Arolygiaeth Gofal
Cymru
Care Inspectorate
Wales

Inspection of Children's Services Isle of Anglesey County Council

December 2018

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Introduction

Care Inspectorate Wales (CIW) last inspected children's services in Isle of Anglesey County Council in November (IoACC) 2016. The inspection found management oversight of safeguarding, access and assessment arrangements were insufficient and the pace of change in improving the provision of help, care and support and/or protection for children and families in Anglesey needed to be accelerated and improvement sustained. Due to the significant concerns identified, CIW undertook to re-inspect Isle of Anglesey children's services within 12 to 18 months from the publication of report.

IoACC developed an improvement programme and engaged an independent support team to monitor progress and offer consultancy advice.

CIW undertook this re-inspection of services for children during October 2018.

Our approach is 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). It 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 re-inspection focused on how families are empowered to access help and care & support services and on the quality of outcomes achieved for children in need of help, care & support and/or protection.

We evaluated the quality of practice, decision making and multi agency work maintaining a clear focus on the impact of services for children and families, in respect of:

- access, including the provision of early help/prevention services
- assessment;
- safeguarding;
- care & support planning/review.

And

- quality of the leadership, management and governance arrangements in place that develop and support service delivery to maximise best outcomes for children and families.

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. We sought to engage children, young people and/or their families/carers with the purpose of listening to their views and experiences of the quality of services they have received.

Overview of findings

- We found IoACC children's services able to demonstrate significant improvement in a number of key areas with some other areas still requiring further work. Staff morale is high and there is passion and commitment at all levels to continuing to work hard on the journey of improvement to deliver excellent services for children.

- The Information, Advice and Assistance (IAA) service has improved significantly since our last inspection and is now more in line with the Social Services and Well-being Act (SSWBA). Staffing levels have increased within this service and 'what matters' conversations are being undertaken with increasing confidence and success. Chronologies are routinely begun at this early stage and referrals passed to other teams appropriately. Decisions and case recording are mostly timely and proportionate.

- Safeguarding responses are mostly timely and proportionate. There is room for improvement in collation and recording of evidence and analysis of risk. We were not always confident all key pieces of information were available at the right time to consistently support managers to make good decisions. This can lead to unnecessary delays in formulating plans for children.

- The quality improvement service has benefitted from increased staffing and external professional support over the past year. This new impetus has led to the development of a number of policies and procedures. Some policies and procedures require more detail to ensure they maximise improvements. There is some evidence of a feedback loop between case audit and practice. However, we are not yet confident current case audit and supervision consistently identifies and improves practice that falls short of the standards expected within legislation.

- Improvements in management oversight and professional accountability at all levels is continuing to highlight cases where opportunities to support children have been missed in previous years. There is firm commitment and direct evidence of the local authority proactively and systematically responding to the needs of these children. This has led to a noticeable increase in the

number of children becoming looked after and corresponding increase in work load for teams.

- There is a lack of suitable placements for children. More work is required to ensure placement options meet the particular needs of children within their community. We heard about and spoke to children with complex needs who are receiving specialist support out of county. We were told these placements can be very expensive and how they need to be carefully commissioned and tightly monitored to ensure children's needs are met. The Service is considering specific measures designed to address this shortage.

- There is strong leadership and governance in IoACC. Members of the council were able to demonstrate their contribution to children's services improvement journey. They were able to demonstrate their knowledge of key challenges facing the council and how they interact to impact upon children and families. Senior officers are visible, available and driving improvements. Partners on the regional safeguarding board, North Wales Police and Health Board operational colleagues are positive about the changes they have seen in Anglesey, describing a new open culture and good joint working.

Areas for development

Access arrangements: Information, Advice and Assistance

1. The opportunity to provide feedback to people who make referrals should be maximised. There is an electronic form already available it could be used more consistently to improve communication with people who make referrals and build the reputation of the service.

2. Ensure chronologies are consistently updated to assist practitioners to access relevant and significant case information in a timely manner.

Assessment

3. Ensure the individual child is not lost in the wider case discussion of the family circumstance. A greater focus must be held on individual children's needs and wishes, as well as impact and mitigation of risk(s) to them.

