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Care and Social Services Inspectorate Wales

Report on the Inspection of *Children's* Services

Rhondda Cynon Taf Council

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Purpose and background to the inspection:

Rhondda Cynon Taf and the Care and Social Services Inspectorate Wales (CSSIW) agreed a number of areas for this inspection of children's services. This was based on a number of key reports, namely the Director of Social Services 2011/12 annual report, the CSSIW annual review and evaluation of performance by Rhondda Cynon Taf for 2011/12, also CSSIW's National Review of Outcomes for Children in Need and Looked After Children inspection carried out in November 2012. Discussions were also held between the two agencies, and four key areas were identified for inspection:

- The impact and effectiveness of preventative and early intervention services
- Understanding the implications of the high numbers of children on the Child Protection Register (CPR) and those children who are looked after (LAC) by the local authority
- The work of the Children's Disability Teams (CDT)
- Workforce and capacity issues across frontline services

Approach and information considered:

Frontline services and outcomes for children were the focus of this inspection, looking at practice as evidenced by:

- case file reading;
- individual, staff group, and senior management meetings;
- discussion with the Director of Children's Services, and information from the council; and
- some service observation and discussion with parents and children.

Case files read by the inspectors were in respect of referrals, children on the child protection register and children looked after by the local authority. The sample also included children with a disability. The cases chosen were open to the local authority, covering a specific time period in autumn 2012.

Summary of key findings:

- On the basis of the number case files read by the inspectors and the inspection itself, inspectors were of the opinion that the systems generally promote effective safeguarding of children.
- It was too early to evaluate the impact of the prevention and early intervention services on numbers of children becoming looked after or going on to the child protection register. There were some examples of good practice by the Integrated Family Support Team (IFST) and the

Team around the Child (TAF) service with effective multi-agency practice and improved outcomes for children.

- Inspectors concluded that the cases they read that were subject to child protection procedures or looked after children were appropriate.
- The role and remit of the Integrated Family Support Team (IFST) for locality teams and the CDT's was not consistently understood by staff. Staff felt a single point of referral for IFST services was needed to improve consistency and timeliness of response.
- There was inconsistency of thresholds and decision making between the teams and with partner agencies. Staff in the three localities felt disconnected from one another and from the wider workforce.
- The protocol for responding to child protection referrals and concerns in relation to disabled children between locality teams and the CDT's was seen by staff as requiring strengthening.
- Staff indicated a lack of cohesion and effective communication between senior managers and staff. A number of service and team managers felt disempowered and not effectively involved in the improvement agenda for children's services. There was dissatisfaction and demoralisation amongst some staff and teams, although morale was good in the IFST.
- The single salary point was attractive for newly qualified social workers and there was a good induction and training and development programme for new staff. Such measures played a positive role in recruiting newly qualified staff.
- Inspectors were told by team managers interviewed that they were the lowest paid team managers in Wales and this, along with a single salary level for social workers, had made recruiting team managers and retaining experienced social workers difficult for the authority.
- Workloads were reported as high and some staff felt overwhelmed by the volume and complexity of the work they were undertaking.
- The annual training and professional development programme was helpful for staff in the early years of employment in the authority. However, more experienced staff felt there were limited professional development opportunities for them. This was in contrast to the extensive programme for IFST staff.
- There were some good examples of supervision though there were inconsistencies across children's services, with some examples of poor and / or inappropriate practice and models of supervision.
- ICS and other systems were still seen by staff as being a major problem in case management.

Recommendations:

- The authority needs to review and develop more effective communication and connectivity between all frontline services, preventative services and partner agencies.
- Improved attendance should be sought at child protection initial conferences of representatives of the police and probation services.
- The review and strengthening of the protocol of managing child protection concerns for disabled children between locality teams and children disability teams.
- Continued attention is needed to secure more appropriate locally based and cost effective placements as part of the authority's strategic approach to providing a sustainable service for looked after children.
- Consistency in thresholds and decision making across children's services and with partner agencies is needed. In addition, practice, assessments and care planning needed to be more consistently child focused.
- There also needs to be improved consistency in working with adult social services, particularly more effective transition arrangements for disabled young people.
- Workforce planning requires a fundamental review if the stability of teams and team managers is to be effectively addressed. This includes the review of the single salary point for social workers and the salary scale for team managers. The size of the locality teams and the workloads of staff should also be considered by the authority.
- Improve and develop a fit for purpose IT system as identified in the recent CSSIW children in need and Looked After Children review.

