AGGCC
CSSIW

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

Inspection of *Children's* Services

Powys County Council

October 2017

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

 Digital ISBN 978-1-78859-669-5 WG33116

Contents

Introduction

Care and Social Services Inspectorate Wales (CSSIW) undertook an inspection of services for children in Powys County Council during July 2017. The inspection focussed on the quality of leadership, management and governance arrangements to develop and support services for children and young people.

The inspection looked closely at how children and families access information advice and assistance, and care and support services.

The inspection was focussed on people's pathway into care and support services. We examined how children and families access help, care and support services.

We considered the quality of outcomes achieved for children in need of assistance, care and support and/or protection including those looked after by the local authority.

Inspectors read case files, interviewed staff, managers, and professionals from partner agencies. Where possible, inspectors talked to children and their families.

Overview of findings

Recent developments in Powys

During the year the local authority has seen significant senior management changes within social services. These include the departure of the director of social services in December 2016, with the chief executive of Powys Teaching Health Board providing support by undertaking the role of interim strategic director of people on a part time basis from January 2017.

The statutory role of director of social services is currently undertaken by the interim chief social work – operations director for social care who commenced in April 2017.

The head of children's services left the local authority in July 2017, after 11 months in post. In June 2017 an interim head of children's services was appointed

These management changes have followed a period of considerable change following the implementation of the Social Services and Wellbeing (Wales) Act 2014, along with financial challenges and an anticipated overspend, the introduction of a new electronic records management system in April 2017, and the commissioning by the local authority of a major external review of both adults and children's services which was completed in 2016.
Following the appointment of the interim chief social work officer in April 2017, issues and areas of concern with regard to children's services were identified and an escalated action plan was developed. The interim statutory director for social services acknowledged that this requires further development to provided a more comprehensive organisationally owned plan.

Summary of findings

We found the implementation of the recommendations of the external review further exacerbated failings in children's services, and destabilised the workforce to a significant extent and as a result placed children at risk of harm.

Children and young people do not appear to be well served by the current arrangements for accessing support services in Powys. A lack of assessment, care and support planning combined with an inconsistent approach to working in line with the child sexual exploitation guidance and the management of sexual exploitation and risk assessment framework process placed children at risk of harm. In addition, child protection processes did not always comply with statutory guidance with delays in investigations and assessments being undertaken and completion of statutory visits.

There is evidence of missed opportunities to safeguard children, despite requests for support. Risks were not being appropriately and robustly assessed and there is no effective system to identify and manage risks.

The vision and strategic direction for children's services has been set out by the interim leadership team, together with members of the operational management team. However, this vision requires significant corporate and political support for it to be delivered. There is a lack of awareness of its content outside of children's services and considering its reliance on the full support of council this is of concern.

There are serious performance issues with front line services, however these arose because of instability in management, poor and confused direction and weak governance. Without effective support and capacity to undertake the work frontline staff cannot be expected to undertake the complex work required in children's social services.

Inspectors noted the commitment of the staff, who have shown resilience and professionalism whilst coping with significant changes, and depletion in support services and leadership capacity. We have seen real commitment to protect and respond to safeguarding children in very difficult circumstances. Staff have been mutually supportive through challenging and difficult times and have shown us their real desire to move on.

The recommendations below identify the key areas where post-inspection improvement and development work should be focused.

Next steps

CSSIW expect Powys County Council to produce an improvement plan in response to the recommendations contained in this report within 20 working days of publication.

The improvement plan will be closely monitored during our programme of inspection, engagement and performance review throughout 2017/18
Due to the serious concerns identified in this inspection consideration will be given to undertaking a re-inspection of Powys children's services within 12 months from the publication of this report.

Recommendations

Immediate priority (within 1 month):

Case management

1. The local authority must ensure assessments are carried out within statutory timescales and are undertaken in partnership with children and families.

Staffing

2. Arrangements for team managers and senior practitioners should be reviewed to ensure capacity to effectively and consistently provide management and leadership oversight and testing of decision making along with support and direction for frontline staff.

3. The local authority and senior managers should take steps to improve the frequency, consistency and quality of supervision for front line staff; an assurance mechanism must be implemented to ensure compliance with expectations and quality of decision making, recordkeeping and reporting.

4. Caseloads monitoring is required to ensure there is sufficient capacity for workers to engage effectively with children and their families.

