AGGCC
CSSIW

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

Inspection of *Children's* Services

at Flintshire County Council

September 2015

Contents

WG26377 Digital ISBN 978 1 4622 9

Introduction

Care and Social Services Inspectorate Wales (CSSIW) undertook an inspection of children's services in Flintshire County Council during May and June 2015. Inspectors looked closely at the experiences of children and young people who had needed or still need help and/or protection.

The inspection also considered the quality of outcomes achieved for children and families including a small sample of children and young people who were, or had been, looked after. Inspectors read case files and interviewed staff, managers and professionals from partner agencies. Wherever possible, and as appropriate, they talked to children, young people and their families.

In addition, inspectors evaluated what the council knew about its own performance and the difference it was making for the people it was seeking to help, protect and look after.

The council had experienced a significant period of change and at the time of the inspection had announced a review of children's services with a view to informing a reorganisation of the service. 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 6 of this report identify the key areas where post-inspection development work should be focused. They are intended to assist Flintshire County Council and its partners in their continuing improvement.

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

Summary

Theme 1: Access Arrangements

The council's early intervention and prevention arrangements were insufficiently developed impacting on the timeliness of early help. The council was responsive where there was an immediate indication that a child was at risk, but the timeliness of the progress of contacts where there was not an obvious indication of significant harm was inconsistent. It was noted that a number of older children and young people who were referred did not receive a timely assessment or appropriate early intervention. The council was in the process of reviewing the resilience of the first contact arrangements.

Theme 2: Assessment

Strategy discussions were undertaken in accordance with guidance, but did not routinely include information from all relevant partners. The quality and timeliness of child protection enquiries was inconsistent.

The assessments seen were of a variable quality; where they were good there was evidence of utilising a range of information to inform the analysis. However, the good social work practice reflected in the content of assessments was undermined by the structure and design of the process, including transfer arrangements between the teams. The duplication of assessment processes and changes in social worker resulted in a loss of impetus that impacted on the engagement of families.

Theme 3: Safeguarding and Care management

All child protection work was undertaken by qualified workers. The decision to convene a child protection conference was not always timely, but once made, the resulting conferences and reviews were well managed and appropriately child focused. The quality of the child protection plans seen were variable but mainly satisfactory and included some that were good. Core group working and child protection planning needed to be strengthened to ensure a more consistent shared understanding of the identified risks to the child, the progress required and the outcomes achieved. The authority's approach to risk assessment and risk management needed to be more effectively communicated and understood by partner agencies. All children had a care plan, but the quality of the plan was not consistently forward looking, outcome focused and did not reflect the council's ambition for looked after children.

Services were being delivered to families and direct work undertaken but this was not always evident in the case file record, and was reported as being subject to resource capacity. The council had developed a clear relationship between the public law outline, child protection and looked after children process.

Theme 4: Leadership and Governance

Leadership, management and governance arrangements complied with statutory guidance. Senior leaders and officers had a shared commitment to improving safeguarding arrangements and had sought to strengthen this within their strategic priorities. Strategic plans needed to be better disseminated throughout children's services and translated into an effective strategy, for the delivery of good quality services and improved outcomes for children, young people and their families. This framework will need to be informed by an ongoing analysis of the underlying complexities and risks associated with the service. The council needs to build-on the relationships

it has with partner agencies to ensure a shared ownership of the strategic direction, and also the operational drive needed to improve services and outcomes for children, young people and their families.

Senior leaders were increasingly knowledgeable about performance and were seeking to ensure that they were better sighted on front line work and on the quality of services. The children's forum was in place and had begun to raise the profile of looked after children across the council.

Services were delivered by a suitably qualified, experienced and competent workforce that was able to meet the needs of local children, young people and their families. Management was seen as accessible, but there needs to be a stronger oversight of practice that supports the workforce to deliver services that result in positive outcomes for children and families.

Recommendations

1. As a priority, the council should progress its commitment to develop an early intervention framework that will deliver integrated services and provide early support to children, young people and families.
2. The council should establish effective systems to ensure that thresholds for assessments are consistent across the service and understood by staff and partners.
3. Multi-agency arrangements should be established to review repeat referrals and quality assure decision making.
4. The consistency in quality and the timeliness of assessments and plans must be improved.
5. Children's services' approach to risk assessment and risk management should be more effectively shared and understood by partner agencies.
6. The council should progress its intention to review children's services structure and ensure arrangements are in place to support the appropriate engagement of staff, partners and service users.
7. The council should ensure that managerial leadership is sufficiently aligned to the professional experience needed to manage the complexity of discrete areas of operational delivery.
8. Strong political and corporate support for children's services must continue to ensure the service improvements needed are prioritised and the pace of improvement sustained.
9. The children's forum should continue to focus on ensuring that ambitious outcomes for looked after children and young people are achieved, and support improved mechanisms to gain the views of service users.
10. The workforce strategy should include leadership and development programmes to build resilience within the operational management team.
11. The draft Quality Assurance Framework must be systematically implemented across the service. Performance management and quality assurance arrangements, including scrutiny of service demand and routine auditing of the quality of practice, should be embedded across the service.
12. The quality of supervision should be reviewed to ensure there is sufficient resource and capacity available to manage it effectively.

Findings

Theme 1: Access to Services

What we expect to see

Thresholds between early intervention (including the provision of information, advice and signposting) and statutory social services are appropriately understood and are operating effectively.

Key Findings

- The council's early intervention/prevention arrangements were insufficiently developed, impacting on the timeliness of early help.
- The authority had maintained consistently good performance in relation to the number of referrals on which a decision was made within one working day. Senior management oversight and the quality assurance of screening decisions were insufficient and the first contact arrangements lacked resilience.
- The council's information system did not support an effective oversight of a family's previous involvement with social services. Chronologies and genograms were not purposeful.
- The council's policy on thresholds, screening decisions and managing referrals were not sufficiently shared with or understood by partners.
- Professionals were not kept sufficiently informed or engaged in the outcome of referrals they made to the authority.
- The progress of contacts where there was not an obvious indication of significant harm was inconsistent, and the help offered to families was not always timely.
- The needs of young people aged 11+ were not always effectively assessed and prevented them receiving timely, preventative support.
- The authority's duty and assessment model consisting of three pods did not sufficiently consider children, young people or families' need for continuity and consistency of social worker.

