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

Inspection of *Children's* Services

Carmarthenshire County Council

September 2016

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Introduction

Care and Social Services Inspectorate Wales (CSSIW) undertook a pilot inspection of children's services in Carmarthenshire County Council in July 2016. The purpose of the pilot was for CSSIW to test out and learn from a revised approach to local authority inspection methodology which introduced a greater emphasis on understanding the extent to which the delivery of social services improves outcomes for people in need of care and support.

This pilot was narrowly focused, specifically testing out inspection tools and methods that supported evaluation of outcomes for children and families accessing information, advice and assistance, preventive and statutory services. An evaluation of outcomes for carers was out of scope for this pilot as was an assessment of advocacy services.

Inspectors looked closely at the quality of outcomes achieved for children in need of help, care and support and/or protection. We focussed specifically on the quality of practice, decision making and multi-agency work in the delivery of information, advice and assistance services. In addition inspectors evaluated what the local authority knew about its own performance and the difference it was making for the people it was seeking to help, support and protect.

Inspectors read case files and interviewed staff, managers and professionals from partner agencies. Wherever possible, they talked to children, young people and their families.

The fieldwork for this pilot inspection took place during a period of significant change for Carmarthenshire County Council, in particular the implementation of the Social Services and Well-Being (Wales) Act 2014 (SSWBA) was embryonic so the requirements of the act had not had sufficient time to embed into new practices and procedures. Also the authority was in the process of introducing revised social work operating models across children's services. Our case file sample included a mix of these new approaches alongside previous arrangements for the completion of assessments and plans. CSSIW recognised that in evaluating the quality of work during this period of major change our capacity to make consistent judgements was limited and this was exacerbated by the very small sample size we reviewed.

Nevertheless we found an authority committed to supporting children and families to stay together whenever it was safe to do so and their approach to delivering family support services underpinned this commitment. Inspectors were pleased to note that elected members, senior leaders, managers and staff were committed to achieving improvements in the provision of help, support and protection for children and families.

The recommendations made on page 5 of this report identify the key areas where post-inspection development work should be focused. They are intended to assist Carmarthenshire County Council and its partners in their continuing improvement.

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

Summary of Findings

Information, Advice & Assistance

We found that generally when referrals were made that children and families were signposted to services and/or offered assessments appropriately. Safeguarding concerns were re-routed to statutory services speedily and appropriately. Regardless of the referral route IAA services could be provided bilingually as well as in a range of relevant formats. Partners broadly understood the route's available for accessing a range of services for children and families. Further development was required at all levels to more effectively align IAA services with the requirements of the SSWBA and improve outcomes for children and families.

Access and Assessment & Safeguarding and Protection

Generally partners and the authority provided a timely and appropriate response to concerns about children and young people who might be at risk. The understanding of thresholds between partners and children's services was inconsistent and multi-agency work to address this was indicated. Overall, assessments were timely and contained appropriate information from a range of sources. The quality of risk analysis within assessments and care planning was variable and although assessments and plans were generally child-focussed, they did not always take sufficient account of the impact that adults' behaviours had on children. Assessments and plans were effectively shared with children and families. Management oversight of the quality of assessment and care planning was insufficiently robust in terms of challenge and quality control. Arrangements for stepping up and down between the preventive and statutory sectors were generally understood. Children, who were or were likely to be, at risk of harm were identified and child protection enquiries were thorough and timely. Regional multi-agency protocols needed to be updated.

Leadership, Management & Governance

We found committed and effective leadership, management and governance arrangements were in place in Carmarthenshire. SMT and elected members demonstrated effective leadership and had a clear vision about what they wanted children's services to look like. This was reasonably well communicated to staff. Children's services business could have been more highly prioritised by scrutiny arrangements. We saw some evidence of the authority monitoring and evaluating its own performance, particularly through the TAF hub and external review of child in need and family support services. Work with partners, especially at a regional level, could usefully be strengthened. We found a committed, stable and suitably experienced workforce. The building blocks were in place to further develop service provision in alignment with the SSWBA.

Recommendations

1. Multi-agency arrangements should be established to strengthen operational plans to support effective co-ordination of statutory partner's completion of Joint Assessment Frameworks.

2. The local authority should establish effective systems to ensure that thresholds for access to statutory services are understood and consistently applied by staff and partners.

