

Early help, care and support and
transition for disabled children
Rhondda Cynon Taf
County Borough Council

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

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	<p>There is a strong vision for remodelling services for disabled children.</p> <p>The Children with Additional Needs Service (CANS) focuses on family strengths and the achievement of personal outcomes. There is an effective and improved response at the 'front door' of children's services.</p> <p>Rhondda Cynon Taf County Borough Council (RCTCBC) provides its own psychological support for children and practitioner consultation.</p> <p>The multi-agency safeguarding hub (MASH) evidenced good joint working arrangements.</p> <p>RCTCBC is reviewing direct payments to ensure there is choice for families and interim support while personal assistants are recruited.</p>
Priorities for improvement	<p>There should be increased focus on strengths, the voice of the child and clear outcomes for assessment and care and support within the Disabled Children's Team (DCT).</p> <p>There should be increased effective management oversight and quality assurance within DCT.</p> <p>There should be increased understanding and improved practice in relation to assessments of parent carers.</p> <p>There should be greater support for siblings of disabled children.</p>
People – voice and choice	
Strengths	<p>Staff are positive and feel well supported by colleagues and managers.</p>
Priorities for improvement	<p>There needs to be greater promotion of the voice of the child throughout services for disabled children, including advocacy. There should be more specialist training undertaken by practitioners in DCT.</p>

	The disability register must be re-established.
Partnerships and integration	
Strengths	RCTCBC is developing an emotional well-being service jointly with Cwm Taf Morgannwg University Health Board (CTMUHB).
Priorities for Improvement	<p>CTMUHB and RCTCBC should continue to focus efforts to achieve a more joined up strategic approach to the advantage of citizens.</p> <p>Current service provision for disabled children and their families should be evaluated and planning of services undertaken against projected future needs. This information would inform improved joint commissioning.</p> <p>There should be resolution of the funding of continuing care. Consideration should be given to the benefits to disabled young people of earlier active involvement by adult services social workers and Personal Advisors (PAs).</p>
Prevention and early intervention	
Strengths	<p>CANS is an effective and valued service.</p> <p>There is understanding of the social model of disability and an intention to improve equality of access for disabled children.</p>
Priorities for improvement	<p>All assessments must be sufficiently thorough (proportionate) and analyse need (and not be viewed as a process just to secure a specific resource).</p> <p>Development of alternative approaches to respite/ short breaks.</p>

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. From 84 surveys completed, three quarters of parents, whose disabled child was subject to assessment in the last year, felt the practitioner listened to their views. Two thirds of parents felt the social worker knew their child well and communicated well with them. Parents told us of practitioners going to significant efforts to engage with children; but other parents described practitioners making less effort to see their child or to communicate with them in a meaningful way.
- 1.2. Just less than half of parents who completed our survey and had asked for help from social services in the last year, found the response helpful, with the remainder finding it only slightly helpful or not helpful. Many parents described confusion or misunderstanding about the eligibility criteria for DCT. Some parents did not know IQ was no longer part of eligibility criteria or did not know why their children had been deemed ineligible to access statutory services. Some parents were unhappy their child's involvement with the team was ended.

Evidence at operational level:

- 1.3. The majority of case files we reviewed did not evidence thorough assessments of disabled children in the context of their families, identifying strengths and personal outcomes the child and parents wished to achieve. Practitioners told us they did not believe all practitioners were confident in identifying well-being outcomes through speaking to people about what matters to them and, as a result, assessments often lacked a focus on outcomes for the child. This approach is fundamental to SSWBA.
- 1.4. We found many examples where there was a lack of evidence of effective engagement with children in the assessment period in order to ascertain their wishes. A senior manager from RCTCBC recognised the child's voice was often absent from assessments. Getting to know disabled children will often involve specialist skills we should expect of practitioners in a disabled children's team. We were more confident assessments reflected the views of parents, although these often did not evidence a thorough assessment of strengths and resources within the family network, parenting capacity and pressures. Practitioners did not necessarily speak to siblings of the disabled child as part of the assessment process.