Good practice and innovation identified:

- A sound base of good social work and case management on which to build further improvement of child focused work. This is supported by some effective strategic and practice partnership relationships, with a range of innovative and locally available services.
- The authority has a good track record in taking an innovative approach to strategic service and practice development and improvement, making use of internal and external review and evidenced based evaluation to drive forward service change and deliver improved outcomes for children and families. Underpinning this is a sound commissioning strategy and the Families First practice framework.
- Development of a strategic approach to reduce the number of children it looks after and delivering more locally based placements as part of a medium term financially sustainable budget. An effective Corporate

Parenting Board provides an informed scrutiny and championing role for looked after children.

Risks identified:

- The effectiveness of Integrated Family Support Service, (IFSS) and its contribution in delivering improved outcomes for vulnerable children, may be diluted unless a clear change and communication strategy is put in place to ensure effective alignment of preventative services with other children's services and partner agencies.
- The failure to address and deliver consistency of thresholds and decision making across children's services and with partner agencies may also compromise outcomes for children and their families.
- The high number of looked after children, and the cost of placements, poses considerable if not potentially unsustainable financial pressures on the authority.
- Long term staff vacancies, resulting from not being able to retain experienced social workers or recruit team managers, could potentially compromise safe practice within children's services.
- Without an effective workforce strategy there could be further de-stabilisation of the workforce. This should consider an urgent review of social worker and team manager terms and conditions, improved training and development opportunities and more effective supervision arrangements.

Areas for future follow up work by CSSIW:

- To follow up on the above recommendations as key drivers for continuous improvement across children's services through engagement meetings.
- Working with the authority to better understand the high numbers of children subject to child protection procedures and those looked after by the authority.

1. The impact and effectiveness of preventative and early intervention and services:

The IFST works with families where substance misuse by parents or carers posed a significant risk to their children. However, while it is too early to evidence the impact of the IFST on noticeably reducing the numbers of children becoming looked after by the authority or those children who were subject to child protection proceedings, there was evidence of some effective preventative work.

There were 84 referrals made to IFST during 2012/13 of which 73 were for RCT. Around half of the families who completed the initial intensive phase went on to receive an intensive service intervention. Feedback from families and professionals had been positive. Parents felt they were given a voice, their progress was acknowledged by professionals, and the IFST service gave them time to reflect on what key changes they needed to make in their lives.

On-going assessment by families and social workers alike was used to measure 'distance travelled', giving families a greater understanding of what changes they needed to make and how successful there were in achieving change. Across the whole RCT/Merthyr Tydfil IFST service, 35% exceeded their goals, 33% achieved their goals and. 32% of families did not achieve their stated goals In respect of substance misuse by parents, 53% reduced substance misuse, 27% stabilised their usage and 20% reported an increase in substance misuse.

Positive outcome measures included the number of children who were looked after by the authority returned home, a number had their names removed from the child protection register and a number children in need were no longer assessed as requiring a service from the authority. Such change in status, particularly for those children who were no longer looked after and those who were no longer on the child protection register resulted in savings for the authority and positive outcomes for children.

The inspectors saw staff working in an honest and respectful way with parents and their children in the Strengthening Parenting programme. Parents and children from the group that overall the sessions were making a positive difference to them. However, for some parenting courses there were up to 25 families waiting for a service, as there was no prioritisation process or threshold assessment in place. For other IFST services there was a waiting time of up to 8 weeks. In addition, some early intervention services were only accepted from the Flying Start areas, which some staff felt was something of a post code lottery as it was not based on need.

