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

Inspection of *Children's* Services

in Monmouthshire County Council

February 2015

Introduction

Care and Social Services Inspectorate Wales (CSSIW) undertook an inspection of children's services in Monmouthshire County Council in November 2014. Inspectors looked closely at the experiences of children and young people who had needed or still need help and/or protection. We also considered the quality of outcomes achieved for children and families. This included a small sample of children and young people who were looked after. Inspectors read case files and interviewed staff, managers and professionals from partner agencies. Wherever possible, they talked to children, young people and their families. In addition, inspectors evaluated what the local authority knew about how well it was performing and what difference it was making for the people who it was trying to help, protect and look after.

During this inspection no widespread or serious failures were identified by inspectors that left children being harmed or at risk of harm. However, management oversight of practice was insufficient.

The local authority acknowledged that prior to April 2014 there was insufficient attention given to improving frontline practice. There has since been a greater focus and attention to improving practice in children's services particularly in the last six months; these developments need to be embedded and sustained. Inspectors were pleased to note that senior managers were committed to achieving improvements in the provision of help and protection for children and families.

The recommendations made on page 5 of this report identify the key areas where post-inspection development work should be focused. They are intended to assist Monmouthshire County Council and its partners in their continuing improvement.

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Summary

Theme 1: Access Arrangements

Thresholds between "early help" (the provision of information, advice and signposting) and statutory social services interventions were not appropriately understood or operating effectively. Although children and young people in need of help and/or protection were generally identified by professionals from all agencies, the quality of referral information sharing was poor. When contacts were received where there was an obvious indication of significant harm, prompt and effective action was taken. However, if there was no obvious indication of significant harm, decisions to progress contacts to a referral and/or an initial assessment were not timely. Neither was the system for tracking/managing contacts acceptable; there was a risk of cases being lost and/or of lengthy delays to children and families receiving the help they needed. Management oversight of access arrangements was insufficient. As a consequence some children were left in need and some were potentially left at risk of significant harm.

Theme 2: Assessment

Children and young people who are, or who are likely to be, at risk of harm were identified and protected. Child protection enquiries were generally thorough and timely although strategy discussions did not routinely include information from all relevant partners. Overall, assessments were timely and contained appropriate information from a range of sources. The quality of risk analysis within assessments was variable; often risk was implied rather than explicitly articulated. Although assessments were generally child-focussed, they did not always take account of children's communication needs. Nor did they detail children's diversity requirements or explicitly express their wishes and feelings often enough. The quality of recording throughout the assessment process was poor and as a result failed to evidence the depth of enquiry that had been undertaken. Most assessments were not shared with children and families. Although the timeliness and quality of decision-making was adequate, management oversight of the assessment process was ineffective. Overall the quality of assessments was inconsistent. The impact of lack of engagement and lack of transparency was that children and families were not always clear about the purpose of the help they received and/or the need for protection.

Theme 3: Care Management & Review

Children and young people identified as being in need of help or protection, including children looked after, generally experienced timely and effective multi-agency help and protection. The quality of care planning and review was adequate. Some good services were delivered to families and good quality direct work with children was evident. However, risk based planning and authoritative practice were not sufficiently well evidenced. There were significant deficits in multi-agency risk management, in particular with regard to the use by social services of "contracts of expectations" which fail to adequately protect children. Managers did not effectively challenge poor quality

risk management practices. Workforce stability had been recently achieved in children's services and social workers were committed to achieving good outcomes for children and families. This stability now needs to be consolidated and sustained in order to achieve continuous improvement in outcomes for children and families.

Theme 4: Leadership & Governance

Leadership management and governance arrangements did comply with statutory guidance and arrangements for effective engagement were in place. Senior leaders were committed to improving safeguarding and this was reflected well in strategic planning. Strategic plans had not been effectively disseminated throughout children's services. More focussed and sustained improvement is required to establish an effective strategy for the delivery of good quality services and outcomes for children, young people and their families. The authority worked well with partners to deliver help, care and protection for children and young people and showed a high level of enthusiasm and commitment to corporate parenting.

Local joint needs analysis did not inform planning for children's services. Neither performance management, quality assurance monitoring nor strategies to ensure the authority sustained a culture of learning were sufficiently well embedded to provide a thorough understanding of the difference that help, care and protection was making for children and families. Senior leaders were insufficiently well sighted on front line work in children's services.

Services were delivered by a suitably qualified, experienced and competent workforce that was able to meet the needs of local children, young people and their families. Most social workers expressed trust and respect for senior managers and said that morale was high within the workforce. Management oversight and supervision was accessible but was insufficiently effective in supporting the workforce to deliver services that result in positive outcomes for children and families.

Recommendations

1. Training should be delivered for all professionals/agencies to ensure that the thresholds for access to children's services are clearly understood and consistently applied; this training should incorporate completion of quality referral information and reports to conference.
2. Effective systems must be in place to ensure that all children who meet the threshold for an initial assessment by children's services receive a timely assessment that is of good quality so that their safety is secured.
3. Strategy discussions and decisions should be informed by the involvement of all relevant professionals and clearly record the rationale for decisions and agreed timescales for action.
4. 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.
5. The quality of risk assessment and risk management should be improved; policies and toolkits should be revised to focus explicitly on risk assessment and management in children's services and staff should be trained appropriately. "Contracts of expectation" should not be used to manage risk; statutory child protection processes should be initiated where there are safeguarding concerns.
6. There should be a greater focus on engaging with children and involving them in the assessment process; this should include taking more account of children's communication needs and a more detailed analysis of their cultural, religious and other diversity needs.
7. 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 that desired outcomes, timescales and accountabilities for actions are clear.
8. Performance management and quality assurance arrangements, including scrutiny of service demand and routine auditing of the quality of practice, should be more effectively 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.
9. The consistency and quality of management oversight, direction and supervision of front line staff throughout children's services should be improved.
10. Senior leaders should take steps to enhance their line of sight on frontline work and ensure the improvements needed in children's services are prioritised and the pace of improvement sustained.