- 1.5. Senior managers were aware improvements were required to many care and support plans. There was often a narrow focus on the support service provided, rather than reflecting the personal outcomes the child and the family wished to achieve. This did not allow for progress to be effectively reviewed. Practitioners were not always clear on what should be included in care and support plans. There was little evidence of contingency planning.
- 1.6. Care and support plan review meetings did not routinely involve the provider of the support service, so valuable information about progress or problems could be missed. Reviews were not always timely, meaning we could not be confident support services remained appropriate if family circumstances had changed.
- 1.7. Each team had recently developed its plan for quality assurance. Implementation was more advanced in CANS, which is part of the early help Resilient Families Service. Further training on the fundamentals of SSWBA and effective management and quality assurance processes are a priority area for improvement in DCT.
- 1.8. Practitioners in DCT sometimes accessed resources in the child's school to aid communication with individual children or drew on support from practitioners in adult services. Given the pressures on adult teams, senior managers should ensure this process works efficiently and to the benefit of the child forming a trusting relationship with their social worker.
- 1.9. Disabled children receiving 'early help' from CANS benefitted from clear plans focussed on individual outcomes and reflected the family's existing strengths. We were confident this service worked within the principles of SSWBA.
- 1.10. RCTCBC completes very few assessments of the needs of parents as carers for disabled children. This was particularly important where many children's assessments did not contain a thorough assessment of parenting capacity and pressures on parents. Practitioners did not routinely offer a carers' assessment and some practitioners told us they were not confident in undertaking these assessments. RCTCBC must ensure all practitioners have the relevant skills and experience in completing the required assessments.
- 1.11. Senior managers had established a task group to review practice and which should raise awareness of carers' legal rights. Senior managers must continue to communicate the strategy and approach if attitudes are to become more positive toward carers' assessments.
- 1.12. RCTCBC provided a range of activities for carers, which included parent carers, and had dedicated workers to support carers. We could not be confident, however, that parents of disabled children under significant stress were identified and supported via these activities.

- 1.13. Ninety percent of parents surveyed, who had children in addition to their disabled child, believed siblings needed support due to the impact of having a disabled brother or sister. RCTCBC recognised this some time ago and secured short-term funding to provide support for siblings. However, this service had not extended and a number of children subject to a support plan were waiting for support, some for two or three years. As RCTCBC has identified these children need support, we must assume the lack of services provided has negatively affected their well-being. We understand managers were looking at commissioning further support services.
- 1.14. There was a lack of clarity about case management practice and recording for parent carers and siblings of disabled children. This may lead to uncertainty, deter appropriate interventions and poor recording. Senior managers should resolve this issue as a priority.
- 1.15. CANS and DCT had recently placed practitioners at the 'front door' to children's services, along with a young carer's worker. The intention was to provide expertise on disabilities at the earliest opportunity. Very recent changes had been made to improve support for staff answering calls from professionals and families. We were assured calls were answered promptly and initial responses and decision making was timely with regard to information, advice and assistance.
- 1.16. Not all information was available on the range of services accessible to people with specific disabilities. This may mean that people have limited information and access to relevant resources to support them in decision making. Managers believed staff were building their knowledge of community services to which to signpost people and will wish to ensure staff are more aware of the Dewis resource website. We had little specific feedback from parents about Disabled Facilities Grants (DFG).
- 1.17. The community support team within DCT providing direct work to support children was oversubscribed and had only half the staff team it had previously due to planned service remodelling. The service was changing from offering long term to short term support. Senior managers should ensure needs will be met through other means and practitioners and families have a clear understanding of support available.
- 1.18. Professionals were satisfied with the effectiveness of safeguarding in RCTCBC and they were of the view arrangements within the multi-agency safeguarding hub (MASH) worked well. Health and education representatives told us they did not always get feedback on referrals made and this should be rectified.
- 1.19. Safeguarding investigations we reviewed complied with guidance, although we identified opportunities for improved practice in a small number of instances. Some health and education professionals queried the social worker in DCT undertaking safeguarding investigations when children were known to the team. We found no evidence of a detrimental impact of this

practice, which is routine in other local authorities. RCTCBC should open a dialogue with partners to ensure understanding and confidence in this approach. The numbers of safeguarding referrals for disabled children was lower than senior managers expected and this should be an area of continued investigation.

