



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

# Inspection of *Children's* Services

Bridgend County  
Borough Council

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

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## **Introduction and next steps**

Care and Social Services Inspectorate Wales (CSSIW) undertook an inspection of children's services in Bridgend County Borough Council in January/ February 2017. Inspectors looked closely at the quality of outcomes achieved for children in need of help, care and support and/ or protection. We focussed specifically on the quality of practice, decision making and multi-agency work in respect of the authority's safeguarding, access and assessment arrangements; including arrangements for the provision of information, advice and assistance and preventive services. In addition inspectors evaluated what the local authority knew about its own performance and the difference it was making for the people it was seeking to help, care and support and/or protect.

The inspection was structured around people's pathway into care and support services, specifically access to preventative and statutory services and the interface between the two, as well as any safeguarding issues arising. We considered carefully the contributions made by social services in partnership with other agencies to achieving good outcomes for children and families and where relevant to protecting children from harm. Inspectors read case files and interviewed staff, managers and professionals from partner agencies. An electronic staff survey was carried out across children's services. Wherever possible, inspectors talked to children, young people and their families.

At the time of the inspection the council was experiencing a significant period of change including the requirement to implement the Social Services and Well-Being (Wales) Act 2014 (SSWBA). The social services and well-being directorate was also actively progressing a transformational agenda of services for children young people and their families while having to deliver medium term financial savings.

Inspectors were pleased to note that senior managers were committed to achieving improvements in the provision of help and protection for children and families.

The recommendations made on page 8 of this report identify the key areas where post-inspection development work should be focused.

They are intended to assist Bridgend County Borough Council and its partners in their continuing improvement.

The inspection team would like to thank Bridgend service users, elected members, staff and partner agencies who contributed to this report.

## **Next steps**

Bridgend County Borough Council is to produce an improvement plan in response to this report's recommendations which will be monitored as part of CSSIW programme of engagement.

## Overview of findings

### Access arrangements

Inspectors found that the authority had worked hard in the context of the Social Services Well-being Act 2014, to reshape its services. The authority's Information Advice and Assistance function was delivered through the Assessment team which provided a single point of contact for both social work and preventative (Early Help) interventions.

Access arrangements to Early Help and statutory services were respectful of peoples' rights and individuality and were available bilingually but there was a lack of accessible quality information for children, young people and their families. The colocation of staff from social services, Early Help and partner agencies within the assessment team was supporting children and families to be directed more easily to appropriate services, but was yet to mature into integrated services. The Assessment team multi agency arrangements will be extended through the development of a Multi Agency Safeguarding Hub from April 2017. The current access arrangements, including the interface between social services and Early Help, were underpinned by a threshold criteria document, but this was not yet sufficiently understood by partner agencies. Screening decisions were timely and Inspectors saw some positive evidence of management oversight. When contacts were received by children's services and there was an obvious indication of significant harm, prompt and proportionate initial action was taken to protect children. The quality of threshold decision-making however, was inconsistent and not sufficiently evidenced. It was acknowledged by the service that the changes introduced to operationalise IAA had brought additional expectations that put pressure on the capacity of the managers and the workload of the assessment team. The information provided by partner agencies was not always of a sufficient quality to support the assessment team in their screening decision and some professional referrers demonstrated a lack of understanding of the requirements of the service. More work was needed to develop multi agency quality assurance systems to support staff to exercise appropriate and proportionate judgements and to provide assurance that children young people and families were being directed to the most appropriate service. The impending transition to a MASH provided a timely opportunity to refresh service expectations resulting from of the SSWBA, including learning from practice. The authority will also need to extend its performance information to include an analysis of the impact that services are having on reducing need and risk.

## **Safeguarding & Assessment**

The assessment team were working hard to implement the requirements of the Social Services Well-being (Wales) Act 2014. Strategy discussions were timely and supported appropriate information sharing from key agencies.

The quality of the assessments and recording seen was variable; some were good but others did not sufficiently evidence the principle of co-production or an analysis of need and risk from the outset. The timeliness and quality of partner's contributions to assessments was not always evident and remained too dependent on individual professional relationships.

Good social work practice to elicit the child's wishes and feelings was not consistently well reflected in the content of assessments. Although most assessments were shared with children and families, lack of effective engagement resulted in them not always being sufficiently clear about the purpose of the help, care and support and/or protection they received. The resulting plans did not always reflect the findings of the assessments and were not sufficiently child focused or outcome driven. In some instances the quality of the plan hampered those taking over a case from swiftly understanding the needs and risks associated with children and families. Assessments and resulting plans need to be better shared with children and families in a way that promotes their understanding of the issues and engagement.

Management oversight of assessments and plans was seen but did not consistently provide the level of challenge and quality control needed.

## **Leadership management and governance**

The authority was working hard to transform children's social services at a time when they had to deliver medium term financial savings. The ambition of the authority's plans signalled their commitment to improving both early intervention and statutory services for children young people and their families. The objective to mitigate the need for statutory social services however was significantly dependent upon the ability of all council directorates to work together in order to deliver against the council's vision and contribute and co-ordinate an effective range of services. The council will need to ensure there is an ongoing analysis of the underlying complexities and risks associated with statutory children's services. It was positive that the council had recently begun work to develop a more comprehensive evidenced based commissioning plan that will be key to the delivery of its early help and permanence strategy.

The council needs to ensure that the strategic direction is translated into an operational strategy for delivery of children's services that is effectively communicated and understood by staff, partners and service users. At the time of the inspection the SSWBA was still at an early stage of being embedded and more opportunities were needed to draw lessons from practice and engaged key stakeholders in reviewing progress and in any resulting service remodelling. The voices of children and families also need to be embedded in shaping service planning to provide a better understanding of the difference that help, care and support and/or protection is making for children and families. The introduction of a new quality assurance framework will help the councils to understand the pace of its service improvement.

Staff were committed to achieving good outcomes for children and families but staff morale was variable across the service and needed to be nurtured at a time of significant change. The recruitment and the retention of social workers had been given significant priority despite some good progress the authority had encountered difficulty in recruiting experienced staff. Services therefore were not always delivered by a suitably qualified and experienced workforce that had the capacity to consistently meet workload demands. Staff valued the approachability of their line managers, and peer support from team members particularly in relation to managing the increase in volume and complexity of their work. Staff would welcome greater visibility of senior managers particularly given the remodelling of services.

The importance of staff development and good supervision practice to retention was recognised and newly qualified workers were found to be well supported in their first year of practice and highly valued the mentoring provided to them. Despite the availability of some good training programmes staff including managers needed help to prioritise training against the competing demands of their work. The quality of supervision was found to be very variable and did not routinely evidence sufficient challenge or reflection, a new supervision policy had not yet impacted on these quality issues. Senior managers were working to develop a stronger oversight of practice and management culture the leadership development of group managers and front line managers was therefore being progressed as a priority.

# Recommendations

## Access

1. A range of user-friendly information should be developed and made easily accessible for families, children and young people not only with respect to signposting to preventative services but also how children's services and early help carries out its work.
2. Effective, multi-agency training and quality assurance arrangements should be established to ensure that the thresholds and referral expectations of both early help and statutory children's services are understood by staff and partners and are consistently applied;
3. The council should continue to develop information systems that include scrutiny of service demand and support an analysis of the difference that early help, care and support and/or protection is making for children and families.
4. Caseload and quality assurance reports should be continuously monitored to ensure there is sufficient capacity for workers to engage effectively with children and their families.
5. The quality and consistency of record keeping and the use of chronologies and genograms should be improved;
6. Effective arrangements should be put in place to ensure that the needs of children and young people are assessed if contacts and referrals about their well-being are repeated.
7. The council should review its Emergency duty team (EDT) arrangements to ensure that EDT referrals are effectively captured on the electronic system and that communication with the daytime service supports timely hand over and action.

## Safeguarding and Assessment

8. The quality of assessments and plans should be improved to ensure that they are consistently of a good quality, with a clear focus on the needs, risks and strengths of children and families, and that desired outcomes, timescales and accountabilities for actions are clear.
9. A service model of risk assessment and risk management should be developed and shared with staff and also partner agencies. This should be accompanied by a programme of training and assurance mechanisms to ensure compliance, quality and impact.
10. Expectations in relation to the timeliness and quality of partner's contributions to assessments and care plans should be established. An assurance mechanism should be implemented to ensure compliance and quality.