Contents

Findings

Theme 1: Access Arrangements

What we expect to see

Thresholds between "early help" (the provision of information, advice and signposting) and statutory social services interventions are appropriately understood and are operating effectively.

Key findings

1. Children and young people in need of protection were identified by partners and appropriate referrals were made to children's social services.
2. The quality of information recorded on referral forms was poor.
3. The arrangements for interface between Joint Assessment Family Framework (JAFF) and statutory services were not working effectively.
4. When contacts were received where there was an obvious indication of significant harm prompt and effective action was taken.
5. When contacts were received where there was not an obvious indication of significant harm, decisions to progress to referral were not timely; as a result children were left at potential risk.
6. Timely decisions about whether or not to progress contacts to a referral and/or an initial assessment were not made.
7. Children, young people and families were not always being offered help and/or protection when needs and/or concerns were first identified.
8. Management oversight of access arrangements was insufficient.

Explanation of findings

1.1. Children and young people in need of protection were identified by partner agencies and appropriate referrals were made to children's social services. Partner agencies reported that, overall the response to referrals by duty social workers was constructive and helpful albeit not always timely. Most partners said that, in their view, thresholds were generally appropriately and consistently applied by children's services staff.

> **Quote from partner:**
> "We find the duty desk very helpful but there are sometimes delays in deciding if our referral meets the threshold".

1.2. Referrals were usually made using the recently improved Multi-Agency Referral Form (MARF). We found that the quality of information recorded by partners on many of the MARFs was poor, containing inaccurate information. Referrals also lacked clarity and detail about background information, in particular reference to former concerns and incidents that would inform the context of the family circumstances. It was not always obvious which agency or professional had completed the referral form. Children's services duty staff receiving referrals were insufficiently proactive about obtaining clarification/ confirmation of poor quality referral information in a timely manner. This meant that social workers needed to source information about families to better inform themselves about the levels and types of risk posed before decisions could be made about whether/how to progress to assessment. In doing so, there was often an over-reliance on self-reporting; with workers frequently relying solely on information obtained from telephone contact with families without verification. These deficits created unnecessary delays in decision making which potentially meant that children were left at risk. Lack of detailed information also inhibited a sensitive and responsive service approach to children and families as well as hindering staff personal safety risk assessments prior to undertaking initial visits.

1.3. The arrangements for interface between Joint Assessment Family Framework (JAFF) and statutory services were not working effectively. There were up-to-date policies, procedures and guidance in place but inspectors did not see firm evidence of a shared understanding of thresholds between these partners and statutory services. This was further borne out by the views expressed by some health partners who reported that their skills, knowledge and experience of working with children and families, particularly younger children, was not sufficiently valued by children's services staff. The authority had already identified the need to improve and further develop JAFF arrangements to ensure children and families were more effectively able to access early help. A social worker had been recruited as a JAFF co-ordinator within the last six months. The post-holder had recently initiated regular monthly training events for staff, centred on achieving a greater understanding of shared thresholds. She was also enthusiastically and actively involved in improving referral pathways, including "step-up" and "step-down" arrangements. Whilst inspectors welcomed these developments it is too early to comment on the sustainability of any improvement achieved so far.

1.4. We found that when contacts were received where there was an obvious indication that a child or children were at risk or had suffered significant harm, a prompt decision was made to progress this to a referral and effective action was taken in all cases inspectors reviewed. Inspectors saw no examples of children and families being subjected to child protection investigations unnecessarily. Child protection investigations were undertaken by suitably experienced social workers following information sharing at a strategy discussion.

> **Quote from a mother:**
> "We got a really speedy service, exceptionally swift in fact. What we got meets our child's needs. How could it be better? The social worker came to our home. There was no need for us to queue in a busy office. The social worker and the duty officer have been wonderful. It took some time in discussion over the phone and at home to work out what we needed. I have much respect and admiration for them. They are both very respectful. They know what the job is about but don't talk down to us and treated us with respect".

1.5. When contacts were received where there was not an obvious indication of significant harm, decisions to progress to referral were not always timely. As a result children were left at potential risk and families were not always being offered help early enough. The volume of contacts received by Monmouthshire children's services had risen during the first half of 2014-15. This increase was not anticipated and remains unaccounted for. The increase coupled with high staff turn-over, staff absence and significant changes in working practices led to a backlog of work during summer 2014. We acknowledge that steps had been successfully taken to improve staffing stability and as a result the backlog had been cleared. However, inspectors found that contacts were still not being dealt with in a timely manner. It was not apparent, in light of the continuing upward trajectory of referrals, how the authority will sustain capacity to avoid the creation of a further backlog or to ensure that all contacts receive a timely and appropriate response in future.

1.6. Between April and September 2014, 215 of 1870 contacts progressed to become referrals in a timely way. Others were appropriately signposted to services or, if current cases, the information was conveyed to the allocated social worker. However, a significant proportion of contacts were routed into a process labelled "further enquiries". This appeared to be a temporary holding position for contacts with as yet insufficient information available to clearly identify the case as meeting the threshold for progression to referral. Timely decisions about whether or not to progress work to a referral and/or for an initial assessment were not therefore being made.

1.7. The unacceptability of these arrangements was exacerbated by a lack of methodical tracking of the progress and/or completion of these enquiries. This meant there was potential for some cases to be lost indefinitely in the system leading to children being

left at risk without action being taken. Inspectors found that there were unacceptable delays in completing enquiries and in some cases children and families were not seen or spoken to for several weeks. This drift resulted in them being left in need and potentially at risk when the provision of early help could usefully have been provided to immediately improve their circumstances and reduce risks.

1.8. Inspectors also 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. The impact was that children and families were not being helped when they should have been.

