

# Inspection of Children's Services City and County of Swansea Council

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

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## Introduction

Care Inspectorate Wales (CIW) undertook an inspection of services for children in the City and County of Swansea during July 2018.

Our approach to the inspection was underpinned by the eight well-being statements and associated well-being outcomes as outlined in the Welsh Government's *National Outcomes Framework for People who need Care and Support and for Carers who need Support* (March 2016). Our approach builds upon the associated local authority quality standards set out in the *Code of Practice in Relation to Measuring Social Services Performance issued under section 145 of the Social Services and Well-being (Wales) Act*. In addition, the inspection considered the local authority's capacity to improve through an analysis of the leadership and governance of its social services functions.

This inspection focused on the effectiveness of local authority services and arrangements to help and protect children and their families. The scope of the inspection included:

- the experience and progress of children on the edge of care, children looked after and care leavers including the quality and impact of prevention services, the effectiveness of decision-making, care and support and pathway planning
- the arrangements for permanence for children who are looked after and children who return home including the use of fostering, residential care and out of local authority area placements
- adherence to fostering service regulation and national minimum standards
- the quality of leadership, corporate parenting and governance arrangements in place to determine, develop and support service sufficiency and delivery particularly in relation to looked after children, care leavers and their families.

While the main focus of the inspection was on the progress and experience of children and young people looked after and care leaver's transition into adulthood, the inspection included a focus on children, young people and their family's engagement with:

- information, advice or assistance (IAA), preventative services;
- assessment / reassessment of needs for care and support and care and support planning;
- child protection enquiries, procedures, urgent protective action, care and support protection plans.

Inspectors read case files, interviewed staff and administered a staff survey, interviewed managers, and professionals from partner agencies. Inspectors talked to children and their families wherever possible. Young people and care leavers attended two focus groups.

## Overview of Findings

- Overall, we found good quality practice in Swansea Council children's services, with positive outcomes being achieved for many children and young people.
- The local authority's vision for children and young people was well-established, corporately owned and invested in throughout the authority. Elected members were committed to delivering positive outcomes for children and had a clear understanding of their role.
- The local authority had begun to re-shape its services in line with expectations of the Social Services and Well-Being (Wales) Act 2014 (SSWBA). However, significant areas of practice need further development, particularly embedding the 'what matters conversation' and ensuring the voice of the child / young person is clearly recorded.
- The local authority is sensitive to the need to review the most effective means of delivering children's services, and a recently implemented restructure aims to improve quality of practice and enhance support for staff.
- The local authority is proactive in identifying areas requiring further development and utilises a range of options for driving improvement.
- Children's services are effectively led with confidence by an experienced Head of Service and management team who managed change well. Staff were dedicated and resilient, they valued the culture of team support within which they worked, and the accessibility of their managers.
- Our review of a sample of supervision files found these were reflective of good supervisory practice; however the quality of records and timeliness of supervision sessions was inconsistent.
- Partnership working within the authority and with its external agencies was generally effective, particularly with regard to safeguarding. However, we heard from staff that working relationships between children services and education could be strengthened and we saw evidence of some children/young people who were receiving inadequate education provision and experiencing poor outcomes.
- Sound assessment and care planning processes were utilised as a basis for identifying need, and planning and delivering the support required to achieve agreed individual outcomes. Again, the 'what matters conversation and voice of the child were not always apparent in assessment and planning records; improvements are also required in recording strengths and personal outcomes.

- Swansea Council children services underpinned their safeguarding practice with the Signs of Safety (SOS) model. This was seen by inspectors as well established, and we saw evidence of families responding positively to opportunities afforded for them to become actively involved in drawing up and implementing safety plans.
- Swansea Council children services were aware improvements were needed in ensuring children were seen within required timescales to ensure their safety and improve individual outcomes.
- The local authority recognised the potential benefits of existing quality assurance arrangements have not been realised in practice. A new performance hub had recently been introduced alongside restructured teams as a means of strengthening quality assurance and management oversight.
- Placement choice continued to present on-going challenges, particularly for children / young people with more complex needs.
- Children and young people we heard from were generally positive about the support they received, and were appreciative of the relationships established with individual social workers.

