

# Inspection of Children's Services Merthyr Tydfil County Borough Council



**August 2018**

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

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## Introduction

Care Inspectorate Wales (CIW) undertook an inspection of services for children in Merthyr Tydfil County Borough Council (CBC) during April and May 2018.

Our approach to the inspection was underpinned by the eight well-being statements and associated well-being outcomes as outlined in the Welsh Government's *National Outcomes Framework for People who need Care and Support and for Carers who need Support* (March 2016). Our approach builds upon the associated local authority quality standards set out in the *Code of Practice in Relation to Measuring Social Services Performance issued under section 145 of the Social Services and Well-being (Wales) Act*. In addition, the inspection considered the local authority's capacity to improve through an analysis of the leadership and governance of its social services functions.

This inspection focused on the effectiveness of local authority services and arrangements to help and protect children and their families. The scope of the inspection included:

- the experience and progress of children on the edge of care, children looked after and care leavers including the quality and impact of prevention services, the effectiveness of decision-making, care and support and pathway planning
- the arrangements for permanence for children who are looked after and children who return home including the use of fostering, residential care and out of local authority area placements
- adherence to fostering service regulation and national minimum standards
- the quality of leadership, corporate parenting and governance arrangements in place to determine, develop and support service sufficiency and delivery particularly in relation to looked after children, care leavers and their families.

While the main focus of the inspection was on the progress and experience of children and young people looked after and care leaver's transition into adulthood, the inspection included a focus on children, young people and their family's engagement with:

- Information, advice or assistance (IAA), preventative services;
- Assessment /reassessment of needs for care and support and care and support planning;
- Child protection enquiries, procedures, urgent protective action, care and support protection plans.

Inspectors read case files, interviewed staff and administered a staff survey, interviewed managers, and professionals from partner agencies. Inspectors talked to children and their families wherever possible. Young people and care leavers attended two focus groups.

## Overview of findings

- Merthyr Tydfil CBC children's service has a dedicated workforce who are professionally committed to promoting best outcomes for children and families.
- Safeguarding procedures and processes were understood and followed by staff ensuring children and young people were protected in a timely and consistent manner.
- There is good corporate support for children's services from elected members and the wider council. The local authority recognises there is a need to further develop its services for young people who are leaving care and is motivated to do so.
- We saw examples of good practice but this was not consistent. Immediately prior to inspection, children's services had experienced a period of challenge having identified areas of poor practice exacerbated by recruitment issues. This included significant drift in assessing and providing care and support to children and their families.
- The Multi Agency Safeguarding Hub (MASH) delivers an integrated approach which brings together a number of agencies who share information, assess vulnerability and make collaborative safeguarding decisions to ensure children and young people are protected from harm.
- The inability to transfer cases between some teams due to staff vacancies has impacted on staff morale, however the commitment and professionalism of staff to continue delivering a high standard of practice to young people and families was evident throughout the inspection.
- The challenges for front line staff were beginning to be addressed through the recruitment of key staff and use of agency cover. In addition, an experienced team manager had been seconded to improve practice. As such we were confident senior managers were committed to ensuring the delivery of good quality services.
- The current quality assurance framework needs further development to drive consistency and incorporate any lessons learned from audit and performance management information. The implementation of Welsh Community Care Information System (WCCIS) presents ongoing difficulties for staff and has impacted on the council's ability to produce robust performance information.

## **Areas for development**

### **Access arrangements: Information, Advice and Assistance (IAA)**

1. Improve arrangements for transfer of cases from the Intake Team to other teams for assessment and provision of support

### **Assessment**

2. Greater consistency in the quality of assessments including detailed analysis of strengths and risks.

### **Care and support and pathway planning**

3. Further development of Pathway Planning to meet the requirement of the Social Services and Well Being (Wales) Act 2014 (SSWBA), particularly in relation to Personal Advisors and When I am Ready guidance

### **Safeguarding**

4. Further work is required to ensure partner agencies have a clear and shared understanding of significant harm when making referrals to the Multi Agency Safeguarding Hub
5. Further development is required to embed the risk management model and the multi-agency risk assessment form (MARAF) with staff and partners, with assurance mechanisms to ensure compliance, quality and impact of services to young people and families.

