AGGCC
CSSIW

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

Inspection of *Children's* Services

Wrexham County Borough Council

June 2017

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

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Contents

Introduction

The Care and Social Services Inspectorate Wales (CSSIW) carried out an inspection of children's services in Wrexham County Borough Council during January and February 2017. The aim was to review how well people were served by the local authority when people contacted it seeking information, advice and assistance.

We wanted to find out how easy it was for people to contact children's services, if they were given enough information, and whether this helped them to get the care and support they needed.

We looked at whether the local authority made the right decisions at the right time, and how effectively it worked with other organisations, such as the health service and the police. This helped in our understanding of whether people could be enabled to lead as good a life as possible.

Where children were at risk of abuse, neglect or harm, we wanted to see if the local authority had responded quickly to make sure that they were safe.

We looked at records that the local authority holds on its computer systems and met with a range of employees, together with people from other organisations they work with. We also talked to children and their families, but only when they agreed to do so.

Overview of findings

Key dimension 1: access – information, advice and assistance (IAA) including early intervention and prevention

The local authority continues to make improvements to its information services that aim to deliver more consistent advice and assistance. This is reflected in the development of several initiatives that aim to provide more ways for people to find out how to improve their well-being, whilst focusing upon the things that matter to them. The local authority wants to help people to be well informed so that they can be as independent as possible and make decisions for themselves.

The recently created Single Point of Access (SPoA) aims to expand its skill mix beyond a current base of mainly local authority staff with plans to expand multi-agency representation over the next few months.

More needs to be done to ensure that agencies, who contact the local authority when they have concerns about a child, are consistently informed about any action that has been taken.

Key dimension 2: assessment

Preventative services underpin the assessment process with established pathways through Together Achieving Change (TAC) to step up to, or down from, statutory child care work. These play a valuable role in providing early help and in supporting parents at key times of child development.

Most assessments are done promptly and focus upon the needs of the child – there is a clear expectation that children are always seen as part of this process. The local authority continues to monitor assessment timeliness, however, some take too long and others do not sufficiently consider wider issues that could have an impact on the wellbeing of a child.

More needs to be done to ensure that assessment services can be consistently provided in the Welsh language.

Key dimension 4: safeguarding and protection

The local authority works hard to keep people safe and there is greater awareness across the council of the early signs of children being at risk. Contact arrangements are improving, with more resilient management oversight processes, and greater transparency in decision-making.

Safeguarding responses are mainly appropriate and timely, but would benefit from discussions with a wider group of agencies early on. The recording of some

safeguarding discussions and meetings could be better. Strategy meetings are focused upon the child, but sometimes these should take place sooner so that any risks could be mitigated at the earliest opportunity.

Key dimension 5: leadership, management and governance

Children's services have a higher profile across the local authority because of the recent transfer of the statutory director role to a more senior officer with direct access to the chief executive and councillors.

Elected members are well informed and supportive of the transforming role of children's social care services. The Council Plan reflects the strong commitment to prevention with the aim of addressing issues facing children and their families at early stages and working with them to avert later crises and need for longer-term care and support.

Commissioning is not sufficiently informed by a good understanding of local need and more should be done to involve local people in shaping and designing services that will support sustainable solutions.

Recommendations

Recommendations	Key Dimension
Ensure that the purpose of the SPoA is more widely communicated to partners and the public.	Access
Reduce delays in accessing TAC service to be consistent with preventative corporate aims.	Access
Consistently capture and record core data set information so that people do not have to repeatedly provide the same information to local agencies.	Access
Ensure that partners, providers and the public, who contact the local authority, are advised of the progress in any resulting action where appropriate.	Access
Continue to prioritise the recruitment of more Welsh-speaking staff.	Assessment
Ensure that assessment practice, and multi-agency referral processes that support this, consistently reflect agreed policies and procedures.	Assessment
The processes to facilitate 'step down' from statutory child care work need to be more efficiently managed to mitigate any potential delays in accessing support.	Assessment
There needs to be a more consistent understanding and measure of risk within the assessment process, with stronger management oversight.	Assessment
There should be greater consideration of advocacy support when undertaking assessment.	Assessment
Strategy discussions should involve all relevant intelligence sources and have a clear audit trail of decision making.	Safeguarding and protection
The recording of strategy meetings should be subject to strengthened quality assurance processes and more clearly detail risk mitigation.	Safeguarding and protection
The corporate vision for social care should be communicated more widely so that staff, partners and the public are clear of its aims.	Leadership, management and governance
The local authority should ensure that commissioning is rooted in a thorough understanding of local population needs based upon comprehensive projection data and more meaningful engagement processes.	Leadership, management and governance

The authority is required to produce an improvement plan in response to the report within 20 days of the draft report being agreed.