1.9. Management oversight of access arrangements was clearly insufficient. These cases did not receive the management oversight needed to assure the authority that children were appropriately safeguarded and families received the timely support they required. 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 saw only very limited evidence of management sign off or approval of work nor were there sufficiently robust systems in place to track progress or oversee the quality of work. There was no up-to-date written guidance for staff undertaking the duty/intake function.

1.10. Inspectors noted that senior practitioners and managers were very responsive to concerns raised by inspectors during the fieldwork period concerning these significant deficits, and that some immediate remedial action was taken to increase the tracking and management oversight of access arrangements. However, urgent action is required to review and improve arrangements for managing contacts made to the authority if thresholds and timely decision making are to be effectively operated to protect children. It is also important that workers receive clear and contemporary guidance about providing early support for children and families to prevent escalation of need and potential risk.

Summary

1.11. Thresholds between "early help" (the provision of information, advice and signposting) and statutory social services interventions were not appropriately understood or operating effectively. Although children and young people in need of help and/or protection were generally identified by professionals from all agencies, the quality of referral information sharing was poor. When contacts were received where there was an obvious indication of significant harm, prompt and effective action was taken. However, if there was no obvious indication of significant harm, decisions to progress contacts to a referral and/or an initial assessment were not timely. Neither was the system for tracking/managing contacts acceptable; there was a risk of cases being lost and/or of lengthy delays to children and families receiving the help they needed. Management oversight of access arrangements was insufficient. As a consequence some children were left in need and some were potentially left at risk of significant harm.

Theme 2: Assessment

What we can expect to see

Children and young people who are, or who are likely to be, at risk of harm are identified and protected.

Key findings

1. Child protection enquiries were thorough and timely and were informed by decisions made at a strategy discussion.
2. Strategy discussions were timely and generally managed in accordance with guidance.
3. Strategy discussions did not routinely include information sharing with all key agencies.
4. Assessments were developed from a wide range of sources including information from partners, parents and carers.
5. Assessments identified when poor parental mental health or substance misuse and domestic violence were adversely affecting children.
6. The quality of risk analysis contained within assessments was variable.
7. Assessments were child focussed but they did not articulate children's wishes and feelings often enough.
8. Assessments did not take account of children's communication needs often enough nor were children's diversity needs sufficiently well captured.

Explanation of findings

2.1. Generally we found that child protection enquiries were thorough and timely and that they were informed by decisions made at strategy discussions. Strategy discussions as well as outcome strategy discussions were timely and generally in accordance with guidance. Strategy meetings were utilised very rarely. The majority of strategy discussions were held between police and children's services and did not routinely involve discussions with other key agencies. Inspectors recognised the resource implications and logistical difficulties associated with multi-agency 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.

2.2. Records of strategy discussions and section 47 enquiries varied too much in quality. Whilst decisions made were generally clear, too many records lacked detailed planning arrangements concerning roles, responsibilities and timescales for future action. Neither was there consistency about methods for storing records of section 47 enquiries. A small number of staff interviewed by inspectors had great difficulty finding these records on case files even where they had a clear recollection of carrying out and indeed recording the enquiry themselves. The impact of such poor recording and storage practices 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. Inspectors recognised that work already underway to develop a new electronic case management system will go some way to address these deficits.

2.3. A significant minority of the assessments we reviewed had not been completed in a timely manner. Nevertheless we found that most of the assessments had been developed from a wide range of evidence, including relevant and appropriate information from partner agencies as well as from parents and carers.

Practice example report from a father:
The child's father was impressed by the fact that the social worker made one of her visits to the child unannounced. He believed that this showed her experience and skills in gathering and analysing information. His overall opinion was that she was respectful, listened, made sure she had all the information she needed and kept him informed of what would be likely to happen next. He felt involved in the assessment processes and in the decision making. He felt she had made a positive difference to his daughter's life and to his, both personally and professionally. She instilled confidence in him, arranged meetings at times and places that were accessible for him. Importantly she recognised the impact her involvement was having on his family.

2.4. Generally assessments reflected levels of need and/or concern appropriately. Most assessments inspectors reviewed identified when poor parental mental health or substance mis-use and domestic abuse were adversely affecting children.

Many assessments were clearly child-focussed and inspectors saw some good analysis of risk, including analysis of history leading to effective action. However, quality was variable.

Practice example from staff interview:
There is evidence that the folder taken out by social workers when completing an assessment improves professional standards. The folder contains the consent for information, a service user feedback form, the complaints and compliments policy and procedures and a copy of the basic information on the child and family. This gives an opportunity for the parent to confirm family details are correct and places the work on a proper footing. The social worker who is from an agency has worked in another authority where this documentation at first point of contact was not available. The agency worker said: "This is brilliant - all the documentation is in one place."

2.5. Risk analysis was frequently not clearly articulated within the assessment framework but rather implied by the descriptions given of children's and family's circumstances. The introduction in May 2014 of a revised Risk Management Policy (fully implemented in September 2014 alongside a new recording template) was seen by inspectors as a constructive attempt to help guide practitioners into more explicit risk analysis. However, this policy requires further work and staff and managers will subsequently need to be appropriately briefed if this welcome development is to support them as intended.

2.6. Assessments did not always reflect sufficient engagement with children. In many of the cases we reviewed, children had not been seen and/or spoken to alone where this would have been appropriate. Whilst inspectors did see some good examples of effective engagement with children in the assessment process a small proportion of assessments did not take account of children's communication needs. Neither were the diverse needs of children arising from their culture, religion, ethnicity, gender, gender identity or sexuality sufficiently well detailed in assessments; this information is critical in helping children understand their experiences as well as informing the care and support they receive. Too often children's wishes and feelings were not explicit in assessments. The impact of this limited engagement in their assessments was that children and young people lacked a clear perception of what needed to be done to ensure their safety and wellbeing. It was noteworthy that the authority had already recognised the need for better engagement with children and as a result the head of service had recently commissioned training for social workers in play therapy, to increase their confidence and capability to engage more effectively with children and to elicit their wishes and feelings.