### **Leadership, management and governance**

6. Ensure strategic plans are owned and understood by staff and are used to drive practice
7. Further work is required to develop a more comprehensive quality assurance system that strengthens the link between strategy and improving practice. This should also include improved focus on the frequency, consistency and quality of front line supervision.
8. Continue to prioritise the workforce strategy to focus on staff retention and the timely recruitment of experienced staff.
9. Review panel arrangements to ensure there is clarity of purpose, timeliness of decision making and engagement from partners.
10. There is a need to strengthen the transfer of cases between teams. The development of a formal transfer policy is currently being undertaken and this needs to be embedded throughout practice and monitored as part of the quality assurance framework.

## **Next steps**

11. CIW expect Merthyr Tydfil CBC to consider the areas identified for development and take appropriate action. CIW will monitor progress through its on-going performance review activity with the local authority.

# 1. Access arrangements: Information, Advice and Assistance

## What we expect to see

The authority works with partner organisations to develop, understand, co-ordinate, 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, including carers, 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 of contact. The service listens to people and begins with a focus on what matters to them. 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 are operating effectively.

## Summary of findings

- 1.1. The local authority has worked hard to meet the requirements of the Social Services and Well Being (Wales) Act 2014 (SSWBA). Considerable work has taken place with staff to develop services in line with the Act. The cultural change required is an ongoing journey.
- 1.2. Within the Information Advice and Assessment (IAA) service we found judgments on eligibility in relation to children and families were often clear, however the process for case transfer between the Intake Team and Early Intervention and Family Support Teams was not always happening due to capacity issues within the teams, and a lack of clarity in implementing the current 'transfer of cases' policy.
- 1.3. This had been recognised with the transfer policy being reviewed leading to the re introduction of case discussion meetings between the team managers to ensure more timely transfer of cases.
- 1.4. Within the Intake team issues of capacity had been identified due to staff vacancies and maternity leave. This resulted in the inability to close cases, caused delays in the transfer of cases to the Intake Team and in referring families not requiring a statutory service on to the Multiple Intervention Assistance (MIA) service. We saw an example of the IAA team holding a case which should have been transferred 12 weeks previously to another team. The recent appointment of new staff including a Team Manager and Senior Practitioner was resulting in improved practice and case loads were reducing in teams. Despite these pressures staff felt supported by their line managers and the head of children's services.



- 1.5. Evidence of signposting to preventative agencies was apparent. Initial data illustrated that 61% of people referred to IAA received no service, 20% were referred on to non statutory agency, and 8.5% were referred to children's services. Work does need to be undertaken with partner agencies on referral thresholds.
- 1.6. There had been considerable focus on strengthening preventative support for families. The implementation of the local authority's anti-poverty strategy resulted in the relocation of the Team around the Family Multiple Intervention Assistance (MIA) service into children's services. We saw evidence this had resulted in some timely and proactive intervention with children and families that supported their independence and improved well-being. We also saw good evidence of partnership working with the third sector with examples of support and advice for parenting especially with fathers through the "DADS programme".
- 1.7. Efforts had been made to meet the requirements of the Welsh language Active Offer. The local authority works with a high percentage of Eastern European families and we saw early access to translation services and the use of specialist support services to work with these young people and their families to help and support them through assessment processes.
- 1.8. The replacement of the children's services business information system with the Welsh Community Care Information System (WCCIS) had recently taken place at the time of inspection. We were told the system should enable safer sharing of information between agencies however there were a number of implementation issues which resulted in duplication of work and added pressure on some staff taking them away from direct work with young people and families.

## 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. All carers who appear to have support needs are offered a carer's needs assessment, regardless of the type of care provided, their financial means or the level of support that may be needed. 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 reasonably practicable and consistent with promoting their wellbeing and safety and that of others. Assessments provide a clear understanding of what will happen next and results in a plan relevant to identified needs. 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 as well as specialist provision.

### Summary of findings

- 2.1 We found positive practice where children and young people were proactively engaged in producing their assessments but this was not consistent.
- 2.2 Managers and staff were committed to increasing the capacity for staff to work directly with families. Some files viewed contained examples of the direct worksheets completed in partnership between the case worker and the young person. We heard from case workers about the direct work they had carried out with children and young people but this was not consistently evidenced in case files. Staff across the service highlighted the impact workload pressures had on their ambition to work directly with children and their families
- 2.3 The quality of assessments was variable. Inspectors saw good examples where the child was seen and the record captured both the child's and the parent's views. This included what mattered to them in the context of their family history and their cultural needs. Assessment analysis focused on potential strengths and risks which informed the basis of plans that were seen to be achievable by families.
- 2.4 In other examples however, inspectors found the use of the "what matters conversation" approach in the assessment reflected what people desired rather than a realistic understanding of what could be achieved. There was also insufficient focus on the ability of parents to change and in being clear what was expected of them in order to conform to the care and support plan. This impacted on achieving good outcomes for children.

