APPENDIX 1

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

# Bridgend County Borough Council

# Report of Performance Evaluation Inspection of Children's Services

May 2022

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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

Care Inspectorate Wales (CIW) carried out a performance evaluation inspection of children's services in Bridgend County Borough Council ('BCBC' / 'the local authority') in May 2022.

The purpose of this inspection was to review the local authority's performance in exercising its social services duties and functions in line with legislation, on behalf of Welsh Ministers. We sought to answer the following questions aligned under the principles of the Social Services and Well-being (Wales) Act 2014.

### 1. People - voice and control

How well is the local authority ensuring people have a voice, and how well they are assessing the needs of individuals for care and support (including children at risk of abuse or neglect), or support in the case of a carer?

### 2. Prevention

To what extent is the local authority ensuring escalation of need is prevented whilst ensuring the best possible outcomes for people are achieved?

How well is the local authority keeping under review care and support plans for children, including where it is necessary to meet the child's needs in order to protect them from abuse or neglect?

### 3. Well-being

To what extent is the local authority ensuring children are protected and safeguarded from abuse and neglect and any other types of harm?

How well is the local authority keeping children safe and promoting well-being in relation to fulfilling statutory responsibilities?

### 4. Partnership and Integration

How well is the local authority working with partners to ensure children's needs for care and support (including those in need of safeguarding and protection) are met and the impact on outcomes for people?

The scope of the inspection included:

- evaluation of the experience of children at the point of performance evaluation inspection

- evaluation of the experience and outcomes people achieve through their contact with services
- evidence of the local authority and partners having learnt lessons from their recent experiences and actions taken/plans for service development and improvement
- consideration of how the local authority manages opportunity and risk in its planning and delivery of social care at individual, operational and strategic levels

## Context and Summary

Like many local authorities across Wales, BCBC has experienced challenges in relation to the provision and delivery of social care. Many of the pressures experienced by the local authority's children's services reflect the national pandemic recovery context including high levels of demand and increased complexity of people's needs. Critical workforce deficits in relation to social work recruitment, retention, and staff absence, had resulted in the loss of experienced staff and a competitive market for and an over reliance on newly qualified and agency social workers.

CIW's assurance check undertaken in April 2021 highlighted some of these pressures and potential service risks, and those findings informed this inspection.

The culmination of these pressures coupled with deficits in some systems and processes, including managerial oversight arrangements, has had a significant adverse impact on the delivery of some children's services in Bridgend County Borough. Concerns were identified in relation to the timeliness of the local authority's Information Advice and Assistance (IAA) service and the ability to meet its statutory responsibilities to promote and protect the well-being of vulnerable children and families.

This inspection was undertaken at a time when senior leaders, managers and politicians had recognised the significant action and resource needed to improve the consistency and quality of children's services and had instigated an internal critical response plan, aligned to the local authority's directorate and corporate risk registers, to oversee the immediate remedial changes needed in relation to the identified deficits in their IAA service. The local authority's response has included the commissioning of a programme of independent quality assurance to provide an assessment of the strengths and areas for development in children's services and to inform practice development, the deployment of a managed care team[1] and re-deployment of staff from across the service/council to provide additional support

[1] Managed care team comprising of a team of agency workers including social workers, a deputy team manager and team manager who work as a team.

to those teams experiencing the most pressure. Management oversight and decision-making has been strengthened by increased frequency of supervision in priority areas and better collection and scrutiny of performance information data. Planning to reconfigure and improve the resilience and sustainability of the service in the longer term is also actively being taken forward.

In March 2022, the local authority established a Children's Social Care Improving Outcomes Strategic Board, which is chaired by the Chief Executive of the Council and is supported by an independent advisor. The board provides regular oversight, challenge, and direction to enable the delivery of the local authority's strategic plan and areas for development.

The local authority has taken action to instigate immediate learning following recent critical incidents. These incidents have been escalated to Cwm Taf Morgannwg Regional Safeguarding Board (CTM RSB) who is responsible for overseeing multi-agency Child Practice Reviews (CPRs). CTM RSB implemented an executive steering group to steer a rapid review of safeguarding in Bridgend County Borough. The steering group's purpose has been extended to include an assurance role across the region.