4. High quality, robust and timely supervision and audit of individual assessments must become routine within the service to drive the pace of service improvement. Supervision and audit need to include reflection on use of professional knowledge, evidence and social work skills

5. Evidence collection, recording and analysis must be brought up to a consistently high level to enable informed decision making and ensure cases where children are suffering significant harm are not allowed to drift. Managers need to be confident and supportive in critically appraising incomplete or inadequate written documentation.

6. Children need to be able to build relationships with social workers they can trust, the number of social workers to which each child has to repeat their story needs to be minimised. Social workers must ensure every interaction with a child counts and be able to evidence their work.

Care and support and review

7. More work is required to support independent safeguarding and reviewing officers (IRSOs) to ensure they have capacity and confidence to effectively challenge where services fall short of standards required for individual children.

8. There needs to be early emphasis and priority given to improving consistency of contact and engagement of IRSOs with children before reviews to ensure children’s voices are clearly and effectively heard.

9. Care planning and engagement with children and carers must be strengthened to ensure consistent development of co-produced plans. Children and carers must receive the support offered to them in care and support plans.

10. Continue to explore and hasten current opportunities to increase the number and range of placements options for children on the island. The provision of new placement opportunities needs to be based upon professional understanding of children‘s needs.

11. Develop mechanisms to ensure looked after children are not disadvantaged by pressures on staff to respond to new safeguarding concerns in other cases.

Leadership and governance

12. Continue with development of robust quality assurance mechanisms across the service.

13. Encourage further joint working between children’s services and education services to ensure all children have timely Personal Education Plans that reflect the importance of education to each child’s ability to reach their potential.

14. Ensure there are opportunities to pause and reflect on the new structure including constructive challenge as to whether the experience and outcomes of children are being best served by the number of practice leaders who are non case holders and the number of changes in social worker experienced by each child.

Next steps

15. CIW view IoACC as having a good understanding of their strengths and areas for improvement. CIW expect the local authority to consider areas of development highlighted to be incorporated into their development plans.

16. CIW will monitor progress through its on-going engagement activity with the local authority. This may include desk top review of a small number cases audited in this inspection to track the progress of children.

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 Teulu Mon, the Information, Advice and Assistance (IAA) service in Anglesey has benefitted from significant investment and development over the past year in line with the Social Services and Well Being (Wales) Act 2014 (SSWBA). We observed the service to be generally offering proportionate and timely responses at 'the front door'. Teulu Mon is an amalgamation of what were previously separate functions carried out by the Family Information Service, Team Around the Family (TAF) and the Children and Families service duty and assessment team.

1.2 We saw evidence of increased staffing in the service including an increase in practice leaders. The three practice leaders work together under one service manager and share the role of decision maker. Staff consistently told us this is a positive improvement, helping them to get timely advice and progress their work more efficiently.

1.3 We met with staff from the IAA service and heard about their positive experience of a range of training opportunities and witnessed commendable level of support for each other within the team. We observed staff using the "*what matters"* conversation and the five steps to eligibility in line with SSWBA guidance.

1.4 We found improved quality of recording of referrals and evidence gathering. We heard from staff how working alongside the Team Around the Family helped with analysis and signposting as information, practical knowledge and

skills were readily shared within the team. We heard how this cooperative approach appropriately facilitates prompt transfer to TAF allowing timely preventative work with children and families to take place.

1.5 Since its recent move into Children’s services from education TAF has changed its thresholds for intervention, with the aim of providing a more targeted service for children and families who need support. Managers told us they believed this to be a better use of the resources available on the island.

1.6 We found improved communication and joint working between children’s services and schools. One Head teacher told us they found Teulu Mon increasingly helpful when they needed to make a referral. They now feel able to pick up the phone and discuss potential referrals with the service. This improvement has followed presentations by the head of Children’s Services to head teachers encouraging them to refer on the basis that services to support prevention are now available where needed.

1.7 We were told the clearer threshold and improved communication will deliver an improved preventative service for children and families on Anglesey who may be more reluctant to use services or may have been hard to reach. It is too soon to tell whether this level of targeting is appropriate to provide early intervention and prevent families and children reaching crisis.

1.8 Teulu Môn Practice Leader described how promoting the IAA service at parent’s evenings and community events is providing information about services that are available to normalise families accessing support before they reach crisis. The impact of this approach will not become clear for some time.

1.9 Beginning chronologies in the IAA service when referrals are first made is a positive development that can support future timely and informed decision making. We found not all chronologies are up to date, we saw work is ongoing to ensure they are brought up to date and staff keep them updated.