Leadership

5. The chief executive must immediately provide strong corporate support for children's services to ensure service improvements are prioritised and the pace of improvement accelerated and sustained.

6. The council leader and the portfolio member must provide strong political support to children's services and take the necessary steps to put in place well informed and effective scrutiny to make sure service improvements are made quickly, effectively and are sustainable.

Assurance

7. An assurance mechanism must be implemented as a priority to ensure compliance with legislation, statutory guidance and protocols with regard to looked after children and children at risk.

Medium term priority (within 4 months):

Case management

8. The quality of assessments and plans must be improved to ensure they are consistently of a good quality, with a clear focus on the needs, risks, and strengths of children and families, and that desired outcomes, timescales and accountabilities for actions are clear.

9. The quality and consistency and timeliness of record keeping must be improved; all staff and managers must ensure that records are of good quality, up to date and systematically stored.

10. The local authority must clarify the role and purpose of Powys People Direct (PPD) within the overall provision of information, advice and assistance and must ensure staff and partners have clear guidance to support decision making. The local authority must ensure that all staff are suitably trained, skilled and supported to deliver this role. A clear protocol is required between PPD and the Emergency Duty Team to ensure cases are not lost between services.

11. The local authority must implement an effective model of assessment to support its interventions with families, which is understood by all staff and partners, underpinned by robust training and development.

12. The local authority must ensure its fostering service provides consistent support, training and guidance to foster carers in order to improve the quality and availability of placements.

13. The local authority must ensure that all care and support plans have a clear focus on outcomes for children, which incorporate the voice of the child.

Staffing

14. The local authority must ensure every employee understands the legislative and statutory requirements in safeguarding children and action is taken to address poor performance.

15. A robust workforce strategy should be developed as a matter of urgency to include short, medium and long term plans for recruitment and retention of social work and senior staff. Permanent appointments are required in key posts as a high priority to provide resilience and stability to the service.

Interagency/ partnership working

16. Effective multi-agency quality assurance systems and training arrangements should be established to ensure thresholds for assessments to statutory children's services are understood by staff and partners and are consistently applied; this should include multi-agency child protection decision making protocols.

17. There is a need for clear strategic direction supported by operational protocols to enable partners to have a clear understanding of the purpose, structure and decision making in children's services.

Leadership

18. There should be an early consideration of the impact of the changes made as a result of the commissioned review and whether decisions made as part of the review should be revisited.

19. Elected members need to be clear about the vision for children's services and recognise this as a high risk area for the council. To support this members need clarity about, and training to understand, the direction of services and the particular risks inherent in children's services.

20. The chief executive with support from the statutory director of social services must make arrangements to ensure all elected members have a clear understanding of, and are able to fulfil, their corporate parenting responsibilities

21. The local authority needs to undertake further work in relation to implementing the requirements of the Social Services and Wellbeing (Wales) Act 2014 so there is understanding at a corporate level in relation to the delivery of information, advice and assistance.

Assurance

22. Performance management and quality assurance arrangements, including scrutiny of service demand and routine auditing of the quality of practice needs to be embedded so that managers at all levels have timely, relevant and accurate performance and quality assurance information.

23. At a corporate level the local authority must establish systems and structures effectively monitor and evaluate progress within children's services'.

24. The consistent application of a quality assurance system must be implemented to ensure families who are referred to the Team around the Family service are not subject to drift and delay and to ensure there

are targeted plans in place which are reviewed and checked by managers.

25. The local authority must strengthen the oversight of the response to complaints to improve reporting and analysis and ensure there is a mechanism to capture lessons learned.

Longer term priority (within 12 months):

Case management

26. The local authority must ensure compliance with the active offer of the Welsh language.

Interagency/ partner working

27. A multi-agency child protection protocol (drawing on regionally agreed arrangements)should be implemented to support decision making on the need for assessments in statutory children's services. This needs to be understood by staff and partners and consistently applied. Multi-agency quality assurance systems and training arrangements are required to support this.

28. The local authority and partners must work together to develop a cohesive approach to the collection and analysis of information about the needs of communities, which includes the views of children and families. This should be used to inform the shaping of strategic plans to achieve effective alignment of service delivery between information, advice and assistance services, the preventative sector and statutory services.

Leadership

29. Future changes to structure and service delivery need to include consultation with all stakeholders in its shape and development. The change needs to be incremental and with changes implemented at a pace that will ensure the full involvement of staff and young people and ensure children are not placed at risk.