## **Areas for Development**

### **Access arrangements: Information, Advice and Assistance (IAA)**

1. The requirements of the SSWB Act need to be fully embedded within IAA, with particular focus on the 'what matters' conversation and capturing the voice of the child.
2. Arrangements need to be improved to ensure that decisions made in respect of referrals take into account all pertinent information.

### **Assessment**

3. The quality of assessments requires improvement to ensure less duplication, and an increased focus on the child's voice, strengths and outcomes.

### **Care and Support and Pathway Planning**

4. Care planning needs to be strengthened by extending the co-production of plans, and ensuring that the voice of the child is prominent throughout, in line with requirements of the SSWB Act.
5. The authority should satisfy itself that all children identified in need of care and support and who are receiving education other than at school (EOTAS) are getting the educational input and support to which they are entitled.
6. Arrangements for children and young people to access their own care plan, reviews and other documentation were unclear; these should be reviewed, and the systems in place for recording this enhanced.

### **Safeguarding**

7. Improve analysis of identified risk, barriers and individual strengths and needs, in order to strengthen the effectiveness of decision making and safeguarding arrangements.
8. Improve quality assurance of child protection practices.

### **Leadership, Management and Governance**

9. Ensure a robust quality assurance framework is embedded throughout the department.
10. Measures need to be put in place to ensure areas of under-performance already identified by the local authority are effectively addressed; for example in relation to the format of care and support plans; recording of statutory visits; the timeliness of review and conference reports; the take

up of 'active offer' in relation to advocacy and staff supervision arrangements.

**Next steps**

CIW expect the City and County of Swansea to consider the areas identified for development and take appropriate action. CIW will monitor progress through its on-going performance review activity with the local authority.



# 1. Access arrangements: Information, Advice and Assistance

## What we expect to see

The 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 local authority had reshaped its services to meet the requirements of the Social Services and Well-Being (Wales) Act 2014 (SSWBA). There had been an increase in demand on children's services over recent years, and the need to work more effectively with partner agencies in order to respond positively had been recognised and acted on. The launch of the multi-agency Pathway to Provision Guidance has promoted clarity around thresholds and pathways for partner agencies.
- 1.2. The Information, Advice and Assistance (IAA) team was made up of social workers, which meant each referral was considered by a qualified professional. We saw evidence of some referral decisions having been made without full consideration of all background and other relevant information.
- 1.3. We saw other agencies were also accessed directly via the first point of contact, including a Child and Adolescent Mental Health (CAMH's) specialist liaison post. We heard how a contact expressing concern about a child's behaviour received an appropriate response, with the primary mental health worker providing timely support to the child in school, resulting in positive individual outcomes.
- 1.4. As part of the local authority's wider Poverty and Prevention agenda, the Team Around the Family (TAF) service has been successfully embedded within the majority of schools across Swansea, and is considered by partner agencies to be working well. The plans we heard about to further develop a 'Signs of Wellbeing' approach at the first point of contact are likely to strengthen the local authority's early intervention and prevention services.

- 1.5. We found more work is needed to embed the 'what matters' approach and in recognising and building upon the strengths of the child and family network. This approach was more often reflected in discussions held with staff than in the documentation viewed, the format of which did not always assist staff in facilitating this.
- 1.6. There are a good range of community-based services to support families, and the 'step-down' interface with partners worked well. On a visit to the Domestic Abuse Hub, we saw this multi-agency service effectively supports children and their families through one to one and group interventions. This approach was established as a result of a previously commissioned review, and demonstrates Swansea Council's proactive approach to improving the range of services provided.
- 1.7. Having recognised the need to significantly improve how people access support, the authority was undertaking a 'Systems Thinking' review of its existing Information, Advice and Assistance arrangements, with a view to launching a more integrated, multi-agency approach. Shortfalls previously identified by the authority were reflected in some individual circumstances we looked at, such as multiple referrals over a short period of time, or instances where children and families had been stepped down to less intensive support too soon. This meant that children and their families could have services withdrawn too early, or not have received input and support as promptly as they should have.
- 1.8. The local authority deserves credit for identifying and responding positively to these deficits, and initiating a comprehensive review aimed at addressing weaknesses. CIW will monitor the impact of this new approach, following its piloting and subsequent implementation.
- 1.9. The need to meet the requirements of the Welsh language 'active offer' had been recognised. The local authority also supports a range of black and minority ethnic populations, and has access to translators and interpreters to assist with this. We saw a few cases where lack of access to appropriate interpreters had delayed the timeliness of response and impacted on the quality of the intervention.