Evidence at strategic level:

- 1.20. RCTCBC had a clear vision for disabled children's services. This inspection took place when changes had been made to the 'front door' and CANS but not yet to DCT. Further changes were planned and eligibility for DCT will be based on the impact of complex care needs, rather than diagnosis of any disability or medical condition. This change reflects the increase of children requiring support with such needs, often including mental health needs. These will be significant changes and will require a comprehensive communication plan to ensure people have clear accessible information and know how to access early help and care and support.
- 1.21. The director and chief executive had the support of the council for changes made to date. The scrutiny function within the council was evident and the director's proposals for next steps were appropriately subject to review.
- 1.22. RCTCBC had been proactive by developing its own psychology resource in response to an identified deficit in psychological and therapeutic resources available via the health board. There were plans to develop these resources further to the advantage of the increasing numbers of children, including disabled children, with emotional and mental health needs.
- 1.23. At inspection, RCTCBC was supporting 152 families with a disabled child by direct payments, which should provide 'choice, voice and control' for parents wishing to arrange their own support. There were identified issues in recruiting personal assistants with the necessary skills that meant families with assessed needs for support were often waiting long periods for this to begin. We were not confident families were always presented with other options for support alongside direct payments.
- 1.24. The assessment process should look at what matters to the child and their parents prior to considering if direct payments, for example, is a means by which this can be achieved. RCTCBC was reviewing its policy on direct payments and this should ensure the views of the child are considered, distinct from the view of the parents. Senior managers told us risk assessments were always undertaken before use of direct payments was decided, but team managers indicated this was not always the case. Robust application of policy and process in operational delivery must occur.
- 1.25. Senior managers knew too many care experienced disabled children were placed out of the area. Although all but one child was placed in

neighbouring local authorities, even moderate distances can impact on contact with family and friends and changes of school. There is a national issue in the availability of quality residential placements for children and this is most problematic for children with the most complex needs.

- 1.26. Senior managers in health and social services were confident in the robustness of regional safeguarding arrangements. The new health board and regional arrangements had resulted in reviews of existing policies and procedures. RCTCBC were viewed as a strong and committed partner to the regional safeguarding arrangements.

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 wellbeing of disabled children**

Evidence at individual level:

- 2.1. We spoke to a group of disabled young people who told us how important it was for them to feel their social worker was trying to get to know them. Although professionals had read the young person's file, one young person told us *'it doesn't make them really know you or know what it feels like to be you.'* There was insufficient attention to the voice of the child in the majority of case files we reviewed and this may have significant impact on the outcomes for the child. RCTCBC should ensure the voice of the child is prioritised in practice and reflected in recording.
- 2.2. The vast majority of practitioners we surveyed felt very well supported by managers, colleagues and Human Resources. Most (80%) viewed their workloads as manageable. The majority of staff received regular line management supervision. Case decision-making was recorded on children's files. A new policy was in place to focus supervision discussions more on outcomes for children, rather than processes and we could see the beginnings of change in some records we reviewed.

Evidence at operational level:

- 2.3. Referrals for assessment were responded to promptly. Due to capacity issues, managers had introduced a practice of 'unallocating' children, where their needs were being met by a support service, but they remained open on the data system and were visible on the team manager's dashboard. We did not see evidence of this being to the detriment of children, although senior managers were clear they would discontinue this practice when capacity allowed. There was a prioritisation system in place

for children referred for an occupational therapy assessment and we were assured urgent referrals were responded to within five days.