3. The consistency and quality of social work and risk analysis contained in assessments and plans must be improved.

4. The quality of management oversight of assessment and planning should be strengthened.

5. Strong political and corporate support for children's services must continue to ensure service improvements underway are prioritised and the pace of improvement sustained.

6. The local authority and partners should continue to work together to develop an integrated approach to delivering information, advice and assistance, preventive services and statutory provision to achieve greater continuity and reduce duplication for children and families accessing these services.

Key Dimension 1: Access, Information Advice & 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 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. 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.

Key findings

- IAA services were available bilingually and in a range of accessible formats
- Children's services worked effectively alongside other public sector services and the voluntary sector to provide a range of interventions to support vulnerable families.
- Those staff providing IAA services were well trained, confident in their ability to recognise safeguarding thresholds and familiar with referral procedures to statutory services.
- Overall commissioned preventative services made appropriate referrals to statutory services.
- More work with statutory partners in health and education to raise awareness of their role and responsibility for undertaking JAF completion was required.
- Local authority and partners could benefit from clarification about the inter-relationship between each other's roles and responsibilities for undertaking the provision of IAA services.

Explanation of finding

1.1. Carmarthenshire local authority was committed to supporting children and families to stay together. The authority's Family Support & Prevention Strategy promoted the least intrusive method of intervention possible, consistent with safeguarding and advocated the importance of engaging with children and families in the co-production of assessments and of person centred planning. The authority provided Information Advice and Assistance (IAA) services that were accessible to the public and to professionals through a variety of formats and offered in people's language of need.

1.2. The Family Information Service (FIS) statement of service 2016 was consistent with the Social Services and Well-being (Wales) Act 2014 (SSWBA) as it defined both *"information"* and *"guidance"* and clearly differentiated between these two activities. The website was well-developed and easy to navigate, evidenced by an 89.6% satisfaction response rate to FIS on-line survey. Users were signposted to a comprehensive range of universal childcare and/or preventative services but inclusion of a hyperlink to the council's website would have created a more direct route for people requiring information about eligibility for care and support services. FIS had been pro-active about promoting their service particularly through a creative approach to working with primary schools and the introduction of a Partnership Working with Schools Award. Despite some very proactive work with primary schools the service recognised it has more to do to engage directly and effectively with older children.

1.3. FIS staff appeared to be well-trained in respect of giving information and they were well-informed about a wide range of local services for children and families in the area. They were able to recognise when it was appropriate to provide more in depth information and to describe advantages and disadvantages of options outlined. FIS staff had recently spent a short time shadowing duty workers and as a result believed they were developing a better insight into the work of the authority's Central Referral Team (CRT). They were familiar with procedures, including issues around consent, for ongoing referral of relevant cases to CRT and they were aware of their safeguarding responsibilities.

1.4. Key to the authority's Family Support & Prevention Strategy was Team Around the Family (TAF). The TAF management board with strategic representation from local authority, health, education and voluntary sector provided governance and accountability and was supported by operational middle management and practitioner groups similarly constituted.

1.5. The TAF hub supported the collection, collation and analysis of data across much of the preventive sector. This information was used to identify areas of greatest need as well as gaps in provision and to inform the commissioning cycle. The authority had utilised this intelligence alongside information arising from regular contract monitoring arrangements to re-commission child and family support provision. This had resulted in the provision of a range of services to: provide choice; help meet the needs of individuals and communities; and prevent the need for statutory services. Services were organised around four tiers of need. Tier 1 included universal services available for all children and families. Services for children and families needing some extra support were at tiers 2 and 3. Tier 4 included services for families and children in crisis requiring statutory intervention. Families in need of access to a number of services could move between tiers depending on circumstances and the effectiveness of support.

1.6. The TAF hub also provided a referral route for families and professionals to access support services for children and families. It comprised a central team of suitably trained and experienced co-ordinators, who provided support, liaison, guidance and training to a diverse range of practitioners and commissioned family support services. The co-coordinators role was to review referrals and make decisions about thresholds. Arrangements for stepping-up from preventive services were clearly articulated in the TAF protocol and evidence from our case file sample reassured us that overall commissioned services made appropriate referrals to statutory services. In many cases of a very small sample agencies continued to support families during this process.