11. Effective, management oversight and challenge systems should be established at the point of transfer between teams to ensure a clear understanding of the needs and risks associated with the case.

### **Leadership Management and Governance**

12. The council should actively evaluate the effectiveness of its inter directorate working in supporting the Statutory Director Social Services in delivering against the statutory requirements of the Social Service Well-being Act and in particular Information Advice and Assistance.

13. The council should progress its commitment to developing an evidence based commissioning plan in relation to both statutory and early intervention services for children and families.

14. The council should consider how it can increase the voices of children and families in shaping service planning to provide a better understanding of the difference that help, care and support and/or protection is making for children and families.

15. The council should consider how it can provide opportunities for staff and partners to be further engaged in the development and transformation of services; the identification of lessons learnt from its implementation of IAA should be used to inform the planned transition to a multi-agency safeguarding hub.

16. The quality assurance framework should be developed and implemented as a priority.

17. The workforce strategy should continue to focus on maximising staff retention and actions to promote the timely recruitment of experienced staff.

18. Staff must have the capacity to complete the training which has been identified to support their professional development.

19. Senior managers should take steps to improve the frequency, consistency and quality of front line staff supervision; an assurance mechanism should be implemented to ensure compliance and quality.

20. Arrangements for group managers, team/deputy managers and senior practitioners should be kept under review as part of the remodelling of services to ensure their capacity to effectively and consistently provide management oversight of decision making, challenge and direction for staff across the service; access to a leadership and development programme should be progressed for managers to build resilience.

## Access Arrangements

### What we expect to see

All people have access to comprehensive information about Information Assistance & Advice services and get prompt advice and support, including information about their eligibility for care and support services. Preventive services are accessible and effective in delaying or preventing the need for care and support. Access arrangements to statutory social services provision are understood by partners and the people engaging with the service and are operating effectively.

### Summary of findings

- The authority had worked hard to reshape its services and had developed an assessment team as a single point of contact for both social work and preventative (Early Help) interventions.
- The colocation of staff from social services, early help and partner agencies within the assessment team was supporting children and families to be directed more easily to appropriate services.
- Access arrangements to Early Help and statutory services were respectful of peoples' rights and individuality and were available bilingually.
- Despite positive performance in the number of Joint Assessment Family Framework (JAFF) completed, partners need to be encouraged to understand the impact that they could make by undertaking the role of the lead professional.
- The interface between social services and Early Help thresholds was underpinned by a threshold criteria document, but this was not sufficiently understood by partner agencies.
- Information provided by partner agencies was not always of a sufficient quality to support the assessment team to make secure screening decisions.
- There was a lack of accessible quality information for children, young people and their families.
- Performance information was being captured but needed to include a better analysis of service impact particularly in relation to repeat referrals.
- Screening decisions were inconsistent and managers and partners needed to be more engaged in the quality assurance of access threshold decisions.
- When contacts were received by children's services and there was an obvious indication of significant harm prompt and proportionate initial action was taken to protect children.
- More multi agency work was needed in respect of Information Advice and Assistance (IAA) service expectations to support staff to exercise appropriate and proportionate judgement.

## Explanation of findings

### Context

1.1. At the time of the inspection the Social Services and Well Being Directorate was progressing work to transform services to children in the context of a wider Corporate 'One Council' vision. This significant change process reflected the authority's corporate priorities and medium term financial requirements, the Directorate's business plan and the expectations and objectives of the Social Services Well-being Act (Wales) 2014. The safe reduction of its looked after children population remained a key priority for the council (387 children as of 31/12/2016). The council had reframed its focus, replacing its placement and permanence strategy within an Early Help and Permanence Strategy that was aimed at developing a "whole system" and multi agency approach to supporting Looked after Children, whilst helping families to remain together.

1.2 Children's Social services, designated as children's "social care", had been relocated from the former Children's Directorate – now the Education and Family Support Directorate and joined with adult social care under the Corporate Director Social Services and Well-being in January 2015. The authority's Early Intervention and support services (Early Help) remained within the Education and Family Support Directorate. The relationship between the Directorates had benefitted from their close ties in the past and these new arrangements were designed to underpin the corporate priority of 'helping people to be more self-reliant'. The location of early help responsibilities outside of the social services and well-being directorate however, means that any mitigation of need for statutory social services is significantly dependent upon the ability of the Directorates to work together in order to, co-ordinate and deliver an effective range of services.

1.3. Managers from across the two directorates, led by the Corporate Director Social Services and Well-being, had recently (summer 2016) developed a 'Vision into Action' document that identified four key change priorities. Children with Disabilities, Residential Services, Early help and Permanence and the development of a Multi-Agency Safeguarding Hub. The resulting shared project plans are now overseen by a 'Remodelling Children's Social Care Programme Board' and this includes other statutory partners.

1.4. The council had taken a national lead in the implementation of the new electronic Wales Community Care Information System (WCCIS). This necessitated that the authority create new operational templates consistent with the requirements of the act and the new system. The new arrangements 'went live' with the introduction of the SSWBA in April 2016, The system's electronic records were still new and recognised as a 'work in progress'. Staff reported early learning from practice was that the prescription of some templates impacted adversely on the proportionality of their work. The aim of WCCIS is to enable health and social services work together in a more integrated way nationally and locally. At the time of the inspection this integration of information with health was still at an early stage and the ambition of the system was yet to be realised. Inspectors found that the electronic record did not currently support readily accessible oversight of the authority's previous involvement with families. Chronologies and genograms were not well developed or purposeful and there was no common methodology. The

templates had not supported the capture of consistently good quality information or analysis. More work and training was needed particularly with those expected to use the tools, to develop a shared understanding of the intention of the templates and how they should be completed.

1.5. The authority was aware of the growth in demand for social services but also recognised the need to maximise the opportunity to promote more timely engagement with families when the threshold for statutory services was not met. The authority therefore had worked hard to reshape its services and had developed an assessment team as a single point of contact for both social work and the early help interventions. For example in 2015/2016: 3777 contacts had not progressed to a referral because they were deemed to be below the statutory threshold.

1.6. Whilst cross directorate work was evident between social services and early help services, the relationship between the assessment team and the council's other information services, including the Family Information Service (FIS) and the Council's Customer Service Centre (sometimes known as the call centre) was underdeveloped. Staff reported that a lack of understanding regarding the remit of the assessment team and its interface with other council information and signposting arrangements, created potential service tensions. The example most often cited by staff and observed by inspectors, was phone calls that could have gone to other services were misdirected to the assessment team blocking access to the duty system. Limited availability of dedicated business support staff to answer the phone had compounded this issue. The imminent transition to a Multi-Agency Safeguarding Hub (MASH) and the appointment of a new customer services manager was seen as an important opportunity for the council to clarify these information service pathways and to better publicise and disseminate the arrangements.

1.7. The authority had progressed work to implement the Dewis Cymru system (the national citizen portal for well being information) but this was still at an early stage. Information, including from the family information system, was still being uploaded onto the system. Once developed it is intended that Dewis will be used across the social services and well-being directorate and other parts of the council as a central information point for the public. As with any electronic information system, the challenge will be maintaining the relevance of information and ensuring ease of access for the public. It was helpful that a link had now been established on Welsh Community Care Information System (WCCIS) to support staff, to access pertinent information, particularly as some partners expressed concern that personnel providing IAA services did not always have sufficient information to signpost the public effectively.

## **A Multi-Agency Safeguarding Hub**

1.8. A Multi-Agency Safeguarding Hub (MASH) was expected to go live from April 2017. Inspectors saw the Council's current approach to Information Advice and Assistance (IAA) as having been both progressed but also impeded by the work undertaken to develop the MASH. Staff involved in the project recognised that this would necessitate a further period of change but were optimistic that a MASH would extend the current multi agency make-up of the team, improve information sharing and the management of referrals, particularly those relating to domestic abuse. However the focus on the Mash had diverted some attention and resource away from ensuring that the operationalization of the SSWBA particularly in relation to the current access arrangements was sufficiently well understood and owned by staff and partner agencies. The transition to a MASH provided a timely opportunity for further joint training on the requirements of the SSWBA that could include learning from practice to date.