This inspection found there was variation in the quality of services and social work practice provided to children and families. The experiences of children and families have benefitted from more recent decisive improvement activity identified through internal and external audits and reviews. However, until a short time ago, managers were not sufficiently sighted on the extent and impact of the shortfalls in the IAA service. Sustainable progress at pace is now needed across a range of service delivery areas if the local authority is to consistently deliver their core business of reducing risks to and promoting the well-being of children in need of help and protection. The application of effective quality assurance processes will be essential to securing and sustaining improvements and to ensure the timeliness, quality, and consistency of services for children and families. The local authority will need to assure itself of the pace, quality, delivery, and impact of its improvement activity.

## Key findings

Key findings and examples of evidence are presented below in line with the four principles of the Social Services and Well-being (Wales) Act 2014. Details relating to areas for improvements identified in previous CIW reports may also appear in this report to emphasise their relevance and importance at this time. However, previous requirements for improvements, which remain outstanding but not referred to in this report, remain relevant and are not negated by omission here.

### People

**Strengths:**

Practitioners recognise the importance of ensuring children's voices are heard. We saw examples where language, communication and level of emotional and developmental maturity was considered and explored by practitioners to obtain and facilitate the views of children.

Social care records seen confirmed practitioners generally maintain regular contact/visits to children and families. Some record templates include prompts in relation to whether the child was seen/seen alone, and if not, the reasons for this. We saw some examples of practitioners working consistently and collaboratively with children and families. The workforce is striving relentlessly to support children and families; however, it is clear demand is outstripping available resource.

The local authority gives regard to the rights of children to be offered independent professional advocacy. We saw examples of children being offered access to independent advocacy services. The top three issues for children/young people accessing issue based advocacy are support at meetings, placement issues and contact issues. There are good links between the commissioned advocacy provider and BCBC. The advocacy provider had provided advocacy awareness refresher sessions for practitioners.

A corporate parenting and participation officer has been appointed whose role includes facilitating improved engagement and involvement of care experienced children and young people.

The recent creation of the care experienced children's team is valued by staff and viewed as supporting a better focus on permanency and facilitating professional relationships with children and young people. The configuration of the service is also described as improving the professional priority afforded to care experienced children and young people, with an improved focus on transition, including stronger links between the 16 plus team and disabled children's team. The creation of the care experienced children's team had resulted in a reduction of caseloads of some practitioners based in the locality safeguarding hubs.

Workforce well-being, recruitment and retention is a key priority for the local authority. It has identified and taken action to stabilise and support the workforce and views this as business-critical, underpinning both its ability to meet its statutory responsibilities and to its improvement agenda. It has recently over established its staffing numbers in some teams and is employing agency staff to reduce backlogs and pressures on workloads in the IAA service, resulting in reduced caseloads. Some staff and managers commented they had experienced improvement in the IAA service but described this as very recent, as until recently the locality safeguarding hubs had needed to support the IAA team by taking cases directly from referral to help reduce the IAA backlog of people waiting for information, advice, or assistance. Action has been taken to increase capacity of the independent reviewing officers (IROs).

Senior leaders and managers remain appropriately focused on workforce recruitment and retention. BCBC is currently expanding its approach to recruitment and retention with a focus on 'growing our own' social workers through sponsorship of formal qualification, traineeships, and secondments. This is important in helping to address recruitment issues. Most staff (93%) who completed our staff survey stated they were supported to do their job. 71% stated their workload was manageable. A workforce development plan is in place and there are early indications this is helping to improve recruitment and retention.

**What needs to improve:**

Opportunities for children's views to be consistently sought and appropriately recorded need to be strengthened. We found the quality of recording in relation to capturing the voice of the child and their lived experience was variable and inconsistent. We saw missed opportunities to collate and obtain the child's views, including obtaining the child's views prior to statutory reviews and a lack of consultation with children and young people about their preferences relating to dates and times of statutory reviews. We were told work had commenced to improve recording in relation to siblings. Care must be taken when individual children are part of sibling groups to ensure children's individual voice and lived experience is not lost. In some examples we found an over reliance on parent's views.

