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

Inspection of *Children's* Services

in City of Cardiff Council

March 2016

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

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Contents

Introduction

Care and Social Services Inspectorate Wales (CSSIW) undertook an inspection of children's services in the City of Cardiff Council in January 2016. Inspectors looked at the access arrangements for children and young people and their families who were either referred for care and support or where information was received about children's well-being. This inspection included reviewing the effectiveness of the interface between preventative and statutory provision; there was no focus on services for disabled children. We considered the quality of outcomes achieved for children and families who received a service. 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, they talked to children, young people and their families. In addition, inspectors evaluated what the local authority knew about how well it was performing and what difference it was making for the people who it was trying to help, protect and look after. We also considered how the council had made preparation for the implementation of the **Social Services and Well-being (Wales) Act 2014**.

According to the 2014 mid-year estimates, **Cardiff** had a population of **354,000**. This compares with an average population in the South East region of **150,000**. The 0-17 population was **73,087** in 2014; the next highest local authority population in Wales for this age group for the same period was **49,977**.

As Wales's largest city it also has the most diverse population, and although it contains areas of significant affluence, there are also those of considerable social-economic disadvantage. This demography is reflected in the demand for statutory services, with 4,195 referrals screened from 28,354 contacts received during 2014/15. The authority has developed a strategy to assist in the management of this high volume of needs presented to children's services and was on the cusp of remodelling the 'access arrangements' at the time of the inspection.

The inspection team would like to thank City of Cardiff elected members, staff, partner agencies and the children, young people and families who contributed to this inspection.

Summary

Theme 1: Providing Direction

The council was committed to prioritising services that support those who are most vulnerable, but had to deliver this against a backdrop of a declining budget and increasing demand. There was strong corporate support for children's services which had a high profile across the council. Elected members and the corporate management team demonstrated a common understanding of the direction and drive needed to ensure the service effectively supported improved outcomes for children and young people in Cardiff.

Scrutiny arrangements had been strengthened. Partner agencies were well engaged strategically and evidenced understanding of the complex issues facing the authority. There were some inconsistencies between the effectiveness of strategic and operational arrangements, but overall inter-agency working was effective.

There was a clear strategic direction articulated for children's services which was effectively led by the director of social services There was a high level of confidence expressed in the leadership arrangements, particularly considering the relatively short time these had been in place. While the senior management team had a common understanding of the approach being planned to remodel the service, overall the workers were less clear about how the operational arrangements would translate into practice.

Theme 2: Delivering Social Services

There had been a high level of staff vacancy during 2014/15 (31%) but investment in workforce planning had resulted in improvement in the ability to recruit suitably qualified and experienced staff. This focus will need to be maintained in order to increase staff retention; sustain the progress made; and further reduce the need to employ agency workers. 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.

Staff morale was generally positive and the senior management team were well regarded by staff. There was a degree of anxiety about the 'agile working' arrangements and relocation of services which were about to be implemented. Workers valued the accessibility of managers, and peer support from team members in assisting them to manage the high volume of work. It was not clear at the time of the inspection how the change of arrangements would impact their effectiveness. There were also potential changes ahead for the senior management structure which could pose a threat for the recently stabilised team.
Performance management was well embedded across the service and the need to review the supervision policy and ensure it was more consistently

applied throughout the service had been identified. Quality assurance was inconsistent and dependent on individual managers. A detailed quality assurance framework had been developed but had not been implemented.

Theme 3: Shaping Services

Corporate and senior officers evidenced good strategic preparation for the impending implementation of the Social Services and Well-being (Wales) Act 2014. Senior managers were able to articulate how the remodelled services and the early help strategy would deliver the intended outcomes. The plans for the overall co-ordination of the services were not fully developed at the time of the inspection. This was reflected in staff's lack of confidence in their readiness for operational changes.

The high demand for family support services and the volume of contacts with children services (particularly with respect to domestic violence) was marked. Managers and social workers were optimistic about the plans for improving early preventative services but had concerns about whether the capacity and range of services would be increased to meet the high level of needs being presented.

