Arolygiaeth Gofal **Cymru**
Care Inspectorate **Wales**

Early help, care and support and transition for disabled children

Torfaen County Borough Council

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Introduction

The purpose of this inspection is to explore how well local authorities, including integrated services, are providing early help, care and support and seamless transition for disabled children and their families. The inspection identifies practice that drives good outcomes for children as well as areas for improvement and barriers to progress.

We focused on the experience of disabled children and their families as they came into contact with social services and received advice, were signposted to community services, participated in assessments and received care and support. We also considered care experienced disabled children and how young people were helped to transition to adult services.

The Social Services and Well-being (Wales) Act 2014 (SSWBA) was intended to bring together and modernise social services. The Act imposes duties on local authorities, health boards and Welsh Ministers to work together to promote the well-being of those who need care and support, and carers who need support. The principles of the Act are:

- To support people who need care and support to achieve well-being.
- People are at the heart of the system and should have an equal say in the support they receive.
- Partnership and co-operation drives service delivery.
- Services should promote the prevention of escalating need and should ensure the right help is available at the right time.

‘A Healthier Wales’ explains the ambition of bringing health and social care services together, so services are designed and delivered around the needs and preferences of individuals, with a greater emphasis on keeping people healthy and promoting well-being. A Healthier Wales describes how a seamless whole system approach to health and social care should be co-ordinated.

Care Inspectorate Wales (CIW) led this inspection, with assistance from Healthcare Inspectorate Wales (HIW).

Strengths and priorities for improvement

CIW draws the local authority and local health board's attention to strengths and areas for improvement. We expect strengths to be acknowledged, celebrated and used as opportunities upon which to build. We expect priorities for improvement to result in specific actions to deliver improved outcomes for people in the local authority area, in line with the requirements of legislation and codes of practice.

Well-being	
Strengths	The arrangement for direct payments are efficient and parents are positive as to their use. There is available support for siblings of disabled children.
Priorities for improvement	There should be a clear focus on the strengths of the child and parents and their identified personal outcomes. There should be a significant increase in the frequency of visits to care experienced children, to meet statutory requirements. Initial child protection conferences must be convened within statutory timescales. Torfaen County Borough Council (TCBC) should comply with its legal duty to offer parents a carers' assessment, and issue guidance to staff to support this. There should be increased opportunities for short breaks for families with disabled children.
People – voice and choice	
Strengths	Supportive and dedicated practitioners and manager within the disabled children's team (DCT). Timely response to concerns and complaints about children's services.
Priorities for improvement	Increased attention and promotion of the voice of the child through increased facilitation for children to attend their meetings and have increased access to formal advocacy. There should be a review of recording practice to ensure this is safe and efficient. There should be access to specialist training for practitioners involved with disabled children, including relevant staff in the multi-agency safeguarding and support hub (MASSH) and 16+ team.

	TCBC should ensure it makes the active offer of services in the Welsh language. TCBC should ensure information on services is promoted, up to date and available to disabled people in a range of formats. TCBC should improve its quality assurance framework.
Partnerships and integration	
Strengths	Very often, effective multi-agency working resulted in good outcomes for young people. TCBC is reviewing the arrangements for children whose care might be eligible for Continuing Care arrangements with Aneurin Bevan University Health Board (ABUHB).
Priorities for Improvement	There should be increased practitioner clarity leading to increased take up of the 'When I am Ready' arrangements. There should be urgent review of the process of transition to adult services to ensure there are no delays affecting young people. There should be improved strategic commissioning arrangements for disabled children, using all available information to anticipate need, including the views of disabled children and their families. TCBC must hold a register of people with disabilities.
Prevention and early intervention	
Strengths	There is a range of recreational and support services in the community, valued by disabled children and their families. Some community services used evaluation measures to evidence effectiveness.
Priorities for improvement	TCBC should continue to monitor sufficiency of places within community services and the range to support families outside of statutory services.