1. Explanation of findings

1.1 In November 2014 the council relocated its operational children's services staff, including fostering, to one location based in Flint. The aim of this move was to promote an improved whole service identity and better working collaboration across the teams. However, staff raised concerns that the new office arrangements did not sufficiently ensure service users had ease of direct access to services. Partners and staff also identified an increased difficulty and delay in telephone contact with children's services as the result of automated responses and unanswered phones being routed through a busy duty desk.

Quote from member of staff

"The telephone system is problematic when people try to contact children's services. Children experience changes in social worker in the duty team within a short space of time."

1.2 The council's arrangements to receive and manage referrals to children's services in Flintshire had been in place for over two years. The duty and assessment team consisted of three pods that each had distinct service responsibilities and largely operated independently of each other. The day-to-day management of each of the pods was provided by a designated senior practitioner. The senior practitioners were managed by an experienced duty and assessment team manager who had overall responsibility for the team including performance and workflow.

1.3 The duty and assessment team's management arrangements had undergone a number of recent changes and the three senior practitioners were all new to their current role. However, arrangements for structured induction/training and initial additional support were inadequate.

1.4 A key strength of the duty and assessment team arrangements was identified as the close working relationship between the senior practitioner and social workers, and the availability of management support. However, changes in the team manager's responsibilities to include additional management responsibility and cover for senior practitioner's work, where they had a reduced hours contract, had impacted on the overall management capacity within the team. Staff stated that managers, including service managers, were accessible, but the expectation that gaps in management time could be absorbed from within the current establishment had adversely impacted on manager's availability.

1.5 Inspectors identified that management oversight of the access arrangements were not sufficient to assure the authority that child and families received the timely support they required.

1.6 The council's first contact arrangements were managed through 'pod one'. This pod, comprising of one full-time senior practitioner and two unqualified but experienced children's services assistants, had responsibility for screening all new contacts and managing initial child protection strategy arrangements. Cases identified as requiring section 47 enquires were transferred to pod two, but could be directly allocated by the senior practitioner in pod one to a social worker in pod two. Those cases requiring an initial assessment were transferred to pod three. Cases were transferred again between pods two and three prior to case conference or for ongoing assessment. The senior practitioners had little oversight or control of the overall workflow across the duty and assessment team.

1.7 Inspectors found that the transfer arrangements between the three pods were designed to support the duty and assessments teams' ability to manage the screening process; convene timely initial strategy discussions; and prompt allocation of section 47 enquiries. However, following the initial transfer, the progress and management of the case became fragmented and inspectors identified delays in allocation as cases moved between the pods. There was also a focus on completing different assessment processes rather than on timely analysis, intervention and support.

1.8 The early throughput of work was seen as impeding social workers spending time with families, and resulted in missed opportunities to make a difference to children and families who experienced too many early changes of social worker, often at a time when the family were in crisis. Staff echoed these concerns and also raised that the throughput of cases between the pods acted to reduce ownership of decisions and prompted risk adverse management.

1.9 The authority had experienced year-on-year growth in the number of referrals – 1,220 (2013/14) to 1,825 (2014/2015) - and a number of unexplained fluctuations in the volume of contacts during the year. These unexpected increases created additional pressure on the service. Despite this, the authority had maintained consistently good performance in relation to the number of referrals on which a decision was made within one working day.

1.10 The number of re-referrals, however, had increased from 158 (2013/14) to 478 (2014/2015) and it was evident from the information provided by the authority, and from the cases reviewed by inspectors, that some families experienced multiple contacts before a case progressed to an assessment.

1.11 Despite the significant increase in overall contact/referrals, the number allocated for initial assessment had remained around the same level with less than a 4% change over the last four years. The council needed to develop a more coherent approach to the collection and analysis of relevant performance information, to better understand the safe and effective operation of the front door (duty and assessment service). Such information would also help to inform the council's service development and commissioning intentions in relation to preventative services.

1.12 The authority's early intervention arrangements to support families were not sufficiently developed. The current Team around the Family (TAF) arrangements located in the education and youth portfolio were under pressure with staff vacancies and a waiting list for services. Staff and partners expressed frustration with the lack of a co-ordinated approach to early help for families, as they believed this would significantly benefit families and also mitigate the need for statutory services. The council had now identified the development of an early intervention framework as a priority, and the management of the TAF was due to transfer to the social services department in September 2015. The development of an early intervention framework will need to take account of and inform the planned review of children's services to ensure a cohesive whole service approach.

1.13 Children and young people in need of protection were identified by partner agencies and timely referrals were made to children's social services. Professional partners expressed some frustration with thresholds but generally welcomed the quality of the duty officer's early advice, and reported that once a referral was accepted the initial response by children's services was constructive and appropriate safeguarding action taken.

Quote from partner agency

"The duty service works well once you're in to the service but getting into the service is not that easy."

1.14 Despite reported confidence in children's services, partners identified that they often lacked clarity regarding how threshold decisions on new cases were determined, and told inspectors that they were not kept sufficiently informed regarding the outcome of referrals. Inspectors were told that partners sometimes challenged the unqualified duty staff and sought to discuss threshold decisions directly with the senior practitioner.

1.15 Some agencies indicated that they did not understand how the pod system worked and that the rapid transfer of cases between teams created uncertainty regarding who to contact in respect of tracking or following up referrals. Partners also highlighted differences regarding the extent to which social workers across the teams sought information and engaged them in subsequent assessments or informed them of the outcomes.