There was evidence of communication with staff who were kept informed of the key developments in the re-modelling of 'early help and targeted services'. There were few opportunities for the workforce to contribute their knowledge and expertise and be engaged in the remodelling of the service. The participation of children and young people appeared to be restricted to the looked after population which, while valuable in itself, did not impact on the reshaping of the 'access arrangements'.

Theme 4: Access arrangements

The arrangements for managing contacts and referrals were well organised and mainly effective. The volume of work coming into the service was very high and numbers of contacts had increased significantly since 2014.

Timeliness for managing contacts and referrals had improved in the first two quarters of 2015/16 but remained an area for progress. The recording of previous history of multiple contacts was inconsistent and did not support effective risk assessment.

Thresholds between 'early help' and statutory social services interventions were generally appropriate but inspectors were informed there was a lack of capacity within community-based support services.

Workers were not confident that partner agencies always understood the threshold for statutory services. While staff reported mainly positive working relationships, there were occasions when partners appeared to exert influence to ensure that child protection procedures were instigated unnecessarily.

The timeliness of initial assessments had also improved in the two quarters of 2015/16 before the inspection took place. The quality of the initial assessment work reviewed was mainly good, though it was not always apparent whether children had been seen.

Children and young people who were, or were likely to be at risk of harm were identified and work was appropriately undertaken to help keep them safe. The arrangements for child protection enquiries and investigations including those which were outside working hours were timely and effective.

Theme 5: Assessment Care Management

The needs of the child were kept at the forefront of assessments but the recording of children's and families' views on case files reviewed was inconsistent.

Core assessments seen were comprehensive and good quality. This quality was not reflected in care and support plans reviewed. Plans were formulaic and did not identify outcomes and measures which when reviewed would indicate where progress had been made.

Transfer arrangements between teams worked well to support the flow of work and weekly meetings had been initiated to improve the process. Workers were clear about the process with the majority expressing satisfaction with the transparency and fairness of case allocation.

Workloads were reported to be manageable and proactively reviewed, although this was dependent on workers bringing cases rather than managers having a system in place. In some cases reviewed, families were not engaged in the step down services before the case was closed. This will need to be addressed if families are to sustain progress made while receiving social work support. Workers reported that supervision was regularly completed but there was no performance management system in place to capture the frequency. The quality of support and management oversight was mainly positive but the loss of a team manager post has significantly increased the team caseload for some managers. Informal management support was readily available and valued by staff.

Child protection procedures were well understood by staff, and despite the variable quality of child protection plans reviewed, families were being supported to keep children safe.

The use of a number of different 'family agreements' was noted, some of which were outside safeguarding and public law outline arrangements. This practice needs to be reviewed so that social workers and managers are clear about their use and effectiveness.

The threshold for instigating the Public Law Outline (PLO) on cases reviewed was appropriate and arrangements to seek legal advice were effective. The system for identifying cases to be considered for PLO was not so defined and

a number of children had been on the child protection register (CPR) for over two years.

Recommendations

Providing Direction

1. Strong political and corporate support for children's services should be continued in order to achieve the council's vision for children and young people in Cardiff, while continuing to manage the consistent high volume of demand on statutory services.

2. The council must strengthen the operational plans to support the effective co-ordination of the remodelling of children's services and its interface with the Early Help Strategy.

3. The council should assure itself that arrangements for accommodation and 'agile working' which it was planning to implement will support effective social work.

Delivering Social Services

4. The workforce strategy should be fully implemented to maximise retention of staff and action taken to promote more timely recruitment of staff.

5. The council should consider how it can increase the opportunities for staff to be engaged in the development and transformation of services; and for the voices of children and their families to be included in service planning.

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

7. The quality assurance framework should be systematically implemented across children's services. This should include management oversight of the quality and frequency of supervision.

Shaping Services

8. The council must review its arrangements to ensure services can meet the needs of children and young people, particularly for those being subjected to domestic violence.
9. A timely review of the effectiveness and the impact on outcomes for people of the remodelling of children's services and its interface with the Early Help Strategy should be included in the planning arrangements.