Practice example from case file:
The social worker appeared to relate very well to this child and carefully took him through the events that led to the allegations being made. This was handled sensitively but directly.

2.7. The template for recording assessments had been updated just prior to the inspection fieldwork, so the inspection team reviewed a mixture of assessments recorded on previous and current models. Regardless of the template many assessments were undated. Some of these documents failed to: evidence the depth of enquiry; reflect the dynamic nature of change in light of emerging issues and risks; or demonstrate the cumulative impact of social work interventions to date.

2.8. The revised Child & Family Assessment template did not encourage practitioners to distinguish the varied risks and needs associated with multiple siblings within the family and again this contributed to confused recording. Some records were duplicated to sibling case files, which meant that they were not always personal to the child. This hampered 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 individual children. Moreover, it reduced the value of the records to children reading them. Evidence from case files, borne out by feedback from some parents, suggest that very few assessments were shared with children and families. The impact of this, coupled with poor recording practice and limited engagement with children, resulted in children and families not always fully understanding the purpose of the help they received, nor what they needed to change to ensure children were appropriately safeguarded, and that their prospects for better outcomes were improved.

2.9. As with access arrangements we found that the quality of management oversight of assessments was ineffective. Although the timeliness and quality of decision making in respect of the initiation of child protection enquiries was adequate, the overall quality of assessments was variable, in particular the quality of risk assessments required improvement. Fewer than half of the assessments we reviewed had been signed off or approved by a manager/senior practitioner.

Summary

2.10. Children and young people who are, or who are likely to be, at risk of harm were identified and protected. Child protection enquiries were generally thorough and timely, although strategy discussions did not routinely include information from all relevant partners. Overall, assessments were timely and contained appropriate information from a range of sources. The quality of risk analysis within assessments was variable; often risk was implied rather than explicitly articulated. Although assessments were generally child-focussed, they did not always take account of children's communication needs. Nor did they detail children's diversity requirements or explicitly express their wishes and feelings often enough. The quality of recording throughout the assessment process was poor and as a result failed to evidence the depth of enquiry that had been undertaken. Most assessments were not shared with children and families. Management oversight of the assessment process was ineffective, although the timeliness and quality of decision making was adequate. Overall the quality of assessments was inconsistent. The impact of lack of engagement and lack of transparency was that children and families were not always clear about the purpose of the help they received and/or the need for protection.

Theme 3: Care Management & Review

What we can expect to see

Children and young people identified as being in need of help or protection, including children looked after, experience timely and effective multi-agency help and protection through risk-based planning authoritative practice and review that secures positive outcomes.

Key findings

1. Social workers could articulate well children's needs and the risks associated with their care, as well as actions required for reducing risk and achieving desired outcomes.
2. The quality of care plans was inconsistent with timescales for action and roles and responsibilities often unclear.
3. The quality of risk management was often ineffective.
4. Social workers were committed to improving outcomes for children.
5. Many children had experienced frequent changes of social worker.
6. Stabilisation of the workforce had been recently achieved along with an improvement in staff morale.
7. Social workers undertake some good quality direct work with children and their families.
8. Although limited in range, the quality of services delivered for children and families was good.
9. Child Protection conferences and core groups were timely, well chaired, child focussed and well attended by families and partners.
10. Statutory visits were not timely or well recorded.
11. Progress of child protection plans were regularly reviewed.
12. The quality of case recording was poor.

Explanation of findings

3.1. Social workers could articulate well children's needs, and the risks associated with their care as well as the actions required for reducing risk and achieving desired outcomes. However written plans did not reflect this. Most plans were explicitly derived from assessments and clearly outlined objectives for change, but many plans were less specific about timescales for completion of work and did not always clarify the roles and responsibilities of the different agencies involved, nor expectations on family members.

3.2. As with risk assessment, the quality of risk management was also variable. Actions identified to address risk tended to be generic and did not include enough information needed to support required responses from agencies or from families. Consideration of patterns of behaviours and/or previous concerns did not routinely inform planning to minimise/manage risk in any of the plans reviewed, nor was there a recognised need to include contingency planning. The impact of this was that other professionals were not always clear about expectations on them to take action in specific circumstances. This limited the effectiveness of risk management. Moreover, evidence from service users suggested that children and families were not fully aware of risk management arrangements, leading to distrust of professionals and of social workers in particular.

3.3. The most concerning examples of poor risk management were reflected in the authority's use of "written agreements" or "contracts of expectations". These "agreements" were entered into with families who were not formally engaged in either child protection or court proceedings. The arrangements were often entered into without the knowledge or agreement of partner agencies and with no clarity about how the family's (lack of) compliance was to be monitored and/or reported on. The consequences of a family's non-compliance with these agreements were neither clear nor enforceable. This practice clearly had the potential for children to be left in unsafe environments.

3.4. All the social workers and managers we interviewed were clearly committed to improving outcomes for the children and families they worked with. However, evidence from case reviews showed that many children had experienced frequent changes of 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 we saw the quality of social work support was poor, with long gaps between visits and an overall lack of purpose, leading to slow progress against the plan.

3.5. Inspectors recognised that the authority had experienced a period of workforce instability with high staff turn-over and a reliance on agency workers. Many staff told us they had seen a good deal of successive and poorly communicated organisational change within children's services over the last two/three years and that this had a negative impact on their morale. However, we noted that the authority had made extensive efforts during the last nine months to successfully recruit appropriately skilled and experienced social workers. We also noted a re-focussing of senior management attention on the improvements required in children's services. This was evidenced for example by additional support to temporarily retain a small contingent of agency social workers over

establishment to support transitional staffing arrangements and provide continuity. Finally, it was apparent from constructive and positive responses that inspectors received from most staff interviewed, that overall staff confidence and morale had improved significantly since the permanent appointment of the new head of service nine months ago.