Access arrangements: Information, Advice and Assistance

What we expect to see

The local authority works with partner organisations to develop, understand, co-ordinate, keep up to date and make best use of statutory, voluntary and private sector information, assistance and advice resources available in their area. All people, including carers, have access to comprehensive information about services and get prompt advice and support, including information about their eligibility and what they can expect by way of response from the service. Arrangements are effective in delaying or preventing the need for care and support. People are aware of and can easily make use of key points of contact. The service listens to people and begins with a focus on what matters to them. Effective signposting and referring provides people with choice about support and services available in their locality, particularly preventative services. Access arrangements to statutory social services provision are understood by partners and the people engaging with the service are operating effectively.

Summary of findings

1.1 The authority established Powys People Direct (PPD) in October 2014 as a single point of access into children's services. In April 2015 PPD the single point of access for adult services was also incorporated. The PPD team is currently based in Llandrindod Wells, and serves locality teams based in Brecon, Ystradgynlais, Llandrindod, Newtown and Welshpool.

1.2 The team includes five contact officers, supported by a social worker, who are responsible for dealing with all enquiries and referrals regarding children and families. Contact officers possess a sound knowledge of the local services available, in order to provide advice and support. However there have been a number of management changes in the team since its inception, leading to a lack of clarity about the direction and purpose of the service. Current management is undertaken by agency staff. There is a clear need for stability in the management of the team.

1.3 The service has also undergone numerous reviews both internal and external. It is not clear how these have provided direction, improved the way of working or clarified the role of the contact officers. There is a need for improved social work support, clear eligibility and threshold guidance, and direction for contact officers in order to make effective decisions at the point of referral. This would improve appropriate access and signposting for children and families.

1.4 We were informed by locality teams that the lack of support, advice and direction for PPD staff has led to referral information being forwarded to the locality teams which lack detail and is variable in quality. This was felt to be inappropriate and as such 'clogging' the system.

1.5 The role and purpose of the PPD remains unclear, together with its relationship with the wider local authority customer contact role. A decision now needs to be made as to the role and purpose of PPD within the overall provision of IAA services. It needs to be configured in a way that supports ease of access, accessibility and transparency.

1.6 The impact of this has been an absence of assistance to families when needed. Health, education, and housing partners and, other areas of children's services all highlighted difficulties with referring cases into PPD and accessing services. This places children and families in need of services and support at risk.

1.7 At the time of inspection there was no agreed universal decision making criteria to guide partner agencies. This has led to referral routes being unclear, and as a result agencies are finding their own solutions, using other networks and inappropriate escalation of referrals to get them to the attention of locality teams.

1.8 A positive development is that a regional approach to decision making criteria has been signed off by the regional safeguarding board and this is due to be rolled out across four local authorities. This provides an opportunity for Powys to agree clear pathways between early intervention and statutory services. This then needs to be communicated to the public, partners and within the local authority.

1.9 Cases that are to be referred to the Team Around the Family (TAF) require parental agreement. Where this cannot be achieved cases remain within PPD for some weeks, leading to delay and drift for children and families. We found this was also prevalent where children needed care and support assessments and there was a delay in allocation. A more proactive approach needs to be adopted in order to progress and monitor this so that children and families receive appropriate and timely care and support.

1.10 It is of concern that there is evidence of 'silo' working between teams within children's services. For example, despite PPD and the TAF service being located in the same directorate they do not share the same referral form, assessment format or have a shared understanding of information, advice and assistance criteria.

1.11 There is a need to clarify and agree the relationship between the PPD and the out of hours service (EDT).This is in order to ensure that referrals that come into PPD at the end of the day, which require out of hours intervention, will be responded to appropriately. A working

protocol is required to ensure cases are not ‘lost’ between the two services.

1.12 There is limited quality assurance and audit activity taking place within PPD. Performance figures are available but these relate to call numbers, calls abandoned, waiting times etc. and do not provide the manager with information relevant to quality and outcomes. There is no mechanism to receive feedback from children, families, partners and teams.

1.13 The service is not able to make the ‘active offer’ of Welsh language on a consistent basis.

1.14 The local authority needs to undertake further work to implement the requirements of the Social Services and Wellbeing (Wales) Act 2014. Whilst planning is evident, the embedding of the changes required is now necessary through leadership, staff training, support and guidance.