## 2. 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 carers 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 there were good arrangements in place to support assessments, resulting in these being based on a range of appropriate information. On the whole, the response to the referral or request for assessment was prompt and efficient, with assessments being completed in a timely way.
- 2.2. Swansea Council's Signs of Safety (SOS) approach, which underpinned their assessments as well as safeguarding and care planning, provided a detailed framework which was well understood by staff, and clearly prioritised risk. However, inspectors identified the need to improve the quality of analysis in some records through the accurate identification of risk and barriers, along with individual and families' needs and strengths.
- 2.3. We found many detailed assessments provided a sound basis for analysis of the issues affecting children and their families with case mapping used to good effect. In some cases, the basis on which decisions relating to the individual outcomes had been made was not always clear in the documentation viewed.
- 2.4. Whilst a focus on risk from the outset is appropriate, we sometimes found an over-emphasis on this aspect, which resulted in insufficient recognition being given to identified strengths. This under-mined the strengths based approach being taken with children and families. The recently piloted 'signs of well-being' framework introduces the potential for greater flexibility of approach, where the assessed need of children and families does not include safeguarding elements.

- 2.5. We found children were assessed by qualified workers, and the child was seen alone as part of this process, when appropriate.
- 2.6. There was duplication of assessment information across a number of aspects of the child's journey through children's services, which impeded effective decision-making. The local authority indicated that this, together with the proportionality of some assessments, were issues they were aware of and intended to take action to address.
- 2.7. Our conversations with social workers about individuals they were working with confirmed they clearly had the best interests of children and young people at heart, and that listening to their 'voice' was an important element of the assessment process. However, in line with our findings in relation to the 'what matters' conversation, this was not consistently captured in the documentation we viewed. There is further work needed in developing these aspects.

### 3. Care and Support and Pathway Planning

#### 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. After a period which had seen a reduction in the number of children looked after by the local authority in line with the objectives of its safe reduction strategy, there had been an overall rise during 2017/18. The local authority has worked hard to understand and analyse the reasons behind these recent trends, and to utilise this information to inform future policy and practice.
- 3.2. Care and support planning is underpinned by the Signs of Safety framework. We saw social workers were confident in their implementation of this model, which offered a positive, solution focused methodology within a consistent and well understood structure. Many of the care and support plans and pathway plans we saw were detailed, of good quality, and in many cases reflected the direct work undertaken with children, young people and their families. We saw that sharing the direct work social workers had undertaken with individual children, for example through 'words and pictures' could have a powerful impact when wider family members were involved in this process. Mapping and scaling, when used effectively with children and families, were helpful in agreeing next steps with families and wider safety networks.
- 3.3. As with assessments, a consistent shortcoming of the care and support plans was not fully embracing the expectations of the SSWBA by failing to embed the 'what matters' conversation or to fully reflect the voice of the child / young person. Whilst we saw and heard about instances where this had happened, these were exceptions to usual practice. The documentation being utilised to record plans did not assist social workers in facilitating this approach.
- 3.4. Staff told us that the PARIS data-base system used to generate and record information could be difficult to navigate, particularly in terms of locating some individual documents. We also found instances where sibling groups were recorded on one plan, rather than these being individualised. It is understood that the local authority intends to pilot new formats for the care and support plan, as a means of addressing these issues. It is important children and families have a copy of their

care and support plan but it was not clear if this was routinely happening.