There was limited evidence to confirm children had benefitted from direct work to inform ongoing assessment and progress care and support planning. Further work is required to maximise opportunities for direct work to inform assessment and care and support planning. Care experienced children should be supported to understand their life history and the rationale for decisions made about them. Whilst the use of chronologies and genograms has improved, further work is required to ensure consistency and quality of work.

Further work is also required to help ensure people consistently feel listened to and feel they are treated with dignity and respect. We received 93 responses to our people survey (people receiving services or their representatives). 33% felt they were 'rarely' or 'never' treated with dignity and respect. 47% felt they were 'rarely' or 'never' listened to. During our assurance check undertaken in April 2021, we received variable responses from people about their experience of contact with the local authority and how well they felt they had been listened to and respected. This remains an area for improvement.

We saw parents/family members involvement in meetings and assessments. Some parents told us there had been delays in them receiving minutes/documentation following meetings/reviews. The local authority has identified the need to strengthen business support for practitioners to assist with this. It should consider how its systems could be strengthened to ensure information is shared with all relevant parties in a timely manner and there is sufficient oversight in relation to this matter.

There was variable evidence of management oversight in relation to social care records of children. Practitioners described how time restraints and prioritisation of work had adversely impacted on their ability to complete social care records in a timely manner. We found records which had been created sometime after the events. Practitioners must be provided with adequate opportunities and support to enable them to consistently record quality information in a timely manner. Systems for management oversight need to be strengthened to ensure consistent and effective monitoring of adherence to policies and procedures, and timescales in relation to meeting statutory requirements and record keeping.

Records of workload supervision were generally brief with minimal evidence of reflective conversation, clear focus, analysis, actions, and timescales for actions. This may be a recording issue, however, in the absence of evidence to suggest otherwise these were missed opportunities to support practice development and analyse the effectiveness and quality of service provided to children and families.

The local authority identified its quality of practice as too inconsistent and has implemented an appropriate focus on 'getting the basics right' to create a shared supportive culture practitioners need, and to support their confidence and competence. It also aims to support managers in their supervisory responsibilities. BCBC has introduced mandatory back to basics training which is in the process of being rolled out. This training must be delivered as a matter of urgency.

Whilst the local authority had undertaken significant work in relation to implementing an outcome focused model of practice, it identified the pandemic and recruitment and retention issues had made it difficult to embed this model. It has now decided to invest in implementing Signs of Safety[2] as a shared model of practice. This work will take time to embed and will need to be progressed with the engagement of partners to promote a shared approach and understanding of risks, strengths, and safety networks.

Whilst there is a training programme in place, we note very few training courses/sessions are mandatory. Given the workforce pressures there is a risk training will not be prioritised by practitioners. Therefore, it is important systems are in place to ensure staff are suitably knowledgeable and skilled to undertake the tasks they perform, and they are provided with opportunities/capacity to undertake professional development, reflect, and embed learning.

The local authority is reviewing its direct payments scheme to widen the offer. Whilst we saw evidence of the offer of direct payments, we heard how parents felt they had to "*jump through hoops*" to provide evidence to "*justify*" receiving direct payments for

[2] Signs of Safety approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children. The approach expands the investigation of risk to encompass family and individual strengths, periods of safety and good care that can be built upon to stabilise and strengthen a child's and family's situation. The approach is designed to be used from commencement through to case closure in order to assist professionals at all stages of the child protection process.

their children. Parents felt the rules around the use of direct payments were "*too strict and not flexible enough to achieve positive outcomes*." We saw how the lack of availability of personal assistants is a barrier to some children and families accessing support via direct payments. Further work is required to ensure direct payments are seen as an integral part of the care planning process and as an important means, where appropriate, to meet a child's needs and/or a carer's need for support. The local authority should ensure there is sufficiency and choice of services for children to make the take up of direct payments a positive and viable option for achieving identified outcomes and not a last resort because of waiting lists or gaps in service provision. Where direct payments are in use, contingency arrangements should be discussed with the child and their parents/carers and include consideration of alternative care and support arrangements, if needed in case of emergencies.

Whilst we saw evidence of completion of carers assessments, some people told us that practice in relation to being offered a carers assessment was inconsistent. The local authority must ensure carer's assessments are offered, where required. Only through assessment of what matters to carers will practitioners be able to signpost appropriately or provide effective support.