Assessment

What we expect to see

All people entitled to an assessment of their care and support needs receive one in their preferred language. All carers who appear to have support needs are offered a carer's needs assessment, regardless of the type of care provided, their financial means or the level of support that may be needed. People experience a timely assessment of their needs which promotes their independence and ability to exercise choice. Assessments have regard to the personal outcomes and views, wishes and feelings of the person subject of the assessment and that of relevant others including those with parental responsibility. This is in so far as is reasonably practicable and consistent with promoting their wellbeing and safety and that of others. Assessments provide a clear understanding of what will happen next and results in a plan relevant to identified needs. Recommended actions, designed to achieve the outcomes that matter to people, are identified and include all those that can be met through community based or preventative services as well as specialist provision.

Summary of findings

2.1 We found that there was an absence of assessment in care and support plans and that practice was not robust.

2.2 Assessments did not reflect the impact that the workers involvement had and did not provide clear analysis or consistently provide evidence supporting decisions. Areas of agreement or difference were not identified between professionals and families nor were care and support needs and the services needed to meet these. The assessments as written appeared to be a blunt tool and at times reflected decisions that were not evidenced.

2.3 We could not always understand how thresholds were applied. There was some manager oversight but evidence of analysis was missing. There is clear evidence that appropriate risk assessments are not always being undertaken, and in the majority of cases examined there was little or no reference to a consistently used assessment tool. There is no collective model of intervention used to inform practice such as a strengths based model that is implemented across both the preventative and statutory services so that workers from other agencies and families have a common understanding as to the values and aims of the work.

2.4 Management oversight has been inconsistent and often missing. Quality assurance has not been established to any meaningful degree. Team managers do undertake some case audits but those carried out by the local authority prior to the inspection often demonstrated a level of positivity that was not shared by the inspectors.

2.5 The local authority had previously invested in the well established Gwynedd model. However, this was not implemented effectively and the local authority is considering introducing the “signs of safety” model in its place. There exists a lack of clarity or understanding as to what model of assessment will be utilised in the future.

2.6 Assessments are not always carried out within statutory timescales. We tracked and reviewed a total of 42 cases, of which 26 required improvement and 16 were considered to be poor. There are some serious and significant delays in children and families receiving a service, an absence of assessment, or where present, often poor analysis and decision making.

2.7 Whilst we saw some evidence of children and families receiving timely support and intervention, we also saw significant evidence where this was not the case, with significant delays of some months between referral, and intervention. There was a lack of assessment in child protection cases, a lack of a sexual exploitation risk assessment framework (SERAF) assessment and review contrary to statutory guidance, an absence of care and wellbeing assessment and a lack of management oversight of these cases.

2.8 The lack of assessment, intervention and support, together with poor follow up and oversight has and is placing children at considerable risk.

Care and support

What we expect to see

People experience timely and effective multi-agency care, support, help and protection where appropriate. People using services are supported by care and support plans which promote their independence, choice and wellbeing, help keep them safe and reflect the outcomes that are important to them. People are helped to develop their abilities and overcome barriers to social inclusion.

Summary of findings

3.1 Care and support for children and families is insufficient, there is a lack of leadership, management oversight and direction in order to provide a responsive and safe service.

3.2 The lack of information in assessments in order to inform accessible care and support plans, has led to plans not being tailored to children's identified needs leading to poor outcomes.

3.3 Care and support plans seen were often generic and we were not confident that social workers picking up a case would understand the focus of the plan. Those involved in the planning and review process informed us this often led to repeating the planning process leading to delay. There was little evidence of challenge in case supervision by managers and although some dip sampling of cases does now occur this is limited with little shared reporting of issues. There has been a consistent theme of a lack of management oversight, and consequently an absence of appropriate measures being implemented in order to address any identified needs

3.4 Plans need to ensure a clear focus on the impact any change has for the child. There was no sense of outcome focused plans and an absence of a focus on the child.

3.5 We saw significant evidence of delay and drift in supporting children and families effectively, however we did see some evidence that planned and timely intervention had been delivered to families.

3.6 Foster carers highlighted a lack of social work support with children with complex needs, this together with a lack of ongoing contact, and frequent changes of social worker, resulted in many foster carers leaving the scheme.

3.7 During 2015 – 16 there were 103 foster parents on the register, at the end of 2016 -17 this had reduced to 57. We are concerned as to the intervention and support children requiring this service are now receiving as a result of a lack of local resource. Social workers told us that matching children's needs to foster carers was limited due to the

decreased number of foster carers available, which may lead to children being placed inappropriately.

