiry for the inspection.

Fieldwork

The inspection team were on site in Anglesey for eight days during November 2016.

Case review: inspectors considered 46 randomly selected cases and explored 20 of these in further detail with social workers and their managers, other professionals involved and children and families. We undertook 24 interviews with allocated case workers and team managers as well as 7 interviews with children, families and/or carers. One follow-up interview with another professional was undertaken.

Interviews & focus groups: inspectors conducted 20 group or individual interviews with senior managers, staff, elected members and partners.

Staff survey: an on-line SNAP survey was administered to 76 staff in children's services; 31 questionnaires were returned.

Observation of practice: inspectors observed the work of the duty & assessment team and the legal gateway panel.

Review of complaints & compliments: inspectors reviewed all complaints and compliments that were made about children's services between April and September 2016.

Review of supervision & appraisal documents: inspectors reviewed a random sample of 11 children's services staff supervision and appraisal documents.

Further detail regarding the framework for local authority inspection, engagement and performance review can be viewed here: http://cssiw.org.uk/providingacareservice/our-inspections/how-we-inspect-local-authorities/?lang=en

Inspection team

The inspection team consisted of four inspectors:

– Lead inspector: Bobbie Jones

– Team inspectors: Christine Jones, Marc Roberts, Katy Young

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