1.7. Those cases not requiring statutory services were either signposted to relevant single agency family support; or if the family presented with more complex needs (falling short of a requirement for an assessment for care and support) they were allocated to a key worker in the commissioned project evaluated as being most relevant to their individual circumstances for a Joint Assessment Framework (JAF) to be undertaken and a multi-agency package of support offered. We noted that there was more work to be done with statutory partners in health and education to raise awareness of their role and responsibility for undertaking JAF completion. Due to pressures of demand there could sometimes be a delay in obtaining a JAF and there were also waiting times for some commissioned services. Although we were reassured that families stepping down from statutory services continued to receive social work support during the wait we were not able to gain a sense of how any other families referred to these services were supported during a waiting period.

1.8. The work of CRT covered the whole of Carmarthenshire. This team of duty workers provided a point of contact for people who had concerns about a child's welfare or safety. As most contacts were received from other professionals the extent to which duty workers directly offered information, and/or advice and/or assistance to children and families (in comparison to third party) was unclear. Local authority and partners could usefully benefit from clarification about the inter-relationship between each other's roles and responsibilities for undertaking the provision of IAA services as the requirements of the SSWBA become further embedded.

Conclusion

We found that generally when referrals were made that children and families were signposted to services and/or offered assessments appropriately. Safeguarding concerns were re-routed to statutory services speedily and appropriately. Regardless of the referral route IAA services could be provided bilingually as well as in a range of relevant formats. Partners broadly understood the route's available for accessing a range of services for children and families. Further development was required at all levels to more effectively align IAA services with the requirements of the SSWBA and improve outcomes for children and families.

Key Dimensions 2 & 4: Access and Assessment & Safeguarding and Protection

What we expect to see: Access and Assessment
All people entitled to an assessment of their care and support needs receive one in their preferred language. 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. 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.

What we expect to see: Safeguarding and Protection
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. People are not left in unsafe or dangerous environments

Key Findings

- Generally partners and the authority provided a timely and appropriate response to concerns about children and young people who might be at risk.
- There was not always a consistent understanding of thresholds; however threshold decisions in relation to safeguarding and child protection concerns were robust.
- Assessments were timely and developed from a wide range of sources including information from partners, parents and carers.
- Families views were considered and reflected in assessments and a copy of completed assessments were effectively shared with them.
- Good social work practice was reflected in the content of assessments and care planning.
- Social workers needed to be more robust and confident in working with families and setting out their professional analysis of risk and needs.
- Management oversight of the assessment and planning process was insufficiently robust in terms of challenge and quality control.
- Child protection enquiries were thorough and timely and were informed by decisions made at a strategy discussion.
- Multi-agency child protection thresholds protocol needed to be updated to incorporate more recent Welsh Government guidance.

Explanation of findings

Access & Assessment

2.1. Arrangements for access to statutory children's services were well organised. Although the quality of information supplied by partner agencies was variable, duty workers were diligent in chasing missing information. There was a perception amongst some staff and managers that despite the shared directorate arrangements a minority of schools still lacked confidence in raising concerns with families and that on occasions this could delay referrals. This is an area that needs to be addressed by training.

2.2. We found generally that partners and the authority provided a timely and appropriate response to concerns about children and young people who might be at risk. Duty workers demonstrated a good awareness of the preventive services available for children and families across the authority. All were experienced and told us that they were "very confident" in their ability to recognise and act appropriately on immediate safeguarding concerns.

2.3. Under the supervision of team managers duty workers undertook thorough additional enquires with professionals and with families to clarify and confirm contact information to inform initial decision making. In cases where the threshold for an assessment for care and support was indicated duty workers subsequently completed referral forms. The majority of referrals seen were of good quality and represented a brief analysis of the presenting risks and needs. Whilst not yet explicitly articulated as such these referrals effectively represented the start of a proportionate assessment. Partners were often not advised of the outcome of referrals.

2.4. The workflow arrangements between CRT and locality assessment teams were well established. All contacts that met the threshold for an assessment for care and support were transferred to locality assessment teams. Partners reported that in a small number of cases the transfer between teams could create delay in decision making leading to a potential impediment to children and families receiving early help. The authority could usefully assure itself that the workflow arrangements between these teams are as streamlined as possible.