The role and remit of IFST needed to be better communicated to locality teams, CDT's and other agencies. There was concern from locality teams and CDT's about the inconsistency of response from IFST. They would welcome a single point of referral for the services to improve consistency and timeliness of response. Staff within IFST similarly agreed that such an approach would be helpful to them in future.

Preventative services within RCT had been assisted over recent years by the Families First programme where a range of early intervention and support

services were available to vulnerable children and children in need. The development of the Canopi partnerships, across RCT, enabled agencies to deliver local community based support services to children and families. The "Team around the Family" (TAF), complements this by providing resources to work intensively with vulnerable children and their parents/carers and we found positive outcomes where this was happening.

Areas of progress:

- There were some examples of good practice within the IFST and TAF with effective support and interventions as part of care planning arrangements to deliver improved outcomes for children.
- There was a well resourced, experienced and increasingly well qualified staff group within IFST, some of whom were involved in providing training for staff in RCT.

Priorities for improvement:

- The authority needs to develop more effective communication and connectivity between all frontline services, preventative services and partner agencies, particularly as the IFSS moves towards greater practice and service integration.
- A single point of referral for IFST services was needed to improve consistency and timeliness of response.

Risks:

- The lack of a clear change and communication strategy for closer integration of preventative and core frontline business could compromise best practice.

2. Understanding the implications of the high numbers of children on the Child Protection Register and those children who are looked after by the local authority

Child Protection

The number of children on the child protection register had risen year on year since 2009 at 276, to 420 for 2011/2012. Such an increase in numbers had put a considerable strain on the capacity and resources for frontline staff. For the period April – end of December 2012, there were 405 on the child protection register, down from 480 in August 2012, a fall of over 15%.

The authority reported that all children on the child protection register were allocated to a key worker. The majority of the key workers were qualified social workers but there were a small, though unknown, number that were allocated to staff other than qualified social workers, usually assessor care managers (ACM's). The authority needs to address this issue as a priority to ensure all child protection cases can be allocated to a social worker.

There were concerns raised by a number of staff that some team managers were operating in a "risk averse" way, seeking registration of a child on the child protection register as a means of abrogating responsibility for decision making. The inspectors were not able to evidence such concerns one way or the other. However, what was problematic for many staff was that when children's names came off the register, in becoming "children in need" their case was often re-allocated to someone other than a qualified social worker even though the case remained complex and potentially challenging.

RCT and Merthyr Tydfil Safeguarding Children Boards recently merged to form the Cwm Taf Safeguarding Children Board (CTSCB). Following the Serious Case Review (SCR) undertaken in December 2011, the CTSCB tasked its Quality Assurance Sub group (QASG) to undertake an audit of child protection conferences, child protection plans and core group meetings. The audit found that there was good attendance and reports from school staff and health visitors at initial child protection conferences. Case files evidenced the marked lack of attendance and submission of clear reports at these conferences from the police and probation services. This was concerning given the prevalence of alcohol and/or drug misuse by parents and associated domestic abuse and its impact on children. The CTSCB needs to seek improvement in attendance of these agencies at initial and review child protection case conferences. Consideration should also be given to developing an agreement as to attendance by these agencies at specific core group meetings, e.g. child exploitation cases.

The protocol for responding to child protection referrals/concerns in relation to disabled children between the locality teams and the CDT's was felt by staff to be inconsistently applied and not effectively managed. There were examples of key information not being shared between teams, including minutes of strategy meetings and core group minutes, and there was confusion at times about who held the key decision making roles. In addition staff reported that the new paperless system in CDT made it difficult to track decision making and build case histories. Locality teams felt there was inconsistency in the timeliness of response and /or the quality of work by the two CDT's in respect of disabled children subject to child protection proceedings. The authority should reassure itself that there are the necessary skills and experience in the

CDT's to appropriately protect and promote the well being of disabled children deemed to be at risk of potential harm.