Access Arrangements

10. 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 carries out its work.

11. The council must develop more effective arrangements to ensure that the needs of children and young people are assessed if contacts and referrals about their well-being are repeated.

12. The council must work with partners to agree a shared understanding of the threshold for statutory services.

13. Careful consideration should be given to how the current effective interface between 'children's access point and the intake and assessment teams' is maintained when the remodelling of the service is implemented.

14. Arrangements for children's services staff to access information held on parents who are users of adult services should be reviewed.

15. The 'out of hours' arrangements for the completion of 'welfare checks' on children and young people should be agreed with partner agencies.

Assessment Care Management

16. The quality of plans should be improved to be more outcome-focused and reflect the needs identified in the assessments.

17. Work to agree a model of risk assessment should be completed with a strong focus on consistency in risk management.

18. More emphasis should be given to recording the views of children, young people and their families.

19. The council should review the use of written agreements with families which should only be used within safeguarding or public law outline arrangements. Guidance for social workers and managers for their use should be developed.

Key Findings

Theme 1: Providing Direction

What we expect to see

Leadership management and governance arrangements comply with statutory guidance and together establish an effective strategy for the delivery of good quality services and outcomes for children, young people and their families. The authority works with partners to deliver help, care and protection for children and young people and fulfils its corporate parenting responsibilities for looked after children. Leaders, managers and elected members have a comprehensive knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively.

1. Leadership, management and governance arrangements complied with statutory guidance.

2. Elected members interviewed had a good understanding of how to interrogate performance and were well informed of the strategic direction of children's services.

3. There were high aspirations to develop an authority-wide approach to improving outcomes for children and young people in Cardiff.

4. There was a clear strategic direction articulated for children's services which was effectively led by the director of social services.

5. Corporate changes in working conditions could impact on the working arrangements which support effective social work.

6. Safeguarding and the development and improvement of children's services had a high corporate profile.

7. The voices of children and young people were not sufficiently captured or used to provide assurance that services were effective.

8. Senior staff and partners were clearly committed to driving forward the preventative and early help agenda; however, staff had not been sufficiently engaged in these developments.

9. Staff and partners commented favourably on the increased visibility and improved leadership of the senior management team.

Explanation of findings

1.1. Corporate support for the improvement of the effectiveness of supporting children and young people to achieve better outcomes was evidenced by:

- considerable investment in promoting improvement in children's services - using expert advice to support better practice and strengthen scrutiny arrangements;
- a Cardiff Partnership Board chaired by the chief executive officer has agreed priorities for actions needed to improve outcomes;
- corporate officers, elected members and senior managers share an understanding of the work and resources needed to successfully implement the strategic plans to transform children's services
- strong corporate support for the development of Cardiff's Early Help strategy.

1.2. There was a high level of confidence in the director of social services' leadership and ability to advocate for children's services on corporate and partnership agendas. Inter-directorate communication and collaboration was reported to have significantly improved since the director of social services had taken up his post.

1.3. Strong performance management and reporting mechanisms which included opportunities to challenge kept elected members well informed. There were no mechanisms in place for elected members and corporate officers to hear the views of children, young people and their families using the intake and assessment service.

1.4. The strategic direction developed for the service evidenced good preparation for the implementation of the Social Services and Well-being (Wales) Act 2014. However, workers were less confident that they were fully trained and prepared.

1.5. There was evidence of good communication and joint working between partners at a strategic level. This included plans for the development of a Multi-Agency Safeguarding Hub which was regarded optimistically as the way forward for the better management of the demand for statutory services. Senior managers were more cautious about this but did believe that potentially thresholds could be more consistent and that joint investigations would be more effective. Operationally, workers expressed concern that they were not adequately prepared for the changes in the intake arrangements and that operational detailed plans were under-developed.