1.16 The referrals, seen by inspectors, received from other agencies contained sufficient information to support initial decision making. The use of multi-agency referral forms was inconsistent but verbal referrals were mainly followed up in writing. The multi-agency referral form (MARF) would benefit from being refreshed. Children's services workers receiving referrals were proactive about obtaining additional required information and confident in challenging partners regarding any shortfall in the quality or timeliness of referral information.

1.17 The volume of contacts from the police (CID16) reporting incidents of domestic abuse remained consistently high and this created additional pressures for the duty team. The quality of the police referrals seen were variable but more recent examples included a helpful summary of previous involvement with the family and an analysis of presenting risk. Children's services operates a domestic abuse protocol that results in all first domestic abuse incidents triggering a letter to the family, as a minimum response – subsequent reports are referred to the multi-agency risk assessment conference (MARAC). During interviews it was clear that not all staff were aware of this protocol or of the resulting outcomes. There also appeared to be limited intelligence regarding the impact of the protocol on the rate of repeat episodes/referrals.

1.18 Duty staff made relevant background checks with other agencies; however, inspectors often found these were not easily identifiable on the electronic information system. The electronic information system did not support an accessible overview of social services engagement with the family, and depending on the type of case, information was not automatically pulled through from the nominal child's file to that of any relevant siblings. This could result in significant information not being appropriately considered as part of determining risk. The genograms seen were not routinely updated and chronologies were not purposeful. An established user group was in place to promote operational improvements to the electronic information system and selective problems were being addressed in addition to reviewing the future requirements of the service.

1.19 Inspectors found that when contacts were received where there was an obvious indication that a child or children were at risk or had suffered significant harm, prompt decisions were made and initial action was taken to protect the child. Child protection investigations were undertaken, in line with guidance, following a strategy discussion. In the cases reviewed, inspectors saw no examples of children and families being subjected to initial child protection investigations unnecessarily.

1.20 When contacts were received where there was not an obvious indication of significant harm, decisions to progress to referral were not always timely or appropriate. As a result, children were left too long at potential risk and families were not always being offered help early enough.

1.21 In some of these cases, evidence was seen of an over reliance on self-reporting with workers determining screening decisions based on information obtained from telephone contact with families, which was not sufficiently verified or challenged. This was particularly seen in relation to concerns around domestic abuse violence.

1.22 Inspectors saw examples of cases being closed where there was a clear indication that children and families were in need of help and support, albeit with no obvious indication that the level of need met the threshold for significant harm. Nevertheless, these cases clearly should have progressed to an assessment prior to deciding how and by whom support could most effectively be provided. The impact of this was that children and families were not being helped when they should have been. The thresholds in relation to adolescents were identified as being set particularly 'high' and concerns were often minimised. Inspectors saw examples where contacts relating to young people living with parents with poor mental health and/or substance misuse were not progressed to an assessment which prevented them from receiving timely support.

1.23 The council had recognised the need to update its policy and guidance for intervention, and the need to work with partners to develop and reinforce a shared understanding in respect of thresholds.

1.24 The authority had systems in place for responding to referrals out of normal office hours. The emergency duty team (EDT) had access to the council's electronic information system and the senior practitioner had systems in place to prioritise cases referred in by the EDT service.

1.25 Inspectors saw some good evidence that the senior practitioner maintained oversight and sign off in relation to screening decisions that included comments. However, the overall management oversight of access arrangements needs to be strengthened to include the routine audit of case files, to ensure better control of the quality and consistency of practice. The council would also benefit from the development of operational multi-agency peer review processes and a clear protocol for managing re-referrals.

Theme 2: Assessment

What we expect to see

Children and young people who are or are likely to be at risk of harm or in need of support are identified and protected.

Key Findings

- Strategy discussions were managed in accordance with guidance.
- Strategy discussions did not routinely include information sharing with all key agencies.
- The quality and timeliness of child protection enquiries seen were inconsistent.
- Assessments did not always ensure a holistic analysis of need/risk from the outset impacting on timely decision making and the help offered to families.
- Delays in case transfer, the duplication of assessment processes and changes in social worker resulted in a loss of impetus that impacted on the engagement of families.
- Good social work practice was reflected in the content of assessments but was often undermined by the structure and design of the system
- Assessments often articulated children's wishes and feelings but the resulting analysis and plan was not always sufficiently child focused.
- The authorities approach to risk assessment and risk management needed to be more effectively shared and understood by partner agencies.

2. Explanation of findings

2.1 Inspectors found that strategy discussions were generally timely and managed in accordance with guidance. However, the records of strategy discussions varied too much in quality and often lacked detailed planning arrangements concerning responsibility and timescales for action.

2.2 Inspectors were concerned that arrangements in the duty and assessment team meant that neither the manager nor the social worker responsible for undertaking the section 47 enquires (from pod two) were involved in the initial strategy process, and had no ability to influence the management of the case. The use of outcome strategy discussions/meetings was not always evident, and staff and partners described this practice as less secure. This contributed to partner assertions that they were not kept sufficiently informed of the outcome of referrals.

2.3 Strategy meetings had mainly been displaced in favour of strategy discussions between children's services and the police. This was partly attributed to the reduced availability of the police, which was also said to have resulted in a growth in single agency (social services) led section 47 enquiries and fewer opportunities for joint social services/police enquires. Partner agencies expressed concern that the use of strategy discussions meant that despite having significant intelligence about the family, they were not able to effectively contribute to this key decision making process. The authority had already determined to take this matter up with the police and evaluate the impact it had on practice.

2.4 The quality of section 47 enquires seen were variable and the time taken to complete enquiries varied across, and within, the teams. Inspectors found that there was a lack of consistency regarding the templates used for recording section 47 enquiries which made it difficult at times to follow the process, particularly for a new worker's understanding of the case. In some instances, inspectors saw section 47 enquiries that had taken several months to complete and the resulting outcome was that further assessment was still needed.

2.5 The council demonstrated clear 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. However, once into the assessment process, including section 47 enquiries, the council appeared reluctant to make planning decisions until all assessment avenues had been fully exhausted. This, at times, impacted on the timeliness of cases being progressed to child protection case conference and delayed help being offered to the child and family. The council will want to assure themselves that assessments do not result in undue delay and are undertaken at an appropriately focused pace.