**Prevention**

**Strengths:**

Senior leaders, managers and politicians have an understanding and appreciation of the importance of the purpose and function of early help and preventative services. The local authority recognises the significant interface between the delivery of early help and the sustainability of children's services. It has identified its review of IAA arrangements and thresholds needs to include consideration of early help and preventative services.

We saw examples of how preventative services had assisted families supporting them with parenting, providing advice on practical strategies and relationships. There are examples of services which were able to respond promptly to meet need despite a high level of demand. It is however clear the significant demand for early help and preventative services, is generally outstripping supply and leading to delays.

BCBC continues to develop its in-house residential provision. It is making progress in relation to its remodelling of residential provision including a targeted recruitment campaign for transitional foster carers. To strengthen the therapeutic support for young people, 11 members of staff have commenced a Practical Skills in Applied Behaviour Analysis university course.

**What needs to improve:**

Despite an understanding of the importance of prevention and early intervention in children's services, opportunities to prevent escalation of need is a challenge for the

local authority given the persistently high volume of referrals together with the complexity of needs of children and families, and workforce challenges.

Demand for early help services has increased, resulting in waiting lists for several services. For example, as of 22 April 2022 there were 119 referrals waiting to be allocated to the Youth Emotional Mental Health Team, the approximate waiting time was 12 weeks. The aim of early help services is to provide support at the earliest opportunity to prevent issues escalating leading to the need for statutory services. Having to wait for services increases the risk of more children requiring targeted social service interventions. Due to workload pressures and increased demand, the authority is not always able to capitalise on opportunities to support the preventative agenda in a way which reduces demand on care and support services.

At our assurance check undertaken in April 2021, we found families were not always receiving the right service at the right time and further work was required to ensure seamless and co-ordinated services which prevent escalation of need, and which secures the best outcomes for children and families. This continues to be an area for improvement. The local authority must ensure opportunities to support children and families are not delayed. The impact of children and families waiting for support means there is an increased risk their needs will increase and require more intensive support.

We saw some examples where risk indicators were not fully considered resulting in missed opportunities to thoroughly explore risk, including historical concerns and action to mitigate risks. Some assessments/interventions would have been strengthened by a more robust approach in relation to professional curiosity. Although it is important to work optimistically with families, it is also essential to recognise past behaviour can be a predictor of future behaviours. Risk analysis of domestic abuse and/or exploitation requires strengthening, including practitioners having reflective conversations with managers about risk indicators and actions.

There has been a reduction in the number of in-house foster carers and availability of foster placements (particularly for children over 11 years of age). Foster care placement availability and sufficiency is described as a challenge, with the local authority experiencing difficulties in matching some children to appropriate foster care placements. We saw examples of how foster carers were supporting some children with very complex needs. It is important foster carers receive the support they require to enable the continuation of foster placements, where appropriate, and to maintain their own and the child's well-being. Foster carers told us the arrangements for providing foster carers with children's care and support plans had improved, although the quality of information was variable. We found some delays in providing foster carers with relevant information. One foster carer commented *"Bridgend have always provided access to documents we need to complete our work. They have invited us to multi agency meetings. Information sharing around the child has been good. Where I have marked this down is in how timely some of the*

*more in-depth documents are shared such as assessments or background documents. This is usually due to social workers time restraints in being able to access and share documents not because they are unwilling to."*

When asked how easy it was to make contact with social services, 30% of respondents to our people survey stated, 'not easy' and 33% stated 'very difficult.' When asked how useful the information, advice and assistance offered by social services was, 63% of the respondents responded either 'not useful at all' or 'not useful.' 55% of the respondents stated social services did not discuss what support options were available to them, for example from family/friends/community. Further work is required to strengthen the accessibility and provision of information, advice, and assistance.

From January 2022 onwards, the workforce position in the IAA service became more difficult. Once senior managers were aware of the impact of the workforce issues swift action was taken to identify the extent of the issues and implement action to address the shortfalls. Senior managers had recognised the quality assurance framework was not providing an accurate assessment of the throughput or quality of work. Work has commenced to strengthen the quality assurance framework. Whilst the range and scrutiny of performance data is now improving, performance management and quality assurance systems are not yet fully aligned. The local authority has identified this as an area of improvement and have appointed quality assurance and policy roles to address these issues and to review relevant policies and procedures to also ensure the necessary link between quality assurance, policy, and training. Corporate leaders, managers, practitioners, and partners, including early help services, need to routinely and robustly interrogate and utilise such assurance arrangements to understand compliance with statutory requirements, quality of practice and gaps/pressures in service provision.