- 2.5 We also saw case files where the assessment did not provide sufficient analysis of risk or provide clear recommendations for action. Staff and partners voiced concerns that there was an inconsistent use of the multi - agency risk assessment form (MARAF), despite all teams having been trained in its use. Some teams told us the tool was not suitable for their area of practice. We were unclear about how the risk assessment informed and identified the outcomes agreed with the family and how this translated into a multi -agency risk management plan.
- 2.6 The Children with Disability Team (CwD) undertakes all assessments for disabled children. We only reviewed a small number of assessments but those seen were of a good quality. Evidence was also seen of the offer to parent/carers of carer's assessments.

### 3. Care and support

#### What we expect to see

People experience timely and effective multi-agency care, support, help and protection where appropriate. People using services are supported by care and support plans which promote their independence, choice and wellbeing, help keep them safe and reflect the outcomes that are important to them. People are helped to develop their abilities and overcome barriers to social inclusion.

#### Summary of findings

- 3.1 We saw evidence of care and support plans being developed in a timely manner and reviewed in accordance with requirements. We saw some very good examples with clear analysis, in-depth risk assessments, transfer or closure summaries and management oversight was evident in the files. For example, we saw a visit to a child's home on the same day in response to a referral from the Probation Service. Contribution of information from the Probation Service was evident in the analysis of risk within the assessment. This was not consistent with the quality of care and support plans which were variable and not always identifying strengths and barriers or containing clear risk assessments.
- 3.2 We saw joint work with partners such as Youth Offending Service, substance misuse agencies and education services in supporting older children to remain at home. We saw good evidence of both the young persons and families' contribution to outcome focused plans that with intensive support and a multi agency response prevented young people becoming looked after.
- 3.3 Merthyr Tydfil CBC has efficient mechanisms in place including panel and Public Law Outline (PLO) to ensure timely effective decision making. We saw effective working relationships between the local authority lawyer and social workers, with social workers feeling supported and empowered. This was demonstrated with court expectations and timescales being routinely met, with clear threshold decisions evidenced within plans. We were concerned about the resilience of current arrangements within the legal team, where all PLO matters are undertaken predominantly by one individual in the team.

#### Care leavers

- 3.4 We saw inconsistent practice in pathway planning. Inspectors found a lack of clarity and understanding amongst staff members about the different roles of social workers and personal advisors (PA) for young people leaving care. We found that some young people were not prepared for the transition, having only being introduced to their PA when they were aged 17.5 yrs, leaving them feeling unsupported. A development programme was underway including a review of the

commissioning arrangements with the appointment of a part time PA to engage young people 21-24 yrs.

- 3.5 We did not find sufficient evidence that “When I am Ready” guidance had been fully embraced by the service or recognised by members, senior managers and partners. We saw evidence of some young people being encouraged to remain with their placement until their 18<sup>th</sup> birthday. This strategy was also being developed with foster carers to promote stability of long term placements and allow young people to remain within their community. Merthyr Tydfil CBC acknowledge that there is further work to be undertaken in this area and are in the process of strengthening their transition process, and reviewing their commissioning arrangements.
- 3.6 We learned that care leavers are a priority for the local authority with strong political and corporate support promoting the development of services that will contribute significantly to positive outcomes for care leavers. There was evident commitment across Merthyr Tydfil CBC to provide opportunities for employment, placement choice and appropriate housing for care leavers supported by strong collaborative working. We were told about the development of employment opportunities and apprenticeship scheme within the local authority and work being undertaken to provide safe accommodation for young people but it is too soon to evaluate the impact of this.

### **Long term planning**

- 3.7 The role of the Independent Reviewing Officer (IRO) was embedded within children’s services with a clear pathway for escalation of care planning concerns and open access to senior managers if required. IRO’s described positive practice with reviews being undertaken on time, positive communication between teams and significant efforts made to engage with young people prior to review meetings.
- 3.8 Merthyr Tydfil CBC has seen an increase in numbers of Special Guardianship Orders (SGO), with a number of these children having complex needs similar to looked after children. The local authority has recognised the need to strengthen the offer of support to parents and those with parental responsibility to prevent re-admission to care.
- 3.9 Panel arrangements need to be reviewed to improve performance. Inspectors found that young people placed out of area were not brought to the attention of the Multi Agency Placement Panel in a timely manner which impacted on the quality of planning. Greater challenge and commitment from partners is required to enable effective planning and decision making, without the need to escalate issues to the Head of Service for resolution.