2.6 Inspectors noted the action taken to strengthen the management oversight and sign off of pre-birth assessments, and that these were now systematically reviewed by the fieldwork service manager following a review of this process in early 2015.

2.7 The authority had used emergency protection powers six times in the last year. Inspectors sampled these cases and found examples were such action was appropriate but also a small number where planned action could have been taken earlier. The authority would benefit from having systems in place to routinely review and learn from such cases.

2.8 The number of initial assessments completed in the period 2014/2015 had reduced from the same period for the previous year. Although the percentage of initial assessments completed in seven days had improved to 88%, the number of assessments completed overall had decreased.

2.9 Child in need cases were held across a number of teams, all of which experienced different pressures and competing demands which impacted on the amount and intensity of work that could be carried out. Workers were being innovative in carrying out direct work but this was not always effectively captured on the case records. Staff viewed work with child in need as being "constantly eroded" by child protection priorities and believed they would have more capacity if early intervention services were in place. Inspectors questioned whether the use of the 'nominal child' on the information system also meant that the overall child in need demand and resulting caseload was not recognised by the council.

2.10 Inspectors saw few examples of initial assessments, as the majority of cases reviewed progressed to strategy discussion or a risk assessment. Staff identified the limited reliance on good quality initial assessments as a barrier to families receiving early support that might divert the need for more intensive intervention. Early opportunities to intervene were therefore potentially being missed.

2.11 The number of core assessments completed in 2014/2015 had reduced slightly from the previous year, but timeliness in completion was reported as remaining consistent at around 88%.

2.12 The council had invested in a whole service risk assessment model (Risk 2) to support social workers to identify and analyse potential risk factors. Most staff told us that the model was well embedded within children services and that they had received or had access to the necessary training. Whilst appreciating the need for a risk framework, some staff found the application of the model was too inflexible and did not work well for some children and families. It was a

concern that some partners were not aware of the council's risk assessment process. This raised questions regarding how the assessment informed and translated into a shared multi-agency risk management plan.

2.13 To prevent duplication, the authority had determined that the assessment resulting from a section 47 enquiry and/or Risk 2 assessment could be used interchangeably as core assessments. Inspectors found that the council's flexible use of assessment formats had not been sufficiently underpinned by clear service expectations, for example timescales or targets for completion. The time taken to complete the assessment was also calculated from the day of allocation, rather than from the date of referral or the date when the decision was made to undertake an assessment. Inspectors were concerned how this impacted on the service user experience and also how well the council understood and accurately reported on the timeliness of its assessment activity.

2.14 Some of the assessments seen were of good quality, utilising a range of information to inform the analysis. However, inspectors identified that the good social work practice reflected in the content of assessments was undermined by the structure and design of the system.

2.15 The unintended consequence of the council's different assessment formats was that assessments often became fragmented and/or protracted. The failure to ensure an appropriate holistic analysis of need and risk from the outset impacted on timely decision making. Inspectors saw examples where decisions were deferred for further assessment rather than being progressed to a multi-agency child protection conference or child in need planning process. Also, despite several assessments, there was often no robust view of the family's parenting capacity and ability to meet the child's needs.

2.16 The duplication of some assessment processes resulted in a loss of impetus that was compounded by the transfer arrangements between the pods/teams that necessitate families re-engage with a new social worker. This also directly impacted on the experience of the family and their ability/willingness to engage in a process that they did not understand.

Quote from parent

"The first social worker worked well with us as a family, but then I had to have a new social worker and I didn't understand why we had to go to a case conference. I felt judged when I had done nothing wrong."

2.17 Evidence from case files, staff and families highlighted that the council did not routinely provide people or relevant partner agencies with a copy of their assessment. This practice, again, must impact on children and families understanding of the purpose of both the assessment activity and the resulting plan, and potentially limit their ability to influence and use the help they receive.

2.18 The extent to which children and young people were involved in their assessments was variable but some good practice was identified. In some cases, social workers were able to describe the persistent efforts they had made to gain the child's wishes and feelings, and it was disappointing that this was not better reflected in case records. In other examples, however, it was not possible to determine from the assessment if the child had been seen or seen alone and this will require further attention.

2.19 Inspectors saw evidence on the files that managers sign off assessments and provide comment. It was positive that managers checked if the child had been seen as part of this process but the council's performance, for example in relation to the percentage of initial assessments where there is evidence that a child is seen/seen alone, has remained stubbornly low. Inspectors also challenged the assertion found on a number of cases that the child involved was too young to express a view. Staff and managers would benefit from greater guidance regarding the council's expectations, particularly around the engagement of younger children in assessments.

2.20 Despite the importance attributed by staff to seeking the child's wishes and feelings, the assessment analysis and resulting plan often lacked a sufficient focus on promoting best outcomes for the child. Most of the manager's comments regarding the assessments related to next process steps rather than a reflection on the content, the quality of the assessment and the resulting plan.

2.21 The timeliness of the sign off process was variable, often reflecting the manager's availability. In some instances this delayed the subsequent planning/transfer of cases.

2.22 As with access arrangements, senior management oversight of the quality of assessments requires strengthening. Inspectors were reassured that the council had recognised that the assessment arrangements were not as effective as they could be, and had commissioned an external facilitator to support them in a review of their process.