- 3.5. We heard about examples of work undertaken by the Family Support Team (this incorporated the Supervised Contact Team, Flexible Home Support Team, and the Family Intervention Teams) with families where children were at risk of being accommodated. By implementing intensive, direct programmes over a short period of time, families were supported to take ownership of agreed outcomes and progress was closely monitored and reviewed. This service had recently been re-structured, and planned to move to a new user-friendly family centre, which was in the process of being re-modelled for this purpose.
- 3.6. We heard from other agencies that partnership working is generally effective, some children and young people were achieving good educational outcomes and no looked after child had been permanently excluded from school. In contrast to this we also identified a number of children who had been identified as being 'educated other than at school' (EOTAS), often following a placement breakdown at a pupil referral unit (PRU). We were concerned to note some of these children were having reduced timetables, and were only receiving five hours per week of home tuition, in some cases over an extended period. This issue had already been raised by Independent Reviewing Officers (IRO's) and was being monitored by the scrutiny committee.
- 3.7. Whilst staff we spoke to were confident that statutory visits to looked after children were being undertaken in line with requirements, this was not always reflected in the documentation reviewed. Again, the local authority was aware of this, and should ensure that steps are taken to resolve this.

### **Care Leavers**

- 3.8. Statutory services for young people aged 16 - 18 in care are provided by the Bays Plus team, with services for those aged over 18 being provided collaboratively by a 3<sup>rd</sup> Sector organisation, which employed personal advisers to support young people. During a visit to this service we saw that these teams were co-located but operated and were managed separately. The design of the environment was young person focussed and non-stigmatising, so as to promote a 'drop-in' ethos. There was a strong emphasis on achieving positive outcomes, with ready access to a range of appropriate advisory services, for example those relating to drug use and sexual health advice. Young people also had access to a 'Skills for Living' service which undertook therapeutic work directly with them.
- 3.9. Young people who were entitled to a personal adviser (PA) were allocated one. We heard positive feedback from young people about how they valued the input of their PA, particularly in assisting with accessing benefits and social or community engagement activities.

There was flexibility in terms of hand-over arrangements between social workers and PA's in response to individual need / circumstances. We saw evidence of continuity in terms of PA relationship, illustrated by one young person having the same PA for a number of years.

- 3.10. The authority embraced the When I'm Ready scheme aimed at supporting young people in foster placements beyond the age of 18, and we heard of instances where this had been administered flexibly, in young people's best interests.
- 3.11. A specialist Supported Lodgings worker was located within the Bays Plus team, and we heard a range of housing options were discussed with a variety of providers on a weekly basis. The Swansea Accommodation Pathway was helpful in securing housing for care leavers; there had been no recent recourse to B&B accommodation.
- 3.12. The authority was proactive in recognising and acting upon its wider role as a corporate parent in supporting care leavers, and had a number of initiatives aimed at supporting young people into work, training schemes and further education.
- 3.13. Effective partnerships were also evident in good working relationships between children services and probation, youth offending and adult services, which facilitated effective transition for young people. In contrast to this, we were also told significant difficulties can arise when young people with mental health support needs transferred between CAMH's and adult mental health services, where current arrangements do not assist in planning effectively for those young people with complex needs.

### **Long Term Planning**

- 3.14. There was a clear commitment evident throughout the local authority to promote permanency for its looked after children and young people. Where appropriate, this involved individual consideration via the public law outline (PLO) process, and we saw this strong and effective legal gateway system was well-understood and valued. Decision-making in relation to the commencement of pre care proceedings and final care planning was robust. Discussions in this forum were founded on good quality assessments and other documentation which informed effective challenge and scrutiny.
- 3.15. The authority had sought to enhance elements of its decision making process by introducing new 'checks and balances' to their panel arrangements. These were aimed at ensuring the timeliness and suitability of individual plans and pathways were considered at a sufficiently early stage, and that appropriate oversight was given to longer term Special Guardianship Orders (SGO's) and When I'm Ready arrangements. Whilst it was too early for CIW to comment on the effectiveness of the new panel arrangements, staff spoke positively

about their initial impact, and felt that they were supportive and facilitative.

- 3.16. We saw that the role of the Independent Reviewing Officer's (IRO) was well understood by others, and the team had the capacity and authority to monitor both individual progress and corporate performance. We found there was sometimes a need for more urgency in overseeing the timeliness of reviews, and for promoting the active participation of young people within this process. The level of escalation, where an IRO formally raises concerns about a child or young person who is looked after, was surprisingly low.