## **Information Advice and Assistance**

1.9. Bridgend County Borough Council's current model for the provision of Information, Advice and Assistance (IAA) services for children, families and professionals was through a countywide assessment team based in Bridgend Civic Centre, or in relation to disabled children through a Disabled Children's team (co located with a multi agency adult social care team). Outside of working hours, a separate Emergency Duty Team responds to referrals that require an immediate response. As well as providing an IAA service, the Assessment team undertook initial safeguarding and child protection activities, child protection strategy discussions, section 47 enquiries, care and support assessments, court work and the accommodation of children as required, holding cases up until the point of closure or transfer.

1.10. The Assessment team consisted of two co-located pods of staff. A statutory services social work team, (team manager, three part-time senior practitioners, nine social workers and three unqualified social work assistant staff), an early help team, plus other specialist professionals.

1.11. The early help pod, comprised of a senior practitioner and screening officer who provided screening function for all new 'requests for help'. Membership had been extended in preparation for the MASH to include other co-located professionals, in order to facilitate more timely intervention and to ensure access to expert advice; these included a specialist health visitor (funded by health and an early help grant), a community drugs and alcohol worker and education child protection officers. Whilst the two pods had distinct functions and separate line management accountabilities, the co-location of agencies had started to improve understanding of each other's roles and the more flexible management of service thresholds. Despite the arrangements only being in place since April 2016, the council's ambition that people be directed more easily between social services and to early help services, had begun to be realised. It was reported by staff that approximately ten referrals a day were being passed directly to the two early help workers in the assessment team for screening, information gathering and direction on to early help services provided through early help locality hubs.

1.12. The interface between social services and early help was underpinned by one referral format and a threshold criteria document that sets out a pathway from universal through to targeted statutory services, including a step up and step down process. It was disappointing that whilst social work and early help staff were generally aware of these criteria, it was not well known by professional referrers. Despite reported confidence in children's services, partners identified that they often didn't know how the assessment team applied the thresholds between early help provision and statutory interventions. More work was needed to meaningfully engage with staff and partners including from across the council in shaping services and to promote greater transparency and understanding of operational thresholds.

1.13. It was not evident that children, young people and families had been consulted about service developments. Inspectors found that there were no leaflets or materials available to the public providing an information guide to the range of services available or how to access them; this gap is not consistent with the Information, Advice and Assessment requirements of the Act. A benefit associated with early intervention was that services did not carry the perceived stigma attached to the social service function. However, staff were unable to articulate how the public understood the differentiation of the council's service arrangements. It was unclear if the development of such published information had been postponed to accommodate the introduction of a MASH or if it was an unfortunate omission. It was significant that some staff indicated that they would also welcome such information, as they were not clear regarding service access thresholds for themselves.

1.14. Responsibility for those cases not meeting the statutory threshold but requiring preventative interventions was transferred to the early help service at the point of the early help request. Following screening, these cases were either closed; signposted or directed to the early help locality teams. It was positive that the parameters for eligibility to early help services were sufficiently inclusive to enable access to services both in relation to children and families with non-eligible and eligible needs and that the arrangements supported step down of cases from statutory social work teams. However, the lack of formal feedback systems regarding the take up of early help services meant that there were potential missed opportunities to actively engage families and ensure that the right response had been made. It had been recognised that some families needed a more prompt intervention in order to engage more effectively with early help and the authority were considering extending the early help service in the assessment team to include support workers able to undertake immediate task-focused work at the point of referral.

1.15. The demand on early help services had increased since its reconfiguration. Between April 2015 to September 2016 the early help service had received a total of 2999 'requests for help' (referrals) of which 40 % (1193) were made by schools and other education services. Children's social work teams made 31% (941) requests for help of which 32 % (303) were made by the assessment team (104 of which were made prior to completion of a care and support Assessment). Safeguarding hubs made 55 % (515) requests for help; 61 formal requests were made for step down support. Only 6 % (187) were self-referrals, whilst this was improved performance it remains stubbornly low and raises the question of whether the ability of the council's approach to early help to 'reach out' and maximise opportunities for identifying and mitigating early risk, are fully effective; this may reflect the lack of public awareness of the service.

## Early Help

1.16. The early help services were configured around a central hub and three localities early help hubs. All of the hubs had strong connections with services commissioned through the Welsh Government's Families First grant and the Flying Start programme. Access to Flying Start support however, was location-specific, so creating some inequality in availability.

1.17. The central hub provided countywide specialist targeted services. These services have a key role in delivering the priority of safely reducing the council's looked after children population. (Services included Connecting Families; Specialist youth service co- coordinators and a regional IFSS team). The authority reported that 42% (394) of the requests for help made by the social work safeguarding teams from April 2015 –September 2016, were allocated to central hub services; 291 for example, were referred to Connecting Families. While staff highly valued these services and reported that they were effective there was frustration that service pressures impacted on their availability and the timeliness of their engagement with families.

1.18. The three early help hubs were co-located with social work safeguarding teams, with two hubs being based in their geographic area to promote better community links. The range of professionals who comprise the early help teams had all received training in 'evidence based practice' and 'motivational interviewing'. The teams operated a 'team around the family or team around the school' model. The service had seen a considerable growth in the number of JAFF assessments completed increasing from 228 in 2014/15 to 681 in 2015. Whilst this improved performance was positive, it appeared to stem in part from the location of the JAFF lead professional within the locality hubs. There was some evidence that the risk of concentrating ownership within a function in this way, rather than broadening it across partner agencies, was beginning to have a potential silo effect. It was recognised therefore that more work was needed to encourage and support partners in understanding the positive impact that they could make to children by undertaking the role of the lead professional.

1.19. Inspectors saw evidence of some timely and proactive early help work with children and families that supported their independence and improved well-being but some concerns were also raised that thresholds for interventions were still poorly understood by partner agencies.

Early help needs to be targeted early enough, some families who used to be able to access services are being excluded but the needs will just get worse '  
(partner agency)

1.20. The complexity of some cases referred to early help caused some staff to feel that the service was not always operating within its professional competence. Early help providers identified that there was a frequent disparity between the reason for referral and the actual problem they encounter when they engage directly with family.

1.21. Inspectors saw a small number of examples where the threshold for service had been inconsistently applied and the case had been directed to early help before safeguarding issues had been sufficiently resolved. Inspectors were somewhat reassured however; that staff in the early help service were confident in their safeguarding responsibilities and that social work advice was available to support them to 'step up' such cases as needed.

### **Range of services**

1.22. The council had developed a positive range of commissioned provision, a significant proportion of which was reliant upon grant funding. Some pressures and gaps in services were highlighted, particularly around services for children related to domestic abuse but the concerns raised by staff mainly related to issues of capacity and responsiveness. At the time of the inspection there were waiting lists for some services and delays in decommissioning and re-commissioning, due to grant funding constraints, meant that some early help organisations had stopped accepting new referrals. The authority was looking to resolve these issues and to strengthen future evidence based commissioning. Senior managers were very aware that access to early support was key to mitigating the need for statutory services and to the delivery of the early help and permanence strategy. Clearly this commissioning deficit is something that needs to be addressed as a priority.

1.23. The authority had recently begun work to capture the demand on services and had developed a shared dataset, which provided some numerical information from across both social services and early help. The data is reviewed by a multi agency Early Intervention and Safeguarding Board chaired by the Corporate Director of Social Services and Well-being. The data as seen by inspectors was at a very early stage but the authority had plans to progress this to include a greater emphasis on impact and outcomes. The analysis of such information will be essential if the authority is to understand the effectiveness of its arrangements and future development and commissioning needs.

### **Statutory services**

1.24. The arrangements for access to statutory children's social services in Bridgend were well organised through the assessment team. In introducing the requirements of the SSWB Act, the service had sought to simplify operational expectations in relation to IAA by defining the role of the assessment team as providing a duty service to receive and screen referrals the result of which may be recorded as information and closed, signposted, or redirected to early help. Where advice or assistance was required, the assessment team undertook a proportionate assessment using a care and support assessment template, the outcome of which might include the identification of eligible need.