Theme 3: Safeguarding and Care Management

What we expect to see

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

Key Findings

- Social workers could articulate children's needs and the risks associated with their care as well as actions required for reducing risk and achieving desired outcomes.
- The council's approach to risk assessment and risk management needs to be more effectively communicated and understood by partner agencies.
- All child protection work was undertaken by qualified staff.
- Once identified as required, child protection conference and reviews were timely, well managed and child focused.
- Many children had experienced frequent changes of social worker.
- Core groups and child protection plans did not always ensure a shared understanding of the risks, the progress required or the outcomes achieved.
- The council had developed a clear relationship between the public law outline and child protection.
- The council had a good range of supportive services to meet the needs of children and families requiring statutory intervention, but access to these services was increasingly subject to a waiting list.
- Looked after children cases were allocated but not all looked after children were allocated to a qualified social worker.
- The quality of care plans was inconsistent and not sufficiently forward looking or outcome focused.
- Looked after children reviews seen were well managed and independent reviewing officers (IRO) had the skills and experience to deliver against the expectations of the service

3. Explanation of findings

3.1 All child protection work was undertaken by a qualified worker and there was a good mix of experience within the teams. All children whose names were included on the child protection register were allocated to a qualified worker. A lack of consistent management capacity was raised as increasingly impacting on management availability and oversight of cases.

3.2 When the decision was made that a child protection conference was required, conferences were convened within appropriate timescales. The council had seen a significant reduction in the number of children whose names were included on the child protection register, from 133 in 2013/2014 to 75 at the end of 2014/15. The children safeguarding managers routinely scrutinised

these figures, providing information and a narrative to the senior management team and to the relevant scrutiny committee The team was intending to develop clearer links with the duty service to better understand the fluctuations in the number of new child protection referrals and track child protection enquiries more effectively.

3.3 The social work child protection conference reports seen by inspectors were found to be of adequate to good quality, providing sufficient information for conference members to make appropriate decisions. Safeguarding managers believe the quality of social work reports is improving and that the Risk 2 assessment has provided a helpful framework.

3.4 The council's transfer arrangements meant that the social work reports for conference, although timely, were prepared by a social worker using the information from the section 47 report written by the previous worker. The time constraints, given the case had to be transferred and prepared for conference in 15 days, resulted in little opportunity to engage with the family. Inspectors were told that these arrangements did not work well for children or families and that it was difficult for professionals to ensure the views of children were represented at the initial conference when they did not always know the child well. All the social workers and managers interviewed were committed to improving outcomes for children and families they worked with. However, the frequent changes of social worker impacted negatively on the quality of casework and, more significantly, the relationships between children's families and staff following child protection registration cases transferred to the family intervention team (FIT) team, and it was only at this point that the pace of social work change slowed down.

3.5 The child protection case conferences observed by inspectors were well chaired and child focused. The council has increased the capacity of its safeguarding managers in response to growth in demand and to ensure better continuity for families. Partner agencies attendance at case conferences is monitored and was described as good, and professional non-attendance was challenged. The police do not always attend review case conferences but provide reports where relevant.

Inspectors saw examples of social workers and conference chairs providing good support to families attending conferences, demonstrating mindfulness of the potential sensitivities involved. The authority had also acted to bolster the child's voice and understanding of the process through the development of an innovative 'buddy' system.

Observation – case conference

The chair was clear and confirmed that reports had been read and ensured that all participants were able to contribute. Both parents attended and despite the uncomfortable nature of some of the issues, people did not shy away from discussing the affect on the children. There was a conference buddy who had completed a piece of participation work with the eldest child – this was relayed to the conference. The discussion was challenging at times but was sensitively done.

3.6 The conference chairs ensured that core group membership and an outline child protection plan was agreed at the conclusion of the first conference. Core group and child protection review arrangements were timely and included those professionals directly involved with the family. However, the ownership and challenge afforded by the core group was inconsistent. In one

example, an agreed parenting assessment was not undertaken, was not challenged and delayed de-registration. There was insufficient evidence of how parents, carers and young people were engaged in core groups or that they had been helped to understand the process as their views were not routinely captured in the record.

3.7 The quality of the child protection plans seen were variable but mainly satisfactory and included some that were good. Children who were subject to child protection plans were mainly visited within agreed timescales. Inspectors saw some constructive work with partner agencies to progress both child protection and child in need plans. Partner agencies equally reported effective working relationships with social workers, but again highlighted that the changes of social worker hindered good communication and "made no sense to families".

Case example from file

The mother's initial resistance to intervention was overcome by the work of the social worker and through the involvement of the freedom programme. The school worked together with the social worker to provide additional well-being support and the direct work undertaken with the children supported them to feel safe. This resulted in positive outcomes for the children and their family.

3.8 The child protection plan template was not considered by inspectors or staff as effective in promoting outcome focused child in need or child protection planning, and this remains an area for development. The format of the plan was overly focused on the social worker as the co-ordinator of tasks and activities, and plans often did not capture the quality or detail of the work undertaken with the family or the outcomes they needed to achieve.

3.9 Some plans seen lacked clarity regarding what change was needed and how progress would be measured. In some instances, the focus on one aspect of risk dominated the plan and other issues became "temporarily lost" potentially leaving the child vulnerable. There was often an over focusing on parent's compliance rather than on the difference the plan made to the child. Inspectors were not confident that parents/young people were routinely provided with a copy of the resulting plan which limited families shared ownership of the issues.

3.10 Overall progress of plans was considered at review child protection conferences and this provided an essential level of quality assurance. Conference minutes were produced to satisfactory standard. However, inspectors were concerned that the council's practice of not producing conference minutes at the point of de-registration obstructed scrutiny and made it difficult to understand the rationale for de-registration.

3.11 Most children and young people who need protection were subject to case conference and child protection plans. However, some cases on the cusp of child protection or following de-registration were managed through the council's child in need arrangements. The timeliness and quality of child in need plans/reviews was variable but included some good structured work and service provision. Other child in need cases, however, reflected over optimism regarding the family's understanding of the issues. In some instances, the decision not to register the child or de-register the child was influenced by the level of co-operation shown by the family during lengthy assessment processes. Despite the family subsequently withdrawing from child in need services there was no evaluation or review of what this meant for the safety of the child. In other instances, cases were closed before the outcome or impact of referrals to other services was known.

3.12 The looked after children population had shown a slight increase, from 219 in 2013/2014 to 224 in 2014/2015. These cases were managed across a number of teams, transferring to a dedicated children and young adults support team (CYAST) once the permanency plan has been determined. The children integrated disability team (CID) and the transition teams also manage looked after children cases.