The CSSIW area manager will review the improvement plan during the Engagement and Performance Review meetings scheduled throughout the year.

Key dimension 1: Access - information, advice and assistance (IAA), early intervention and prevention

What we expect to see

The authority works with partner organisations to develop, understand, coordinate keep up to date and make best use of statutory, voluntary and private sector information, assistance and advice resources available in their area. All people have access to comprehensive information about services and get prompt advice and support, including information about their eligibility and what they can expect by way of response from the service. Arrangements are effective in delaying or preventing the need for care and support. People are aware of and can easily make use of key points for contact. The service listens to people. Effective signposting and referring provides people with choice about support and services available in their locality, particularly preventative services. Access arrangements to statutory social services provision are understood by partners and the people engaging with the service and are operating effectively.

What we found

1.1 The Social Services and Well-being Act 2014 (SSWBA) introduced a new duty for local authorities to develop information, advice and assistance services. This was intended to provide a stronger voice and more control for people in accessing support and removing barriers to wellbeing. In practical terms, everyone should be able to have an accessible contact point in their council area that can provide a gateway to the care and support that matters to them.

1.2 The local authority undertook a self-assessment of its progress against this requirement as part of the inspection process. This identified existing strengths whilst also acknowledging continued development is required. It provided good analysis and evidence for further evaluation, and our findings largely mirrored it.

1.3 We noted a strong commitment to refocusing attention upon achieving better outcomes for children, young people and their families at earlier stages, with both partners and providers repositioning to better identify and meet lower level needs. The local authority had adopted a hypothesis that the delivery of targeted support at the right time would correspondingly reduce the later need for specialist intervention.

1.4 Consequently, preventative programmes were given greater prominence and an operating model was being developed that aimed to equip all front-line workers with the skills and knowledge to promote the value of early help services. A key component of this involved the assimilation of the TAC service

and the Integrated Family Support Service (IFSS) into the front line of children's services.

1.5 Several recent developments have had the potential to deliver better alignment of information, advice and assistance services that the local authority anticipates will provide a more consistent response, with reduced re-referrals and improved signposting.

1.6 A key example of this was the continued commitment to the development of the Dewis Cymru website that provides information about sources of help that can support wellbeing for people in Wales. Although most of the current content we saw related to adults, a growing proportion focused upon the needs of children, young people, families and carers. This represented a further opportunity to provide people with greater choice and control in meeting their own needs.

1.7 The recent creation of a SPoA demonstrated further commitment to remodelling existing resources to provide a more accessible and streamlined service. This seeks to channel all contacts and referrals through a central team, although it was too early to measure its impact on children, young people and families.

Observation of the Single Point of Access

The team is based together in an open-plan office with direct access to management support. A large-screen monitor is highly visible and tracks referrals in real time. There are important contact details on the walls. Staff were seen to take calls promptly, signpost appropriately and seek further management advice where necessary.

1.8 The SPoA represented an important step, and a clear acknowledgement of the need to establish robust systems for managing contacts through a central information hub. Management arrangements had been strengthened - the team manager was supported by two assistant managers - to provide greater oversight of contacts, ensure a proportionate and timely response, and appropriate pathway for a child's needs is followed.

1.9 The single point of access team comprised mainly local authority employees - including a housing officer and TAC worker. It had recently added a police community support officer and an Inspire youth worker, who was able to provide one-to-one support to young people who have attended hospital with self-harming and other risk taking behaviours. Plans to add a youth justice worker and health visitor were currently being progressed, with the aim of providing a broader base for firmer multi-agency working.

Quote from local authority worker

"The Single Point of Access is a definite improvement on the former MASH as there is more partner agency involvement"

1.10 The local authority was aware that the SPoA was not the only gateway to social care information, advice and assistance, and that there were other contact points across the council. Consequently, it had prioritised the need to support wider local authority staff in acquiring the necessary skills to provide appropriate information and advice.