1.25. The authority had experienced year-on-year growth in the number of referrals. In 2015 /2016 the authority reported an 8% rise in contacts from 4619 to 4988 of which 1288 were screened as requiring social services involvement (a 28% increase in the overall number of referrals.)

1.26. Professional oversight of the duty arrangements was in place with the three designated senior practitioners sharing the day-to-day management of the first contact arrangements. Their responsibilities included screening cases, making and



signing off decisions on all new contacts, managing initial child protection strategy arrangements and allocating cases for assessment within the team. Increased pressure on the service meant that at least two of the senior practitioners were now engaged in the screening process on a daily basis. Inspectors noted that whilst they were there, the early help senior practitioner, again an experienced social worker had to step in to support the social work function because it was under capacity and could not manage the flow of work on that day.

1.27. A team manager has overall responsibility for the social work pod including supervision, performance and workflow. The team manager and the senior practitioners were all suitably experienced and secure in their professional decision making abilities. A key strength of the assessment team was the close working relationship between the managers and the staff and their shared commitment to safely supporting children and their families. The central location of the team meant that group managers were accessible and they were viewed as supportive. Staff reflected however, that changes in the group manager's roles to accommodate 'vision into action priorities' had necessarily impacted on their time, availability and continuity of responsibilities.

1.28. The authority had maintained consistently good performance in relation to the number of referrals on which a decision was made within one working day, and had retained this performance indicator as a means of providing assurance. As part of the introduction of the Act, the manager and senior practitioners had all 'worked' cases using the new templates, to better understand the practice changes needed. The team manager had also instigated systems including daily meetings with the senior practitioners to help support the consistency of decision-making and some sampling of cases was undertaken with the group manager. Inspectors saw some positive evidence of management oversight but found that whilst screening decisions were timely, the quality of the threshold decision-making was not yet consistent.

1.29. Inspectors saw examples of cases that were well managed and where screening attention was focused on safeguarding considerations but also on 'what matters' to the individual. When contacts were received where there was an obvious indication that a child was at risk or had suffered significant harm, prompt decisions were made and effective initial action was taken to protect the child.

1.30. In other cases the detail of the referral record was incomplete and information from the range of agency checks undertaken as part of the screening process was not always evident. The reason for the referral was also not always clear, or sufficiently clarified to ensure the appropriateness of the response. Staff reported and inspectors confirmed that EDT referrals were inconsistently captured on the electronic system and communication with the daytime service was too limited to ensure timely hand over and action.

1.31. Inspectors found it difficult to evaluate the quality of management decisions, as the underpinning rationale for the application of thresholds was not routinely recorded and did not reflect for example, the extent to which the cumulative effect of multiple incidents had been considered. Senior managers need to consider the extent to which this presents a potential safeguarding risk. In a minority of the cases seen, screening had not identified and reduced risks to children at the point of contact and referral. In these instances inspectors viewed the case as being

prematurely closed, inappropriately transferred to early help or requiring a more immediate statutory response.

1.32. Despite reported good 'working relationships with partner agencies it was evident that there was no shared common understanding of threshold criteria and staff told inspectors that referrals from partners were not of a consistently sufficient quality to support the assessment team to make informed decisions. Some partners equally described access to services as becoming increasingly bureaucratic and they did not understand the intentions behind the single point of contact arrangements.

1.33. The issue of consent was particularly highlighted, as being insufficiently addressed by referrers and it was clear that families were not always fully aware that they had been referred to the assessment team even where this was for early help. The perceived 'resistance' to gaining appropriate consent was often attributed to professionals 'wanting to preserve their relationship with families' but equally reflected a lack of understanding of the requirements of the service. The assessment team were seeking to positively challenge these issues and support partners to make more appropriately targeted referrals; this was being facilitated by the interventions of co-located multi agency colleagues within the team, who also helped to gather relevant information. The development of the MASH is intended to resolve some of these concerns. However, it was clear that more multi agency work was needed in respect of current IAA service expectations. Staff and Partners also need to be more engaged in the quality assurance process, particularly with regard to access threshold decisions.

'The assessment starts when enquiries on third party contacts start and then they go nowhere because when we speak to the families they didn't know about the referral and they don't want a service'. It all takes time ".  
(Social workers)

1.34. The council's operationalization of the new legislation and particularly IAA had clearly resulted in some significant unintended consequences for the service that militated against the effectiveness of the team and had impacted on staff morale. Whilst welcoming a framework some staff told inspectors that they felt disempowered to exercise professional judgement, for example to close cases at the point of contact. The combination of incomplete information provided by professional referrers, the service trigger for instigating a proportionate assessments and the overly prescriptive nature of the accompanying assessment template, was all said to have resulted in 'excessively time consuming activity that was disproportionate to need'.

1.35. It was positive that senior managers had sought to respond to these concerns and had introduced new transfer arrangements to improve the throughput of work for the team. It had also been decided, prior to the implementation of the MASH, to reinstate a joint screening meeting with the police to better manage the high volume of police contacts and improve the identification of risk and timely action.

1.36. Whilst these changes were all helpful, it was nevertheless clear that the template driven nature of the assessment methods that have been introduced, had created a formulaic approach overall. Good safeguarding practice is predicated on the ability of experienced practitioners to exercise appropriate and proportionate judgement on a case-by-case basis. Whilst judgement always needs to be exercised within a clear framework, senior managers should review the extent to which the active social work analysis and decision-making function is being displaced by process and the potential for this to undermine confident professional decision making. Staff, partners and service users need to be actively engaged in the on-going review of the implementation of the SSWBA and in any resulting remodelling of the service.

### **Conclusion: - Access arrangements**

Inspectors found that the authority had worked hard in the context of the Social Services Well-being Act 2014, to reshape its services. The authority's Information Advice and Assistance function was delivered through the Assessment team which provided a single point of contact for both social work and preventative (Early Help) interventions.

Access arrangements to Early Help and statutory services were respectful of peoples' rights and individuality and were available bilingually but there was a lack of accessible quality information for children, young people and their families. The colocation of staff from social services, early help and partner agencies within the assessment team was supporting children and families to be directed more easily to appropriate services, but was yet to mature into integrated services. The Assessment team multi agency arrangements will be extended through the development of a Multi Agency Safeguarding Hub from April 2017. The current access arrangements, including the interface between social services and Early Help, were underpinned by a threshold criteria document, but this was not yet sufficiently understood by partner agencies. Screening decisions were timely and Inspectors saw some positive evidence of management oversight. When contacts were received by children's services and there was an obvious indication of significant harm, prompt and proportionate initial action was taken to protect children. The quality of threshold decision-making however, was inconsistent and not sufficiently evidenced. It was acknowledged by the service that the changes introduced to operationalise IAA had brought additional expectations that put pressure on the capacity of the managers and the workload of the assessment team. The information provided by partner agencies was not always of a sufficient quality to support the assessment team in their screening decision and some professional referrers demonstrated a lack of understanding of the requirements of the service. More work was needed to develop multi agency quality assurance systems to support staff to exercise appropriate and proportionate judgements and to provide assurance that children young people and families were being directed to the most appropriate service. The impending transition to a MASH provided a timely opportunity to refresh service expectations resulting from of the SSWBA, including learning from practice. The authority will also need to extend its performance information to include an analysis of the impact that services are having on reducing need and risk.

# Safeguarding & Assessment

## 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 prompt, well-coordinated multi-agency responses. People experience a timely assessment of their needs and risks which promotes their safety, well-being and independence. Assessments have regard to personal outcomes, views, wishes and feelings of the person subject of the assessment and that of relevant others including those with parental responsibility. Assessments provide a clear understanding of what will happen next.