3.13 The council had developed a discreet project which had developed a clear relationship between the public law outline (PLO), child protection and section 20 accommodations. Cases were now referred to a PLO screening process after the second or third case conference. This system included prompt access to legal advice and senior management oversight of decision making, including reviewing timescales for the period a case should remain in the pre-proceeding stage. This development was viewed positively by staff and helped families as it supported more timely identification and action on cases where families had been unable to make sufficient progress to meet the child's needs. This project was now embedded within the FIT team.

3.14 Good performance was reported in relation to the timeliness of first placements that began with a care plan, as well as timeliness of reviews and statutory visits. The council's systems supported the identification of any shortfall in performance across the teams. The council was yet to translate what this performance meant in relation to the outcomes achieved for young people. It was noted that there had been recent corporate focus on the timeliness of health assessments and personal education plans, and this had resulted in some improved compliance but further improvement is required.

3.15 The council's ambition that all looked after children were allocated to a qualified worker was mainly realised, but some looked after children were allocated to experienced but unqualified staff. The council had systems in place to support the oversight of these arrangements. Once cases transferred to the CYAST team, children and young people had a greater opportunity to develop more consistent relationships with their social workers.

Quote from social worker

"Social workers are changed too often for families and often at critical times. When allocated to the long-term team they should then stay with the allocated social worker and not be passed on as this is very disruptive for the family and teams working with them."

3.16 Evidence from the interviews and the files reviewed indicated that children did not become looked after unless it was necessary but in some instances earlier intervention may have:

- prevented the escalation of issues that resulted in the need for care;
- supported more timely decisions to intervene.

3.17 The council worked hard to try to ensure that, where possible, children were looked after within their extended family or supported to maintain more meaningful relationships. The authority had developed a positive family group conferencing service that was being used to promote this aim. The council had also had success in increasing the recruitment and support available to kinship carers. Whilst recognising and supporting the council's focus on maintaining children within their family where safe to do so, the perception of some staff was that the council's placement panel arrangements "slowed the decision to admit a child into care" despite community services not being available or agile enough to meet the child's identified needs.

3.18 The council had a good range of supportive services to meet the needs of children and families requiring statutory intervention. There was evidence that children and families benefited from these services but service pressures and reduced capacity within the FAST team was increasingly impacting on the availability and timeliness of delivery. Social workers and partners saw the reduction of the service as directly affecting the outcomes achieved for children and were frustrated by the extent to which they saw good services being "eroded" and perceived this as due to the need for efficiency savings.

3.19 The evidence from the cases reviewed was that care planning was mainly satisfactory but inconsistent. Children had a care plan but the current format of the plan was often not sufficiently forward looking or outcome focused. The health and education plans also needed to be better integrated into the overall plan. The looked after children education service was valued and communication between education and social services was described as supporting the focus on attainment and school stability.

3.20 The most frequently highlighted gap in service provision for looked after children remained the limitation on the availability of Child and Adolescent Mental Health Services (CAMHS) although the work of the looked after children CAMHS worker was valued by staff.

3.21 Social workers had a good understanding of their cases including potential risk to the child but this was not always well reflected in the plan and, in some instances, there was a lack of timely contingency planning in relation to the child's placement needs.

3.22 The vulnerability of looked after children who go missing from care was recognised by staff but there was a lack of clarity regarding the procedures in place for managing this issue. Rather, there appeared to be an over reliance that "a manager would advise them what to do". The safeguarding arrangements for managing this and the involvement of children and young people in other "risky behaviours" need to be more firmly established across the service to ensure that staff are confident to take timely action to protect the child.

3.23 Staff saw themselves as strong advocates for children and sought to be creative in their work to engage children and young people in their care planning. Formal advocacy was commissioned on a regional basis but the recent re-commissioning of the service had resulted in some temporary shortfall in provision. Issues of poor communication were highlighted by staff regarding the re-commissioning process and the service was said to not yet be fully established, for example in relation to its independent visiting service. Senior managers were seeking to manage these issues to limit the impact for children and young people in Flintshire.

3.24 Looked after children reviews were compliant and independent reviewing officers (IRO) routinely met with children and young people prior to the reviews to encourage their engagement. The IRO service was represented on the children forum and also contributed to the council's placement panels; this provided them with good opportunity to ensure a strong focus on continuity of planning and on best outcomes for children and young people. The quality assurance responsibilities of the IRO service include reporting (for example) on the timeliness and quality of statutory visits.

3.25 Staff, managers and partners across the teams were clearly confident in their role, responsibilities and commitment to looked after children. However, staff were concerned that budget pressures were increasingly impacting on the council's level of ambition for looked after children, with a more perceived focus on "meeting requirements" and being "good enough". It will be important for the council to address this perception and demonstrate its clear commitment to driving and achieving best outcomes for looked after children and young people.

Quotes from staff

"Looked after children are the priority and staff always try to ensure their voice is heard and will challenge the council on behalf of the child if necessary.

Changes in the budget to support looked after children in education has meant they can no longer access direct support from tutors – this is a backward step."

3.26 The council has recently developed a single safeguarding unit, co-locating the adult and children's safeguarding teams with the IRO service, together reporting to the head of safeguarding. Managers and staff were energised by the management interest that had brought about this change and were optimistic that the new unit would support better sharing of intelligence, a stronger line of sight on the quality and responsiveness of operational practice and a stronger focus on the child. This unit has only just been located together and it was therefore too early to determine what impact it would have.

Theme 4: Leadership and Governance

What we expect to see

Leadership management and governance arrangements comply with statutory guidance, and together establish an effective strategy for the delivery of good quality services and outcomes for 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.

Services are delivered by a suitably qualified, experienced and competent workforce that is able to meet the needs of local children, young people and their families.