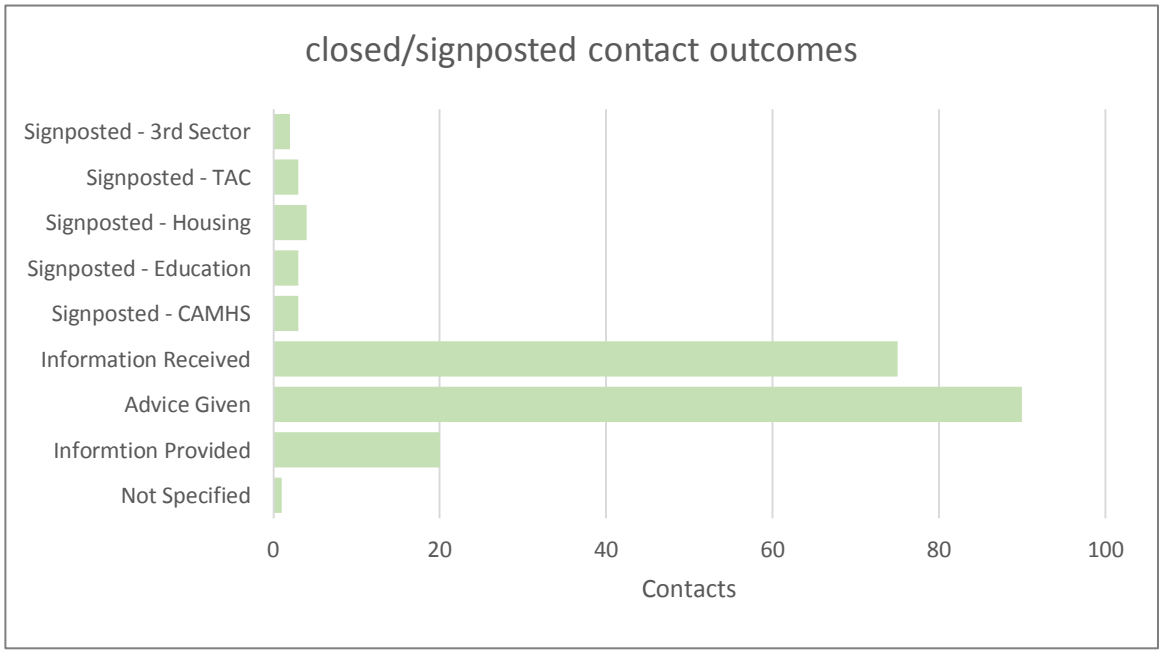
1.11 A survey carried out by the local authority in September 2016 of children and young people, aged seven to 17, found that 66% had the right information or advice when they needed it, with a further 15% stating that this sometimes happened.

1.12 Performance management arrangements had been strengthened and we saw data that supported tracking, analysis and scrutiny of contact outcomes. This was collated on a weekly, monthly and quarterly basis, and provided enhanced management oversight and improved public accountability, whilst additionally providing key information regarding the effectiveness of signposting.

1.13 The number of people contacting children's services has been increasing in recent years – up from 6,255 in 2010/11 to a projected 10,350 for 2016/17. For the week ending 10 February 2017, 263 contacts were received by the local authority. The table below breaks these down into referrals, enquiries, information only and those awaiting further information.

Contact type	Adults	Children	Total
Referrals	0	31	31
Enquiries	0	81	81
Information only	2	106	108
Awaiting further information	0	43	43
Total	**2**	**261**	**263**

1.14 Some 201 of these contacts were closed or signposted elsewhere. Of these, 'advice given' was the largest contact proportion, which suggests that this is a significant part of the service provided – a factor that the local authority has acknowledged will require ongoing monitoring to ensure that right skills are in place to deliver high quality advice.



1.15 Approximately 40% of contacts shown above were from the police. There were signs that the creation of the police central referral unit, despite some initial early snags, had resulted in better quality and more consistent management of contacts. The police reported very positive working relationships with the local authority, and there was evidence of this in several cases that were reviewed with some responsive joint work that resulted in timely mitigation of risks to children.