3.8 Care and support for children and families has been affected by the changes in teams, numbers of staff leaving the service and use of agency workers.

3.9 In talking to staff, they know their cases well but that is not reflected in records. Staff are clearly hard working and committed, and have been throughout this time, facing colleagues leaving, staff shortages, significant use of agency staff, and an absence of management support and direction.

3.10 Children and parents spoken with expressed their dissatisfaction with the inconsistency and changes in social workers assigned to their case. They are concerned with the delays in their cases being progressed, with examples of new workers challenging actions previously agreed, and not being fully briefed.

3.11 Parents also expressed concerns that support plans are not moving quickly enough, and children are concerned they are not being kept fully informed as to why decisions are being made. They told us they are not being consulted as to their future plans and they do not see their allocated social worker on a regular basis, especially following placement with a foster carer. They are left with a feeling of being in limbo with no future plan in place.

3.12 We saw evidence of children being disadvantaged whilst being looked after in not being supported in having contact with their parents. Social workers and partner agencies expressed concern that children are not able to build a relationship with a consistent worker, this has led to some children expressing their feeling that the service does not respect or value them.

3.13 We saw evidence that engagement by families in planning meetings is inconsistent. We saw examples where there was no evidence of a care and support plan and a lack of monitoring arrangements. We found cases being left inactive with families not receiving a service, or there being drift in child protection planning with evidence of statutory visits not having been carried out as required. We also saw written agreements with families being used as the only strategy to reduce risk. This clearly places children at risk of harm.

3.14 All of the above cases were referred back to the local authority for further investigation and review, in order to satisfy itself all appropriate action is now being taken.

3.15 There is a need to improve multi-agency working with partners who have lost confidence in the service. Communication was described as poor and there is a lack of understanding of the model of service

delivery in place. We found no evidence to demonstrate partnership working with respect to planning and shaping services.

Safeguarding

What we expect to see

Effective local safeguarding strategies combine both preventative and protective elements. Where people are experiencing or are at risk of abuse neglect or harm, they receive urgent, well-coordinated multi-agency responses. Actions arising from risk management or safety plans are successful in reducing actual or potential risk. People are not left in unsafe or dangerous environments. Policies and procedures in relation to safeguarding and protection are well understood and embedded and contribute to a timely and proportionate response to presenting concerns. The local authority and its partners sponsor a learning culture where change to and improvement of professional performance and agency behaviours can be explored in an open and constructive manner.

Summary of findings

4.1 There is evidence of missed opportunities to safeguard children with a lack effective systems to identify risks, nor are risks being appropriately and robustly assessed.

4.2 There were missed opportunities to include a wider range of partners in strategy discussions. These were mainly between children's services and police and in some instances could / should have involved a multi agency forum, for example, health, education and housing.

4.3 Safeguarding decisions were not always timely and several cases noted delay due to lack of availability of staff from both the police and social services. This meant that families often did not understand the concerns or were less clear as to why the issue was ongoing. The local authority has no shared approach to risk assessment management with partners. We saw evidence in two cases of an awareness of potential child sexual exploitation (CSE) and vulnerability of going missing. However, we saw evidence in three cases where CSE protocols were not adhered to.

4.4 The local authority's own quality assurance audits indicate poor representation at strategy meetings from partner agencies, and a lack of critical analysis in child protection (S.47) reports. There was poor recording generally within these reports as indicated by a lack of evidence to support the agreed actions and whether the need for legal advice or criminal investigation was appropriately considered. This was compounded by a lack of appropriate recording of team manager decision making in the minutes / case supervision notes.

4.5 Partners in the police expressed concern at the inconsistency in response from senior managers, which did not give them confidence in the quality of decision making. Police and health staff were concerned

if there was an issue that could not be resolved at an operational level they would not know who to escalate it to. This had been clear in the past.

4.6 External agencies were also concerned with the poor quality of some assessments, the absence or ineffectiveness of family group conferencing, the poor quality of pre- court work, and poor analysis. With subsequent plans not being followed, with the voice of the child not being evident with insufficient access to advocacy services.

4.7 Education partners expressed the view safeguarding practice appears to be sound but that this is not supported by timely or sound documentation. The timeliness of communication with education about S.47s is an issue, with education not always being informed of such referrals nor investigations relating to children in education.