- 2.4. Independent reviewing officers (IROs) told us there was room for improvement in their consultation with care experienced disabled children prior to the review meetings to ensure their views are central. RCTCBC should ensure they provide clear expectations for IROs, in line with national good practice guidance.
- 2.5. RCTCBC changed its advocacy provider earlier in the year and the transition from one provider to another was managed to minimise impact on children in receipt of advocacy support at that time. We could not be confident all children who should be referred for advocacy were being referred (the 'active offer') and disabled young people may have particular needs for advocacy to ensure their voice is heard. The provider told us no disabled child had been referred for advocacy since the start of the contract in May 2019. DCT practitioners stated they did make referrals, but we were unable to verify this as reporting information did not identify disabled children. RCTCBC should ensure appropriate referrals to advocacy for disabled children and should consider measures to allow specific monitoring of advocacy services for disabled children.
- 2.6. RCTCBC made the active offer to provide communication in Welsh, from the 'front door' through to DCT and knew which of its staff could provide services in Welsh. There were no Welsh speakers in the case file sample we reviewed and so we were unable to test this in inspection.
- 2.7. There was a robust and proactive complaints management system across children's services and the vast majority of complaints were resolved at the earliest stage. There were very few complaints made by disabled children or their parents and no themes had emerged in the last 12 months.
- 2.8. Staff working in CANS had received a wide range of training in behavioural and therapeutic approaches in the previous year. Practitioners in the DCT team attended some of this training but told us they needed training to improve their communication skills with children with learning and sensory disabilities. They described communication aids that were not available to them. They also identified mental health as an area for training and no practitioners in DCT were proficient in British Sign Language (BSL). Managers were confident they could draw on other colleagues for support but this may not provide a child with a consistent practitioner. Managers have identified training as a priority for the next financial year. There is a specific responsibility to provide services suitable for deafblind children and managers were confident they commission expertise from a national agency.

Evidence at strategic level:

- 2.9. RCTCBC had not maintained a disability register since a change to a new case file management system. The register provides the information to

help the local authority plan services for disabled children. This is a requirement and senior managers are aware they must re-introduce this.

- 2.10. More could be done to consult with families about the support they receive. One third of parents we surveyed recalled being asked for their views by RCTCBC and it is encouraging the majority were confident their views were of influence. The director was aware further consultancy with disabled children and their parents would be required at the final stage of remodelling disabled children's services.

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. Less than half of parents surveyed believed social services, education and health had worked well together to support their child to receive the best education. Social work and education managers were content social workers attended selected annual statement review meetings (when there was an allocated social worker). However, a number of parents told us they wanted their social worker to attend or participate more actively in their child's meeting. RCTCBC should ensure the wishes of parents and children are central to decisions about attendance. There may be missed opportunities for joint educational and care and support plan reviews.
- 3.2. Just one third of parents surveyed believed social services, education, health and other agencies had worked well together to plan for their child's transition between schools, to adult services or to supported living. Some young people described difficulties in adapting to the different approach of adult services social workers, where they felt they were treated as adults too suddenly.
- 3.3. Less than a third of parents surveyed believed their disabled child had access to a range of activities outside of the home so they could have fun and make friends. The group of young people we spoke to described activities they enjoyed but also identified further activities they would like to get involved in that they did not believe were accessible to them for a range of reasons.