## **Placement choice, stability and wellbeing**

- 3.10 Merthyr Tydfil CBC has projected growth in the number of young people leaving care over the next 5 years. Planning to address this increase in demand was underway with the commissioning process being strengthened to develop appropriate support alongside the provision of suitable accommodation.
- 3.11 Inspectors met with a group of children/young people who were placed with Merthyr Tydfil CBC foster carers. They spoke of feeling a sense of belonging and security in their placements and spoke positively about their ability to remain with their carers under the “When I am Ready” scheme. The 2018/19 Foster Carer Recruitment Strategy underpins the local authority’s commitment to recruiting and supporting foster carers and improving placement choice for children and young people. The appointment of a recruitment officer has seen an increase in the interest to apply and appointment of new foster carers.
- 3.12 A Placement Strategy was also being developed in partnership with the Children’s Commissioning Consortia Cymru (4C’s) with the aim of increasing resources for in-area and specialist placements including sustainable emergency placements for young people with complex needs.
- 3.13 Inspectors found that young people placed out of county had difficulty in accessing child and adolescent mental health services.

## **Participation**

- 3.14 In order to provide an ‘Active Offer’ of advocacy, the local authority has a regional contract with Rhondda Cynon Taf to commission services from the National Youth Advocacy Service ( NYAS). NYAS described their relationship with Merthyr Tydfil CBC as good and that the head of children’s services was proactive in responding to any issues. For example, children’s service had been proactive in responding to a drop in advocacy referrals by actively promoting the benefits of using independent advocates to support children and young people to have their voice heard and to receive information and representation.
- 3.15 Young people had a seat on the corporate parenting board; with the views of young people being a standing agenda item providing an opportunity for them to raise issues that matter to them and to contribute to developing services that contributed to improving outcomes for looked after children.

## 4. Safeguarding

### 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. Actions arising from risk management or safety plans are successful in reducing actual or potential risk. People are not left in unsafe or dangerous environments. Policies and procedures in relation to safeguarding and protection are well understood and embedded and contribute to a timely and proportionate response to presenting concerns. The local authority and its partners sponsor a learning culture where change to and improvement of professional performance and agency behaviours can be explored in an open and constructive manner.

### Summary of findings

- 4.1 Merthyr and Rhondda Cynon Taff local authorities with their partners share a Multi Agency Safeguarding Hub (MASH) based in the police station in Pontypridd. Whilst being co-located, the two social work teams operate independently but benefit from the close working arrangements with each other and other partners which support discussion and action in relation to cross boundary issues.
- 4.2 The MASH was established to be the route in to social services for safeguarding referrals from professional agencies. In practice we found this was not well understood by some partner agencies. For example, referrals being made to MASH for preventative support, not safeguarding. This was being addressed by staff within the MASH, for example training being provided to schools by the education worker about threshold criteria and signposting of referrals to the MASH to reduce inappropriate referrals.
- 4.3 Case file reviews carried out by inspectors noted referrals were appropriately screened in relation to safeguarding concerns whilst also considering what *mattered* to children and families. When referrals indicated risk or significant harm, prompt decisions were made and effective initial action was taken to protect the child.
- 4.4 Within the MASH we found strategy discussions and/or meetings were mainly held within the 24hour time frame. The relationship between social services and the police was viewed by staff as positive and arrangements for organising strategy discussions and meetings were effective. Outcome strategy discussions or meetings were also convened and were an effective means of keeping agencies informed, reviewing progress and determining next steps.
- 4.5 It was evident the local authority understood and considered the risks factors which some looked after children experienced. The local authority and partner agencies were working proactively together in

relation to child sexual exploitation and children who go missing. We saw an example of direct work with a young person using Sexual Exploitation Risk Assessment Framework tool (SERAF) which enabled the young person to understand the risks posed and felt able to contribute their multi agency protection plan to reduce risks and promote their safety and well-being.