### **Placement choice, stability and wellbeing**

- 3.17. The authority had worked hard to increase the proportion of children and young people placed with in-house foster carer placements as opposed to being placed outside of the local authority. We saw that attempts were consistently made to maintain children within their families, where this was in their best interests.
- 3.18. Whilst we found that stability of individual placements was good, the choice and availability of placements continued to be a significant challenge. We heard from social workers these restrictions can mean they are sometimes faced with the 'least bad' option in terms of choice, or placements which are 'not quite right' for the child or young person. This inevitably limits their ability to make the best plans for children, and reduces options for contingency planning. We also saw children could be waiting for some time for a long term placement, which potentially impacts on outcomes and their subsequent transition. Both a Placement Sufficiency and Recruitment and Retention Strategy have been produced and signed off by the Corporate Parenting Board. Swansea are also hosting the Western Bay Fostering Development Officer post funded by the National Fostering Framework and a regional development plan has been produced.
- 3.19. The wider need to improve placement choice had been recognised and responded to regionally in the shape of a Multi-Agency Placement Support Service (MAPSS). This aims to identify and support appropriate placements for looked after children with more complex needs. We heard the joint funding of these placements with some partner agencies can be problematic.
- 3.20. Connected person carers who had undergone a formal process of assessment were positive about the service they received. Some reported positively to inspectors in terms of the support they received from both the child's social worker and the supervising social worker from the fostering team. Support was described as 'fantastic' by one set of carers; 'brilliant' from another. They also spoke positively about the quality of the training on offer. Another set of carers were in the process of becoming Special Guardians - and were pleased they would



still be able to access the training available to foster carers. Connected carers also had a weekly support group, which they valued. We heard some Special Guardians were not afforded the same level of support as connected carers.

## **Participation**

- 3.21. We read in case files and heard about direct work being undertaken with children, for example using the '3 Houses' model. It was clear social workers routinely listened to children and took account of their wishes and feelings in their decision making. In contrast to this, the documentation we viewed via the PARIS database and elsewhere often failed to sufficiently reflect the voice of the child. The templates we saw in use frequently generated long and duplicated reports, and it was unclear how accessible these were for children, young people and their families.
- 3.22. The local authority had a clear commitment to promoting co-production, which was actively facilitated by an independent participation unit supported by the corporate parenting board. Direct feedback from young people as part of the wider 'Bright Spots' initiative was recently utilised in re-shaping services at the contact / information centre. Regular events were held to celebrate the achievements of looked after children and young people. Children and young people were represented on and regularly presented issues to the corporate parenting board. Elected members told us they engaged in an annual challenge event, enabling matters of interest to children and young people to be raised and responded to directly.
- 3.23. Children and young people we spoke with confirmed they were offered advocacy and had received appropriate information and advice when requested. They spoke about having a positive relationship with their social worker, and having a voice and a say over their assessment and plans for their care and support. The active offer of advocacy is monitored via IRO's, and whilst offered to a large majority of those who are entitled to it, the authority are aware they need to further improve their performance in this area.

## 4. 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. It was evident from discussions held with staff members, in case files reviewed, and our observation of practice throughout the department that the local authority prioritised keeping families together, and worked hard to explore all appropriate avenues prior to looking at alternative options. It had a good grasp of local risk and vulnerability factors, and had augmented the available expertise by deploying a dedicated missing person and child sexual exploitation co-ordinator. They assisted in the daily tracking of activity, and facilitated closer working relationships and information exchange with partners.
- 4.2. The Signs of Safety (SOS) approach to safeguarding children has been established across the local authority for a number of years and has evolved over time to meet the needs of families in Swansea. It permeates throughout children's services, and provides staff with a clear understanding of Swansea Council's framework of safeguarding practice. Staff we spoke to - particularly newly qualified staff - were very positive about the model and liked the structure this gave them. Experienced staff were generally positive about the professional discretion afforded for them to use other approaches as appropriate, particularly with older children / young people.
- 4.3. The model focuses on direct work with children, outcomes from which were observed to be compelling - a powerful tool in facilitating change when utilised at child protection conferences. There is a clear expectation by the department at legal meetings and conferences that direct work with children has been undertaken, and that this is evidenced in assessments and other documentation presented at court or conference.
- 4.4. Partner agencies we spoke with were generally positive about the Signs of Safety framework providing a sound approach to safeguarding. We found effective use of coordinated initial strategy discussions to inform decision making in relation to risk, and

subsequent joint s47 child protection enquiries. Police, education and health professionals all spoke highly of the responsiveness and level of involvement of the children's services department in assessing and managing risk. Review and core group meetings were held in accordance with expected timescales, with good attendance from partners.