Evidence at operational level:

- 3.4. There were robust internal and multi-agency meetings overseeing use of resources for children with a care and support plan and decisions around placements for care experienced children. Social care practitioners and teachers were complimentary about their working relationships to ensure a coherent approach for disabled children. They told us enhanced case management meetings to share information about children with complex care needs worked well, when they arranged these, and allowed them to develop best practice. However, we are mindful of parental views outlined above and further consultation with parents may be beneficial to identify specific areas for further improvement.
- 3.5. Educational psychologists employed by RCTCBC liaised with education to support the transition for young disabled children from childcare to education, working with individual schools. There were good arrangements where sixth formers at special schools took some of their lessons at local colleges to ease subsequent transition. There was an agreement with a college to expand an existing scheme to access work placements for disabled young people and other work opportunities created for disabled young people were described to us.
- 3.6. Pressures on adult care and support teams resulted in late allocation of adult social workers to young people transitioning from children's to adult services. This meant there was less time for planning and relationship building with young people and their families. Children leaving residential schools and/or moving into adult living arrangements did not know of plans sufficiently in advance. This did not allow for the co-productive approach to young people expected from SSWBA.
- 3.7. Senior managers told us practitioners in adult care and support teams did not feel sufficiently confident working with disabled young people; this is a matter requiring resolution and we were told this was being addressed. Young people transitioning to the adult complex learning difficulty team had a better experience due to clearer processes, more confident practitioners and dedicated transition workers.
- 3.8. There was an awareness parents needed to be more prepared for the potential introduction of charging when their child transitioned to adult services. We understand there were newly developed operational and strategic multi-agency panels to improve on support for young people in transition.
- 3.9. Health managers told us management of transitions within health had improved but there was room for further improvement. Handover to adult psychiatrists for young people with severe learning difficulties worked better than handover to GPs for young people with moderate learning difficulties. Review systems were in place for young people with severe physical disabilities or multiple difficulties to coordinate the range of inputs from medical and social care professionals. We were informed transitions

for young people with less severe disabilities sometimes resulted in a gap in provision and more could be done to prevent the development of crises for these young adults.

- 3.10. PAs were not active with care experienced disabled young people until they were 18 years old, despite being allocated when the young person was 16. Such late involvement of a PA will inevitably affect relationship forming and thereby the quality of support provided at this important time in the life of a young person. We were told PAs were less confident or clear in their role with disabled young people. Senior managers should confirm clear expectations in line with the relevant code of practice and address any training needs.

Evidence at strategic level:

- 3.11. Senior managers in RCTCBC recognised they did not have a specific commissioning strategy for disabled children based on up to date information and reflective of the vision for service provision. Current arrangements were disjointed and not the responsibility of any one senior manager. RCTCBC could do more to systematically evaluate service provision, map needs and work with providers to plan services.
- 3.12. CTMUHB and RCTCBC should continue to focus efforts to achieve a more joined up strategic approach to the advantage of citizens. The new health board and regional arrangements, provides an opportunity for progress. There was recent commitment to joint fund an emotional well-being service, which will provide support for children and families and complement the child and adolescent mental health service (CAMHS).
- 3.13. We were told of gaps in provision for health support for children with moderate learning difficulties and short breaks for children with complex medical needs. A service providing support for parents in managing their child's behaviour was oversubscribed. We were told there was no appropriately trained occupational therapists within health to undertake sensory assessments of children.
- 3.14. Senior managers in RCTCBC and CTMUHB had taken initial steps to develop a joint commissioning approach for children with complex needs via the regional partnership board. There are national drivers for this work and RCTCBC recognised this is a priority area for development.
- 3.15. RCTCBC and CTMUHB do not have a shared understanding of their financial responsibilities for children subject to Continuing Care and do not anticipate this will be resolved following new guidance in 2020. Consequently, a priority area for improvement is to reach resolution on Continuing Care and we understand this is a priority for the regional partnership board for 2020. However, no instances of impact on individual children were brought to our attention during inspection.

- 3.16. Senior managers were working with partner agencies to enact a strategy around supporting education, employment and training for young people and there was additional work to expand opportunities in further education. RCTCBC wished to ensure more of its young people leaving care, and other young people, were in education and employment and continued to be so.
- 3.17. Plans were at an early stage in increasing the range of accommodation options for disabled young adults moving to supported accommodation arrangements. This included considering further promotion of 'when I'm ready' arrangements and the 'shared lives' scheme.