## Summary of findings

- Proportionate urgent action was taken to protect children and young people at risk of immediate significant harm. Strategy discussions were timely and supported appropriate information sharing with key agencies.
- The assessment team were working hard to implement the requirements of the Social Services Well-being (Wales) Act 2014.
- The quality of the assessments and recording seen was variable; some were good but others did not sufficiently evidence the principle of co-production or an analysis of need and risk from the outset.
- Good social work practice to elicit the child's wishes and feelings was not consistently well reflected in the content of assessments.
- The timeliness and quality of partners' contributions to assessments was not always evident and remained too dependent on individual professional relationships.
- The quality of plans should be improved to reflect the needs identified in the assessments, plans should be child focused and outcome-driven.
- Management oversight of assessments and plans was seen but did not consistently provide sufficient challenge and quality control.
- Assessments and resulting plans need to be better shared with children and families in a way that promotes their understanding of the issues and engagement in any resulting plan.

## **Explanation of findings**

### **Safeguarding**

2.1. For those children whose needs are greater or risks require action, the assessment team responded in a mainly timely way. Where children and young people were identified as at immediate risk of harm, children services convened a strategy discussion or meeting with the police.

The authority appeared clear in its decision making when moving into child protection investigations and proportionate urgent action was taken to protect children and young people at risk of immediate significant harm.

2.2. The senior practitioners in the assessment team and safeguarding hubs shared responsibility for managing strategy meetings and for section 47 enquiries on new cases. To promote continuity the social workers undertaking a section 47 enquiry within the assessment team reported to one designated senior practitioner who maintained oversight of the investigation. From the cases reviewed inspectors identified that social workers undertaking child protection investigations were suitably qualified but not always experienced. Staff holding child protection and looked after children cases were not always qualified but additional management oversight was provided.

2.3. Inspectors found that strategy discussions and/or meetings were managed in accordance with guidance. The relationships between social services and the police were viewed as positive and the arrangements for organizing strategy discussions/meetings were effective. Strategy discussions/meetings were timely and as required could be undertaken on the same day. A weekly 'set day' arrangement for strategy meetings was also in place and staff and partners described this as providing greater opportunity for relevant agencies to provide information and contribute to the decision making process. It was noted that, where relevant, early help staff also attended these meetings. Outcome strategy discussions /meetings were also convened and used effectively as a means of keeping agencies informed, reviewing progress and determining next steps.

2.4. The small number of strategy discussions, section 47 enquiries and case conference reports seen by inspectors as part of the case file sample were viewed as being appropriate and of a sufficient quality to inform decision making. Children were seen /observed and seen alone as part of the enquiry. Inspectors did not see any examples of children and families being subject to child protection investigations unnecessarily. When the decision was made that a child protection conference was required, the conference was convened within appropriate timescales. Child protection procedures were well understood by staff, and despite some variability in the quality of care and support protection plans seen, families were being supported to keep children safe.

2.5. Arrangements to seek legal advice were well established through legal gateway meetings (LGM). The decision making relationship between the LGM and the resource panels would benefit from clarification. Social workers and managers would also benefit from having clearer parallel processes between child protection

and the Public Law Outline (PLO) underpinned by a shared understanding of risk and the potential for change.

2.6. The authority had used emergency protection powers very infrequently in the last year. In the one case reviewed by inspectors it was questioned if planned action taken earlier might have resulted in a better outcome. The introduction of the MASH should support a system for review and learning from such cases.

2.7. As well as being an active member of the Western Bay Safeguarding Board (WBSCB) Bridgend has established a Safeguarding Operational Board chaired by the Corporate Director Social Services and Well-being and including partners from across the council. This has helped to ensure a local perspective and oversight of safeguarding activity for adults, young people and children within the County Borough. It was noted that the authority had undertaken significant work to raise the profile and response to risks of child sexual exploitation through the development of a Child Sexual Exploitation Task Force within the Bridgend area. All staff interviewed told us about recent training on this topic which included innovative ‘mapping sessions’ involving staff and partners. A similar approach is now needed in relation to risk assessment.

## **Assessment**

2.8. At the time of the inspection Bridgend children’s services had sought to harmonise assessment practices with the new requirements of the SSWB Act. The consequence of this was that all assessments including those designated as providing advice and assistance (proportionate) were completed using one care and support assessment template that included the five domains of the SSWB. Staff in the social work pod of the assessment team were allocated responsibility for assessment, safeguarding and care and support planning on new cases. Case transfer points had been determined to maximise early opportunity to engage with and make a difference to children and families and minimise the early change of social worker, at a time when a family might be in crisis.

2.9. The Disabled Children's Team (DCT) undertook all assessments for disabled children including those where there are concerns of risk or potential harm for a disabled child. Inspectors only reviewed a few assessments undertaken by the DCT but the assessments seen were of a good quality. Inspectors also saw evidence in the files that the DCT routinely offered carers assessments to the parents/carers of disabled children.

2.10. Commitment in the assessment team was good, with varying levels of experience including newly qualified and non-qualified workers all of whom undertook assessments. Staff and managers said that the capacity of the team was being ‘stretched by the ‘competing and relentless’ demands being placed on the service. Caseloads, particularly of the more experienced staff were described as ‘increasingly unmanageable’ and manager’s oversight of cases was correspondingly under pressure.

2.11. At the time of the inspection the authority was in the first year of capturing base line performance data in relation to the introduction of the SSWB Act. Bridgend reported that in the nine months since the introduction of the Act, (April 2016 – December 2016) 1931 children and families had received advice and assistance (which were deemed as proportionate assessments). There had been 784 assessments for care and support undertaken of which 381(49%) had resulted in a care and support plan, with 404 (51%) assessed as not having eligible needs. Information from the shared data set captured for the Early Intervention and Safeguarding board, identified that 65% of all requests for help (early help) received from the assessment team between April 2015 to September 2016, were made following a care and support assessment. The volume of demand on the team had showed no signs of reduction and the authority will need to analyse its performance including its re-referral rate, to better understand if the current activity is proportionate, sustainable and promoting improved independence and outcomes for those using the service.

2.12. Managers were proactive and had systems in place to track assessments but the individual targets for the completion of assessments were not well recorded on the file. Inspectors found that the timeliness of assessments did not therefore consistently match the child's needs and some assessments were not completed within 42 days. Staff told inspectors that the repetitive nature of the assessment template did not support an overview of the case and was overly time consuming.

2.13. The quality of assessments seen was very variable. Inspectors saw some good examples that were proportionate to need and holistic in approach.

The assessment set out key aspects of the incident, discussion and an effective what matters conversation that included a clear focus on the child. The overall engagement was sensitive and carried out in a timely manner. Interviews and the case file record demonstrated that children were seen and the assessment was proportionate. The assessor directed the family to the possible support services available and to safeguarding and well- being information for children where they may witness domestic abuse. The mother was reassured by the intervention and felt able to access services as needed. (CSSIW inspector)

2.14. The best examples evidenced that the assessments built on from the initial information, the child was seen and the record captured both the child's and the parents' views (both resident and non-resident parent). This included what mattered to them in the context of their family history and their cultural needs. The analysis focused on potential strengths and risks and supported the identification of both eligible need and appropriate early help.

In other examples however, Inspectors found that the use of the "what matters conversations" as evidenced in the assessment reflected what was desired rather than what might be needed as a result of an over reliance on self-reporting. In a number of examples there was a lack of historical context and little exploration of the impact of previous support services provided.

2.15. Social work staff told inspectors that the timeliness and quality of partners' contributions to assessments was very variable and often remained dependent on individual professional relationships. In some cases seen by inspectors, it was apparent that despite persistent efforts by social services staff, relevant partners had not contributed effectively to complex assessments compromising social services decision-making.

Children's services compilation of a risk assessment of a father who had been convicted of a serious offence was initially compromised by the lack of information and risk analysis provided by those agencies working with the father's offending. (CSSIW Inspector)

2.16. The assessments of the need for care and support often did not provide a consistently sufficient analysis of risk or clear recommendations for action. It was a concern that staff and partners interviewed were not aware of the authority's risk assessment process and this raised questions regarding how the assessment informed and translated into a shared multi-agency risk management plan.