4.8 Housing partners have experienced some difficulty in reporting safeguarding concerns following visits to families. Access to services is not clear or simple and as such there are delays in responding to safeguarding concerns. An example was given of a concern that was not able to be progressed satisfactorily through PPD and the social work team and as consequence housing officers had to escalate this to the Interim Chief Social Work officer in order to secure appropriate action for the child.

4.9 Children at risk of harm are not safeguarded due to a lack of a consistency in managing the sexual exploitation risk assessment framework (SERAF) process. There is a lack of compliance with child protection process and delays in S.47s and assessments being undertaken with safety plans lacking clarity and SMART objectives.

4.10 Overall it was the lack of timeliness and lack of rigour in following up concerns which posed the most risk with safeguarding work. We did not see evidence of risk management on the files we reviewed.

4.11 As a result of the absence of sound quality assurance and significant management and staffing changes there is no comprehensive picture of the unmet need and vulnerability of children. As such there is a need for a whole service case review in order for the service to get a full picture of the need and vulnerability of children and whether safeguarding measures are required. Until this is done children remain at risk.

4.12 In addition to a lack of robust safeguarding assessment and planning, there has been a reduction in legal support to children's services. This has had a significant impact with managers having to chase advice and causing lengthy delays in cases being brought to the attention of the court.

4.13 Whilst we saw evidence in two cases of timely and positive responses

to child protection referrals, we also reviewed six cases where this was not the case.

4.14 We saw evidence that child protection procedures were not followed. In one example there was no record of child protection statutory visits for a period of six months, November 2016 to June 2017. There was no written record of S.47 investigations, core group meetings were not held within required timescales with a lack of review and management oversight of this case until June 2017.

4.15 In a further example we were concerned that despite clear child protection issues being evident the case did not progress to conference. A care plan was not in place and no home visit had been undertaken in order for the voice of child to be heard. The initial referral in respect of concerns of physically harmful behaviour was some years ago, with no meaningful work undertaken with the family since then which could indicate that the child has been exposed to ongoing suffering or harm.

4.16 There is evidence of missed opportunities to safeguard children, despite requests for support. A number of cases were referred back to the local authority for their review due to concerns in respect of children's safety.

4.17 There is evidence of a lack of effective systems to identify and thoroughly assess risk. In a significant number of cases we tracked there was a lack of effective multi – agency safeguarding, with child protection procedures not being followed and a lack of effective decision making and management oversight to prevent drift and further risk. This is further affected by the lack of a robust Independent Reviewing Officer structure and service which is lacking clear leadership and pathways for escalating concerns.

4.18 An interim lead for safeguarding had been appointed immediately prior to the inspection.

Leadership, management & governance

What we expect to see

Leadership, management and governance arrangements comply with statutory guidance and together establish an effective strategy for the delivery of good quality services and outcomes for people. Meeting people's needs for quality services are a clear focus for councillors, managers and staff. Services are well-led, direction is clear and the leadership of change is strong. Roles and responsibilities throughout the organisation are clear. The authority works with partners to deliver help, care and support for people and fulfils its corporate parenting responsibilities. Involvement of local people is effective. Leaders, managers and elected members have sufficient knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively.

Summary of findings

5.1 Leadership in children's services is a significant vulnerability in this local authority.

5.2 It is apparent there has been an absence of systems and structures in place to monitor and evaluate progress with the changes within the service at a senior level. Consequently this has resulted in disconnect between the chief executive, the corporate management team, and children's services and a lack of oversight in relation to corporate parenting responsibilities and roles.

5.3 Children's services sit within the People Directorate. The directorate is represented on the corporate management team by the interim Strategic Director of People and the interim Chief Social Work officer. We are aware the chief executive of Powys Teaching Health Board has been providing support by combining their substantive role with that of interim Strategic Director for the local authority.

5.4 Children's services have been subject to frequent changes of management at all levels over the past two years. This includes four changes of head of service with the current post holder being an interim appointment. This is in addition to the interim arrangements for the part time strategic director and an interim chief social work officer - who holds the statutory role of director.

5.5 Lack of substantive management arrangements presents a fragile organisation without clear structures on which to base sound and safe practice.

5.6 The local authority requires a clearer understanding of the significance of the role of the statutory director and the key role of the chief executive in supporting the statutory director to deliver.