## 5. Leadership, management and 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 people. Meeting people's needs for quality services are a clear focus for councilors, managers and staff. Services are well-led, direction is clear and the leadership of change is strong. Roles and responsibilities throughout the organisation are clear. The authority works with partners to deliver help, care and support for people and fulfils its corporate parenting responsibilities. Involvement of local people is effective. Leaders, managers and elected members have sufficient knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively.

### Summary of findings

- 5.1 Merthyr Tydfil CBC vision and ethos underpins the delivery of practice and is predicated on services working together to achieve shared goals. We found the vision was well established at a corporate and strategic level but it was not well understood by all staff. We found that staff members were not always able to relate or explain the vision, and how it informed their practice in delivering an outcome focused service.
- 5.2 Corporate parenting arrangements were well developed and ensured that members, officers and partners understood, owned and met their corporate parenting responsibilities. We saw evidence of working with partners to develop therapeutic services, improved life journey work and improved housing and employment options for looked after children.
- 5.3 Merthyr Tydfil CBC recognised the need to review their services to young people leaving care in line with the recommendations in the Children's Commissioner's *Hidden Ambitions* report. The local authority ensured that it was compliant with its legal responsibilities in respect of post -18 living arrangements for young people in accordance with "*When I am Ready*".
- 5.4 The local authority is committed to supporting looked after children and its priorities are reduction of care leavers who are not engaged in education, training or employment (NEET), support for independent living skills for care leavers, new apprenticeship scheme and appropriate placements.
- 5.5 The lead member, director and senior management team have a comprehensive knowledge of the pressures of front line practice, enabling them to discharge their statutory responsibilities, and act quickly to promote improvements. We found elected members understood their responsibilities, were able to challenge decisions and worked closely with the director and senior management team. In addition they were visible to the workforce, undertaking meetings with

staff members and attending events for staff and young people to gain a better understanding of the challenges and strengths of children's services.

- 5.6 The local authority acknowledged that the transfer of its information system from Swift to WCCIS in July 2017 had impacted all levels of the service. A major challenge had been the inability to access accurate performance data from the system resulting on the reliance of informal data being gathered by teams using a variety of their own systems. Considerable work had been undertaken over the last 12 months to try to rectify the problems and performance information now available at all levels of the service. In order to support staff and develop the processes and guidance required a bespoke team had been established. A programme of training was being planned for staff to update them on the changes to the system, and how the system can inform practice. Staff reported an improving picture.
- 5.7 We saw evidence that Merthyr Tydfil CBC were reviewing their quality assurance framework for Looked After Children and had appointed a lead officer to take this forward. The remit was to ensure that the system was an integral part of practice, and a useful tool to drive continuous practice improvement and to inform the shaping of services.
- 5.8 We found positive working relationships between the local authority and its partner agencies. Partners from both health and education told us the population assessment was being used to drive developments with plans in place to consider more detailed needs analysis specifically for children. We saw evidence of how this had impacted on service delivery in respect of re negotiating a counselling service and combining work with education psychology to make both services more accessible.
- 5.9 Overall, services were delivered by a competent well qualified work force who were committed to achieving good outcomes for children and families. Despite financial and resource pressures, teams were focused on the stability, safety and well being of looked after children, care leavers and their families.
- 5.10 Staff supervision and appraisals had been inconsistent. Whilst some staff received regular formal supervision, this was not the case for others; there was inconsistent approach to appraisals. Some staff members reported a supervision policy and template were available to them on the intranet, but not all staff were aware of this. A performance management policy and procedure had been developed, and this needed to be embedded into practice to ensure staff members were receiving consistently good quality supervision and appraisal. Senior managers were aware of this deficit and were working with human resources department to address the inconsistencies.

# **Methodology**

## **Fieldwork**

We undertook 9 days of fieldwork activity.

We selected case files for tracking and review from a sample of cases. In total 47 case files were reviewed; of these 18 were followed up with tracking interviews with social workers and family members and 3 were subject to a tracking focus group which involved multi-agency partners.

We interviewed, children, parents and relatives.

We interviewed a range of local authority employees, members, senior officers, Director of Social Services and the Chief Executive.

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

We reviewed a sample of 5 staff supervision files.

We reviewed supporting documentation sent to CIW for the purpose of the inspection.

We looked at a sample of complaints that were made about children's services.

## **Inspection Team:**

Lead Inspector: Ann Rowling, Supporting Inspectors: Duncan Marshal, Katy Young, Pam Lonergan, Tracey Shepherd

## **Acknowledgements**

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