1.6. The senior management team were highly motivated to implement the proposals for the transformation of children's services. There was a

constructive collaborative approach to managing change, despite the possibility that there could be an impact on them individually. The impending change to the post of assistant director and the requirement for all operational managers to apply for their own posts had the potential to impact on the effectiveness of the team.

Key Findings

Theme 2: Delivering social services

What we can expect to see

Services are delivered by a suitably qualified, experienced and competent workforce that is able to meet the needs of children, young people and their families. The council is able to ensure that staff and services meet the standards that have been set for them.

Key findings

1. The ability to recruit suitably qualified staff has been improved by investment in the recruitment strategy, but some managers reported delays in the recruitment process.

2. There was a culture of supportive management that prioritised staff well-being and promoted their professional development which was valued by staff.

3. There was a good range of training opportunities but staff reported they did not always have the capacity to take them up.

4. Workers interviewed valued the support available for them to complete a 'first year in practice' programme.

5. The quality of supervision recording was inconsistent across case and staff files.

6. Staff morale was positive despite some anxiety about capacity to manage the high level of demand at the 'front door'.

7. Workers were concerned that the impending moves to 'agile working' and relocation of the service may impact on the opportunity for management oversight, effective peer support and 'shared learning' ethos within teams.

8. Performance management was well embedded and understood across the service.

9. A draft quality assurance framework had been developed but this had not been implemented; there was limited service user feedback or organisational learning from complaints.

Findings

Explanation of findings

2.1. Senior managers were kept well-informed of workforce capacity issues and a draft workforce strategy had been developed. All vacancies were covered by agency staff at the time of the inspection, but cover for sickness and other staff absences was provided by existing staff. Although overall the percentage of vacancies across children's services had reduced, there were still 33 vacancies (23%) at the end of December 2015, with 11 of these posts in the appointment process.

2.2. The intake and assessment service experienced a high level of vacancies over the previous 12 months. It was reported that during December 2015, staff had to work long hours to ensure that the service was effective although they were well supported by mangers during this period. Senior managers were well aware of the need to build more resilience in the workforce. There was evidence that the high rates of vacancies and sickness, combined with turnover of social workers, was impacting on continuity and the progress of work with some families. Managers and workers were very conscious of this and efforts were made to minimise the effect whenever possible.

2.3. The remodelling of the service has been designed to support better retention of staff and all workers interviewed were positive about working in Cardiff, with some agency staff agreeing to become permanent employees.

2.4. Morale amongst workers interviewed was good, but the staff survey indicated this was not consistent across the service. The majority of concerns expressed in the survey were about volume of work, retention of staff, and the changes to working arrangements. There was a level of optimism about the plans to increase the preventative approach and the new models of intervention being introduced. The authority had made attempts to engage with the workforce by carrying out a staff survey in 2015 and had developed a number of communication and engagement strategies. It was apparent that, given the risk posed to staff morale by multiple changes to both models of service and working conditions, there needed to be more focus on engaging representatives from all teams and different roles in the planning process.

2.5. The experience and long-term local knowledge of the service inherent in the operational manager group had provided stability and continuity for the service. Although not co-located, workers were confident they could access senior managers. The team managers were on the whole a stable and experienced group who were valued for their support and approachability. It was evident that social workers and managers particularly in the intake and assessment service had developed effective working relationships.

Quote from a team manager
"Staff are getting on well with the day job, with a strong focus on better outcomes for children and young people, ensuring that safety and effective management of risk is central to everything they do."

Quote from Operational Manager
"Social workers in the CAP team would stay at their desks until all their work was completed no matter how late it was."

2.6. These arrangements were mutually supportive and improved the capacity in the service, particularly for managing the high demand and the risks. There was anxiety amongst this staff group that the agile working arrangements about to be introduced, the relocation of the teams, and the move of the Children's Access Point (CAP) team into the Multi-Agency Safeguarding Hub (MASH) would impact on their positive working environment. While accepting that these significant changes were being introduced to improve the ability of the service to respond to the needs of people, staff expressed their concern about a lack of detailed planning. Senior managers did not appear to have clearly communicated the plans for a phased introduction of MASH, nor the chief executive officer's undertaking that corporate resources would be made available. Crucially, workers need to be engaged better in the change process to reduce the possibility of destabilising the workforce and the disruption of service delivery.