Views expressed by parents and grandparents:
Both mother and grandparents spoke very positively about their contact with the social worker. Mother said she was always accessible and returned calls. She explained what she was doing and why. The mother felt listened to, supported and involved in the process. She had trust and confidence in the social worker to do what was right for the child. She believed that the decisions made to date were right for the child despite being very distressing for her. This was echoed by the grandparents who scored the social worker "ten out of ten" for all aspects of her work.

3.6. A review of contemporary practice demonstrated that in many cases, social workers now undertake direct work with children and their families. They also form positive relationships with children that help them to express their wishes and feelings. Inspectors welcomed this move to a more child and family centred approach which promoted the value of effective engagement as a critical component of the social work role. This positive improvement needs to continue to be built upon, embedded and sustained.

Quote from social worker:
"I have put a great deal of work into this case and I think the family are pleased with the outcome. There has been a lot of input from other professionals such as Action for Children and the school which has all contributed to a better outcome."

3.7. As in many other rural authorities, the range of family support services available was limited. The specific gap in service provision most frequently highlighted was the limitation of the availability of Child and Adolescent Mental Health Services (CAMHS). However, evidence from case reviews and some service user feedback suggests that the quality of health and voluntary sector social care services, as well as direct work undertaken by social workers and including services delivered to children with disabilities, was good.

Quote from a parent:
"The staff in the service are very personable and friendly. It was a speedy response. There are a lot of good services here. They met my son and talked to him. They know their jobs very well but treat you with respect and listen carefully. They don't talk down to you. My child got just what he needed."

3.8. We saw examples of professionals from partner agencies contributing constructively to progressing both child protection and child in need plans. Partner agencies equally reported effective working relationships with social workers notwithstanding some reservations concerning a lack of information provided about recent organisational changes in children's services.

Practice example of direct work with children:
"The use of the NSPCC tool 'Underwear Rules' afforded a very good opportunity to engage this four-year-old child in some meaningful discussion"

3.9. When decisions were made that a child protection conference was required following an investigation, conferences were convened within appropriate timescales. Overall social work reports to conferences were of an adequate or good quality that provided sufficient information for partners to make appropriate judgements based on an analysis of risk. The quality of reports from partner agencies was too variable and a lack of a standard format for reports exacerbated this.

3.10. We saw some mixed examples of the quality of planning by social workers for conferences, and partners reported that families did not often have a clear understanding of the child protection process including the purpose of core groups and conferences. However, arrangements to share reports with families beforehand were reported to have improved significantly in the last 12 months.

3.11. Conferences were well chaired and child focussed. They were attended by most statutory agencies and by families. We also saw good examples of the mindfulness and support given by social workers and conference chair to the potential sensitivities for families attending conferences.

Practice observation case conference:
During a review conference there was a professional dispute. A representative from a partner agency was confrontational and expressing views and opinions that were not child-focussed; the professional was prioritising a parent's needs over those of the child. Both social worker and conference chair stayed calm and responded in a measured way; they reminded the professional of the purpose of conference and stressed the priority for protecting the child whilst being mindful of the needs of the parent. The confrontation was resolved and the professional agreed to contribute more actively to core groups than had been the case to date. This outcome both protected the child and provided appropriate support to the family.

3.12. Generally, satisfactory plans were made to safeguard and promote the welfare of children, or multi-agency child in need plans were determined when de-registration had taken place. Overall the progress of plans was considered thoroughly at review child protection conferences and, with one significant exception seen by inspectors, escalated to pre-proceedings agreements under the Public Law Outline when plans had not reduced risk or concerns were increasing.

Quote from a father:

"I am very happy with the service we are receiving. Social services can't get it right first time but they learn from what works and put it right. When things came to a head earlier in the year and my wife was at breaking point, the social worker and manager got to grips with the problem and gradually over the past few weeks things have got much better. Both the social worker and the conference chair are always very accommodating. I was apprehensive about working with social services at the start because of the bad press but I now have every confidence in the service. The social worker makes herself easily available - we have her mobile number and can contact her easily. She always gets back to us within good time. The social worker has arranged and chaired a number of multidisciplinary conferences for our child. The meetings were well chaired and we received copies of reports in good time. The reports are always accurate and well written. After a difficult period for us as a family we have got to a settled arrangement. We've got there now. They have done a good job."

3.13. Core groups were convened sufficiently frequently and were well attended by relevant agencies and by families. We saw recent evidence that core groups kept the child at the centre of planning and were progressing work within the child protection plan. However, when children were subject to a child protection plan they were not always visited within agreed timescales, although an improving picture was emerging since greater workforce stability was recently achieved. It is too soon to comment on the extent to which this improvement was embedded into routine practice.

3.14. The quality of recording by social workers when children were seen alone and for distinguishing when visits were unannounced was inconsistent. An explicit record of discussions with children and families about the progress of plans and whether their lives were improving was too variable. The majority of recording we saw showed general conversation about day to day activities and interests, although we did see some good records of children clearly expressing what life was like for them. We noted that the local authority had recognised the need to improve recording practice and had already commissioned staff training due to be delivered in the near future.

3.15. Although generally we found the quality of care planning and review to be adequate, the quality of risk management and contingency planning was poor. We noted that managers recognised that the quality of plans, and specifically risk management planning, needed to improve. Some staff training in risk assessment had been undertaken; however, other improvement activities such as managers undertaking regular case audit have still to be put into practice. Additionally, we saw little evidence of managers challenging poor risk management practice either with individual practitioners or with the workforce as a whole.

Summary

3.16. Children and young people identified as being in need of help or protection, including children looked after, generally experienced timely and effective multi-agency help and protection. The quality of care planning and review was adequate. Some good services were delivered to families and good quality direct work with children was evident. However, risk based planning and authoritative practice were not sufficiently well evidenced. There were significant deficits in multi-agency risk management, in particular with regard to the use by social services of "contracts of expectations" which fail to adequately protect children. Managers did not effectively challenge poor quality risk management practices. Workforce stability had been recently achieved in children's services and social workers were committed to achieving good outcomes for children and families. This stability now needs to be consolidated and sustained in order to achieve continuous improvement in outcomes for children and families.