Key Findings

- Leadership, management and governance arrangements complied with statutory guidance.
- Senior leaders and officers saw safeguarding as a priority and were committed to improving safeguarding mechanisms.
- The council's strategic direction needs to be translated into a strategy for delivery of children's services that is effectively communicated to staff, partners and service users.
- The council needs to ensure there is an ongoing analysis of the underlying complexities and risks associated with children's services.
- Elected members' ability to challenge performance needs to be strengthened by improved quality assurance information.
- The authority is seeking to improve how the voices of children and young people shape service development.
- The cross cutting responsibilities of the social services senior management team were not well understood by staff and partners.
- The council should ensure that managerial leadership is sufficiently aligned to the professional experience needed to manage the complexity of discrete areas of operational delivery.
- Performance and quality assurance information needs to be more effectively captured and used to systematically drive operational performance.
- A suitably qualified, experienced and committed workforce was in place.
- The council has a strong commitment to learning and development.
- The council needs to ensure that structured induction and core training programmes is available for all staff, including managers and agency staff.
- Staff received and valued regular supervision but the quality was inconsistent and subject to work pressures.
- The morale of some staff was being affected by changes in service and management capacity.

4. Explanation of findings

Strategic direction

4.1 At the most strategic level, the council has determined the important principle that families are supported and their whole family approach is clearly established within the council's Single Integrated Plan (SIP 2013–2017). However, It was not evident the extent to which its strategic direction had been informed by an analysis of either joint strategic or shared local needs.

4.2 Leadership, management and governance arrangements comply with statutory guidance and arrangements were in place for engagement with strategic partners. We noted the chief executive's leadership role on the local service board and the chief officer's social service (statutory director of social services) role on the regional safeguarding children's board. The evidence provided by partners suggested that the contribution of the chief officer to the regional safeguarding board, whilst influential, had been hindered by capacity issues within the senior management team. Flintshire's representation on the board and the relevant subgroups has been strengthened with the recent appointment of the senior officer safeguarding/lead for children.

4.3 The council was aware of its strengths and areas for development, and had undergone a significant period of reorganisation to align its senior management arrangements with its model for delivering sustainable services. This focused on a leaner approach underpinned by improved cross directorate working. The changes in the senior officer team were described by officers and members as positioning the council to make efficiency savings, but also supporting a changed delivery model that reduced silo working.

4.4 Elected members and officers were clear that safeguarding was a long established corporate priority, but believed that this had been recently strengthened by the council's decision, as a response to such UK wide emergent issues as child sexual exploitation and adult safeguarding, to designate safeguarding as a strategic priority within the councils Improvement Plan for 2015/16.

4.5 The council was confident that the focus on families promoted the ability of the statutory director to shape the corporate agenda. There was corporate assurance that although children's services would contribute to future savings they would remain relatively protected. At the time of the inspection, the council had determined a significant change agenda for children's services, to be overseen by a modernisation board chaired by the chief executive. Despite a greater awareness of the challenges facing children's services, there needs to be ongoing analysis of the underlying complexities and risks associated with the service.

4.6 Inspectors found a good level of political support for the council's strategic direction and children's services. The cabinet member for social services met regularly with the chief officer for social services and his management team. The cabinet member expressed confidence in undertaking the responsibilities of the role. The briefing arrangements described, however, were mainly informal and would benefit from being more structured to ensure officer accountability.

4.7 The scrutiny arrangements undertaken through the social and health care overview and scrutiny committee were well established. Committee members understood their challenge role and could provide some positive examples of how they discharged their responsibilities in monitoring the council's performance. Inspectors had reservations that the reports provided to scrutiny did not always include a sufficiently robust analysis, and believed that elected members' ability to challenge performance would be strengthened by improved information regarding the quality of services and the experience of people receiving services.

4.8 Elected members and senior officers undertook regular visits to front line staff to directly hear their views, as recommended by Lord Lamming (following the death of Victoria Climbie). Staff welcomed these visits but believed that the arrangements could be more purposeful and create more opportunity for front line workers to discuss service pressures.

4.9 The children's forum (corporate parenting board) is established and elected members are well represented. The forum membership includes four young people and their direct involvement helps to inform service improvement. Issues raised in this forum are reflected and tracked through scrutiny. Members of the board could give positive examples of what difference corporate parenting had made to children receiving services, and believed the recent appointment of a participation officer will support better engagement of children and young people in service design and strategic thinking.

Leadership

4.10 Children's social services had experienced a period of change. The departure of a long serving head of service had resulted in a loss of expertise in children's services and in what staff and partners described as a period of "leadership inertia". The chief officer social services management team was configured to reflect the strategic focus on families, with all managers having a role in both children and adult services. This team, although confident in its ambition, was only recently fully established and was still developing its working relationships and accountabilities.

4.11 Inspectors found that the strategic direction for children's services had not been effectively translated into a strategy for delivery of children's services that had been disseminated throughout the workforce. The shared service responsibilities of senior managers was therefore not yet well understood, and some staff and partners said that they did not know who was responsible for decision making for some services. Whilst understanding the intention behind the revised management arrangements, inspectors viewed the stated advantages as yet untested and mainly aspirational. The council will need to ensure that managerial leadership is sufficiently aligned to the professional experience needed to manage the complexity of discrete areas of operational delivery.

4.12 Staff consistently reported that there had been a recent change in culture with the appointment of the senior manager safeguarding/lead for children in February 2015. Staff and partners expressed confidence both in the post holder and also to there being a designated senior lead for children's services.

4.13 At the time of the inspection, children's services were in the process of initiating a significant programme of change. This programme included:

- review of children services to inform a restructuring of services;
- restructuring of business support services;
- development of an early intervention and prevention service;
- implementation of a quality assurance framework;
- review of assessment processes.

4.14 Whilst reflecting the lack of sustained management focus in the past, and the current need to manage growing demand and efficiencies, inspectors recognised that the scope of the council's plans signalled their renewed commitment to improving both early help and statutory services for children, young people and their families. The council fully acknowledged that it had "much to do to translate these aspirations into a focused framework for delivery of children's services."