- 4.5. In a few cases it was evident that stronger safeguarding processes were required in order to ensure sufficient focus was maintained on identifying and managing risk. This includes a need for fuller consideration of longer-term issues, alongside the immediately presenting risks. The improved analysis of presenting factors as a basis for the management of risk is an area in need of further development.
- 4.6. We observed family network meetings being used to very good effect in capturing and reflecting the views of significant people involved in identifying and reducing risks to individual children / young people. In one such meeting led by experienced professionals specialising in SOS we observed very skilled intervention, resulting in the development of an effective safety plan for the children involved. The professionals ensured the wider family network were kept involved throughout the meeting and 'scaled' it at the end with the result that all present felt the plan was manageable and achievable.
- 4.7. In the files audited we found detailed minutes of strategy meetings with clear action plans and direction for any further investigation. In relation to safeguarding, we also saw some detailed risk analysis within the danger statement and safety planning process, with very clear next steps and information about consequences of not following the safety plan. In a few cases we considered, we raised issues about how effectively safeguarding concerns were initially responded to by the local authority.
- 4.8. We also found that an appropriate balance between identified risk and individual strengths and needs was not always struck, with a tendency for those risks identified by the authority to be prioritised. This meant that opportunities to build on individual strengths when identifying next steps were lost.
- 4.9. The safeguarding lead for children's services had close oversight of performance and was focussed on outcomes for children and young people. We heard that reports for conference were not always made available to all parties sufficiently in advance of meetings, which had the potential to impair the quality of discussion and subsequent decision making. This was also disadvantageous for families who had not had sight of reports in sufficient time before the conference, which impaired their ability to fully participate and respond effectively.

- 4.10. The regional safeguarding board had been in place for some time and had established close strategic partnerships across the three local authority areas. Swansea Council children services were actively involved in the work of the board, and benefitted from the knowledge and experience within the partner agencies represented. The local authority was considering augmenting these arrangements via the development of a local safeguarding board, with the aim of monitoring and reinforcing local operational practice which they considered was not sufficiently supported by the current framework.

## 5. Leadership, Management 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 people. Meeting people's needs for quality services are a clear focus for councilors, 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. Corporate ambition and support for Swansea Council children's services was evident at all levels within the local authority, along with a clear understanding of its vision and future direction. Key aspects of its strategy are set out in the Child and Family Services Improvement Programme 2017-21, which includes elements specific to looked after children and care leavers, such as the 'Safe Looked After Children Reduction Strategy'.
- 5.2. Children's services have benefitted from committed and stable leadership; a number of personnel in senior posts have quite recently been confirmed in those positions, having initially been appointed on an interim basis. The local authority is currently undertaking a review of some of its leadership arrangements.
- 5.3. Elected members clearly understood, and were committed to meeting their statutory responsibilities to children. The creation of apprenticeship opportunities and the introduction of exemption from council tax for young people who are looked after by the authority, were cited as recent examples of longer term support. There are processes and protocols in place to identify, support, and report on the most 'at risk' groups of children, including those at risk of sexual exploitation, those who go missing, abuse drugs and alcohol, and those children being educated out of school. There are robust scrutiny arrangements in place to hold senior officers of the local authority to account. These are supported by comprehensive dashboard data and reporting arrangements, which facilitate analysis and challenge.
- 5.4. Partnership working was generally described as good, with the Regional Partnership Board identified by senior managers as a useful forum for the exploration of common strategic themes. The Population Needs Assessment was being utilised as a basis for identifying and planning to meet future need, with commissioning arrangements for

those with complex needs, and the identification of potentially unmet ethnic minority need cited as recent examples.