1.16 The Family Information Service (FIS) was based within a library complex in the town centre and there were further plans to install a Dewis Cymru portal for public access on this site. The local authority was, however, reviewing how to better integrate FIS within its new information, advice and assistance operating model, to comply with its commitment to a single public contact point. We saw that FIS played a significant role in the provision of information, advice and assistance that benefitted a high number of people and underpinned the preventative agenda of the local authority. On that basis, the council needs to carefully consider ways in which its strengths can be preserved, whilst areas for development, such as addressing rural disadvantage, can be progressed.

1.17 The TAC service was a key element of a range of support that aimed to provide flexible, creative and timely opportunities with the goal of preventing more-intensive intervention later. It could be triggered by anyone - a young person or parent can self-refer - but it would require the consent of the family or individual concerned.

1.18 Although a valued resource, there were delays in accessing TAC services for some people – we saw one case in which a parent waited over four months and the interim education provision they needed did not materialise either. This means that some families do not get early help and necessary preventative support in a timely way. Information packs offering some guidance were provided to people waiting for their first TAC meeting to take place, but more needs to be done to reduce any delays in the first instance.

1.19 A review conducted by the local authority during 2016 found that people were mostly positive about their TAC experience, although only just over half reported that they understood what the TAC process would achieve. However, most people stated that extra help through TAC had made a difference to their lives for the better, and that this position had been sustained.

1.20 There was a commitment to the replacement of the existing children's services information system by the Welsh Community Care Information System (WCCIS) in autumn 2017. This will enable safer sharing of information with agencies and is intended to support the delivery of improved care and support across Wales. It will provide a framework for more consistent documentation and forms, and will go some way towards avoiding duplication and repetition of information needing to be provided by the public.

1.21 However, this is reinforcing the need to ensure that current information is accurate and up to date, before it is transferred on to the new system. Whilst recording was frequently of high quality, some was inconsistent and lacked sufficient detail. Core data set information, such as language preference, was often not captured at all nor reflected in specific fields within the information system. The local authority intended to address this, but it will need to ensure that such important details are routinely recorded if it is to provide a more person-centred service and reduce the need for people to repeatedly share the same information with agencies.

1.22 Referral routes were not universally understood. Not all partners or providers were aware of the development of the SPoA, for example, and this needed to be more extensively communicated. In addition, some referral routes were managed in a different way - for example, referrals for children with disabilities were progressed through a weekly multi-agency panel with separate thresholds. It was not clear how well this aligned with the need to provide a consistent response at the point of contact.

1.23 Partners generally expressed positive views of contact arrangements and there was good evidence of this working effectively to achieve some good outcomes. However, some reported variable communication following contact despite a policy of providing a response within ten working days. The local authority was

aware of this issue and was working to provide greater clarity to referrers as to its action, and outcomes, where appropriate.

Summary of findings

- The local authority was committed to the retention and further development of preventative services.
- The Dewis Cymru development had strong potential to promote wellbeing through the provision of information.
- The SPoA provided a simple pathway to information, advice and a clear gateway to support resources.
- The SPoA will require health service representation if it is to maximise its potential.
- More needs to be done to promote the role of the SPoA with partners and providers.
- Management oversight of decision making at the front door was increasingly resilient and better positioned to respond timely and appropriately
- Performance management information was increasingly robust and able to support strategic analysis.
- FIS provided a valued service, but needed to be more accessible in rural locations.
- The TAC service was an important preventative component that delivered some good outcomes, but people can wait too long for a service.
- Core data, such as language preference, was not consistently recorded within the current information system.
- Partners were not consistently informed of the outcome of referrals they made to the local authority.

Recommendations

- Ensure that the purpose of the single point of access is more widely communicated to partners and the public.
- Reduce delays in accessing TAC service to be consistent with preventative corporate aims.
- Consistently capture and record core data set information so that people do not have to repeatedly provide the same information to local agencies.
- Ensure that partners, providers and the public, who contact the local authority, are advised of the progress in any resulting action where appropriate.

Key dimension 2: assessment

What we expect to see

All people entitled to an assessment of their care and support needs receive one in their preferred language. People experience a timely assessment of their needs which promotes their independence and ability to exercise choice. Assessments have regard to the personal outcomes and views, wishes and feelings of the person subject of the assessment and that of relevant others including those with parental responsibility. This is in so far as is reasonable practicable and consistent with promoting their wellbeing and safety and that of others. Assessments provide a clear understanding of what will happen next. Recommended actions, designed to achieve the outcomes that matter to people, are identified and include all those that can be met through community based or preventative services.