2.7. Workers interviewed were positive about the support for the 'first year in practice' programme, although the co-ordination was said to be affected by variation in the numbers of staff who were in the programme. Individually, social workers were positive about managers' support for their personal development and were able to give examples of how they had benefited. There was also a comprehensive programme of relevant training available with an effective system in place to facilitate its delivery. The consistent demand on workers' capacity was reported to have impacted on their ability to attend planned training.

2.8. 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 any dips in performance. Workers interviewed were all aware of the standards expected by the service and that managers used the Care First System to generate reports on whether timescales were being met. Timeliness for making decisions on referrals and completing assessments had improved over the previous six months, but this was still vulnerable to increases in demand and unplanned staff vacancies. The remodelling of the 'front

door' services poses a potential risk to performance and this will need to be monitored closely during the transition period.

2.9. A draft quality assurance framework had been developed but had not yet been implemented. Case file audits undertaken by inspectors indicated that quality assurance of assessment and planning work and feedback to staff was inconsistent across the service and dependent on individual managers. Supervision notes reviewed confirmed this view. There were some examples of managers keeping good practice files which could be shared more consistently across the service. Whilst peer supervision had been recently introduced, opportunities for both formal and informal sharing of good practice and experience were limited by the high demand on capacity.

2.10. Information about making a complaint was not routinely provided to children, young people and their families and this was evidenced on files reviewed.

2.11. Systems were in place with a clear role for the complaints officer (which was followed) but complaints are not routinely investigated within the prescribed timescales nor reasons for delay clearly evidenced. Investigations of complaints at Stage 1 and written responses did not always address all the issues raised leading to escalation. The format and tone of letters seen by inspectors was at times confrontational and should be reviewed.

Good practice
One team manager had introduced a buddy system for social workers which not only supported less experienced workers but improved continuity for families.

Quote from staff survey
"Difficulties in recruitment and retention impact my day-to-day work and more importantly the families and children who require support from the local authority."

Quote from case track interviews 'an agency worker'
'S' spoke very highly of the supervision she receives and of the support of her team. She described her Principal Social Worker as "amazing". She is enjoying the challenges of working in such an ethnically diverse authority. She also commented on the availability of the Operation Manager and quoted ringing her from court, getting through straight away, having a decision and being able to report straight back to the court.

Theme 3: Shaping Services

What we can expect to see

The services and support for children, young people and their families improves their outcomes. Work with partners in shaping the pattern and delivery of services is informed by local needs analysis assessment and includes the views and experiences of children and young people. Strategic plans are converted into commissioning arrangements which provide safe, quality services and deliver best value

Key findings

1. Sound preparation for the implementation of the Social Services and Well-being (Wales) Act was evidenced in the strategic direction outlined by the authority.

2. The strategy for remodelling early preventative services was ambitious, well-developed and had been jointly developed with partner agencies.

3. There was a lack of engagement and consultation with staff around the implementation of plans to support the early prevention strategy and the remodelling of the service.

4. There was an unmet need for the high demand for support services for the victims and perpetrators of domestic violence, and workers also reported a lack of capacity in the community support services which impacted on families moving to non-statutory interventions.

5. The voice of the child was not evident in shaping service planning.

6. Senior managers were able to articulate how families would benefit from the strategy to develop an integrated approach to preventative and targeted service provision, but operational plans to co-ordinate the whole model were under-developed.

Findings

Explanation of findings

3.1. A number of developments indicated that the authority had made good strategic preparation for the implementation of the Social Services and Well-being (Wales) Act 2014:

- An 'Early Help' strategy designed to make prevention everybody's business with a strong partnership approach was in place.
- The remodelling of the 'first point of contact' access to services helping to provide information, advice and assistance.
- The development of a range of services to help prevent children and young people needing to be looked after.