Looked after Children

The number of children looked after by the authority during 2011/12 was 595, and at a rate of 118.8 per 10,000 children was the fifth highest in Wales. The authority believes these numbers reflect high levels of deprivation and poverty that exist in RCT.

At the end of December 2012, of the 624 looked after children 70% were allocated to social workers, with the remaining usually allocated to an assessor care manager. Given the complexity of looked after children cases and the potential change of care status, placement and planning arrangements, the authority needs to give greater urgency to increasing the numbers of looked after children allocated to social workers.

The authority had considerably strengthened its arrangements for care leavers in respect of appropriate accommodation and support arrangements, in line with the Southwark judgement.

The Corporate Director's annual report for 2011/12 set out the challenges facing the authority in the coming months and years, particularly in respect of the number of children becoming looked after by the authority. There was a reported overspend in the LAC budget of £2.232 million at the end of December 2012, a reduction of some £400,000 from the previous quarter. Key cost pressures for 2012/13 were identified around higher individual placement costs of the 210 children placed with independent providers compared to the 272 looked after children placed with local authority foster carers.
The authority had been working hard to strategically address such challenges on a number of fronts including;

- Establishing a placement panel that sought to control admissions and monitor looked after children placements against outcomes.
- Further improvement to the fostering service to ensure a greater number of in-house foster carers.
- Residential care review group reviewing residential placements with a view to placing children, where it is their best interests, back in more local settings.
- The development of a residential and accommodation strategy.

In addition to the above was the recent development of the Rapid Intervention Response Service. Although the service had only been running for a few

weeks its aim was to reduce the number of children becoming looked after and ensuring children who are looked after remain so for as short a time as possible. CSSIW will monitor the progress and impact of the new service.

A report on the safeguarding arrangements for looked after children was commissioned on behalf of the Cwm Taf Safeguarding Children Board (CTSCB) by the Service Director Children's Services following the Chief Inspector CSSIW seeking confirmation that looked after children had appropriate care plans in place and were being visited and reviewed by the authority. The report, completed by RCT's Head of Safeguarding in December 2012, was thorough and included a good analysis. There were twelve recommendations for action by the CTSCB and its partner agencies. The effectiveness of implementing the report's recommendations will be closely monitored by the Board, the Corporate Parenting Board and elected member Scrutiny Committees.

The Corporate Parenting Board played an important and effective scrutiny and championing role for children looked after by the authority. The board received regular reports on CSSIW regulatory inspections on its fostering and adoption services and on its residential children's homes. In addition, the board received reports of visits made by an experienced independent visitor to its own children's homes which provided a well informed child focused approach to the visits. The Corporate Parenting Board had a central part in the annual looked after children awards celebration which was attended by senior elected members and the Corporate Director for Community and Children's Services, reflecting the whole authority commitment to the children whom it looks after.

Areas of progress:

- Some skilled and effective case work practice is taking place. There is evidence of working with complex, and challenging families, delivering better and safer outcomes for children. This was assisted by some innovative and effective services, with good practice and partnership arrangements with statutory and voluntary agencies.
- There is a focused approach to reducing the number of children becoming looked after; the time children remain in care, and providing locally based and cost effective placements.
- Effective in-house legal services are in place assisting timely interventions to secure safe practice and better outcomes for vulnerable children.

Priorities for improvement:

- Improved consistency in the use of thresholds and decision making across children's services and with partner agencies. In addition, practice, assessments and care planning needed to be more consistently child focused.
- Ensuring children who come off the child protection register received safe children in need service from a social worker.
- Ensuring that children who are looked after are allocated to a social worker.
- Continued attention to securing more appropriate locally based and cost effective placements as part of the authority's strategic approach to providing a sustainable service for looked after children.

Risks:

- The lack of attendance and provision of clear reports of key agency personnel submitted to child protection conferences means children, and some parents may be disadvantaged.
- Failure to address and deliver consistency of thresholds and associated decision making across children's services and with partner agencies would compromise best and safe practice.
- The high number of looked after children, and the cost of placements, poses considerable if not potentially unsustainable financial pressures on the authority.