What we found

2.1 Assessments were carried out by appropriately qualified staff, with good management support arrangements. The local authority had recognised the challenges it had faced during the year because of vacancies and absences, and there was a decreasing reliance upon agency workers. This was helping to create greater stability within the workforce and secure a more consistent approach to assessment.

2.2 The local authority had been proactive in aligning assessment documentation in line with the SSWBA in preparation for implementation by the end of March 2017.

Quote from a parent

"I had a very good relationship with the social worker and felt that she definitely helped to sort the things out that made a big difference at that time"

2.3 Much preventative assessment work was done through the Flying Start and TAC services, with assessments for care and support primarily undertaken by the Assessment and Intervention Team (AIT), FST and the Disability Service. This was supported by a wide range of resources such as parenting assessments carried out within family centres.

2.4 Referrals to TAC by statutory agencies should use the Joint Assessment Family Framework (JAFF), however, this was not routinely the case and will require more focused attention to ensure that partners apply this practice in the same

way and children, young people and families experience a more consistent assessment process.

2.5 Pathways to TAC through the SPoA were clear and understood, but less well-defined if progressed by AIT. Nor are interim support arrangements particularly clear in such 'step down' situations.

Case example from file

Several cases reviewed involved a 'step down' process, where the threshold for care and support was not met. However, referrals to the Together Achieving Change team were not allocated due to the case having not yet been closed by the Assessment and Intervention team. This resulted in unnecessary delay for the families concerned.

2.6 Specialist assessment activity was conducted by services such as the IFSS, a multi-disciplinary team that can provide intensive support for families with complex needs.

2.7 The Waking Hours Team provided a valuable role in supporting families between 7am and 10pm, whilst also enabling a process of ongoing assessment and helping to reduce crises.

2.8 Assessment practice was increasingly focused upon personal outcomes and there was a clear momentum building that reflected more of what really matters to people. However, this was a relatively recent development and, at this stage, was more representative of the new direction of travel that the local authority wished to embed, rather than mainstream practice.

Quote from a young person

"My social worker sorted out my benefits, accommodation and helped in managing my shopping after I left care – I couldn't have done this without her"

2.9 All assessment documentation is available in English and Welsh, with access to other language services available under contract with an external provider. However, Welsh language skills are variable and some teams, such as AIT did not have any staff who were confident enough to carry out assessments in Welsh and this could disadvantage some families. It was not always clear how the 'active offer' of a having a service in Welsh was being tracked and monitored, and this was further evidenced in the gaps within information system recording.

2.10 Most assessments were done well and there was evidence of very complex, multi-agency work that resulted in some positive outcomes. Assessments were mainly person-centred and there was an explicit expectation that children were always seen, with strong evidence to support this seen in case review and in local performance data.

2.11 There was a clear protocol for the assessment of risk, with a long-standing commitment to the Thornton Risk Model with associated policies, procedures, documentation and training. Whilst this remained effective for the more detailed RISK 2 tool, there was insufficient information in several assessments using the RISK 1 tool - this meant that indicators of significant harm were not subject to a consistent breadth of consideration.

2.12 There was evidence of relevant research on evidence based practice to ensure good outcomes for children being used within the assessment process, and a culture of reflection and review being actively encouraged as a means of practice review and development. Staff were clearly able to articulate this and described how this helped to facilitate a climate of learning and support.

2.13 Whilst there were many examples of effective assessment practice, several would have benefitted from a broader scope – a number were basic, whilst others contained limited analysis. Some took too long to complete, resulting in unnecessary delays in children and families accessing care and support. In several instances, sufficient management oversight was not evidenced – a position mirrored by a recent audit carried out by children' services.

2.14 There was increasing awareness of the need to adopt a more proportionate approach to assessment and staff had undertaken appropriate training to prepare them for the SSWBA and the need to continue to adapt their practice, particularly in view of the forthcoming implementation of WCCIS.

2.15 The local authority contracted with Tros Gynnal and Second Voice to provide advocacy services, although there was little evidence of its consideration where this may have greatly assisted highly vulnerable young people in some complex situations. The purpose and value of advocacy needs to be better understood by workers, as reported data suggested that the number of referrals were low.