Theme 4: Leadership & Governance

What we expect to see

Leadership management and governance arrangements comply with statutory guidance and together establish an effective strategy for the delivery of good quality services and outcomes for children, young people and their families. The authority works with partners to deliver help, care and protection for children and young people and fulfils its corporate parenting responsibilities for looked after children. 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 meet the needs of local children, young people and their families.

Key findings

1. Leadership, management and governance arrangements complied with statutory guidance.
2. Arrangements for effective engagement with strategic partners were in place as was good cross service area joint working within the council.
3. The local authority knew its strengths and areas for improvement.
4. The pace of improvement needs to be sustained for managers and leaders to be assured that arrangements are effectively delivering good quality services and outcomes for children, young people and their families.
5. Local needs analysis did not sufficiently inform the authority's service strategy, partnership arrangements or commissioning for children's services.
6. The voices of children and young people were not sufficiently captured or used to shape service development.
7. Lack of clear communication or translation of strategic plans into a more focussed framework for delivery of children's services hindered the workforce from achieving better outcomes for vulnerable families.
8. Senior leaders were committed to improving safeguarding.
9. Senior leaders did not have a direct line of sight on the experiences and challenges that front-line workers were often confronted with.

10. Regular and effective case audit of child protection work was established. However, case file audit by managers throughout children's services had not been embedded into core business. The use of performance monitoring information and quality assurance monitoring did not effectively drive continuous improvement.
11. Strategies to ensure the authority sustained a culture of learning were not sufficiently well embedded.
12. A suitably qualified and competent workforce was in place and workforce stability had recently bought about a positive improvement of the quality and consistency of service delivery to children and families.
13. Generally staff had welcomed new ways of working and reported an increased trust in senior managers. Most social workers reported good morale. A significant minority of staff and some partners reported that communication about changes needed to improve.

Explanation of Findings

4.1. At the most strategic level in the authority, the important principle that families are supported was very clearly established within the council's Single Integrated Plan (SIP) 2013 – 17. The unified strategic needs assessment that underpinned the SIP drew widely on relevant information sourced from within the council, as well as from partner agencies, and was compiled in consultation with key stakeholders. Local authority elected members, the chief executive and chief officers were clear about their respective roles, and clear lines of accountability were in place to ensure that they effectively discharged their individual and collective responsibilities to deliver on the plan.

4.2. Leadership, management and governance arrangements complied with statutory guidance, and arrangements were in place for effective engagement with strategic partners. We noted the authority's leadership of the Safeguarding Children's Board (SCB) and its involvement to the Local Service Board (LSB). Evidence provided by partners suggested that the contributions of the director of social services and the chief executive officer were seen as cohesive and confident within these Gwent-wide fora. Inspectors also recognised the effectiveness of leadership and management arrangements in place within the council for cross-service area communication and joined-up working; this was specifically evident in respect of children's services with children and young people and enterprise service areas.

4.3. The local authority was aware of its strengths and areas for development. Political leaders, chief executive and chief officers stated that improving safeguarding arrangements and supporting children's services to deliver better outcomes for children and families were the council's highest priorities. Inspectors recognised the commitment and enthusiasm for improvement shown by chief officers and elected members and also

that some progress had been made. However, we found that in order for management and governance arrangements to deliver strong strategic local leadership, which clearly demonstrates improved outcomes for children and their families, the pace of improvement needs be sustained.

4.4. Senior managers and elected members told us that they had responded constructively to the improvement notice issued by Estyn in 2012, and that they had utilised the accompanying recovery plan as a catalyst to drive improvements to safeguarding arrangements across all council service areas. Estyn noted in April 2014 that the authority had appropriately prioritised safeguarding in its strategic planning and set the foundations in place for improving safeguarding arrangements. We found that elected members, the chief executive and the director of social services recognised the need to secure and sustain the improvements made to date.

4.5. Leaders, including elected members, had identified that improvements were required in children's services. In April 2013 services were restructured. Subsequently, many plans, procedures and practices have been implemented and a new head of service had been permanently appointed nine months ago. Additional investment to support a targeted development programme for children's services had also been agreed. These initiatives demonstrated a clear commitment from leaders to focus improvement activity on children's services. We recognised that work had been initiated by senior leaders to increase their awareness of the challenges facing children's services and as such we observed an improving picture. Nevertheless, we found that an insufficient analysis and understanding of underlying complexities and continuing risks had sometimes resulted in reactive or retrospective responses rather than those based on effective strategic planning. Moreover, the authority was still to evidence the sustainability of positive change, as well as a beneficial impact on outcomes for children and their families. Elected members and senior officers demonstrated an appreciation that although some services for children and families had begun to improve, they still had a long way to go.

4.6. The authority's children's services development plan was not sufficiently well informed by an analysis of the needs of local children, young people and families. Although some useful information had been obtained during consultations for the unified strategic needs assessment, this information had not evidently informed commissioning for children's services. Neither did we see evidence that partnership arrangements were grounded in joint strategic needs analysis, with improving outcomes for children and families stated as shared priorities. This lack of alignment meant that the collective accountability for helping and protecting vulnerable children was inhibited. We noted that the recent decision to re-position the strategic arrangements for JAFF into the policy and partnerships service area, alongside other Families First funded initiatives with direct links to the LSB, had the potential to create more effective joint service planning for children and families in need of help. Moreover, the corresponding systematic needs tracking process recently introduced for all families referred to JAFF will assist the authority and its partners to increase their understanding of the needs of local children and families to better inform service planning in future.

4.7. A high level of enthusiasm and commitment was expressed by leaders and senior managers towards corporate parenting, and inspectors welcomed plans to recruit a care leaver to an apprenticeship post within the council with the purpose of promoting greater participation of children and young people in influencing service design and strategic thinking. However, generally we found that improving effective engagement with service users had been too slow. Therefore, the voices of children and young people were not sufficiently captured or used to shape service development.