3. The work of the Children's Disability Teams

There was evidence of effective partnership working with other agencies, including health, education and other specialist agencies. There had been a recent improvement in effective joint working practice between the CDT's and Child and Adolescent Mental Health Services (CAMHS). Recent service shortfalls, notably the withdrawal of clinical nurses and behavioural psychology services, including children on the autistic spectrum and those with behavioural difficulties, placed additional strain on parents and carers. In some instances, CDT staff felt this may have contributed to potential child protection issues and /or children becoming looked after.

Social work staff in the CDT's carried caseloads of up to 30 cases that include children in need, children who were subject to child protection procedures and children looked after by the authority. There were good links with adult social services, including where their input was required in terms of case work and parenting assessments, though improved input and engagement by adult

mental health services was needed. In addition, greater consistency was needed in planning and managing transition services between CDT's and adult services. This was particularly critical for young people with complex, multiple and at times challenging needs, including those in receipt of partner agency funding for continuing health care needs.

Children using the family link or residential short stay services available had a six monthly review of their needs, chaired by Independent Reviewing Officers. The family support service and occupational therapy services had waiting lists, the latter reportedly being 65 families. The opportunity for access to play schemes for physically disabled children is now available through Early Years and Family Support service. The authority and its partners will want to monitor resource capacity and provision for all these services. There were 110 disabled children who were in receipt of direct payments at the end of December 2012.

Staff and managers in the three localities and in the CDT's acknowledged inconsistency of decision making between the teams. Such inconsistencies of decision making and thresholds were commented upon by other staff and managers, as well as the Child protection and looked after children Independent Reviewing Officers. The authority needs to ensure clear and demonstrable threshold and decision making criteria were in place for its staff and partner agencies.

Case Files

CSSIW considered thirty case files during the course of the inspection. Many of the cases were complex and challenging and were tackled with skill by the case managers. No cases were referred by the inspection team as being cases of concern that required immediate action and/or intervention, or required a review by the authority. In addition, inspectors felt that in all the cases seen, where children were subject to child protection proceedings or were looked after by the authority, such action was appropriate.

There were some examples of good practice, and the inspectors brought this work to the attention of the Director of Children's Services. This included child focused work, placing the child's voice, experience and needs at the centre of work and actions carried out by the social worker and colleagues assisting their case work. There were, however, cases were the quality of work was less sound and improvement was needed to ensure case management and intervention was more strongly child focused.

The quality of initial and core assessments was also variable. In discussion with staff, they cited capacity issues and compliance with performance

indicators as being underlying reasons for a drop in the quality of work. This had been acknowledged in a report by the Head of Safeguarding in 2011 that indicated that while timeliness of the completion of core assessments had improved, the authority needed to tackle quality. As evidenced in the CSSIW recent Children in Need report as well as in this report, such improvement was very much work in progress. The authority needs to give further attention to drive up the quality of core assessments.

Areas of Progress:

- Some skilled and experienced staff, providing effective case work and care planning for disabled children.
- There were some effective services and partner agency provision for disabled children and their families

Priorities for improvement:

- Additional occupational therapy, family support resources and behavioural support services.

Risks:

- Key aspects of service provision, if not addressed, had the potential to compromise the health, well being and development of disabled children and young people.

4. Workforce and capacity issues across frontline services.

RCT has a large number of committed staff and managers who were passionate and professional about their practice and committed to deliver the best possible outcomes for children and their parents and carers. There was however variable levels of skills and experience amongst staff. In the locality teams and CDT's, staff instability, including vacancies and sickness, along with the inability to retain experienced staff and recruit experienced team managers, had led staff to be concerned about delivering the appropriate quality of service to vulnerable children and their families.