3.2. More work is needed to plan for the co-ordination and interface between these developments and statutory services. Workers expressed concern that they had not been sufficiently engaged in the scoping and planning of the remodelled service. It was not evident that children, young people and families had been consulted about the new developments.

3.3. Staff had concerns about the current lack of capacity for some crucial support services, particularly those for families experiencing domestic violence and primary mental health care. It was not clear how the demand for these services would be met, and the opportunities to reduce repeat contacts and referrals and promote better emotional well-being for those affected could be maximised.

3.4. Although the views of families had been sought with respect to the development of the 'Early Help' strategy, there had been no consultation with respect to the remodelling of children's services.

Quotes from staff survey

- "There has been an important commitment of resource to develop arrangements for early intervention and prevention. The longer-term ambition is to reduce numbers coming through needing higher tier interventions."
- "There has been good vision and leadership shown by senior managers in developing the Early Help Strategy. There is also a commitment to continuous improvement, for instance, the development of restorative practice, the introduction of signs of safety and the remodelling of children's services."

Theme 4: Access Arrangements

What we expect to see

First contact services are readily accessible and prompt in their response. Children, young people and families are offered help appropriately and proportionate to risks when need and/or concerns are identified. Thresholds between "early help" (the provision of information, advice and signposting) and statutory social services interventions are appropriately understood and are operating effectively.

Key findings

1. Children and young people in need of protection received a timely and effective service, including 'out of hours' to help keep them safe.

2. Access arrangements were well organised but there was no system in place to monitor repeat contacts; this resulted in a lack of timely preventative support for some children.

3. There was a lack of clarity about the system to access information from adult services when screening contacts and referrals.

4. There was insufficient analysis of the very high volume of contacts from partner agencies into the intake service.

5. Appropriate thresholds for access to statutory services were not consistently understood by partner agencies.

6. Workers did not feel well informed about the range of preventative services available in the community.

7. The range and quality of information for children, young people and families was limited and dependent on individual workers rather than a service standard.

8. There was evidence that families signposted to support services as they were assessed as not meeting the threshold for a statutory service were frequently re-referred to children's services.

Feedback from family interview
The father of S was very happy with the service he had received. He believed that he had been treated fairly and with respect he was kept well informed of decision making and planning for his son. The rehabilitation plan was well implemented which was clear from the young child's evident well-being.

Findings

Explanation of findings

4.1. The arrangements for access to children's services were well organised and mainly effective. Timeliness for decision making on referrals in one working day stood at 83% for 2014/15, and the 28,354 contacts screened during the year had resulted in 4,195 referrals. This consistently high volume of work continued into the first two quarters of 2015/16 with 7,280 contacts received in quarter 2, but there was an improvement in timeliness to 94%. Improving and sustaining timeliness is dependent on stable capacity in the CAP team and is vulnerable to unplanned staff absence or any delays in recruiting into vacant posts. The percentage of re-referrals within a year remained constant at 25%; given the numbers of referrals this equates to 968. This indicated that not only is there a possible duplication of a high volume of work but that there was a lack of timely support for some families.

4.2. The threshold to statutory services was relatively high but there was timely appropriate response to concerns about children or young people who might be at risk. It would appear from the high number of repeat contacts seen by inspectors that the demand will only be reduced if there are sufficient preventive services to effectively support families sooner. Multiple contacts meant that the same case was screened many times, but even though the majority of families were signposted to support services, this was not effective in meeting the presenting needs. Systems to record multiple contacts had been disabled following a systems review, which resulted in a difficulty for staff in being able to easily consider the accumulative effect of multiple incidents which might have led to a decision for an initial assessment to be carried out. This had subsequently been identified as an issue and the process had been amended at the time of the inspection. Inspectors were informed that other agencies were not contacted in these cases, as if the parent's consent had not been sought at the point of contact this was a barrier to gaining further information. The development of the information advice and assistance service (IAA) and the MASH is intended to help ensure that contacts and referrals are better prioritised. This should result in families being able to receive support at an earlier stage reducing the need for statutory services and improving outcomes. Senior managers were aware that supporting families to engage in accessing support was the key to the success of this approach.