2.5. Staff reported that despite good personal working relationships with partner agencies there was not a shared common understanding of thresholds for access to statutory services. Partners also commented on some inconsistencies in the application of thresholds. However they were also clear that threshold decisions in relation to safeguarding and child protection concerns were robust. Evidence from our case file review also suggested some inconsistencies in the application of thresholds in respect of referrals where there was no obvious indication of significant harm. Nevertheless, we found that the constructive relationship between CRT and locality assessment team managers facilitated healthy challenge around threshold decision making and as such was a key strength that made a positive contribution to

arrangements for management oversight. We also noted that the TAF manager participated in quarterly threshold review meetings but judged that a wider range of partners could usefully be engaged in the quality assurance process to more effectively achieve a consistent and shared understanding of thresholds.

2.6. The authority had appropriate systems in place for responding to referrals out of normal office hours. The Out of Hours Team had access to the authority's electronic information system and the CRT manger had systems in place to prioritise cases referred by this service if required.

2.7. The authority had identified the significance of domestic abuse and children's services were participating in a domestic abuse conference call (DACC) pilot at the time of our fieldwork. This regular multi-agency arrangement aimed to protect victims and reduce the likelihood of further harm to children from domestic abuse. We observed the DACC to be effectively chaired by police and that all other partners were well prepared for the call and participated constructively. Any actions agreed for each agency were clearly articulated and it was evident that when there were repeat victims previous actions were reviewed. The authority and partner's needed to assure themselves that this initiative was achieving its aim. Although a governance and accountability structure was in place to monitor the pilot the authority had yet to determine how or when the outcomes from the pilot would be evaluated and/or reported on.

2.8. A new template for recording proportionate assessments and care and support plans was introduced in May 2016. The format encouraged practitioners to apply the principles of the SSWBA when undertaking assessment and planning activities. Staff we spoke to had been involved in the development of these forms through the Form Review Group (FRG) and were generally positive about the changes.

2.9. Most of the assessments we saw were timely. However, we found that social workers and their managers were still making the transition toward more flexible timescales advocated by a proportionate approach to assessment. The impact of this was that although a small number of families were undergoing assessment in what would previously have been considered a (procedurally) timely manner, some faster decision making could have more effectively contributed to their well-being sooner. Nevertheless, it was clear that the authority was preparing well to manage the changes they faced introduced by the SSWBA. Team managers had already set up supervision systems to monitor timeliness of assessments so as to minimise drift. Additionally they were taking a flexible approach to progressing casework to closure/signposting dependent on individual need rather than being determined by process driven timescales.

2.10. We found that most of the assessments we reviewed contained some good quality information developed from a wide range of evidence including relevant and appropriate information sought from partner agencies as well as parents

and carers. Families we spoke to reported that social workers engaged them well in their assessment and that their views were considered and reflected. A copy of the completed assessment was given to them and they reported that it was easy to read and was provided in their language of need. It was clear that social workers were working hard to engage children and families in what matters conversations and co-production of plans. We saw evidence of children contributing to assessments, including in some instances through their participation in direct work. Children were seen alone as appropriate often at school or in a safe environment.

2.11. However, good social work practice was sometimes undermined by the structure and design of the assessment template. The format for assessments was still very new, and was being used inconsistently across and within assessment teams. Whilst assessment often captured children's wishes and feelings and that of their parents and family the social work and risk analysis was not as evident. Analysis did not always sufficiently explore the impact of the adults' behaviour on the child or the depth of enquiry that had been undertaken which then impacted on the resulting plan. This was to the detriment of achieving transparency with families when setting out clearly what was required of them and/or the potential consequences of failing to make necessary changes. Social workers needed to be more robust and confident in working with families and setting out their professional analysis of risk and needs.

2.12. The introduction of the SSWBA has meant a period of adjustment for staff. Those social workers interviewed told us that they viewed the aims of the act as building on and promoting good practice. Staff had undertaken introductory training on the principals of the act and had started to feel more comfortable with the use of new language. Having had an opportunity to apply the intentions of the act the authority recognised that more training was needed to better embed changes into practice. To support this the authority was at an early stage of introducing the Signs of Safety model of social work across locality assessment teams and we saw evidence of practitioners using Signs of Safety tools, for example in relation to the direct work undertaken with children, in some of the assessments reviewed.