5.7 The local authority commissioned a major external review of children's services during 2015 and 2016. Whilst focussing on service development, and ensuring the local authority was able to meet its duties under the Social Services and Wellbeing (Wales) Act 2014 it was also tasked with establishing 'if efficiencies to the value of £2.7m are deliverable and sustainable'. The report concluded that if implemented it would provide the authority with £1.5m in efficiency savings (10% of the overall budget) and £750k of income generation, leading to £2.2m in total. A significant element of this review was reliant on an overarching restructure of children's services.

5.8 The review commissioned by the local authority did not focus on mapping needs, meeting demands of the new legislation nor did it ensure safeguarding is prioritised.

5.9 The decline we saw in children's services during, and following, the external review undertaken in 2015 – 16 has been marked. The implementation of the review by the local authority significantly destabilised the workforce and consequently placed children at risk of harm. As a result the local authority has failed to fulfil its corporate parenting responsibilities by ensuring that children are provided with good quality placement options, protection and effective support.

5.10 The interim managers had developed an escalated improvement plan that identified the significant level of improvement needed against all aspects of the service. This marked a critical move away from the conclusions of the external review with a new focus on practice. However this was at a very early stage of implementation and will require significant corporate support.

5.11 The chief executive acknowledged he has not been as sighted as necessary on the growing failings within the service. The need for the chief executive and his corporate management team to have a number of indicators of service performance in place is clear. There needs to be greater analysis of performance information, staff engagement and user consultation.

5.12 There was little evidence children's services are recognised as a priority by the local authority. Political and officer support for children's services at a senior level was not well evidenced. Systems and processes had not been established to facilitate corporate oversight of the service. This included a lack of performance information in order to ensure children and families are receiving support within statutory timescales. A lack of a sound, effective and user friendly quality assurance model, a depletion in legal support , a HR function that whilst robust , has not always supported timely front line recruitment, and an inconsistency and delay in IT support for new and agency staff.

5.13 There is little evidence the Social Services and Wellbeing (Wales) Act

2014 is understood at a corporate level and in that context the delivery of information, advice and assistance is seen too narrowly as a social services responsibility only.

5.14 When considering financial savings and investment it needs to be recognised that short and medium term financial planning and goal setting for children's services is inherently risky, and any lack of action and investment now will cost significantly more in the future, and will lead to increased failure to meet statutory accountabilities.

5.15 The vision and strategic direction for children's services has been set out by the interim leadership team, together with members of the operational management team. This has been cascaded to staff via a number of roadshows, which were well received. However, this vision requires significant corporate and political support for it to be implemented. It is of concern that there is a lack of awareness of the strategic direction outside children's services considering its reliance on the full support of the council. Senior management in children's services, members, and the chief executive, all had a different view on how this should be shaped.

5.16 The lack of a clear strategic direction and operational protocols means that partners do not have a clear understanding of the children's directorate vision, structures and thresholds. Equally partners are not being given clear expectations regarding their role and accountability in relation to services for children.

5.17 The council has many new members since the election in May 2017. It is hoped, that with the appointment of the new portfolio holder the profile of children's services will begin to rise within the local authority, despite the fragility of the situation.

5.18 The local authority acknowledges there has been an absence of challenge from Members for some time. There is a need to ensure the direction of the service, its targets and performance is clearly understood by Members and that support and training for them in order to challenge and hold officers to account is in place.

5.19 Recruitment and retention of staff remains a key concern for the service. Its inability to retain experienced staff has impacted significantly on children's services and as a result, on those children and families being supported. As of the 14 July 2017 the authority report that they are employing 19 agency staff covering social work and senior posts and have 36 vacancies across children's services.

5.20 Staff supervision has been inconsistent; however, staff report a more consistent approach and regular formal supervision is now being introduced. Staff advised that team managers and senior practitioners are now more accessible and case discussion is ongoing. Good peer

support is evident, with staff supporting each other through a very difficult and challenging time. All staff report there is good access to training throughout the service and all are supported to attend.

5.21 However, the absence of a workforce strategy at this time means the local authority is unable to map the strengths of its workforce and thereby build a service from that point, to meet demand and need. The development and implementation of a workforce strategy will be crucial in retaining not only the newly recruited staff but those who have stayed throughout the re structuring but are still in need of additional support. This has resulted in a workforce that remains very vulnerable at this time.

5.22 Capacity to deliver a quality assurance system in children's services is challenged by the lack of an agreed review framework, different models being favoured by different senior managers, morale and capacity in the workforce.