1. Well-being

The local authority must ensure;

- **Disabled children and families receive the right care and support at the right time**
- **Children feel safe and are protected and safeguarded from abuse, neglect and harm**

Evidence at the individual level:

1.1 Information and advice provided to parents was not always adequate; however, the multi-agency support and safeguarding hub (MASSH) had recently been established which is better resourced to respond to these enquiries. Many parents viewed budget restrictions as directly affecting the support available to their child and themselves. Some saw the turnover and absences of practitioners in the disabled children's team (DCT) as affecting relationship forming and meaningful communication with their child.

1.2 We saw good examples of planning for individual care experienced children; a child moving in with foster carers at the child's pace, another in a bespoke single placement planned to adapt as they get older. We saw a social worker making considerable efforts to keep a disabled child at home by finding a rented property when the family became homeless.

Evidence at operational level:

1.3 We were not confident disabled children and their families were supported to identify individual outcomes they wished to achieve. Outcomes were not clearly recorded in assessments or care and support plans. While practitioners and managers told us this was a recording issue, we did not find sufficient evidence of this. Strengths and outcome focused approaches are pivotal to social care in Wales and should be addressed as a priority.

1.4 Care and support plans were not always comprehensive, as they did not always record support and services already in place. There were timely responses to requests for aids and minor works following occupational therapy assessment. We saw limited evidence of the use of disabled facilities grants, but no concerns were raised with us.

1.5 Responses to requests for use of direct payments were timely. Parents in receipt of direct payments to arrange care for their children were generally positive. We saw many examples of disabled children accessing leisure and sporting activities via this arrangement. Senior managers will wish to monitor the availability of personal assistants as the use of direct payments potentially increases. They will also wish to continue to ensure the availability of support services so that direct payments remains a positive choice for families.

1.6 TCBC is aware siblings of disabled children may need additional emotional and social support and opportunities for this were available from the young carers' service. Provision for all young carers was restricted due to pressures on capacity and a recent broadening of the age criteria risked the sustainability of the service with the current resource.

1.7 Performance information indicated half the care experienced children were not receiving visits from their allocated social workers within statutory timescales. This is inadequate and represents a significant area for improvement. We cannot be confident care experienced children are receiving sufficient support from their social worker or there is sufficient oversight of the placement and quality of relationship with caregivers.

1.8 Care experienced disabled young people should have a personal advisor (PA) in addition to their allocated practitioner in DCT when they reach 16 years old. Some disabled young people were allocated to the 16+ team as they did not meet the eligibility threshold for DCT. There was a lack of confidence voiced by some practitioners in the 16+ team about working with disabled young people, which should be considered and addressed as it may be affecting the quality of support provided to young people.

1.9 Generally, we found the safeguarding process for disabled children was satisfactory, although we did review some files where safeguarding practice required improvement. We saw a few instances where professionals had not raised a high number of missed health appointments for a disabled child as a concern. There were occasions where managers could have raised concerns with the police when the length of investigations was distressing for children. We were aware of complexities where a sibling group had disabled and non-disabled children. Safeguarding arrangements must maintain an oversight of sibling groups, while also recognising disabled children are particularly vulnerable to abuse.

1.10 We had substantial concerns that initial child protection conferences were not always taking place within statutory timescales. Decision-making and the formulation of safeguarding care and support plans to protect children was delayed many instances. Some child protection care and support plans required considerable improvement because outcomes, and how these were assessed, was unclear.

Evidence at strategic level:

1.11 While the Chief Executive had a clear vision of services for disabled children in TCBC, practitioners we spoke to did not articulate this. Members of the council outlined their commitment to children's services and their role as corporate parent. It would be beneficial for members to develop a deeper understanding of the particular challenges facing disabled children and for the corporate parenting board to maintain a particular focus on this group of children. Leaders told us they wished to develop support that is more ambitious for disabled children including more accommodation and short break options, greater access to apprenticeships and sufficient community services.

1.12 Children’s services were undergoing a significant remodelling. This had not yet affected the DCT, but should align it to a greater degree with the rest of children’s services. Senior managers intend to introduce a new model of social work practice across children’s services. This will encompass the strengths-based and outcome focused approach required in legislation and identified as an area for improvement in this inspection.