- 5.5. Performance is monitored and reviewed, and managers have access to live dashboard information at all levels. However, the authority is aware that the current quality assurance processes are not sufficiently embedded across children's services to enable them to effectively inform practice development. An example of this was the high quality of the internal audits undertaken in preparation for CIW's inspection. This elicited a range of high quality information about practice, and if similar quality assurance procedures were embedded they could help to further improve outcomes for children and young people.
- 5.6. There had been a recent re-structuring of the supported care planning and children with disabilities staff into geographically based teams and pods with the aim of providing more effective support to social workers, help prevent drift, and facilitate quicker step-down to other services. The future role and function of therapists within these teams was being explored. Whilst it was too early to evaluate its impact at this stage, the change had been well led and had been well received by staff, who welcomed the co-location of teams and told us that there had been extensive consultation prior to this being implemented. We heard staff appreciated the increased level of support available from the newly created professional lead roles, and felt the smaller teams allowed greater consistency for families as more workers get to know each of the cases. A new business support role had also been established, giving each team dedicated additional capacity to help manage performance data and quality assurance functions. The performance hub which sits alongside this new structure presented opportunities for children services to enhance the current arrangements for oversight and quality assurance.
- 5.7. The managerial energy and focus on implementing new structures meant opportunities to comprehensively embed the SSWBA principles had not been fully exploited. Senior managers in children services recognised there was more work to be done in ensuring that the 'what matters' conversation is enshrined throughout its engagement with children and families. In parallel with this, there is a need to ensure the voice of the child is fully reflected in the assessment, care planning and other documentation utilised as the basis for information gathering and decision-making.
- 5.8. Swansea Council children's services have a relatively stable and resilient workforce that is committed to being child focused, and is passionate about keeping families together and achieving good outcomes for children. Staff consistently told us they enjoyed working for the local authority where there was a culture of support which they valued. The accessibility and visibility of the Principle Officers and the Head of Children's Services was appreciated. Individual good practice was acknowledged by senior managers and we saw examples of

emails sent to individual members of staff from both the Head of Service and the Director reflecting this.

- 5.9. Managers told us there had been no use of agency staff for some time, and 'over-recruitment' to vacant posts was utilised in order to provide cover. However, recent absence levels due to sickness and maternity leave were raised as issues which were causing considerable workload pressures for staff we spoke with in some teams.
- 5.10. Access to training was reported to be good, and we heard this extended beyond the 'core' aspects of routine training, to include those of particular professional interest / specialism. Staff welcomed the opportunity afforded by supervision to review individual cases, although some feedback there could sometimes be an emphasis on this being overly-task driven. An internal audit undertaken in advance of our inspection identified staff supervision was not always taking place frequently enough and there needed to be a clearer rationale for decision making in some instances. Whilst our review of a sample of supervision files found these were generally reflective of good practice, the quality of records and timeliness of supervision sessions was inconsistent. We endorse the local authority's own conclusion that there needed to be an update and review of current implementation of supervision policy and practice, together with a standardisation of formats across the service.
- 5.11. We found complaints were well managed and effectively responded to, with the exception of those which in part related to services provided by other agencies, and were therefore outside of the local authority's span of control.

## **Methodology**

### **Fieldwork**

We undertook 9 days of fieldwork activity.

We selected case files for tracking and review from a sample of cases. In total 69 case files were reviewed; of these 20 were followed up with tracking interviews with social workers and family members and 4 were subject to a tracking focus group which involved multi agency partners.

We interviewed children, parents, carers and relatives.

We interviewed a range of local authority employees, members, senior officers, the Director of Social Services and the Chief Executive.

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

We reviewed a sample of 8 staff supervision files.

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

We looked at a sample of complaints that were made about children's services.

### **Inspection Team**

Lead Inspector: Duncan Marshall; Supporting Inspectors: Sharon Eastlake, Vicky Poole, Sara Hubbard, Katy Young, Leigh Thorne & Pam Lonergan.

## **Acknowledgements**

CIW would like to thank the children and young people, parents and carers, staff, managers and members and partner organisations who gave their time and contributed to this inspection.