'Sometimes assessments prior to cases coming to conference are inconsistent, some are good and some not so good, some do not understand the domains they should be covering when constructing a child's plan however some are also very new to the role.'  
(Staff survey)

2.17. Whilst it was positive that the assessment template required the identification of 'risks and strengths', this often produced a list rather than the analysis that is necessary for effective decision-making. In some case assessments and the resulting plan did not reflect a sufficient focus on the child's experience and lacked analysis of the impact of the adult behaviours on the child. Opportunities to use the assessment to support a learning context for the family, enabling them to reflect on how they might do things differently or better, were therefore missed.

2.18. Issues of disguised compliance were not always recognised and this meant that in some cases too much reliance was placed on the family's ability to improve outcomes for children without evidence of sustainable change. Social workers needed to be more confident in working with families in setting out their professional analysis of risk and needs. The lack of an appropriately holistic and coherent analysis of need and risk was at times detrimental to achieving a shared understanding with families regarding the level of concern, what change was required of them and/or the potential consequences of failing to make the changes needed. Staff and partners stated that they would welcome a defined whole service approach to the assessment and management of risk. It was understood that these materials were in the process of being redeveloped and would be re-launched and include a comprehensive training programme.



2.19. There were some good practice examples where children and young people were proactively engaged in producing their assessments but it was not always apparent. Managers and staff were very committed to undertaking direct work with families but staff across the service highlighted the impact workload pressures had on this ambition. It was disappointing that the extent of the good work undertaken by practitioners with children and families as part of the assessment was not always well evidenced in the records but rather was elicited through inspectors' interviews with staff.

We just want the best for our children, it's hard but the social workers and all the services working together have helped us sort it out and we are doing well now as a family. The social workers were honest about what we had to do, we just wanted to keep our children and they have helped us to do that.  
(Service user – parent)

2.20. Advocacy was a mandatory domain in the assessment format and social workers told us that issues of support to engage in the process were routinely made to children young people and their families. Inspectors however saw few examples of formal advocacy being offered during the assessment phase.

2.21. Inspectors were not confident that assessments and the resulting plans were routinely shared with service users in a way that promoted their understanding of the issues. Information from the files reviewed and inspectors' direct contact with families led to the conclusion that while most were mainly positive about their experience, others were not clear about the purpose of children's services involvement in their lives. In a minority of cases this had directly impacted on the experience of the family and their ability/willingness to engage in a process that they described as oppressive and that they did not understand.

Quote

'It was my problem and I'm getting help, they never said it affected the children so they should leave us alone, it's against my human rights '(service user-parent)

'Initially I didn't find the social workers attitude helpful, I felt very pressured, but now I feel they are working with us and I can understand where they were coming from, its ok now, it feels like we all want the same thing '  
(Service user – parent)

2.22. Inspectors again saw a positive emphasis on people being signposted to early help where the care and support assessment concluded that there was no eligible need. Despite being told that the requirements between statutory services and early help did not result in unnecessary duplication of assessments, inspectors were not confident that this was how families experienced the interface between the two services.

2.23. Inspectors found that where the assessment identified eligible need, a timely care and support plan was developed and this triggered the transfer of the case to the relevant social work safeguarding hub. Inspectors were concerned that the quality of the care and support plans seen were inconsistent and did not adequately reflect the assessment outcomes. The plans seen often did not routinely feature timescales, responsibilities for actions and what services were to be provided and why. Significantly, some plans did not include the level of risk or the contingencies needed if change was not achieved. It was not always clear how families were engaged in the co-production of their plans or whether they had received copies of the plans. In some instances Inspectors were concerned that the generalised nature of some plans demonstrated a lack of ownership and possibly reflected the necessity to expedite the transfer of work.

2.24. Staff and managers across the service described variability in the assessments but particularly in the quality of care and support plans. The plans were not seen as routinely providing newly allocated workers with a clear understanding of the needs and risks associated with the case. This was compounded by a lack of useful chronologies and limited commitment to joint introductory meetings at the point of transfer. Whilst staff were positive that some of the shortfalls in the written plans were mitigated through informal conversations between workers they also described having to 'unpick the plan' and 'start again' with families, in order to develop a shared understanding of what was needed including in relation to safeguarding issues. In some instances this clearly resulted in a loss of impetus while families re-engaged with the new social worker.

2.25. Transfer points for cases between the teams were established and the majority of staff were satisfied with the arrangements. Some concerns were expressed that there was a gatekeeping culture which did not support continuity for families and timely support. Case transfers were mainly managed through weekly transfer meetings and advanced information was provided so that receiving teams could plan and organize their work. Inspectors found that managers were not always using this opportunity to confirm that assessments and care and support plans were of sufficient quality to provide a cogent basis for on-going work. The importance of managers having a clear understanding of the issues and threshold for involvement with families is also essential to ensure the appropriate allocation of cases; particularly as the authority's workforce skill mix included unqualified staff. In some instances inspectors were concerned that safeguarding issues had not been sufficiently recognised.

2.26. Whilst all of the assessments and care and support plans reviewed had been appropriately signed-off, the current quality assurance systems in place were not sufficiently robust to oversee the consistent quality of work or to promote the improvement needed. The authority had recognised this and was actively developing a new quality assurance framework. Managers from across the service need to be supported to be more confident to evidence the extent to which they provide effective challenge and direction.

## **Conclusion: - Safeguarding and Assessment**

The assessment team were working hard to implement the requirements of the Social Services Well-being (Wales) Act 2014. Strategy discussions were timely and supported appropriate information sharing from key agencies.

The quality of the assessments and recording seen was variable; some were good but others did not sufficiently evidence the principle of co-production or an analysis of need and risk from the outset. The timeliness and quality of partner's contributions to assessments was not always evident and remained too dependent on individual professional relationships.

Good social work practice to elicit the child's wishes and feelings was not consistently well reflected in the content of assessments. Although most assessments were shared with children and families, lack of effective engagement resulted in them not always being sufficiently clear about the purpose of the help, care and support and/or protection they received. The resulting plans did not always reflect the findings of the assessments and were not sufficiently child focused or outcome driven. In some instances the quality of the plan hampered those taking over a case from swiftly understanding the needs and risks associated with children and families. Assessments and resulting plans need to be better shared with children and families in a way that promotes their understanding of the issues and engagement.

Management oversight of assessments and plans was seen but did not consistently provide the level of challenge and quality control needed.

# Leadership, Management & 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. The authority works with partners to commission and deliver help, care and support for people. Leaders, managers and elected members have a comprehensive knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively. Services are delivered by a suitably qualified, experienced and competent workforce that is able to recognise and respond to need in a timely and effective way.

## Summary of Findings

- Leadership, management and governance arrangements complied with statutory guidance.
- The authority was working hard to transform services at a time when they had to deliver medium term financial savings. The ambition of the authority's plans signalled their commitment to improving both early help and statutory services for children young people and their families.
- The SSWBA was at an early stage of being embedded. More opportunities were now needed to draw lessons from practice and engage staff partners and service users in reviewing progress and any service remodelling.
- The ambition to mitigate the need for statutory social services is significantly dependent upon the ability of the directorates to work together in order to contribute, co-ordinate and deliver an effective range of services.
- The council should ensure there is an ongoing analysis of the underlying complexities and risks associated with children's services.
- Work had been recently instigated to develop a more comprehensive evidenced based commissioning plan in relation to both statutory and early intervention services.
- The council should ensure that the strategic direction is translated into an operational strategy for delivery of children's services that is effectively communicated and understood by staff, partners and service users.
- The principal of colocation of services was generally valued by staff but more work was needed to evaluate the service user's experience.
- The voice of the child was not evident in shaping service planning.
- Elected members' understanding of service improvement would be strengthened by reports that focus on outcomes and the impact for service users.
- Performance and quality assurance information needs to be more effectively captured and analysed to understand how the ambition for the service is being delivered. The new quality assurance framework will be essential to this understanding.
- The council needs to ensure that structured induction and core training programmes are available for all staff, including managers and agency staff.

- Staff valued supervision but the regularity and quality was inconsistent and subject to work pressures.
- Newly qualified workers reported that they were well supported and positively regarded the in house mentoring provided.
- Staff valued the approachability of their line managers, and peer support from team members. Staff morale was variable across the service issues raised included capacity to manage the level of demand, resource constraints, complexity of managing competing workload pressures and the potential impact resulting from planned remodelling of services.