1.13 TCBC had recently established a MASSH. This was in its initial formation and had police staff within the team. It was anticipated education and health representation would become part of the approach. The ‘front door’ function undertook proportionate assessments and signposted people to early help services, which relieved children’s teams of this responsibility. During inspection, DCT was not benefitting from this arrangement as all relevant enquires and referrals continued to go straight to DCT. This was unfortunate considering the particular capacity pressures on DCT. Senior managers had identified a training need for MASSH staff, which they will address. The system for forwarding enquiries and immediate decision-making to DCT could quickly be altered to increase efficiency.

1.14 Parents were very unlikely to be offered a carers’ needs assessment, even where there were significant pressures on them. Senior managers believed these were not required because assessments of children were sufficiently comprehensive. Assessments we reviewed did not evidence this. TCBC was not complying with its legal duty to offer parents a carers’ assessment and there was no system to monitor offers made. This is a priority area for improvement.

1.15 TCBC had very limited provision to provide overnight short breaks for disabled children and their parents. TCBC did not take any action to replace a residential short break provision when this service, commissioned from another local authority, became no longer available a few years ago. There were insufficient options for parents who required overnight respite and parents raised this with us as a major concern. TCBC should focus service planning on the needs of parents of disabled children in order to promote the well-being of children and reduce the potential for family breakdown.

1.16 Managers had identified disabled children were under-represented in the safeguarding system but had not explored this further. The local authority must be fully assured safeguarding thresholds and procedures are equally rigorous for disabled children. We did not identify any examples that raised our concerns. Senior managers in TCBC are active participants in the regional safeguarding board.

2. People – voice and choice

The local authority must ensure;

- **A rights based approach ensuring disabled children and their families have a voice, informed choice and control over their lives**
- **Leadership is effective in ensuring a sufficient, confident and skilled workforce to promote the well-being of disabled children**

Evidence at individual level:

2.1 We spoke with parents and a small number completed an electronic survey. Parents generally felt listened to and involved in their child's care and support plan. Overall, we were not confident practitioners were engaging directly with disabled children sufficiently to be able to ascertain their individual wishes and feelings. High caseloads, changes in allocated worker and periods of decreased management support were contributory factors. There were clear exceptions to this and we acknowledge communication with some disabled children is complex. We could identify the views of the parents in assessments and care and support plans and practitioners we spoke with could readily outline the needs of the child and the services in place. However, the voice of the child was not adequately reflected in case files and we were not assured about the degree of attention given to this by managers.

2.2 Seventy-seven practitioners who had a role with disabled children responded to our survey. This included staff in DCT but also staff from a range of other teams within children's social care. Virtually all staff responding felt well supported by colleagues and managers to do their jobs. The most prevalent positive comments were about accessible and supportive managers and regular supervision that involved discussion about their individual well-being. We noted a very supportive ethos within DCT and all evidence gathered indicated the team manager and practitioners were fully committed and had worked very hard in difficult circumstances to support disabled children and their families. This was during a period when there was high staff and management vacancies/absences.

2.3 Three quarters of respondents to the survey saw their workload as manageable. Respondents were mostly from other teams in children's services and this result is unlikely to reflect the views of DCT practitioners, where caseloads were high. The most common priorities identified by staff was increasing the participation of children in decision-making and greater use of strengths based practice.

Evidence at operational level:

2.4 Most children did not attend meetings to review the care and support they received, despite the many meetings held at school. If this is because parents did not want their child to miss lessons, consideration should be given to the timing of meetings. We could not identify how the child's wishes and feelings were represented, distinct from their parents. We saw little use of independent advocacy and we but we identified foster carers or teachers were presenting the child's views. While this is completely appropriate in some circumstances, managers need to be assured the child is able to voice their own feelings with regard to placements, school and key aspects of their lives. We could not evidence Independent Reviewing Officers were routinely speaking to care experienced children in advance of their meetings and between meetings.