The resilience and morale of many frontline staff, team and service managers was low, with many staff saying they felt under valued and that senior managers did not understand the workload pressures they faced. They felt

there was a lack of cohesion and effective communication between top managers and operational staff; even though staff felt senior managers were approachable and listened to them. Some team and service managers and staff felt they were not given an opportunity to contribute to the improvement agenda for children's services. Although the Director of Children's Services and the senior management team were aware of workforce issues and the discontentment of some staff, the inspectors felt the extent of the issues may not have been wholly appreciated by senior managers. One area for improvement would be for service managers to be copied into the minutes of the Director of Children's Services and Heads of Service meetings.

Staff in the three locality districts felt disconnected from one another as well as from staff in other teams in their own district. There was a lack of locality meetings in each of the districts for all staff which fragmented communication. Locality teams appeared to lack the critical mass of staff to have the capacity to cover sickness and maternity leave, especially as these posts were reported as not usually covered by agency staff. There was an example of a locality team manager post being vacant for nearly a year that was covered by other team managers.

The two CDT's report markedly different staffing experiences over the last year or so. The East CDT has had a stable workforce, with a good range of skills and experience. By contrast, the West CDT had been seriously short staffed with vacancies with little agency cover, and the team experienced workload pressures and considerable stress. The team had new staff starting in early 2013. The new open plan office accommodation has the potential for closer cross team working though CDT staff felt the new working environment had compromised their quality of work.

A number of quotes from frontline staff reflect their concerns:

"The department has always had a stable work force: this has deteriorated over last eighteen months".
"Frontline staff were happy to go the extra mile but senior managers expected us to go an extra five miles at evenings and weekends".
"The department runs on good will and our loyalty to children and families in RCT and to the local authority. Many staff live in RCT and want to improve the life of kids in RCT".
"There is no personal/professional capacity to support other team members".
"We do feel children are safe but we have no work/life balance".
"The instability of teams and team managers along with staff shortfalls are a threat to consistent and good quality practice".

Morale and staff stability in IFST was good, and staff felt valued and respected by managers. Workloads in the team were said to be manageable, and staff had time to carry out their work in a professional and structured way. There was good leadership and management provided by the team manager, who staff felt was visible, available and supportive. There was some uncertainty about the future change and development of the IFST and service, though staff felt this would be systematically considered and that their views would be sought and reflected in future service development plans. The IFST team manager is leaving and the post is to remain vacant for six months.

Caseloads for locality team staff were said by senior managers to be around 22, which they felt was too high. There were, however, examples of case loads up to 33 cases in some front line teams. For some senior practitioners, where they had such high case loads, consisting of child protection and looked after children cases, they had no capacity to carry out their wider development and support functions within their team. There were some examples of unallocated cases, 18 in one team with 13 of these being CP cases. There was a review system for these cases but such levels of unallocated cases was unacceptable. Although there was an additional one million pounds made available the authority needs to review such difficulties to reassure itself that it has sufficient resources in place to effectively address caseload issues and staff capacity concerns.

The single salary point for qualified social workers was attractive for newly qualified social workers. There was a good induction, training and development programme for new staff, including reduced and protected caseloads for newly qualified social workers. Such measures played a positive role in recruiting newly qualified staff, as did the secondment opportunities for staff/ assessor care managers to undertake the social work degree course.

There was difficulty in recruiting team managers and retaining experienced social workers in children's services. Team managers were reported by staff to be the lowest paid in Wales and this, along with a single salary level for social workers, led to staff shortages for these two critical roles in the authority. Four team manager posts were advertised at the time of the inspection, for some of these posts, this was the fourth advert.

The Director of Children's Services indicated to the inspectors that a review of the structure, size and associated capacity of social work teams across children's services was being considered, although the timescale for this to be completed was two to three years. An urgent requirement for the authority is to review current workforce issues, particularly team manager and social worker salary grades, as part of its workforce recruitment and retention policy.

In addition, a review of the high cost of agency staff, reported as being over £650,000 last year, could also be undertaken as part of a workforce and best value exercise.