4.15 Most staff and partners welcomed the announced plans to review services, but some were frustrated that a number of key vacancies had remained unfilled whilst a service restructure was being considered. The council will need to ensure that the speed of change is appropriately paced and is undertaken in a way that takes staff with them and supports the meaningful engagement of partners and service users.

Performance information and quality assurance

4.16 Management information was being used to measure some aspects of performance, but this was not sufficiently systematic to improve the quality of services for children and families. Inspectors recognised the close and regular attention paid by senior officers and members to key performance indicators, and that the council reported mainly positive and/or improving performance on that basis.

4.17 Managers had access to performance data through a dedicated performance officer and bespoke reports, and the information system supported further development of reports. Although some recent audit activity was noted, inspectors were concerned how performance such as that relating to re-referrals and assessments was routinely captured and used to challenge the authority's practices. It was disappointing that many operational staff understood performance information to be a management tool rather than as a means of improving the experience of children and young people.

4.18 Managers recognised that overall quality assurance mechanisms was underdeveloped and were in the process of introducing 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. The recent development of a safeguarding unit, including safeguarding managers and the IRO service, was seen as a positive means of supporting a more effective line of sight on the quality of operational practice, but this was still at a very early stage.

4.19 The council was developing strategies to ensure it sustained a culture of learning. Most staff we interviewed expressed positive views about the availability/accessibility of formal and required training, and inspectors recognised the council's strong commitment to learning and development. However, 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. It will be important to ensure that the CID/transition services are routinely included in any wider children service learning. It was noted that the complaints officer attended social work team meetings on a quarterly basis to look at lessons learnt. Many of the complaints seen by inspectors echoed concerns around frequent changes of social worker and the lack of communication; this intelligence should inform the planned restructuring of services.

Workforce

4.20 The council had introduced a number of changes to support staff to work flexibly, but also to improve communication and create a stronger children's service identity. These changes included the introduction of agile working that supported staff to access and input information whilst working from a range of locations, also the relocation of staff to one office in Flint. Staff welcomed these developments and many could see potential benefits, some citing agile working as one of the reasons they remained with the council.

4.21 However, staff and managers also raised issues that the open plan office space as well as agile working fragmented the identity of the team, and described a loss of peer support and staff development opportunities. Opportunities for team learning and development were inconsistent across the service, but the working environment had impacted on this too. Managers also told us that they found it more difficult to maintain oversight of the work and the morale of the team.

Quotes from staff

"Agile working has improved relationships with other teams. I have missed the peer support from a smaller setting."

"The team ethos has also been impacted by the agile working process which in my opinion has reduced the ongoing peer support necessary within this working environment."

"There are good opportunities for professional development in Flintshire but while it's easy to move into the duty team – it's not so easy to move out into another team?

Quote from agency worker

"There is very good admin support here and positive morale – I would like a permanent job here."

4.22 The concept of a whole children's services identity was not seen as having been extended to include the CIDs team. This service was managed through adult services and was now located away from children's services. The intention to promote seamless transitions into adult services was understood and appreciated by staff. However, social workers in the CIDs team and the transition team hold casework responsibility for delivering all aspects of statutory children's services, for both the disabled child and for any siblings in their family. The move from children's services was therefore viewed by staff as potentially weakening multi-agency links and staff access to professional advice and support. This was a particular issue given the reduced child care management capacity within the team.

4.23 The council will need to evaluate the impact of these changes with staff and service users, to ensure that there is no diminution in the principle that children with a disability are children first, and that the timeliness and quality of service reflects best practice.

4.24 Social worker recruitment and retention was highlighted as one of children's services strengths, and most social work teams included a good mix of experience and qualified staff, many of whom had worked for the authority for a number of years. A small number of experienced agency staff had been employed, but these were mainly to meet additional service demands or staff absences. There was no proactive induction or training for agency workers to ensure that they understood the Flintshire policy and procedures. The feedback from staff generally was that Flintshire had a good reputation and was a positive place to work, staff valued that the authority promoted a good work life balance.

4.25 The majority of the staff interviewed told us that workloads were manageable but were becoming increasingly pressured, both in terms of volume and complexity. Staff believed that the demands of their caseloads were not always apparent or sufficiently recognised by senior managers, as child in need cases were recorded on the basis of one child. They felt supported to manage their work demands by their line managers and viewed managers across the service as equally approachable and responsive. Supervision of social workers was routinely undertaken by the senior practitioners. Most social workers reported that supervision was sufficiently frequent and of a good quality. The inspector's review of the supervision records demonstrated that despite a comprehensive format for supervision, including training and development needs, the records mainly reflected task centred case discussion.

4.26 There was some significant vulnerability identified at team manager and senior practitioner level across all of the teams. The supervision received by team managers and senior practitioners was less regular and often said to be vulnerable due to competing demands. There was also no proactive induction or training programme for staff moving into the management role. Senior practitioners had no opportunity to meet as a group with team managers or as peers, which limited opportunity for shared learning and support.

Quotes from staff survey

"The current senior practitioner post is on hold; this is having an adverse effect upon the team."

"Loss of experienced management is unsettling the working environment and morale."

"Team meetings are rushed with no space for reflecting on practice and learning from case work."

4.27 Managers and staff expressed growing anxiety that the overall reduction of both management time and experience was increasingly impacting on the resilience and safety of the service. Inspectors were concerned that senior officers should evaluate the management needs of the service, and ensure that current vacancies were not impacting on the quality of services received by children and families.

Appendix

Information about the inspection

The inspection of the local authority was carried out under chapter 6 of Health and Social Care (Community Health Standards) Act 2003.

Methodology

Fieldwork for this inspection was undertaken during the weeks commencing 25 May and 1 June 2015.

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 50 case files. This included 15 interviews with staff/other professionals, six interviews with families and/or direct observations of practice.

The inspection team

The inspection team consisted of four inspectors employed by CSSIW inspectors.

Lead inspector: Katy Young

Team inspectors: Pam Clutton, Rob Gifford, Bobbie Jones