2.13. Management oversight of the assessment and planning process was insufficiently robust in terms of challenge and quality control. Whilst all of the assessments we reviewed had been signed-off, managers needed to be confident and evidence the extent to which they had provided challenge and direction. We also found that managers had signed off a small number of assessments that were of insufficient quality.

2.14. We saw a number of assessments with an outcome that included appropriate signposting to a single agency and/or to multi-agency (TAF) services. We found the TAF protocol outlined processes for signposting and stepping down. However, there was little guidance to help staff practically distinguish between signposting to other services as an *outcome of assessment* compared to stepping down as an *outcome of good engagement over time with a care and*

support plan. In terms of the former, it was positive that we saw some cases where signposting followed short focused interventions. However, the social workers delivering these interventions sometimes conceptualised signposting as a mechanism for progressing cases to an early closure and in so doing underestimated the value of their own work as a preventive service. Whilst our sample did not include cases stepping down from a care and support plan the strategic commissioning arrangements for Family Support Services (FSS) recognised families need for support during the transition from statutory to preventative services. The TAF protocol also outlined arrangements for ensuring that these families properly understood the potential impact on their own well-being and that of their children, of declining to take up services offered.

Safeguarding & Protection

2.15. Inspectors found that when referrals were received where there was an indication that a child or children were at risk or had suffered significant harm, prompt decisions were made and initial action was taken to protect the child. Child protection investigations were undertaken, in line with guidance, following a strategy discussion. A rota of social workers from locality assessment teams ensured that there was no delay in completing Section 47 enquiries when these were needed. Whilst within the small sample of cases we reviewed the quality of this work was good the clarity and timeliness of recording needed to be improved to ensure new workers or those taking over a case when the allocated worker was absent, as well as managers, achieved a swift understanding of the needs and risks associated with children and families. In the cases reviewed, inspectors saw no examples of children and families being subjected to child protection investigations unnecessarily.

2.16. Effective multi-agency arrangements ensured compliance with All Wales Child Protection Procedures and facilitated information sharing. The regional Children's Safeguarding Board (CSB) was established and chaired by Carmarthenshire's director of social services (DSS). Joint multi agency training took place between police and social workers and it was reported that this worked well. However, multi-agency protocols had not been updated since 2008 and did not include regional arrangements for addressing child sexual exploitation (CSE) or female genital mutilation (FGM). Rapid multi-agency work to update protocols and improve consistency of thresholds was indicated.

Conclusion

Generally partners and the authority provided a timely and appropriate response to concerns about children and young people who might be at risk. The understanding of thresholds between partners and children's services was inconsistent and multi-agency work to address this was indicated. Overall, assessments were timely and contained appropriate information from a range of sources. The quality of risk analysis within assessments and care planning was variable and although assessments and plans were generally child-focussed, they did not always take sufficient account of the impact that adults' behaviours had on children. Assessments and plans were effectively shared

with children and families. Management oversight of the quality of assessment and care planning was insufficiently robust in terms of challenge and quality control. Arrangements for stepping up and down between the preventive and statutory sectors were generally understood. Children, who were or were likely to be, at risk of harm were identified and child protection enquiries were thorough and timely. Regional multi-agency protocols needed to be updated.

Key Dimension 5: Leadership, Management and Governance

What we expect to see

Leadership, management and governance arrangements 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. The authority works with partners to deliver help, care and support for people. Services are designed and commissioned to: improve outcomes for individual people; reflect community need; and address key priorities within the local population. Work with partners in shaping the pattern and delivery of services is informed by the views and experiences of people who use or may need to use services. Services are delivered by a suitably qualified, experienced and competent workforce that is able to recognise and respond to need in a timely and effective way.

Key Findings

- There was strong corporate support for children's services; leadership, management and governance arrangements complied with statutory guidance and the director of social services had established systems that supported effective oversight of children's services.
- Elected member, directors and heads of service demonstrated a common understanding of the direction and drive needed to ensure both statutory and preventive services effectively improved outcomes for children and families.
- There were strong links between children's services schools and education welfare services although links with housing services were less well embedded.
- Scrutiny arrangements could be strengthened.
- There was a clear strategic direction for children's services which was effectively led by the head of children's services.
- Locally good foundations for IAA services were in place but more work with partners and staff was required to better understand and plan for the changes to practice required to more fully implement the requirements of the SSWBA .
- The planning and commissioning strategy for modelling family support services was well developed and made efficient use of resources.
- We found a stable, suitably qualified, experienced and committed workforce who felt valued.
- Children's services had a strong commitment to learning and development; staff received and appreciated regular supervision.
- Staff and managers were signed up to the values of the SSWBA and committed to making it work.