4.8. The council's strategic vision, "sustainable and resilient communities", had not translated well into policy and practice in children's services, nor was it effectively disseminated throughout the workforce. Whilst some staff were able to conceptualise their own role as making a contribution to the wider authority theme that "families are supported", most could not. All staff we interviewed, without exception, expressed commitment to improving outcomes for children in need of help and protection. However, some staff and operational managers expressed frustration and concern about how organisational changes within children's services had hindered professionals from forming effective working relationships with children, young people and families. We found that lack of clear communication and a disconnect between strategic plans and a focussed framework for delivery of children's services had militated against staff, operational managers and partners understanding of what was expected of them. This had resulted in some confusion and inefficacies which had negative implications for achieving better outcomes for children in need of help of protection.

4.9. We found that senior leaders and elected members were insufficiently well sighted on how well children and young people were being helped and protected. We noted that formal arrangements were established for chief officers and members to meet with heads of service and other senior managers to better facilitate their own learning as well as to review progress; also that staff commented positively about more recent improved visibility of senior managers. However, senior managers and elected members did not take sufficient action to ensure they regularly and systematically heard the views of front-line workers through direct feedback. Arrangements, as recommended by Lord Laming[1] following the death of Victoria Climbié, for senior managers and elected members to regularly monitor front line work through visits to children's services teams were not in place. As a result, senior leaders did not have a direct line of sight on the experiences and challenges that front-line workers were often confronted with, learning from which could help drive improvement.

4.10. Management information was not systematically utilised to challenge performance or improve the quality of services for children and families. Inspectors recognised the close and regular attention paid by senior leaders to children's services key performance indicators and that the authority had made improvements in achieving these targets. Since the establishment of the Safeguarding and Quality Assurance Unit in September 2012, a quality assurance and performance reporting framework has been in place. However, this was still being developed. We found case audit focussed on child protection work.

1 The Victoria Climbié Inquiry Report Her Majesty's Stationary Office 2003

This successfully included direct and immediate constructive feedback to allocated case workers and their managers. However, routine auditing of cases by managers across children's services had not been embedded into core business. Nor did performance monitoring and quality assurance arrangements include information gained from a sufficiently wide range sources, including user feedback, analysis of complaints or direct consultations with staff. Inspectors noted the authority's recognition that the value of performance reporting could be increased by taking a thematic rather than a purely numeric approach and that work had begun to progress this methodology. However, we found that reporting on performance and quality had not yet routinely or effectively contextualised quantitative with qualitative information in a way that was sufficiently meaningful to better inform analysis of service effectiveness in respect of improving outcomes for children.

4.11. Strategies to ensure that the local authority sustained a culture of learning were not sufficiently well embedded. Most staff we interviewed expressed positive views about the availability/accessibility of formal and required training and inspectors recognised an increasing commitment from the authority to invest in learning and development. However, systematic arrangements were not yet sufficiently well-established to effectively capture and disseminate wider learning from social work practice, complaints or compliments to facilitate the service improvement. Neither were improvement actions arising from child protection case audit or complaints incorporated into the Children's Services Development Plan. All of this, coupled with the ineffective management oversight identified through the case review aspect of this inspection, not only inhibited contemporary understanding of the service's effectiveness but also potentially failed to deal rigorously with areas for development. As a result the use of performance information and quality assurance monitoring to drive continuous improvement was not consistently effective.

4.12. Impediments to recruitment and retention of a skilled and experienced workforce had, until recently, negatively impacted on performance in children's services. However, social workers have now been recruited into permanent posts following a targeted recruitment campaign over the past nine months. A small number of experienced agency workers had been retained to facilitate continuity; however, reliance on agency workers to deliver core business functions had been significantly reduced. Inspectors welcomed this workforce stability and recognised it as significant progress. We found that there had already been a positive impact on the quality and continuity of the social work services received by children and their families. Strategies for retention of staff and for succession planning now need to be further developed, implemented and embedded in order to consolidate the good progress made to date.

4.13. Overall, we found a suitably qualified competent workforce with the capacity to deliver good quality services to children and families. The majority of staff we interviewed told us that workloads were manageable both in terms of volume and complexity. Social workers also reported that supervision, both formal and informal was sufficiently frequent and of good quality. However, our review of supervision and appraisal records

demonstrated that the quality of supervision and appraisal of social workers was too variable. Whilst a number of supervision records did include reflective supervision and a consideration of welfare and training needs, too many poorly recorded case consultation or the rationale for decision making. Appraisal documentation we reviewed did not include any 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. Inspectors also had some concerns about the lack of clarity between senior practitioner and team manager roles and responsibilities in respect of supervision and management oversight. We found that management oversight and supervision was accessible, but not sufficiently effective, in supporting the workforce to deliver services resulting in positive outcomes for children and families. A review of these roles and their respective workloads could potentially result in more effective support for staff.

4.14. The authority had implemented an "agile working" model for all staff including children's services. Staff had been provided with the necessary IT equipment to support remote working and a wide range of communication methods had been encouraged. Until recently teams and individuals had been dispersed throughout the county. In June 2014 all children's services teams moved into one building. Inspectors noted that three 'satellite' contact centres were in the process of being identified and that these will also be appropriately equipped for agile working. These whole service efficiencies had been broadly welcomed by most staff we interviewed. Some staff articulated that the move had broken down silo working and greatly improved communication within and between teams. Most of the staff we spoke to told us that senior practitioners and managers were now more visible and more accessible for both formal and informal case consultation and supervision.

4.15. Staff in children's services consistently reported a positive change in culture since the permanent appointment of the head of service nine months ago. Many staff told us that trust and respect for senior managers had increased and that they felt more involved in the process of change. This was evidenced by the enthusiasm shown by staff for contributing to "experiments" in new ways of working, such as the introduction of specialist court workers. We also found that operational managers had been innovative and had worked hard to champion a supportive and nurturing environment for staff through, for example, the implementation of "buddying" arrangements and weekly "moans & groans" sessions. Finally, many relevant policies and procedures had been updated and loaded onto the children's services computer hub for access.