4.3. There was a lack of user-friendly information for children, young people and families to inform them about their right to make a complaint or the availability of advocacy services. There was good availability of translation services which were in constant demand given the diverse profile of the population in Cardiff. Families interviewed were very positive about this facility and complimented staff on their efforts to ensure communication was good.

4.4. Workers reported that although there were good 'working relationships' with partner agencies they did not have a common understanding of the threshold for statutory services. It was evident that families were not fully aware that they had been referred to children's services, or what this might mean. More multi-agency work was needed to improve communication and agree how the remodelled service would translate into practice. Partners should be engaged in the quality assurance process, particularly with regard to decision-making around thresholds.

Feedback from interview with a family

"The family was not informed about the complaints process until the social worker had postponed a number of parenting assessment sessions for the mother. The complaints were about lack of communication, lack of empathy e.g. mother was asked if she wanted 'adoption counselling' she declined but then received both a leaflet on 'having your child adopted' and a call about an appointment although this was not the plan for her child."

Quote from staff survey

"This is a demanding job and at times, morale can be very low and the amount of work required outside of normal working hours is extensive, to the point of affecting my home life. Currently, my morale is high as my case load is more manageable."

Theme 5: Assessment care management

What we expect to see

Children and young people identified as being in need of help or protection, including looked after children, experience timely and effective multi-agency help and protection through risk-based planning authoritative practice and review that secures positive outcomes.

Key Findings

1. There was evidence that outcomes for children and young people had been improved as a result of social work intervention.

2. Timeliness of assessments was variable but the quality of those seen on case files was good.

3. Workers were using a number of risk assessment models and the quality of risk analysis within assessments and care planning was variable.

4. Care and support plans did not reflect assessments and were not outcome-focused with timescales for action and roles and responsibilities often unclear.

5. Case work was child-focused but did not articulate children's wishes and feelings often enough.

6. Child protection enquiries were thorough and timely and were informed by decisions made at a strategy discussion.

7. The actions of partner agencies did not always prioritise the best interest of the child.

8. There was a lack of consistency in the guidance for the use of 'written agreements' with families and there was a lack of clarity about their purpose and effectiveness.

9. Thresholds for the instigation of PLO were appropriate but those for admission to care following police powers of protection were inconsistent.

10. Effort had been made to improve the interface with 'Team around the Family' which was positively received by workers in both services.

Findings

Explanation of findings

5.1. Timeliness for completion of initial assessments had improved significantly in quarter 2 of 2015/16 to over 91%; numbers of assessments completed remained high at 841. This was good progress as timeliness varied between 46.5% at the lowest and 67% at the highest in the previous 12 months. The volume of demand showed no signs of reduction, and sustaining this improvement will be a challenge unless the remodelling of the service described earlier in this report succeeds in signposting families to access appropriate community-based services.

5.2. The quality of initial assessments seen was good, with appropriate decision-making and records clear and up to date. A good range of information had been used to develop the analysis of need, but it was not always evident that the child had been seen. All assessments were signed off by managers in a timely way and included their comments. There is a need to address the inconsistency in which elements of the work were being quality assured by managers.

5.3. Timeliness for core assessments also improved in the same period with 75% of the 555 assessments being completed in 35 days; performance in the previous 12 months varied between 55% and 71%. The quality of core assessments reviewed was good, with analysis of needs well recorded. Recording of risk assessment was inconsistent, although management of risk was apparent in the majority of assessments reviewed. Core assessments reviewed by inspectors were embedded in the Sect 47 investigations. This allowed easy access to critical information and supported the timely updating of recording. It was less helpful when Sect 47 investigations were discontinued because risks were assessed to be minimal but there were presenting needs.