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. Case files evidenced mostly good immediate outcomes for disabled children receiving early help services. Staff surveyed identified CANS as what RCTCBC did best for disabled children.
- 4.2. Three quarters of parents surveyed, who had a disabled child under 5 years old, said there was not enough childcare in their area suitable for their child.

Evidence at operational level:

- 4.3. It was helpful to families that CANS did not require the child to have a specific diagnosis to access the service, as children were often going through diagnostic assessments with health. CANS had developed links with the neuro-developmental team to aid families involved with both services and the team was trying to improve links with CAMHS. CANS was well placed within the Resilient Families Service and staff could access psychology employed by the local authority for advice and support. It was evident RCTCBC had significantly invested in this early help service and it had a clear purpose. Data provided to us indicated 95% of parents felt more able to manage independently following their involvement with CANS. While more rigour could be applied to how parental views were gathered, all our information indicated CANS is an effective and valued service for families.

- 4.4. Where appropriate, families could be 'stepped down' to receive further support from Barnardo's or 'stepped up' to DCT and effective internal systems were in place. There were identified capacity issues due to the level of demand for CANS, which resulted in families receiving fewer direct work sessions. CANS had provided some work with siblings of disabled children but this was on hold at the time of inspection.
- 4.5. There was a waiting list for disabled children to stay overnight in the two registered children's homes that provide residential short breaks. In our survey, approximately half of parents who said they had requested respite had this in place. Many parents expressed frustration at being on a wait list for a very long time or believed they had been denied access to respite. RCTCBC must ensure thorough assessments of children are undertaken when parents request respite to be confident this is the most appropriate response to address the pressures and needs outlined. RCTCBC was reviewing short breaks and consultation with families will be imperative to ensure their views are considered.
- 4.6. RCTCBC provided services for disabled children and their parents. These included parenting programmes for parents of young children with autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and challenging behaviour. A youth practitioner was attached to each special school to ensure holiday schemes and other activities. RCTCBC helped parents find appropriate play provision for pre-school disabled young children and provided additional support where required.
- 4.7. Practitioners in DCT did not seem to make use of the Dewis website to signpost families to community support and social opportunities.

Evidence at strategic level:

- 4.8. RCTCBC had moved CANS (within Resilient Families Service), early years and youth participation and engagement teams to sit under Community Wellbeing and Resilience. This meant services were more aligned with the corporate plan to encourage resilience and independence within communities. The remodelling of disabled children's services should result in coherence of approach across teams.
- 4.9. The chief executive (CEO) was clear early intervention and prevention meant disabled children should not be isolated from the wider population of children. The CEO described improvements to the accessibility of public transport and school transport arrangements for disabled children, including travel training. Challenges remain, however, for a public transport system in the large valley areas in RCTCBC.
- 4.10. The CEO described investment in leisure facilities and the appointment of a disabled sports officer. Practitioners identified social opportunities for disabled young people as a significant gap in RCTCBC and we understand this is being considered. The local authority wished to align its approach with the social model of disability, promoted by Welsh Government and the

major disability organisations to improve equality of access for disabled children to social and sporting activities.

Method

We selected case files for tracking and review from a sample of cases. In total, we reviewed 45 case files and followed up on 15 of these with interviews with social workers and children and/or their parents. We spoke to parents of disabled children and issued a survey to gather their views. This survey received 84 responses. We spoke to approximately 10 children directly.

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 31 responses.

We reviewed 27 records of line-management supervision from nine 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 relevant multi-agency panel 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 one or more Welsh speaking inspectors available to make the active offer of conducting parts of the inspection process in Welsh.

Acknowledgements

CIW would like to thank all those who gave their time and contributed to this inspection: children, parents, staff, managers, members, partner organisations and other relevant professionals, including colleagues from Health Inspectorate Wales.