## Explanation of Findings

### Leadership and Governance

3.1. At the most strategic level the authority had determined the vision to “always act as one council working together to improve lives” and the important principle of ‘helping people be more self reliant” is set out within the council’s corporate priorities and reflected in the corporate plan that came into effect in April 2016. The council had translated this priority as meaning developing approaches and practice to ‘reduce and prevent people from becoming vulnerable or dependent on our services or us.’ This priority had recently been developed into a children’s social care vision statement and an action plan aimed at “Together enabling better outcomes for children, young people and their families via responsive and timely services which support them to live together, work on difficulties and be safe.” The visions had been shared and were understood at the most strategic level within the council and by senior managers.

A ‘Vision into Action ‘ document was launched at an event in December 2016 .The Cabinet Member addressed the session and the event was attended by 111 staff representing every team from across the service (Head of Children’s Service)

3.2. As part of the remodelling of children’s services program, the authority was working to develop a more comprehensive understanding of need and provision. The extensive work undertaken as part of the population needs assessment will support this understanding and this information will be essential to the development of a comprehensive commissioning plan in relation to both statutory and early intervention services.

3.3. The managers and staff interviewed all expressed a commitment to improving well-being and safety outcomes for children and families. While less aware of the strategic vision, staff and partners were able to articulate the action taken to implement the requirements of the Social Services and Well-being (Wales) Act 2014, particularly in relation to Information Advice and Assistance. However critical elements of the early help approach, including the necessity for consent from families, were not sufficiently understood or embedded. Staff welcomed the priority being given to delivering a holistic service for people but, despite some recent consultation events, felt that there needed to be more opportunity to shape and

review access and IAA arrangements. Some staff described an unrealistic 'over optimism' by managers that the co-location of services in itself promoted effective joined up working.

3.4. Leadership, management and governance arrangements complied with statutory guidance. The authority was aware of its strengths and areas for development and the pressures resulting from its ambitious change agenda. The creation of a Corporate Director Social Services and Well-being was reported to have improved accountabilities and also efficiencies between adult and children's services. The council was confident that its 'one council vision' promoted the ability of the statutory director to help shape the corporate agenda. The strong reporting links between the Chief Executive Officer (CEO); Director of Social Services (DSS); corporate management board and Members was seen as providing good opportunities to share and oversee council priorities. Inspectors were reassured, for example, by the recent intervention and direction provided by the Chief Executive to address what were described as fragmented commissioning arrangements which staff and partners viewed as weakening the early help delivery model.

3.5. At the time of the inspection the authority's transformation agenda for children's services was being progressed alongside the requirement to contribute to medium term financial savings. There were considerable expectations being placed on the service particularly regarding the speed with which remodelling would deliver financial sustainability. Despite a greater shared awareness of the challenges facing children's services, there needs to be on-going recognition of the underlying complexities and risks associated with the service.

3.6. The successful delivery of remodelling in children's services is reliant on effective and constructive inter-directorate and interagency collaborations. While this was developing in relation to the work with the Education and Family Support Directorate, the contribution of other council services was not as apparent. There was evidence of some good communication and joint working with partner agencies at a strategic level, as highlighted by their engagement on the children services remodelling board and joint work to deliver new SSWB Act requirements in relation to the local prison. While such engagement provides a useful means of developing a shared strategic agenda it was yet to have had the necessary impact on promoting secure multi agency partnership working and "joined up practice". Poor communication was often highlighted by staff as a concern; however the Director and Head of Children's Service were actively committed to extending staff engagement.

3.7. Inspectors found a good level of political support for authority's strategic direction and children's services. Strong performance management and reporting mechanisms, which included opportunities to challenge, kept elected Members, well informed and also maintained safeguarding as a priority.

3.8. The reports provided to Members and scrutiny would benefit from a greater focus on outcomes, as this would support a more complete understanding of the level of improvement achieved. Mechanisms for elected Members and corporate officers to routinely hear the views of children, young people and their families using the assessment and early help services were underdeveloped. Elected Members and senior officer's visits to front line staff to directly hear their views also need to be

better planned and more purposeful. Staff told inspectors that they had limited awareness of these visits, as they did not know who people were, including the Chief Executive and members of the senior management team.

3.9. The Corporate Director Social Services and Well-being was working hard to promote a significant agenda of organisational and cultural change. This had been supported by the appointment of a permanent Head of Children's Services in 2015. It was noted that these managers had introduced regular management team meetings, which were routinely extended to include business support, legal services, early help managers, the complaints manager and human resource managers. This was aimed at improving shared ownership of governance arrangements.

3.10. Inspectors recognised that the scope of the authority's plans signalled their commitment to improving both early help and statutory services for children, young people and their families. The authority fully acknowledged that it had 'more to do to translate these aspirations into a secure framework for delivery of children's services.

3.11. It was recognised that the reorganisation of services and delivery of medium term financial savings necessitated more effective management oversight and 'grip'. An important emphasis was being given by the Director of Social Services and Head of Children's Services to improving the resilience of the children's services management culture, aimed at supporting group managers and team managers to take informed decisions in line with their accountabilities. While the intentions were broadly welcomed, staff reported that changes in management responsibilities and expectations of senior managers had created uncertainties and, what was perceived by staff as, additional bureaucracy that delayed key decision-making. Managers and staff need to be clear regarding service expectations, the location of decision-making accountabilities and have confidence in the timeliness of the response. Staff and managers also need to be supported to develop the skills needed to deliver the requirements of senior managers. The service changes to previously established ways of working will take time to embed. It is important that they are undertaken in a way that supports the meaningful engagement of staff and partners.

### **Performance Information and Quality Assurance**

3.12. Performance management was well embedded across the service with effective mechanisms in place to collect and disseminate information. Data was systematically discussed at management meetings and compensatory actions agreed to address performance issues. Inspectors recognised the close and regular attention paid by senior officers and Members to children's services performance information and despite the change in performance targets resulting from the implementation of the SSWB Act, workers interviewed were all aware of the standards expected by the service. It was disappointing that some staff understood performance information as a management tool rather than as a means of improving the quality of services.

3.13. Officers and managers recognised that the quality assurance mechanisms required improvement and were in the process of developing a new framework that would better inform analysis of service effectiveness. This will need to be embedded as core business at all levels across the service. To provide a real understanding of the quality of services any framework would need to include a multi-agency

approach to monitoring thresholds and feedback from those providing, commissioning and using the service.

3.14. A safeguarding and quality assurance unit had been established across both children and adult services and this, plus the recent reinvigoration of the independent reviewing service, provided a helpful platform to monitor and drive service improvement. Overall the authority had more to do to ensure a sustained culture of learning. Most staff we interviewed expressed positive views about formal and required training but workload demands were said to impact on the ability of staff to access training. Systematic arrangements were not yet sufficiently well established across the service to capture and disseminate wider learning from social work practice and service user feedback mechanisms. Inspectors noted that complaint resolutions were coordinated and managed. While the outcome of complaints and compliments were shared with managers, including in an annual report, a more consistent mechanism for the prompt dissemination of learning points from complaints is needed to inform service improvement.

## **Workforce**

3.15. As well as the central assessment team and the Children with Disability Team, children's social care comprises 4 other assessment and care management teams. These include a Just Ask Team (care leavers) and since July 2015 three safeguarding hubs. Staff in the safeguarding hub teams carry out the same functions as the assessment team in relation to children and young people who have eligible need and are subject to a care and support plan. Co-location with the early help teams meant that two safeguarding teams were based in the locality to promote improved public access and direct links with the local communities.

3.16. The authority has given significant attention to recruitment and retention of social workers and viewed this as a business critical area. Significant progress had been achieved in recruiting to social work posts however many of these were newly qualified workers and the recruitment of experienced workers had remained a challenge. The planned remodelling of the service will require a suitably experienced workforce if it is to be successful in reducing the demand for statutory services, and support better outcomes for children and young people living in the community.