1.10 Further work is required to enhance the newly established IAA service to enable workers to provide a comprehensive information service to the public. The Family Information Service is part of IAA and staff members are currently inputting Anglesey information on to the DEWIS web based resource directory. Resources will be required to ensure the information is kept up to date.

1.11 It was positive to see the Wellbeing and Inclusion worker included within service whose role is to respond to referrals, signpost to community and preventative services and map areas of need. The local intelligence gained by this worker should be a useful contribution to the population needs assessment.

1.12 The active offer of the Welsh language is fully embedded in the services offered. We heard on a regular basis staff regularly alternating between English and Welsh with a high level of accomplishment.

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 were told and inspectors saw how the restructure implemented in October 2017 was positively impacting upon practice. Staff told us they found the new ' Practice Group arrangements with practice leaders to be a positive improvement. They told us they valued sitting in the same room as their practice leaders and how it provided easier access to support now that managers are much more visible.

2.2 There is a wide skill mix of social workers in IoACC. With a spread of experienced, newly qualified and agency workers. We saw evidence in supervision files of staff saying case loads were too high. We also spoke to staff who told us they felt very well supported and whose case loads were manageable.

2.3 We found many children with more than one social worker involved and were told complex cases were shared with practice leaders, and the social worker from the Resilient Families Team may also be actively working with the child. For this reason it was difficult for inspectors to say whether the caseloads were appropriate. Senior managers will want to consider concerns raised by workers and take steps to respond to staff.

2.4 We did hear about and witness the positive drive by senior managers for improvements in practice and professional accountability at all levels. We are

aware some staff have found this challenging while many told us they found the extra support and drive for improvement helpful.

2.5 The inclusion of a 'legacy team' as part of the re-structure has facilitated a concerted focus on cases where there had been significant 'drift'. We saw many cases where this team has brought a renewed focus to specific children and were taking action to ensure children receive the support they should have benefitted from in previous years. We saw this work was quite quickly making a positive difference to the lives of children.

2.6 We found the quality of assessments to be inconsistent ranging from very good to some requiring improvement. In the best examples we saw high quality evidence presented well with ongoing analysis. Very good examples provided a clear picture of the child and an understanding of what matters to them and identification of risk and strengths.

2.7 These very good assessments and plans provided a sharp contrast to others where statutory visits to children were undertaken by workers who had not previously met the child and the subsequent recording added little or nothing to the service's understanding of the child's immediate concerns or ambitions for the future.

2.8 We did not see a correlation between the quality of written work and the experience of the worker. We saw some very good assessments written by Newly Qualified Social Workers.

2.9 Regardless of the individuals experience or length of service, we did not see quality of recording or professional analysis challenged consistently enough to ensure past experiences are not repeated.

2.10 We found some examples of good direct work with children, focused on ensuring children could express their concerns and their voices were captured. We also audited cases with insufficient evidence of children's voices being sought or heard. Particularly when there was a sibling group or families were linked by marriage or complicated relationships. We found this unacceptable.

2.11 On these occasions we saw cases where the child was at risk of being missed in the wide ranging discussion going on around them. This included assessments where the child was only referred to once or twice in many pages of notes in their own case file. This was explained to us as being due to the nature and structure of regional forms. Regardless of the reason inspectors found this unacceptable.

2.12 We spoke to children and foster carers and saw within case notes how they had experienced many changes in social workers, we also saw many social workers being involved in the same cases. This may be an unintended consequence of the Practice Group within the new structure. We heard from some children how this caused them confusion and they were not sure who they should speak to if things went wrong. One child asked inspectors “what’s the point of having a named social worker if I never see them and other people keep turning up instead”.

2.13 In discussion with social workers it was evident they had a clear focus on children, however, written records did not always capture the quality of the positive work including direct work with children being undertaken as part of assessments.

3. Care and support and review

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 The local authority has further room for improvement to ensure looked after children and young people have timely care and support plan as required in SSWBA guidance. We found the quality of plans was variable. Staff report struggling with the regionally developed care planning documentation following implementation of the SSWBA. Inspectors were made aware there is work ongoing to review the forms and the new IT system.

3.2 IoACC struggles to find placements that match individual needs of children. This has resulted in some children being placed out of county placements and some children being placed in settings that are 'best fit' rather than setting of choice. We saw children placed with their own parents because of the lack of availability of an alternative placement which then require intensive support to manage risks.