There were tensions between frontline teams and the IFST. This was focused on the lack of capacity for frontline staff to undertake best social work practice, including undertaking direct work with children and young people, when compared to that of the IFST. The frontline staff also felt the IFST, and the three new Rapid Intervention Response Teams (RIRT's), were better resourced, though less pressured, in terms of workload, staffing numbers and supportive technology including mobile phones and laptops. Senior managers should consider reviewing such practicalities as greater integration and closer working practice develop between the three services.

Supervision

In some teams, there was good, proactive supervision, held every four to six weeks, including in some instances joint supervision with staff when visiting families and team manager support to staff when attending court. The model for such supervision included case review, reflection, challenge and opportunities for learning, as well as consideration of work-life balance issues.

However, staff in other teams indicated that supervision was more driven by achieving performance indicator timescales for cases, which meant staff had little time for reflection or learning during supervision. In one locality, team managers indicated they had not received supervision from their line manager for over a year but this has now been resolved.

Inconsistency of supervision had not been identified in the CTSCB Child Neglect: practice guidance and protocol tool of March 2013. This appeared to assume supervision was consistently provided across children's services. The authority needs to consider this and give priority to delivering a consistent and sound management culture of supervision along with introducing an annual appraisal system.

Training and development

Training and development for newly qualified social workers and non-social work staff was good and there was an effective induction programme. There was an annual training calendar that provided a range of training and development opportunities. For newly qualified staff in their first year protected case loads in terms of not managing and/ or being allocated complex cases was part of the attraction of working for RCT. However, given

staff shortfalls in frontline teams and all staff being on the same single salary point, there was pressure for recently qualified staff to take on complex cases. This was seen as a way of relieving pressure on more experienced colleagues, though placed recently qualified staff in potentially vulnerable positions.

More experienced staff indicated the lack of more advanced training and development opportunities. This was in part reflected in the CDT's though there had been some effective specialist professional development courses for the CDT's. Staff felt that workload pressures sometimes prevented them from attending training courses.

Staff in the IFST benefitted from an extensive training and professional development programme in line with Continuing Professional Education Learning, reflecting recommendations from Welsh Government. The IFST also provided a range of training in multi-agency working for children's services staff and other agency personnel. This was within its service improvement role as part of its Welsh Government "*transformation and system change agenda".* Much of the training had been well received and was a key part of local partnership working between children and adult social care services and health services across RCT and Merthyr Tydfil.

The authority had very recently introduced a management development programme which is initially being prioritised for Assessment Care Planning managers but is also available to senior practitioners and consultant social workers.

There was no clear evidence of effective workforce planning in children's services to enable experienced staff to develop the skill sets to be able to progress to become a team manager, informally known as "grow your own staff". There was a consensus amongst staff that RCT had been good at succession planning in the past, a return to such good practice was seen by many staff as now being essential. The authority should review its workforce strategy to address the above staffing issues and practice shortfalls.

ICT

There continued to be concern and frustration amongst staff about IT systems used in the authority. This included ICS, other IT systems and the move to paperless systems. Staff would welcome involvement in ensuring that systems "*were fit for purpose, reduced duplication and avoided excessive desk and computer work that detracted from face to face work with children and families*". Senior managers were aware of such sentiments and need to action IT systems' improvement.

Areas of progress:

- There were some skilled and committed staff and managers in children's services.
- The IFST had delivered a programme of training and development for social services and partner agencies in the statutory and voluntary sector.

Priorities for improvement:

- The authority needs to put in place a new workforce strategy to address staff dissatisfaction and low morale and difficulties of staff recruitment and retention. Such a strategy should include a review of team manager and social work salary grades, training and development opportunities for experienced staff, the implementation of an effective model of supervision and annual appraisal, and work towards achieving a realistic case load for frontline staff.
- Ensuring appropriately qualified and experienced staff manage complex cases where there were recent child protection concerns and children who are looked after by the authority.
- Continued attention to the development of an integrated, fit for purpose IT systems.

Risks

- Staff vacancies resulting from failure to retain experienced social workers and recruit team managers could potentially compromise safe practice within children's services.