Summary of findings

- We saw many assessments that were timely, focused upon personal outcomes and what really matters to children, young people and families.
- A strong commitment to preventative work underpinned the Council Plan and there was a clear emphasis upon the value of the right early intervention.
- We saw examples of complex multi-agency work that resulted in some very good outcomes.
- However, some assessments had limited scope, others took too long to complete and there were not enough Welsh-speaking staff.
- Management oversight of work was inconsistent and we identified several examples where practice would have benefitted from greater scrutiny – particularly when risks were being determined.
- Referral pathways were not universally understood, and some processes, such as those using JAFF, are not rigorously applied.
- We saw some examples where 'step down' arrangements would be enhanced with more efficient case transfer practice to minimise delay.
- We did not see sufficient evidence of engagement of advocacy services to support the assessment process.

Recommendations

- Continue to prioritise the recruitment of more Welsh-speaking staff.
- Ensure that assessment practice, and multi-agency referral processes that support this, consistently reflect agreed policies and procedures.
- The processes to facilitate 'step down' from statutory child care work need to be more efficiently managed to mitigate any potential delays.
- There needs to be a more consistent understanding and measure of risk within the assessment process, with stronger management oversight.
- There should be greater consideration of advocacy support when undertaking assessment.

Key dimension 4: safeguarding and protection

What we expect to see

Effective local safeguarding strategies combine both preventative and protective elements. Where people are experiencing or are at risk of abuse neglect or harm, they receive urgent, well-coordinated multi-agency responses. People are not left in unsafe or dangerous environments.

What we found

3.1 Corporate safeguarding arrangements had been strengthened since a review carried out by the Wales Audit Office in 2015 and, consequently, safeguarding responsibilities for all employees and elected members had been formalised. This had resulted in improved corporate awareness of the need to be alert to early signs of children at risk, and the duty to report any concerns.

3.2 Scrutiny systems provided increasingly informed political oversight and greater challenge of safeguarding work. This was facilitated through the presentation of performance reports to the Safeguarding, Communities and Wellbeing Scrutiny Committee twice a year.

3.3 The SPoA had been developed to provide greater assurance that safeguarding matters were quickly identified and appropriate action instigated. The early indications suggest that this model will provide greater resilience to the decision-making process and result in better safeguarding. This is bolstered by more transparent operational arrangements that are subject to increased scrutiny and performance reporting systems.

3.4 Staff within the SPoA had a crucial role in ensuring the right response at the right time, and this involved undertaking necessary checks with other agencies. Appropriate checks were seen to have been done thorough case analysis, with sufficient information gathered, that enabled provisional analysis of presenting risks.

3.5 The quality of referrals from other professionals was reported to be improving, particularly regarding police CID16s that were more considered and increasingly analytical. We saw evidence of this through case analysis and in discussion with managers and staff.

3.6 The SPoA use of a red, amber and green (RAG) coding system helped to quickly, and visually, prioritise response to contacts based upon assessed

provisional risk. The SPoA manager had oversight of all referrals and the RAG categorisation is available for all staff to see on a large screen monitor, reinforcing greater transparency of decision making.

3.7 Of the referrals made the week ending 10 February 2017, a decision was made that 18 would require either a safeguarding strategy discussion or meeting – this represented approximately 7% of contacts. A decision was made within 24 hours in 262 of the 263 contacts - this demonstrated that the new arrangements were effective in determining prompt initial response to enquiries.

3.8 Out-of-hours support was provided by the Emergency Duty Team (EDT), hosted by the council, and delivered collaboratively across the Flintshire and Denbighshire areas. Working protocols were well established and staff spoken with were experienced, knowledgeable and reported access to up-to-date training in safeguarding matters.

3.9 Multi-agency safeguarding arrangements worked effectively and the local authority had established good relationships that were focused upon reducing risk, particularly with the police. Safeguarding strategic priorities with the police were generally aligned, but we were told that there can sometimes be operational capacity issues when convening joint investigations.

Case example from file

Concerns regarding risk of neglect for children were quickly shared with other professionals, enabling swift decision making and timely responses. Attempts at parental engagement were appropriate and carefully managed. The use of the Public Law Outline process reflected this - the resulting care order outcome was in the best interests and wellbeing of the children.