Explanation of Findings

Direction of Services

3.1. We found the authority was committed to prioritising services that support the most vulnerable children and families in Carmarthenshire. This was against a backdrop of declining budget and increasing demand alongside the implementation of the most significant legislative change to social services in Wales for many years. There was strong corporate support for children's services generally and for the family support and prevention strategy in particular. Elected member, directors and heads of service we interviewed demonstrated a common understanding of the direction and drive needed to ensure these services effectively supported improved outcomes for children and families in Carmarthenshire.

3.2. The children's services division was located within the department for education and children. This structure was well embedded. Directors and heads of service offered assurance that the DSS had good oversight of children's services issues and confidence that children's services were linked in to the wider social services and housing agenda. This was achieved through a formal protocol for social care governance and a range of other intuitive and more informal networks established over time.

3.3. We saw evidence that the corporate structure supported strong links between children's services with schools, education welfare services and with the educational psychology service. Links between children's services and housing services were more tenuous. The authority had invested in training for housing advice staff since the implementation of the Housing (Wales) Act 2014. Despite this the senior management team (SMT) recognised that further work was required to help housing advisors support vulnerable children and families more effectively. We saw evidence in case-files that supported this view.

3.4. Elected members were clear about the strategic direction for children's services. Senior managers reported that elected members were supportive of children's services. They visited front-line teams regularly and had attended training on the SSWBA so were aware of the implications of the act on the service and the authority. Routine scrutiny arrangements were well established and members generally had confidence that officers were delivering good quality services to children and families. However inspector's review of the content of scrutiny meeting minutes did not provide adequate assurance that children's services business was sufficiently highly prioritised in these meetings. A greater emphasis on eliciting feedback from children and families about their experiences and a more thorough interrogation of information about emerging trends arising from the impact of the preventive sector and their inter-relationship with statutory provision was needed to provide greater assurance that outcomes for children and families were being improved.

3.5. Leadership management and governance arrangements complied with statutory guidance and constituted an experienced and stable SMT. We heard that there was an ethos of healthy and constructive challenge within SMT and that this contributed to a culture of driving improvement to service models that promoted integrated services to meet the needs of communities.

3.6. We found clear strategic direction for children's services was effectively led by the head of children's services and that this was disseminated to other managers and staff. The organisational structure that incorporated both the statutory and preventive sector under his line management symbolised the authority's vision of a joined-up model of family support, as well as giving him access to pooled core funding and anti-poverty budgets and providing him with a good line of sight on front-line practice across the piece.

3.7. Inspectors had some reservations, at a strategic level about the pace with which the IAA requirements of the SSWBA were embedding in children's services. We saw evidence of strong foundations in place to achieve compliance with the principles of the Act; supported by the family support and prevention strategy as well as changes to social work operating models through the introduction of Signs of Safety and Reclaiming Social Work. Also in the longer-term there was an aspiration to create a single "front door" to social care services, integrated with health and housing. A project, part funded by health had been set up to progress this. However, in the meantime, a clearer understanding of pathways and the inter-relationships between the preventive sector, delivery of IAA services and access arrangements to statutory children's services could assist the authority and partners designing and commissioning future services to achieve efficiencies through streamlining processes. More importantly, an earlier clarification could contribute to making an immediate improvement to social care outcomes for children and families accessing these services in the shorter term.

3.8. Members of SMT reported good relationships with partners and some collaborative regional work in preparation for the implementation of the SSWBA was evident. The Mid & West Wales Health & Social Care Collaborative, now the Regional Partnership Board had commissioned an independent evaluation of IAA services in the region and a children's services work stream chaired by Carmarthenshire's DSS had been set up as mechanism for implementing future shared initiatives. It was however unclear at the time of the inspection how effectively and at what pace these arrangements were progressing to support and develop a multi-agency approach to local IAA services in Carmarthenshire.