3.17. The newly qualified workers interviewed reported that they were well supported through such arrangements as the First Year in practice programme, Continuing Professional Education and Learning (CPEL) Consolidation Programme and particularly through the in house mentoring provided. Most staff across the service were generally positive about the availability of training and managers were said to be attentive to staff development. Demand on workers' capacity however was reported to have impacted on their ability to attend planned training. All staff and managers interviewed demonstrated a good awareness of the changes to practice required by the SSWBA and had attended and valued initial training on the new Act. Further training including lessons from practice would now be timely and appropriate.



Social services are working well towards implementing the new Act. Children's Social services in Bridgend have a good mentoring scheme for newly qualified workers; I have received regular supervision and mentoring since being employed in Bridgend. Children's Social Services work well with preventative agencies (staff survey)

It is a stressful job to do and it is difficult when there are staffing issues, sickness and or annual leave and although this is recognised as a problem the expectation continues to be complete all work in a timely fashion and this is difficult to achieve without going over and above working in your own time.

(Staff survey)

3.18. The authority had experienced particular difficulties in the recruitment to senior practitioner's posts and had responded by implementing a successful 'grow your own approach'. This approach needs to be accompanied by a suitable induction and training programme to support staff moving into the management role.

3.19. The recent promotion of experienced social workers to a new senior practitioner role, their replacement with often less experienced staff, (many starting at the same time) and the presence of experienced but unqualified workers in the service structure meant that the authority was managing significant workforce vulnerabilities. These issues, as well as some sickness absence, were described by staff and seen by inspectors as impacting on the ability of teams to routinely allocate complex cases to suitably experienced and qualified practitioners.

3.20. It was positive that the need to strengthen some teams had been recognised and that the authority was using a small number of experienced agency staff to manage vacancies and absences. It was disappointing that there was no consistent approach to their induction to ensure that they understood Bridgend policy and procedures.

3.21. Despite the creation of deputy team managers in the safeguarding hubs (not the assessment team) the capacity of team managers to provide the level of support and oversight needed was identified as being under pressure across the service. Senior managers were actively seeking to develop and build the resilience of their workforce including their management staff group but recognised the difficulty they had in balancing this ambition whilst also managing capacity pressures. Management capacity has also been increased with the appointment of a new principal officer who will have line management responsibilities for the MASH but also for permanence.

3.22. Staff told inspectors that whilst they believed there were potential benefits of the new configuration of services, these were yet to be fully realised. The geographical location of some teams was seen as positive for building community links but not for service cohesion. Inspectors heard that social work staff 'did not know each other' and were concerned that social work teams were developing an unhelpful negative perception of each other that needs to be addressed. More work

is needed to support strategic and operational alignment and to ensure that teams have a clear sense of shared identity and value within the service.

3.23. Morale amongst workers was variable. The majority of concerns expressed particularly in the staff survey were about volume of work, retention of staff and changes in the service.

Bridgend has the most amazing loyal and hard working staff who try hard in the most difficult of circumstances to provide a good service to the children and families they work with. Within my own team everyone supports each other and really cares about each other.

Highly experienced staff are being replaced by newly qualified staff, which has an effect on service.

Resources for children and carers are diminishing by the day, and no new options are available to replace them.

(Social workers and staff survey)

3.24. The majority of the staff interviewed told us that workloads were becoming increasingly pressured both in terms of volume and complexity. Whilst most staff felt supported by their team manager they expressed concern that the demands of their caseloads were not always apparent or sufficiently recognised by senior managers. The demands created by different team boundaries were also said to impact inequitably on staff workloads.

3.25. Staff expressed significant frustration that communication was poor across the service and that they did not know how actively senior managers were addressing recognised challenges that impacted on the team's capacity. For example, the growth in demand for supervised contact meant that, despite contact workers in the team, social workers and manager's time was increasingly taken up with finding venues and arranging supervisors for contact. At the time of the inspection social workers also had to undertake transport responsibilities for children within the service due to a contract issue with the voluntary driver scheme.

3.26. Managers and staff expressed anxiety that the demands on both management time and on experienced workers were increasingly impacting on the resilience of the service. Staff were particularly concerned that looked after children on their caseload did not receive sufficient time despite permanence being a council priority. Staff indicated that time constraints reduced their ability to undertake meaningful direct work with children and that whilst they valued the support services available they increasingly felt like case co-ordinators rather than agents of change. Equally social workers need to be supported to recognise the significance of their own work as a preventive service in itself.

3.27. Staff experience of supervision varied across the service. Team managers routinely undertook supervision of social workers; deputy team managers supervised some social work assistants and contact workers. Those interviewed told us that while most had regular supervision, few thought it was reflective. The supervision received by team managers, deputy team managers and senior practitioners was also described as inconsistent across the service and often said to be vulnerable due to competing demands. Inspectors found that supervision records were of poor quality and focused on task centred case discussion. The supervision policy had been refreshed and launched through briefings and skills workshops in April 2016 aimed at supporting a better outcome focus but this had not yet made any significant impact. The authority was working with managers to develop their skills and recognised that targeted training was needed on the new supervision framework. More work is needed to ensure workers receive good quality reflective learning opportunities through supervision as this supports practice but is also crucial to the retention of competent, confident staff.

### **Conclusion: - Leadership, Management and Governance**

The authority was working hard to transform children's social services at a time when they had to deliver medium term financial savings. The ambition of the authority's plans signalled their commitment to improving both early intervention and statutory services for children young people and their families. The objective to mitigate the need for statutory social services however was significantly dependent upon the ability of all council directorates to work together in order to deliver against the council's vision and contribute and co-ordinate an effective range of services. The council will need to ensure there is an ongoing analysis of the underlying complexities and risks associated with statutory children's services. It was positive that the council had recently begun work to develop a more comprehensive evidenced based commissioning plan that will be key to the delivery of its early help and permanence strategy.

The council needs to ensure that the strategic direction is translated into an operational strategy for delivery of children's services that is effectively communicated and understood by staff, partners and service users. At the time of the inspection the SSWBA was still at an early stage of being embedded and more opportunities were needed to draw lessons from practice and engaged key stakeholders in reviewing progress and in any resulting service remodelling. The voices of children and families also need to be embedded in shaping service planning to provide a better understanding of the difference that help, care and support and/or protection is making for children and families. The introduction of a new quality assurance framework will help the councils to understand the pace of its service improvement.

Staff were committed to achieving good outcomes for children and families but staff morale was variable across the service and needed to be nurtured at a time of significant change. The recruitment and the retention of social workers had been given significant priority despite some good progress the authority had encountered difficulty in recruiting experienced staff. Services therefore were not always delivered by a suitably qualified and experienced workforce that had the capacity to

consistently meet workload demands. Staff valued the approachability of their line managers, and peer support from team members particularly in relation to managing the increase in volume and complexity of their work. Staff would welcome greater visibility of senior managers particularly given the remodelling of services.

The importance of staff development and good supervision practice to retention was recognised and newly qualified workers were found to be well supported in their first year of practice and highly valued the mentoring provided to them. Despite the availability of some good training programmes staff including managers needed help to prioritise training against the competing demands of their work. The quality of supervision was found to be very variable and did not routinely evidence sufficient challenge or reflection, a new supervision policy had not yet impacted on these quality issues. Senior managers were working to develop a stronger oversight of practice and management culture the leadership development of group managers and front line managers was therefore being progressed as a priority.

## **Methodology**

### **Pre-fieldwork**

The authority completed a self assessment and provided CSSIW with documentation and performance information relating to the focus of the inspection. The information provided was reviewed and used to shape the detailed lines of enquiry for the inspection.

### **Fieldwork**

The inspection team were on site in Bridgend for 8 days during January and February 2017.

Case Review: inspectors considered 60 randomly selected cases and explored 21 of these in further detail with social workers and their managers, other professionals involved and children and families. We undertook 21 interviews with allocated case workers and team managers as well as 10 interviews with children, families and/or carers.

Interviews & Focus Groups: inspectors conducted over 24 group or individual interviews with senior managers, staff, elected members and partners.

Staff survey: an on-line SNAP survey was administered to staff in children's services; 115 returns were received.

Observation of practice: inspectors observed 2

Review of complaints & compliments: inspectors reviewed 10

Review of supervision & appraisal documents: inspectors reviewed 20

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

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