5.23 As a result quality assurance and performance monitoring is limited and in some instances non-existent. There is a clear lack of quality assurance and audit across the service. The quality assurance work that has been carried out by the service is in relation to a very small sample size and whilst it has identified some good practice it is clear there is significant work to do.

5.24 Analysis of complaints received should be a source of internal performance monitoring. During the year June 2016 – June 2017 there was a gradual increase in complaints being made. There were no specific trends identified. However, our inspection identifies there were a number from families of children with disabilities regarding the poor level of support they were receiving. Senior managers acknowledged there had been significant drift and delay in cases within the disability service.

5.25 Complaints were in the main not being investigated within the required timescales, recording was poor, and as such it was difficult to assess the robustness of the investigations and responses. Correspondence was missing from the files examined, and there was no evidence of management oversight or audit. The complaints process did not involve action planning nor was there any oversight to support lessons learned.

5.26 In order to address the shortfalls within the service the interim leadership team has produced an escalated action plan which identifies all areas of service delivery require improvement. The leader of the council is aware of the council's own escalation action plan, but it is clear that a greater narrative is needed, together with timescales, and milestones, in order for members to effectively measure and monitor progress.

5.27 Despite an escalation action plan having been produced, it was clear

that the local authority is waiting for CSSIW's report and recommendations in order to arrive at a work plan. Whilst it is evident some progress is now being made, it is a concern that the local authority may be waiting for the external regulator to give them direction, as opposed to moving forward positively with their own clear plan of delivery.

5.28 The current care and support population assessment does not provide the council with the knowledge and information required to commission effectively to meet the needs of children.

5.29 The interim nature of the senior management team means it may not be in a position to deliver the work required with the speed, and coverage it requires. Corporate support is vital along with a decision as to how to make permanent appointments to these vital posts to provide a permanent and stable senior management team.

5.30 There continues to be a debate about the future leadership structure, there is no consensus yet amongst corporate and political leaders. This raises questions about the level of political and corporate understanding of the vision for children's services. Any changes need to consider the disruption and changes that would follow and must be based on a realistic understanding of the impact of any reorganisation on the workforce and on service delivery.

5.31 There is an urgent need to finalise and agree the senior management structure alongside the wider workforce structure, which is keenly anticipated by staff.

5.32 Considering the turbulence of recent months, the core of staff have shown resilience and professionalism whilst coping with significant structural and staff changes, together with service changes brought about by successive heads of service, and a depletion in support services and leadership. Frontline staff and managers are desperate to hold onto any 'green shoots' that the interim leadership and management arrangements have been able to deliver and we have seen real commitment to protect and respond to safeguarding children in difficult circumstances. Staff have been mutually supportive through very difficult times and have shown us their real desire to move on.

5.33 It is a concern the senior leadership in the local authority has not been able to ensure the workforce is supported to provide an effective service for children and families who need support at all levels. The need to address the corporate and wider partnership issues is required as a matter of urgency as without the level of corporate support needed, the budget pressures will not be resolved.

Methodology

Self Assessment

The local authority completed a self assessment in advance of the fieldwork stage of the inspection. The authority was asked to provide evidence against *'what we expect'* to see under each key dimension inspected. The information was used to shape the detailed lines of enquiry for the inspection.

We sample-selected for tracking and review an initial 30 cases, together with a further 20 contact cases, a number of which we further reviewed, from a long-list provided by the local authority that was consistent with a thirteen-category criterion applicable to the period 1 June 2016 to 1 June 2017.

Fieldwork

We were on site in Powys the weeks commencing 17 July and 31 July 2017.

We reviewed a total of 42 cases of which 16 were subject to more detailed case tracking that involved interviews with local authority employees and other professionals.

We interviewed six children and/or their families.

We interviewed a range of local authority employees, including senior officers, the chief executive, the leader of the council and the portfolio lead for children's services.

We interviewed a broad range of partner organisations, representing both statutory and third sectors.

We looked at all complaints and compliments that were made about children's services between 1 June 2016 and 1 June 2017.

Inspection team

The inspection team consisted of:

- Lead Inspector: Ken Redman

- Supporting Inspectors: Katy Young, Pam Clutton, Sharon Eastlake and Lesley Roberts

Acknowledgements

CSSIW would like to thank the people who contributed to the inspection; parents and carers, staff and managers of Powys County Council; the service providers and partner organisations – including the independent and third sector; for their time, cooperation and contributions to this inspection.