5.4. The quality of care planning was inconsistent with limited identification of desired outcomes. Timescales, responsibilities for actions and what services were to be provided were not routinely outlined. It was not evident how families were engaged in the planning process or whether they had received copies of the plans. Workers were using the ‘signs of safety‘ model to address risks and identify and build on the strengths of the family. The quality of these plans seen was again inconsistent and it was noted that risks identified on case file recording did not always feature in the plans. Some files contained a child protection plan in addition and it was not always clear which plan was being implemented with the family. More guidance is needed for staff to increase consistency of risk management and agree planning priorities.

5.5. While it was evident the children and young people’s welfare was paramount for social workers, examples were seen of where this was not

always the case for partner agencies. It was not clear why social workers were unable to successfully challenge these actions. Managers had identified these issues and reported that work was on going to address the concerns.

5.6. There had been a relatively high number of occasions in the 12 months prior to September 2015 when police had invoked their powers of protection (41). A third of the children and young people subject to these arrangements only remained looked after for a very short period. Senior managers agreed to work with partners to analyse this practice to ensure that the best outcomes are being achieved for children and young people.

5.7. Inspectors noted that social workers were using written agreements with families outside those within child protection or public law outline arrangements. These agreements cannot be monitored effectively unless they are part of multi-agency work so have the potential to provide false assurance that children are being protected. There should be guidance developed for the use of these agreements and cases where they are in place should be reviewed to ensure that they are being used appropriately.

5.8. The workflow arrangements in the access service were timely at the time of the inspection. The system was well established and the handover from the CAP team into the Intake and Assessment team worked well, ensuring that there was no delay in completing Section 47 investigations when these were needed. The quality of this work seen by inspectors was good with some examples of very good outcomes being achieved for children and young people.

5.9. Action had been taken to improve the working together arrangements between children's services and the 'Team around the Family' (TAF) service. This was reported to have worked well with a member of the TAF team routinely spending time in the intake and assessment team. Social workers did have a concern that the criteria for referral to the service were too specific as it related to the number of services the child required (4) rather than the level of need.

5.10. There were delays in families accessing the support services which had been identified as part of their plans. Inspectors were informed that there had been an overall reduction in the range of services available and there could be up to a six month waiting list for others. Certain key services for parents to help reduce domestic violence were in high demand, and examples were seen where families remained apart or s child's name had to remain on the child protection register because this work could not be completed.

5.11. Where 'children in need' cases were concerned, these delays influenced workers referring families to these services as there would be

a long gap before families would be able to access the support they needed.

5.12. During the previous 12 months, a significant investment had been made to reassess the high number of ‘children in need’ cases which had accumulated due to a lack of capacity. This had resulted in increasing the ability to focus on those families in the highest need. Inspectors did see some cases closed where it appeared there was work outstanding, and while this was not a concern with respect to risk, it had the potential to result in families being re-referred because ‘step down‘ services were not in place to help sustain the progress made. Monitoring was in place to identify families who were re-referred but there needed to be more effective arrangements to help reduce the likelihood of this happening.

Quote from a social worker

"It's been a really positive experience as a newly qualified social worker in Cardiff; I feel well supported and am staying here for the foreseeable future."

Appendix

Information about the inspection.

Methodology

Fieldwork for this inspection was undertaken during the weeks commencing January 11th 2016 and January 28th 2016.

Most inspection evidence was gathered by looking at individual children and young people's experiences. This was done through a combination of case tracking and case-file reviews.

Additional evidence was collected from a review of documentation including a staff survey, supervision records and complaint documents. Also, a range of individual interviews and focus groups with senior and operational managers, elected members, partner agencies, senior practitioners, social workers and support staff.

We reviewed/tracked 64 case files. This included 27 individual interviews with staff.

Six interviews with families and 7 direct observations of practice.
A staff survey – we received 100 responses.

The inspection team

The inspection team consisted of:

- 2 inspectors employed by CSSIW
- 2 fee paid inspectors
- Area manager for Cardiff.

Lead inspector: Pam Clutton;
Area Manager: Bernard McDonald;
Team inspector: Bobbie Jones;
Fee paid inspectors: Sheila Booth and Norman Host.