3.3 There is a need to strengthen engagement and direct work with children to enable them to have an improved understanding of their care plans. There is also a need to improve engagement with children at a more strategic level. Discussions are underway with a national organisation to help move this work forward and ensure the service benefits from learning directly from children who rely on services.

3.4 We found the Resilient Families Team to be clear in its remit and confident in its abilities. The team were able to demonstrate the direct in-depth work they had undertaken with children and families and had good examples of 'reflective letters' used as a means of engaging with children and parents.

3.5 The local authority has developed a more robust approach to permanency planning for cases that have been subject to 'drift' as identified by CIW previous inspection. The legacy team was introduced during the restructure in October 2017 to provide a new focus on children where there has been an unacceptable tolerance of long term neglect. We saw evidence of refreshed planning, improved case management and management oversight, including

panel arrangements. These interventions were leading to more robust and longer term planning for children.

3.6 Managers accept that while most cases of this type have now been identified there may be others with unacceptable delays and there is a need to identify these as soon as possible.

3.7 Funding has been identified to engage an additional solicitor to increase the legal advice available to teams and the post is currently out to advert. This should increase timely support to social workers and directly improve outcomes for children.

3.8 The local authority demonstrated it was committed to successfully returning children and young people home where it was in their best interests. There were arrangements in place to support step up and step down of cases where it is safe to do so. Workers recognised the importance of parental and child bonds and were proactive in offering opportunities for children to remain with parents and offer substantial support.

3.9 The reviewing process should be child focused with any challenge in respect of children's rights to be escalated appropriately. We were shown a new policy that is being developed to support Independent Reviewing Safeguarding Officer's (IRSO's) to escalate concerns. Successful implementation of this and other support to IROs will be crucial to these officers having the confidence and ability to monitor the performance of the local authority as a corporate parent.

3.10 Reviews of children who are looked after are mostly held in line with guidance, however there is a need to strengthen reviewing arrangements and consistently offer children opportunities to meet with the reviewing officer prior to review. This would provide opportunity to have regard to a child's wishes in respect of how and where the review is held and the child's desired outcomes.

3.11 We saw occasions where life story work was planned but did not take place. Social workers told us this work is not prioritised because of competing demands on their caseload. Gaps in this type of work and limited opportunities to meet with IRSOs means opportunities for children to have their voices heard and make sense of their own stories are not being maximised. We heard some evidence from children and parents whose voices had been heard and recorded in assessments and care and support plans but the associated action by practitioners had failed to materialise. Individuals did not get the response they felt they needed and were expecting.

3.12 There was celebration of children who had been looked after and who had gone on to achieve in higher education or a chosen career with clear

expectation this should be the ambition for all looked after children. We found Personal Education Plans were not always in place and up to date for all children. Some managers told us they were already aware of this and understood the importance of ensuring this is addressed.

3.13 Advocacy services are commissioned for children in Anglesey by the local authority but take up was inconsistent. More work is required to ensure workers and children are aware of the opportunity for support and how to access the service. We were told by the advocacy service it was confident steps will be taken by the local authority to improve the workforce's understanding of the requirement of offering advocacy in certain cases.

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 Safeguarding children was prioritised within the department. Mostly we saw competent and supported workers providing timely and proportionate responses.

4.2 The local authority has recently re-introduced a new model of risk management to safeguard children, based on the Bruce Thornton model. Training including mentoring and coaching sessions for individual staff has accompanied the new approach and staff told us it is a positive improvement to their practice.

4.3 We saw the new risk documentation had been completed on many occasions. We found some assessments lacked detail of evidence and contained limited analysis of risk. We saw missed opportunity to complete home conditions assessments. Improved quality and completeness of assessments would inform decision making around risk.

4.4 Managers told us about the positive work they were undertaking on child sexual exploitation and adverse childhood experiences. We also spoke with North Wales Police, members of North Wales Regional Safeguarding Board and operational staff from Betsi Cadwaladr University Health Board. All were very positive about the new open working relationships with Isle of Anglesey County Council and very positive about the joint work being undertaken. They were all able to describe different case work that had been successful due to improved joint working. We saw evidence of joint working in the cases we audited.