**Partnership and Integration**

**Strengths:**

Positive working relationships with the regional safeguarding board and neighbouring local authorities is ensuring children's services have a professional support network from which they can draw expertise, knowledge, support, and constructive challenge.

Fortnightly joint operational group meetings were held with partners as part of the response to the critical incident in the IAA service. We heard how these meetings provided challenge from partners but also demonstrated the commitment to partnership working and to making improvements for children and families.

Partners mainly spoke positively in relation to partnership working with BCBC. Some partners described recent improvement in the culture within social services, with improved communication being cited as evidence of this. Partners talked about wanting to be involved and willing to help support improvement.

Despite the current pressures there is evidence of partnership working to improve policies and systems and mutual understanding of roles and responsibilities within the safeguarding process. Arrangements are underway for joint multi-agency training to re-establish relationships and offer guidance on joint working and procedures around strategy meetings and sharing of information and escalation protocols.

Generally, opportunities for partnership working are positively exploited at an operational level. We saw evidence of police, health and education services contributing to safeguarding decisions.

The co-location of some teams with practitioners from different sectors and services helps to facilitate partnership working, where there are opportunities to regularly meet either physically or virtually, and work together.

**What needs to improve:**

We heard how pressures in the IAA service and workforce challenges had resulted in some tensions in relation to partnership working on an operational level. Some partners felt the quality of partnership working was dependent on individual relationships rather than being well embedded in the service culture. They cited staff turnover and issues in the IAA service, including not being provided with updates following referrals and difficulty in contacting people, as barriers to effective partnership working.

Despite recent improvements, staff and partners indicated some issues relating to inconsistent thresholds and standards of practice remain. The local authority will need to ensure its communication strategy is sufficiently robust to effectively communicate to staff and partners the vision for children's services and the many developments taking place/planned to take place. Further work is required to ensure a shared understanding of thresholds and access to services. It is important key partners are aware of, and where appropriate, involved in service developments. Opportunities for joint training should be maximised.

It is important learning from reviews and audits is shared with staff and partners to identify what works well and what needs to improve to safeguard children.

**Well-being**

**Strengths:**

Following critical events, the local authority has undertaken relevant reviews and audits which have highlighted areas of good practice and areas for improvement. Action plans have been developed and implemented. Systems and tools to support practice are being reviewed and developed.

Since our assurance check in April 2021, a deputy head of children's service has been appointed to strengthen managerial capacity within children's services.

The recent establishment of a managed care team, over establishment of staffing in the IAA service and additional management support for the IAA service is starting to result in improved timeliness of screening, manageability of caseloads and improved management oversight. These improvements are very recent, and more work is needed to ensure improvements are embedded and sustained.

A peripatetic team manager has recently been recruited to enhance management support available to teams, so that practitioners have access to professional advice, guidance, and support prior to attending legal gateway meetings. The peripatetic team manager supports management oversight. Evidence obtained indicates the value of this work in providing assurance, oversight and identification of actions needed.

Where children need protection, strategy discussions are generally timely and attended by relevant professionals. Information is shared to inform decision-making and action to safeguard children. Subsequent child protection enquiries aid the decision-making about next steps. The template for the strategy meetings provides helpful prompts but the record does not always capture the rationale for decision-making.

Initial child protection conferences and review conferences are timely and attended by partners and families. Consistency of chairing arrangements provides continuity. Relevant child protection plans are agreed and reviewed at child protection conferences.

IROs complete monitoring forms after conference reviews highlighting any shortfalls against compliance/practice to enable the follow up of action to be taken.

During our assurance check in April 2021, the provision of specialist behavioural support for disabled children with complex needs was highlighted by some practitioners as an area for improvement. Following the assurance check, action was taken to improve the offer of behaviour management support to parents to assist them in supporting their child and prevent crisis. We heard of how care experienced young people had benefitted from the therapeutic support they had received.