2.5 Some children will not wish to attend meetings if they are held formally and involve many professionals. The child's age or level of understanding may be such that a meeting appears not meaningful for them. However, senior managers could do more to create the expectation of attendance and ensure consideration to creative ways of organising reviews to promote the participation of the child. Disabled children's views on alternative approaches would be valuable.

2.6 TCBC regionally commissions advocacy services but fewer referrals than expected for disabled children had been made and the agency had raised this with senior managers. We were given several reasons for this and TCBC should assure the rights of disabled children to independent advocacy are fully provided. They will need to be confident advocates have the skills to engage meaningfully with children with a range of disabilities and practitioners must be clear on the difference between their role to advocate for children and independent advocacy.

2.7 We saw good evidence of decision making within staff supervision records reflected on case files. Supervision records did not sufficiently evidence critical reflection on professional practice as prescribed in the local authority's supervision policy.

2.8 Case file recording in DCT was comprehensive. We noted systemic use of paper recording which was copied onto the electronic case management system. This practice should be reviewed, as it may constitute a secondary recording system, with the legal complexities and data security issues this can represent. Practitioners were reluctant to record onto their laptops when speaking with people. Seeking the views of children and parents about this may be useful. Staff indicated a wish to streamline recording and documentation and there may be opportunities to save practitioner time.

2.9 There were some gaps in the regularity of practitioner supervision meetings due to manager absence. Absences and vacancies within the team clearly contributed to individuals experiencing work pressures and individual stress. We were not confident sufficient action was taken to support staff individually.

2.10 There was no training on communication, behaviour and specific disabilities in TCBC's training calendar. Specific training would be of benefit to practitioners working with disabled children and should include practitioners in the 16+team, some of whom told us they were not confident to support disabled young people. Relevant training would improve the support provided to disabled children.

2.11 Managers responding to concerns raised by people using children's services resolve the vast majority of these within 24 hours. Very few concerns proceed into the formal complaints' process. There is a system for senior managers to oversee complaints and identify learning.

Evidence at strategic level:

2.12 Senior managers did not take sufficient or timely action to backfill staff and management resource in DCT during the prolonged period when there was significant deficit in the team. Senior managers reflected on this during our inspection and agree with this finding.

2.13 TCBC did not make the active offer to provide services in the Welsh language to disabled children and their families. There were no Welsh speakers at the 'front door' (MASSH) or in DCT. While we were informed a family requesting a service in Welsh would receive this, TCBC was not collating data and so could not demonstrate it was meeting its legal duty.

2.14 Information on TCBC's website on services for disabled children was out of date with respect to available services and did not reflect current legislation. There were no information leaflets available for disabled children in different formats. Local authorities have a duty to provide accurate information on services to families. Practitioners and managers did not routinely use Dewis, the national database for well-being information, due to a lack of confidence in it. TCBC was investing in developing its own resource. We were unclear if people were being signposted to Dewis in the meantime.

2.15 TCBC has a basic quality assurance system, primarily reliant on audits of case files and supervision files. The audit format for case files does not reflect the principles of SSWBA and is focused on process rather than quality and effectiveness of practitioner input and children achieving their identified outcomes. The local authority must improve quality assurance systems and processes to ensure it reflects the principles of the SSWBA and drives improvement in practice.

2.16 The team manager in DCT made decisions on all referrals, approved all care and support plans and chaired most or all care and support meetings. These meetings were held frequently as a management approach to maintain oversight. While this demonstrated a high degree of commitment, it is unlikely to be sustainable. Senior managers should consider alternative means of effective management oversight and resources required.

3. Partnership and integration

The local authority must ensure;

- **The local authority has effective partnerships and integrated arrangements which commission and deliver high quality and sustainable services that meet the needs of disabled children and their families**
- **Planning for disabled care leavers is based on their strengths, fully involves the young person and maximises their potential for independence**

Evidence at individual level:

3.1 We found evidence of good multi-agency working that resulted in good outcomes for young people transitioning from children's services to adult services and increased independence. We could see good communication between social workers and teachers and between social workers and the occupational therapist in DCT. There was good attendance by school staff at children's meetings.