Shaping Services

3.9. In the main it was evident that commissioning and resources allocated to services for children and families were being used to promote the most positive impact on outcomes for children and families. The commissioning process was informed by data collected by the TAF hub. Building on this work the authority could usefully develop a more cohesive approach to the collection and analysis of performance information at the interface between preventive and statutory services to create a more robust evidence base to support their understanding of the impact of preventive services on mitigating the need for children and families to (re)enter statutory provision.

3.10. Despite constraints on the use of grant funding the authority had been innovative about using resources as flexibly as possible to meet the diverse needs of its communities. This resulted in achieving a wide range of appropriate services that met the needs of children in need of a care and support plans and those in need of preventative services. As well as an extension of TAF provision to 16 – 25 year olds changes to arrangements for FSS created by a 50:50 split between core and grant funding facilitated greater consistency of provision for families stepping-down from care and support plans.

3.11. A weekly resource panel, jointly managed by practice and planning team managers, had been established. This provided a mechanism to identify gaps or barriers in service provision and assisted practitioners to find alternative solutions for immediate needs. Information collected by the panel also informed the future planning and commissioning cycle. Some social workers reported that they found the panel useful although others were unaware of the level of flexibility in provision that could be achieved. Given the potentially negative consequences of this lack of awareness for some families more effective communication about the panel's purpose throughout the workforce could be beneficial.

3.12. Despite the clearly effective and constructive working relationships between children's services and the preventive sector that facilitated transition between statutory and non-statutory services for children and families, there generally remained a distinct boundary between the two. The authority were still looking at how the work of the preventative services could be more effectively aligned with the provision of IAA services and assessment thereby aiming to achieve as much continuity and as little duplication for children and families as possible. Benefit could be achieved from determining how preventative and statutory services could work better together to produce proportionate assessments and to concurrently address eligible and non-eligible needs.

Workforce

3.13. Generally we found a stable group of staff and managers who felt valued and supported. We found a suitably qualified and/or experienced workforce across

CRT and locality assessment teams. The Children's Disability Team was also reported to be more stable after a period of change although a health funded post remained unfilled at the time of the inspection. Staff including (assistant) team managers had received recent child protection training. All CRT members, including the manager, had enrolled on TALK (NVQ level 4) training for IAA staff to further enhance their skills and competence in engaging with people.

3.14. We found a culture that supported learning, review and improvement. The head of service welcomed external review and validation of service improvement and modelled this approach to the workforce. Staff reported that managers and senior managers were visible and approachable and that they valued the authority's approach to delivering services. All staff and managers we spoke to were clearly committed to the ethos of family support and prevention. Staff welcomed opportunities to contribute to innovation and service improvements and met regularly with the head of service to do this. We saw evidence through the work of the Feedback Information Group (FIG) and the Form Review Group (FRG) of senior managers listening to staff feedback and responding accordingly to it.

3.15. Effective arrangements were in place in respect of workforce development and support. Whilst social workers in the locality assessments teams reported an increase in the complexity of some the work allocated caseloads were manageable and they felt well supported by their managers. All staff interviewed told us they were generally confident in the supervision and oversight provided by their managers; formal supervision was regular and of good quality and they were encouraged to take up development opportunities as they arose. Evidence from our case file review suggested however that managers could usefully have been more critically challenging in their oversight of the quality of assessments and plans.

3.16. Training for the SSWBA had been delivered in a series of workshops to all children's services staff, including FIS advisors. This focused on the principals, culture and attitudinal change required by the act. We found commitment from staff to make new arrangements work and staff we interviewed were clearly signed-up to the values of the act. Now having had an opportunity to start implementing new arrangements a targeted approach to attaining a more in depth understanding of the impact of the act on practice, specifically in relation to the development of IAA services, was required.

Conclusion

We found committed and effective leadership, management and governance arrangements were in place in Carmarthenshire. SMT and elected members demonstrated effective leadership and had a clear vision about what they wanted children's services to look like. This was reasonably well communicated to staff. Children's services business could have been more highly prioritised by scrutiny

arrangements. We saw some evidence of the authority monitoring and evaluating its own performance, particularly through the TAF hub and external review of child in need and family support services. Work with partners, especially at a regional level, could usefully be strengthened. We found a committed, stable and suitably experienced workforce. The building blocks were in place to further develop service provision in alignment with the SSWBA.