4.5 The same partners told us about the development of a disputes escalation policy used by all six Local Authorities in North Wales. It has been used

successfully in Anglesey and achieved a positive outcome for the child and agencies involved.

4.6 We heard there was more work to do to improve the quality of referrals received from partners into children's services. Joint training is being planned to ensure sufficient and appropriate information is provided to enable social workers to make informed decisions and ensure children are safeguarded.

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 IoACC leaders and managers were able to demonstrate a good understanding and strong commitment to supporting the most vulnerable people in their community. They were able to clearly explain key existing and rising challenges in their communities and the opportunities and challenges presented by social care legislation.

5.2 Elected Members had a clear understanding of their role and with officers are aware of their responsibilities as Corporate Parents. Members were equally clear of the need for accountability at all levels and the importance of quality assurance systems and processes being able to identify any dips in performance or missed opportunities and support improvement before they escalate.

5.3 Children services benefits from a permanent and stable senior management team with a wide range of experience and knowledge. Staff told us in focus groups and through questionnaires they feel supported by managers and many told us how pleased they were with changes in the service and how they were enjoying being part of a positive culture with clear direction.

5.4 The lead member and other elected members demonstrated a good understanding of the preventative agenda inherent in the SSWBA and a commitment to supporting children and families to be resilient. We heard about free leisure membership cards and other practical opportunities being developed corporately to support children, young people and their families. Members were able to explain and weigh up their concerns about the unintended consequences of reduced funding in some areas impacting the

lives of children and the good work undertaken by the Resilient Families Team to keep families together.

5.5 Members suggested they were supporting joint working between education and children's services. Some members expressed their anxieties about children who do not attend school, are absent and children who may be 'lost' to the system. It was acknowledged this is an area that could benefit from more work.

5.6 Members demonstrated commitment to improving services for children by agreeing the terms of reference for the Children's Improvement Panel before the last election immediately after CIW last inspection. The improvement panel has continued to meet monthly and members report their confidence has grown and the panel is productive, giving them insight to progress being made in the service.

5.7 Leaders and managers recognise the progress that has been made by the local authority and clearly understand the need to continue to drive service improvements to a position where children's services are consistently good, cases are not allowed to drift, and every child is safeguarded from abuse.

5.8 There is recognition of the increasing numbers of looked after children and plans are being formulated to develop a leaving care service to meet rising demand. Given the increasing numbers of children who will be leaving care over the coming years, there is urgency for this work to be competed to ensure young people will be supported through what can be a difficult period of transition.

5.9 There are a number of key documents that have been freshly developed or reviewed including; workforce strategy, performance framework practice standards, prevention strategy and supervision policy. We found some of the policies could benefit from more work, however they do have the potential to contribute to improvement when implemented, supported and translated into daily practice.

5.10 Overall, staff were positive and enthusiastic about their experience of working for the local authority. They told us they felt supported by managers who were visible and approachable and were able to raise concerns as they arose. They were aware of the range of new documentation and although they recognised some needed further work, particularly the supervision policy, they welcomed them as positive steps on a journey of improvement.

5.11 Challenges remain around recruitment of experienced social workers and reliance on agency staff. While the numbers of agency staff are reducing and the situation improving, the frequent changes of staff is leading to poor

outcomes for children. Inspectors were told about recruitment plans and positive links with Bangor University which supports the local authority in attracting high quality newly qualified social workers. We were also told about new initiatives to ‘grow our own’ social workers. Together it is envisaged these projects will resolve the shortage of social workers in the local authority area.

5.12 We found the quality of case audit to be inconsistent. At times the focus was more upon key dates being adhered to rather than quality of the work or the outcome for the child. We also saw audits that had missed deficits in cases for example one case had been closed with work not completed. We found very little comment on quality of evidence or professional practice.

5.13 We are aware of a drive by senior managers for improved supervision and are aware a revised supervision policy is to be implemented. Staff told us they regularly receive supervision and managers are very supportive. In the cases we saw we found the quality of supervision to be variable and one file to be overly negative. We could not be confident that all supervision was effective at improving practice or confidence in social workers.

6. Methodology

Fieldwork

We undertook 10 days of fieldwork activity

We selected case files for tracking and review from a sample of cases. In total 48 case files were reviewed; of these 18 were followed up with tracking interviews with social workers and family members some 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 9 staff supervision files.

We reviewed 74 staff survey results.

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

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

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