3.10 Most strategy discussions were seen to be timely, however, we found the quality of recording to be variable with several not providing clear evidence of the justification for decision making. In one instance, a child at risk went missing from home on several occasions - and despite there being several strategy discussions, a strategy meeting was never convened. Consequently, a structured multi-agency consideration of risk and its mitigation did not take place and the child continued to go missing. The local authority expressed confidence that the new SPoA arrangements would address such issues, but this will require ongoing monitoring to ensure improvement.

3.11 Some strategy discussions would have clearly benefitted from a wider pool of intelligence than the police and children's services alone. This was particularly relevant where information from health, education or regulatory sources would have provided greater scope, and a stronger platform of evidence, upon which to better assess provisional risk and degree of response.

3.12 Although safeguarding thresholds were understood by the local authority and its partners, some strategy meetings were not held as quickly as they should be, and the recording of several was too basic to capture the rationale for decisions or how risk had been effectively mitigated. These represented the exception, but such key safeguarding documents require more robust quality assurance methods and stronger audit trails.

3.13 The Thornton Risk Model was supplemented by several toolkits, such as a home conditions evaluation, that combined to provide a broad scope overview of risk factors to inform the assessment process. These were mainly used appropriately, particularly in more complex situations, although a number were limited in their application and consequently less holistic.

Summary of findings

- Corporate safeguarding arrangements were stronger and the corporate workforce was better sighted on matters of children at risk since the Wales Audit Office review of 2015.
- Elected members were better informed to enable greater challenge within the safeguarding scrutiny process.
- The SPoA was providing a prompt, structured response to contacts, and management decision-making was increasingly robust with better systems to support prioritisation of response.
- Records of strategy discussions varied in quality with evidence of decision-making inconsistently sufficiently captured.
- Strategy discussions too often excluded the valuable intelligence of a wide pool of agencies.
- Safeguarding thresholds were widely understood, with information exchange arrangements underpinned by local protocols.
- We saw comprehensive assessment of risk in several complex and challenging situations, but in others it was less holistic with a more limited scope.

Recommendations

- Strategy discussions should involve all relevant intelligence sources and have a clear audit trail of decision making.
- The recording of strategy meetings should be subject to strengthened quality assurance processes and more clearly defined risk mitigation.

Key dimension 5: Leadership, management and governance

What we expect to see

Leadership, management and governance arrangements together establish an effective strategy for the delivery of good quality services and outcomes for people. Meeting people's needs for quality services are a clear focus for councillors, managers and staff. Services are well-led, direction is clear and the leadership of change is strong. The authority works with partners to deliver help, care and support for people. Services are designed and commissioned to: improved outcomes for individual people; reflect community need; and address key priorities within the local population. Work with partners in shaping the pattern and delivery of services is informed by the views and experiences of people who use or may need to use services. Services are delivered by a suitably qualified, experienced and competent workforce that is able to recognise and respond to need in a timely and effective way.

What we found

Direction of services

4.1 The local authority sought to develop services that promoted wellbeing and empowered people to take greater control of their lives. The new Council Plan for 2017-2022, strongly promoted these values with a clear emphasis upon prevention, tackling poverty and prioritising the most vulnerable in society.

4.2 However, not all staff and partners were aware of this and the corporate vision for social care needed to be articulated more widely for there to be a shared understanding of the direction of travel and why things needed to be done differently to ensure positive outcomes for people.

4.3 There was strong political and corporate support for children' services and this was reflected in the commitment to a range of preventative services that significantly contributed to positive outcomes for local families.

4.4 Leadership arrangements had been considerably strengthened by the reassignment of the statutory director role within the executive tier of the local authority. This had undoubtedly provided greater strategic focus to children's services matters and the higher profile of social care issues generally.

4.5 Elected members were well briefed on children's social care matters through training and workshop events – recent topics had included corporate parenting,

safeguarding, child sexual exploitation, SSWBA, Future Generation Act (FGA) and population needs assessment.

Quote from an elected member

"Elected members are regularly trained in aspects of social care and child protection, so we are reasonably knowledgeable"

4.6 Performance management systems supported strategic analysis of the effectiveness of the local authority, although it would benefit from a greater balance between quantitative and qualitative information – more emphasis upon the latter would provide a stronger voice to those who access services.

Shaping services

4.7 The local authority recognised that its population needs assessment was not yet sufficiently developed at a local level to effectively inform strategic commissioning. This will require more focused attention if it is to realise and sustain its high-level vision for better preventive services. The specific needs of children, young people, families and young carers will need to be mapped against current provision of IAA, and care and support to measure effectiveness, identify gaps and inform planning processes.