4.16. All of these positive developments were not only recent but were also very reliant on staff proactively accessing them. Inspectors saw only limited evidence of managers monitoring staff access or taking remedial action in respect of staff who were either less capable or less enthusiastic about the new arrangements. We also heard from a small number of staff that they felt ill-informed and unsupported within the new working environment. Some partners expressed the view that the authority had failed to keep them informed about changes in children's services and that as a result they

had experienced difficulties and/or delays in accessing relevant services. Inspectors were concerned that the authority could not reasonably be assured at the time of this inspection that they had effective mechanisms in place to effectively communicate with all staff, particularly new staff. Nor were there sufficiently robust systems in place to monitor the extent to which staff were consistently accessing and capitalising on the support arrangements available to them. We found a significant minority of staff were feeling disenfranchised. Further work is required to embed new arrangements, to ensure that all staff are adequately supported on a continuous basis and that partners are appropriately updated.

Summary

4.17. Leadership management and governance arrangements did comply with statutory guidance, and arrangements for effective engagement were in place. Senior leaders were committed to improving safeguarding and this was reflected well in strategic planning. Strategic plans had not been effectively disseminated throughout children's services. More focussed and sustained improvement is required to establish an effective strategy for the delivery of good quality services and outcomes for children, young people and their families. The authority worked well with partners to deliver help, care and protection for children and young people and showed a high level of enthusiasm and commitment to corporate parenting.

4.18. Local joint needs analysis did not inform planning for children's services. Neither performance management, quality assurance monitoring, nor strategies to ensure the authority sustained a culture of learning, were sufficiently well embedded to provide a thorough understanding of the difference that help, care and protection was making for children and families. Senior leaders were insufficiently well sighted on front line work in children's services.

4.19. Services were delivered by a suitably qualified, experienced and competent workforce that was able to meet the needs of local children, young people and their families. Most social workers expressed trust and respect for senior managers and said morale was high within the workforce. Management oversight and supervision was accessible but was insufficiently effective in supporting the workforce to deliver services that result in positive outcomes for children and families.

APPENDIX 1

Contextual information about Monmouthshire

Children living in this area

- In 2013 Monmouthshire had the fourth lowest rate (10.8%) of children under the age of 16 living in working age households with no one in employment amongst the Welsh local authorities.
- According to the 2011 Census the percentage of people age three and over who spoke Welsh in Monmouthshire was 9.9%. This was one of the lowest rates amongst Welsh local authorities compared to 19.6% Wales average.
- The percentage of pupils of compulsory school age eligible for free school meals is 11.9%, lower than 19.3% nationally. This level of eligibility is the second lowest in Wales.
- None of the 58 areas of Monmouthshire are in the 10% most deprived area in Wales.
- Approximately 18,355 children and young people under the age of 18 years old live in Monmouthshire. This is 0.6% of the total population in Wales. (Welsh Government 2013 mid-year population estimates, as of June 2014)
- 12% of the population aged under four were on Flying Start health visitors caseloads during 2013-14, compared to the Welsh average of 19%. (Welsh Government Flying Start summary 2013-14)

Child protection in this area

- Timeliness of initial child protection conferences, core group meetings and child protection reviews was an area for improvement in 2012-13. The council's performance in these areas has improved significantly during 2013-14.
- As at 31 March 2014, there were 49 children on the child protection register, a decrease of 13 compared with 31 March 2011.

Children looked after in this area

- As at March 2014, Monmouthshire had 103 children being looked after by the authority, an increase of 23 compared with 31 March 2011.
- 34% of looked after children were placed outside the local authority at 31 March 2014[2].
- Monmouthshire's percentage of looked after children with three or more placements in the year was higher than the Wales average in 2013-14.

2 based on children for which a valid placement postcode has been provided and excluding children placed for adoption

- Completion of statutory visits to looked after children in accordance with regulations had deteriorated from 66.9% to 65.3%, considerably lower than the Wales average of 85.3% in 2013-14.
- Performance in relation to initial care planning and statutory visits for looked after children were weaker than other comparable local authorities and the Wales average in 2013-14.
- School attendance statistics for looked after children has improved during 2013-14, with the percentage attendance of looked after pupils whilst in care in primary and secondary schools at 95.9% and 93.3% respectively.

Children in Need

- Performance in respect of completion of child in need reviews in accordance with statutory timetable had significantly improved during the year 2013-14 from 19.5% to 57.5%. However, this remains well below the national average of 78.8%.

APPENDIX 2

Information about the inspection

The inspection of the local authority was carried out under chapter 6 of Health and Social Care (Community Health Standards) Act 2003.

Methodology

Fieldwork for this inspection was undertaken during the weeks commencing 10th November 2014 and 24th November 2014.

Most inspection evidence was gathered by looking at individual children and young people's experiences. This was done through a combination of case-tracking and case-file reviews.

Additional evidence was collected from service user survey, review of documentation as well as interviews and focus group discussions with staff, managers and elected members.

- We reviewed/tracked 44 case files. This included 35 interviews with staff/other professionals, 11 interviews with families and three direct observations of practice.
- We undertook a survey of 64 service users. We received responses from six children and seven adults.
- We reviewed 10 sets of staff supervision records as well as six sets of appraisal documentation.
- We reviewed 17 stage one complaints, 1 stage two complaint and 13 compliments.
- We undertook a range of individual interviews and focus groups with senior and operational managers, elected members, partner agencies, senior practitioners and social workers.

The inspection team

The inspection team consisted of four inspectors employed by CSSIW and two fee-paid inspectors.

Lead inspector: Bobbie Jones
Team inspectors: Ann Ferris, Pam Clutton, Sandy Pearce
Fee Paid Inspectors: Bryan Isaac and Sheila Booth