3.2 We reviewed a file where there was insufficient contact between practitioners in DCT and the child and adolescent mental health service (CAMHS) to ensure joined up support for a young person experiencing difficulties with their mental health Conversely, we reviewed another case file where there was very good multi-agency working with CAMHS and paediatrics.

3.3 We reviewed files where young people had pathway plans in place and allocated personal advisors (PAs). This included an example where a young person's wishes differed from their parents, which resulted in creative decision-making around independent living arrangements. However, we also found evidence of care experienced young people, shortly to turn 18 years old, who did not have pathway plans in place and assessments for eligibility for adult services had not yet taken place. The lack of certainty about arrangements for young people and their parents does not provide positive well-being outcomes and may increase a sense of anxiety amongst young people. We reviewed pathway plans that had no recorded outcomes and we could not be assured how progress was measured.

Evidence at operational level:

3.4 We observed multi-agency meetings that were effective and demonstrated positive professional relationships, including constructive challenge. The absence of health representation at one meeting limited decision-making and required further meetings, which affected efficiency. We were assured health representatives regularly attended.

3.5 A representative of Gwent police described strong joint working arrangements with regard to safeguarding. They described confident relevant police officers having the knowledge and skills to communicate effectively with disabled children and to access specialist resources where appropriate.

3.6 Representatives from education were positive about effective and constructive working relationships in respect of disabled children. Reviews of statements of special educational need were sometimes combined with reviews of care and support plans, which is good practice. Teaching staff described multi-agency meetings to share information about effective support strategies and formulate risk management plans, which improved consistency of approach with individual children. Increased involvement of teaching assistants in meetings about children with complex needs may be helpful if they can represent valuable information on the child's wishes.

3.7 Some senior health staff were aware of the reduced resource within DCT and believed this had impacted on multi-agency reviews for disabled children in mainstream school. Senior managers should explore this with their partners in health to address any issues.

3.8 Housing managers described their role with young people transitioning to adult services and while this was considered an improving picture, more could be done to develop partnership working at the operational level. A housing officer based in the 16+ team was considered helpful by practitioners to ease communication between agencies. There were a small range of accommodation options for disabled young adults with varying levels of support and bespoke arrangements were in place for a small number of individual young people. There was no agreed protocol for escalation between agencies, which would ensure delays and barriers affecting young people requiring housing are raised and resolved efficiently.

3.9 Support for young people to remain with their foster carers after their 18th birthday under the 'When I am Ready' arrangements was significantly under developed. Social workers in the fostering team and children's social workers did not have a consistent understanding of their roles with regard to this. Barriers identified by practitioners should be considered and addressed by senior managers.

3.10 There was a difference of understanding between DCT and adult services with regard to the effectiveness of the process for young people to transition from children's to adult services. Capacity issues in the adult learning disability team and a transition worker vacancy were raised as resulting in delays for young people. This significantly impacts on young people as they didn't know about the ongoing support they would receive or their plan for adulthood. We brought this to the immediate attention of the Head of Service. We reviewed files where delays were apparent and expect senior managers to identify how widespread this is. This requires urgent review and resolution for the benefit of disabled young people.

Evidence at strategic level:

3.11 TCBC had added resources to DCT to review children with complex medical needs and engage in discussions with ABUHB about funding and responsibility for oversight under Continuing Care arrangements. This is a complex area. We were assured there was no delay to children receiving appropriate care due to funding discussions and we found no evidence of this. TCBC was appropriately seeking to clarify these arrangements and work toward a joint understanding of the available guidance with the health board.

3.12 Managers had identified a need for medical oversight and training for some personal assistants delivering care to disabled children with medical needs. We understood managers were addressing this as a priority.

3.13 Children had long waits to be assessed for a potential diagnosis of autism which had a significant impact on families seeking to understand their child and know how best to care for them. Many people we spoke with raised pressures on the Child and Adolescent Mental Health Service (CAMHS) as a major issue. We were made aware of a health led and funded pilot project to support families with a child with a learning disability, where there is a risk of family breakdown and to provide an early intervention service.