4.8 The local authority had developed some constructive working relationships with partners, and there were good examples of effective commissioning, such as the Repatriation and Prevention Service which is jointly commissioned with the Child and Adolescent Mental Health Services (CAHMS), and delivered by Action for Children providing a valuable service to children with mental health needs.

4.9 Governance of consultation activity was a corporate function, but it was not clear how well this supported social care participation and engagement strategy priorities. Evidence of impact was difficult to discern and it was clear that the principles of co-production have not yet gained sufficient traction - more work needs to be done in this area to secure a cohesive approach and empower people to have more influence on service development.

4.10 The local authority accepted that there needs be a stronger voice for local people that more routinely and consistently captures their views and experiences. Although there are several examples of where this had been done well, it too often remained outside of mainstream activity.

4.11 In the period April to December 2016, children' services received twelve complaints which represented a significant reduction since the period 2014/15 when there were 35. Of these, eleven were not escalated beyond stage one,

and only one directly concerned the contact and referral point. There were 18 compliments received during the same period. There were good arrangements in place for sharing learning from both complaints and compliments.

Workforce

4.12 There had been significant investment in building resilience within the workforce and this was resulting in a more stable staff group with reduced sickness levels and turnover. Recent monitoring data supports this trend, but the position remains fragile – the challenge will be to sustain the current momentum. A sizeable proportion of staff were relatively newly qualified and the local authority needs to retain their services if it is to rebalance levels of experience within the workforce.

4.13 There had been considerable progress in reducing dependency upon agency staff to cover vacancies, with the most recent recruitment campaign in November 2016 resulting in all advertised posts being filled. This had run alongside a sustained emphasis upon developing a productive working relationship with Wrexham Glyndwr University in the provision of student placements.

4.14 Staff valued management support arrangements, accessed regular supervision and spoke of a broad range of training opportunities for their continued development. Caseloads were manageable and staff described confidence in challenging this position if it was to change. Ongoing practice review and reflection was encouraged, and this was having an important impact in developing strong supportive team cultures that promoted continuous operational learning.

Quote from a local authority worker

"I really value being able to come back to the office after a really difficult time and being able to discuss things with colleagues. I feel I can do that and even share where I might have done things differently in hindsight, without any blame culture"

Summary of findings

- Leadership, management and governance arrangements complied with statutory guidance.
- The realignment of the statutory director role within the local authority executive tier was providing greater corporate strategic drive for social care matters.
- There was strong political support for early intervention, and prevention forms a key component of the new Council Plan.
- Elected members were well informed of social care matters.
- The local population needs analysis was not sufficient developed to effectively support commissioning activity.
- Co-production had not yet been embedded in mainstream engagement and participation activity.
- Recruitment and retention policies were securing greater stability within the workforce and there was reducing dependency upon the use of agency staff.
- Staff spoke positively of management support arrangements and the ongoing commitment to their training and development.

Recommendations

- The corporate vision for social care should be communicated more widely.
- The local authority should ensure that commissioning is rooted in a thorough understanding of local population needs based upon comprehensive projection data and more meaningful engagement processes.

Methodology

Self Assessment

The local authority completed a self assessment in advance of the fieldwork stage of the inspection. The authority to provide evidence against *'what we expect'* to see under each key dimension inspected. The information was used to shape the detailed lines of enquiry for the inspection.

We sample-selected 47 cases from a long-list provided by the local authority that was consistent with a thirteen-category criterion applicable to the period 1 April to 9 December 2016.

Fieldwork

We were on site in Wrexham the weeks commencing 30 January and 13 February 2017.

We reviewed 40 cases of which 22 were subject to more detailed case tracking that involved interviews with local authority employees and other professionals.

We interviewed seven children and/or their families.

We spent time observing the single point of access team at work.

We interviewed a range of local authority employees, including senior officers and lead councillor for children's services.

We interviewed a broad range of partner organisations, representing both statutory and third sectors.

We looked at all complaints and compliments that were made about children's services between 1 April and 9 December 2016.

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

Inspection Team

The inspection team consisted of four CSSIW Inspectors:

- Lead Inspector: Rob Gifford
- Supporting Inspectors: Bobbie Jones, Christine Jones and Angela Mortimer

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