**What needs to improve:**

Key areas of performance have been impacted by increase in demand and workforce pressures. Performance data indicates there has been a decline in performance in some areas. Further work is required to improve the timeliness of meeting statutory responsibilities in relation to completion of assessments, initial core group meetings, statutory visits and care and support reviews.

We saw examples of monitoring forms completed by IROs that highlighted shortfalls in relation to compliance with statutory responsibilities. Managers need to ensure prompt effective action is taken to address any identified shortfalls. The local

authority should assure itself the systems in place to monitor compliance and practice are informing and making a positive difference to practice and improving outcomes for children and young people.

Facilitation of supervised contact between children and members of their families is sometimes a challenge for the local authority. We saw/heard evidence of family members frustration regarding the short notice provided in to confirming contact arrangements and of contact being unable to take place due to social worker's unavailability to supervise the visit. Social workers described how the task of supervising contact due to unavailability of contact workers was placing additional pressures upon them. The current arrangements in place for supervised contact is clearly adversely impacting on practitioners but more importantly on children and families.

Written records need to be of a consistent high quality so that they provide an accurate accessible audit trail and account of decision-making. They should provide a clear account of the focus and impact of any interventions, a clear analysis of situations including risks and needs, and the daily lived experience of the child, what has/has not worked well, required actions and timescales for actions. We saw examples where children and families would have benefitted from practitioners undertaking more consistent critical thinking about the potential for harm, contingency plans, and the availability of wider support. The quality of information relating to the identification of strengths, barriers and risks was variable in relation to the quality and detail of information contained within social care records.

We saw some examples of records in relation to episodes of children going missing[3] and children at risk of exploitation which were not sufficiently detailed to assure us appropriate action had been taken in a timely way to mitigate risks to children. It was not always evident with whom and what information had been shared and the action taken. The local authority is reviewing its Child Sexual Exploitation (CSE) and Child Criminal exploitation (CCE) processes as part of its exploitation strategy. A suite of documents has been created, one of which is a direct intervention work programme which is tailored to the child. The local authority is looking at how it can strengthen the consistency and facilitation of the triangulation/mapping of CSE and CCE information. It is important that interventions remain child centred and children at risk of or abused through CSE and / or CCE should receive care, support, and protection in line with statutory guidance and the Wales Safeguarding Procedures.

We found in the locality safeguarding hubs, social workers in the first year of practice held child protection cases and cases in the Public Law Outline (PLO)[4] process.

[3] The All Wales Practice Guide – *Safeguarding children who go missing from home or care*, defines a child as missing when their whereabouts cannot be established, they will be considered as missing until located and their wellbeing or otherwise confirmed.

[4] PLO process takes place when the local authority is concerned about a child's well-being and unless positive steps are taken to address and alleviate those concerns, the local authority may consider making an application to Court.

While first year of practice social workers did not identify this as a concern, it is important the necessary checks and balances are in place to ensure the competence and confidence of staff undertaking such work. Pivotal to this is good quality consistent supervision and oversight. Due to the shortfalls we noted in supervision records and management oversight, we could not be assured newly qualified social workers are receiving appropriate supervision and that sufficient oversight is provided. The local authority should take steps to assure itself of the supervision and oversight arrangements in place for newly qualified social workers and student social workers.

**Next Steps**

We expect BCBC to consider the areas identified for improvement within this report and take the required action to address these areas as soon as practicable. CIW will closely monitor the progress and pace of improvement and delivery against the identified action plans through our ongoing performance review activity.

## Methodology

**Fieldwork**

Most inspection evidence was gathered by reviewing the experiences of children through review and tracking of their social care records. We reviewed 59 social care records and tracked 10 of these.

We spoke with a range of local authority employees.

We spoke with a range of partner organisations, representing both statutory and third sector agencies.

We spoke with children and care leavers, parents/carers and foster carers.

We reviewed a sample of staff supervision records.

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

We administered surveys to staff, partner organisations and people/representatives of people accessing information, advice and or assistance from the local authority.

We observed the Cwm Taf Morgannwg Regional Executive Steering Group meeting, the local authority IAA Critical Incident Gold meeting, the Workforce Project Board meeting, and the Children's Social Care Improving Outcomes Strategic Board meeting.

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