3.14 Health staff identified transition as the priority area requiring more joined up working. There were areas for improvement in health and social care, particularly when medical oversight for some young people with complex medical needs transfers to the GP from paediatrics. The Gwent transition protocol and the related guide for parents were out of date with regards social care legislation and should be reviewed.

3.15 There was new drive for greater strategic collaboration between housing and social services to identify housing for families with disabled children and young adults, suitable to their needs or able to be adapted. However, there was no specific commissioning strategy for disabled children. There was no formal work to assess future need for placements and accommodation. We could not identify how information from the population needs assessment was being used. TCBC did not maintain a register of disabled children, which is a legal requirement.

3.16 While the Head of Service made us aware of an intention to increase residential and short break provision, there was no plan to address the demand for short breaks in the short or medium term. We understand a recruitment strategy will be developed to find foster carers for disabled children. Disabled children and their families had not been consulted on their views of services required.

3.17 Commissioners did not consider outcome measures produced by commissioned support services when reviewing contracts. Although we saw one example of careful contract monitoring, in general, commissioning and more rigorous contract monitoring for disabled children is a priority area for improvement.

3.18 The director informed us the Gwent Regional Partnership Board is developing its approach to joint commissioning for children with complex needs and there is a subgroup dedicated to this. Joint funding approaches with other local authorities and the health board were at varying stages. There was an acknowledgement further development is required in the strategic relationship between TCBC and the health board and a confidence this will be achieved over time. The new law in relation to children with additional learning needs should drive increased collaboration between health, education and children’s services and TCBC is involved in planning for the implementation of this.

4. Prevention and early intervention

The local authority must ensure;

- **A planned strategic approach to timely and proportionate early help and prevention**
- **Disabled children are actively supported in resilient communities to reach their full potential; to live, learn, develop and participate in society**

Evidence at individual level:

4.1 Parents valued community services that provided their children with access to play and social opportunities and support for themselves. Parents of children with autism valued a dedicated support group. The Families First service and Torfaen Young People's Support Service (TYPSS) was also well regarded by parents and practitioners. We saw some evidence of signposting, where parents were informed of play and health services suitable for their children.

Evidence at operational level:

4.2 Performance information across children's services indicated most families receiving early help services did not need intervention from statutory social services at the end of involvement. Most families receiving support from TCBC's rapid response service at times of crisis achieved the outcomes agreed at the outset.

4.3 There was a range of activity-based services for disabled children in TCBC, run by third sector agencies and local charities. These provided play and activity opportunities for disabled children after school, weekends and in school holidays. Most had a waiting list. ABUHB also provided some support services for disabled children and their parents. Staff from services attended reviews of children's care and support plans, which promoted coherent support. Resource in Family First service dedicated to disabled children and their families was very limited and a review of remit and sufficiency would be of value.

Evidence at strategic level:

4.4 The director believes increasing early intervention and preventative services would benefit families with disabled children and reduce the numbers of children requiring statutory services. A webpage for families to find out about local support will be launched in March 2020 resulting from consultation and the requirements of the play sufficiency action plan.

Method

We selected case files for tracking and review. In total, we reviewed 45 case files and selected a sample of 15 where we sought the views of children, parents, practitioners and team managers. Overall, we spoke to approximately 30 parents and several children. We issued a survey to gather parents’ views and received 10 responses.

We interviewed a range of social care practitioners and their managers, elected members and senior officers. We issued a survey to social care staff working with disabled children. This survey received 77 responses.

We reviewed 13 records of line-management supervision from four practitioners and managers. We looked at a sample of three complaints and related information.
We reviewed performance information and a range of relevant local authority documentation. We observed three relevant multi-agency meetings.

We interviewed a range of operational and strategic staff from the local health board and relevant provider organisations.

Welsh Language

We ensured there was a Welsh speaking inspector available and made the active offer of conducting parts of the inspection process in Welsh.

Acknowledgements

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