

Inspection of Older Adults Services Wrexham County Borough Council

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

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Background

1. The Social Services and Well-being (Wales) Act 2014 (SSWBA) has been in force for almost three years. The Act is the legal framework that brings together and modernises social services law in Wales.
2. The Act while being a huge challenge has been widely welcomed across the sector as a force for good, bringing substantial and considered opportunities for change at a time of increasing demand, changing expectations and reduced resources.
3. The Act imposes duties on local authorities, health boards and Welsh Ministers that requires them to work to promote the well-being of those who need care and support, and carers who need support.
4. The principles of the act are:
 - Support for people who have care and support needs to achieve **wellbeing**.
 - **People** are at the heart of the new system by giving them an equal say in the support they receive.
 - **Partnership and co-operation** drives service delivery.
 - Services will promote the **prevention** of escalating need and the right help is available at the right time.
5. Welsh government has followed up the SSWBA with 'A Healthier Wales'. A strategic plan developed in response to a Parliamentary Review of the Long Term Future of Health and Social Care.
6. A Healthier Wales explains the ambition of bringing health and social care services together, so that they are designed and delivered around the needs and preferences of individuals, with a much 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 seamlessly co-ordinated.
7. Ministers have recorded the importance of having confidence and ambition in the sector to delivering results. In response we have developed our approach to inspection with a focus on collaboration and strengths with the intention of supporting innovation and driving improvement.
8. This inspection is led by Care Inspectorate Wales (CIW) and delivered in collaboration with Healthcare Inspectorate Wales (HIW).

Prevention and promotion of independence for older adults (over 65) living in the community

1. The purpose of this inspection was to explore how well the local authority with its partners is promoting independence and preventing escalating needs for older adults. The inspection identified where progress has been made in giving effect to the Act and where improvements are required.
2. We (CIW and HIW) focused upon the experience of older adults as they come into contact with and move through social care services up until the time they may need to enter a care home. We also considered the times when they experienced, or would have benefited from, joint working between Local Authority services and Health Board services.
3. We evaluated the quality of the service within the parameters of the four underpinning principles of the Social Services and Well-being Act (as listed above) and considered their application in practice at three levels:
 - Individual
 - Organisational
 - Strategic
4. We are always mindful of expectations as outlined in the SSWBA codes of practice:
 - What matters – outcome focused
 - Impact –focus on outcome not process
 - Rights based approach – MCA
 - Control – relationships
 - Timely
 - Accessible
 - Proportionate – sustainability
 - Strengths based
 - Preventative
 - Well planned and managed
 - Well led
 - Efficient and effective / Prudent healthcare
 - Positive risk and defensible practice
 - The combination of evidence-based practice grounded in knowledge, with finely balanced professional judgement

Strengths and Priorities for Improvement

CIW and HIW draw 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 by the local authority and local health board to deliver improved outcomes for people in the local authority area in line with requirements of legislation and good practice guidance.

Wellbeing	
Strengths	<p>People can be increasingly confident the local authority recognises adults are the best people to judge their own wellbeing.</p> <p>The local authority is able to demonstrate a good understanding of its own strengths, areas of challenge and areas for improvement.</p>
Priorities for improvement	<p>Senior managers must have a consistent clear line of sight on front line practice and workflow. Ensure provision of services is directly linked to outcomes the individual wants to achieve, and service quality is maintained. (A framework for quality assurance and audit).</p> <p>Consistency of opportunities for carers to have their voices heard could to be improved and support for carers tailored to enable them to achieve their own wellbeing outcomes.</p>
People – voice and choice	
Strengths	<p>People who lack mental capacity can be confident the importance of assessments and best interest decisions is firmly embedded in practice.</p> <p>Formal advocacy is available and the voices of informal advocates are regularly seen in case recording.</p> <p>Good communication and engagement with private care providers.</p>
Priorities for improvement	<p>Record of assessment must include outcome of assessment and any advice or guidance given on the assessment and eligibility tool. This applies to those needs that are to be met through the provision of care and support and those met through community based or preventative services.</p> <p>The local authority must consistently consider people's personal outcomes and co-produce solutions with people themselves. Proportionate and timely must underpin this process. People should not be signposted to teams without consideration of outcomes to be achieved.</p> <p>In collaboration with key partners drive a whole sector plan to ensure a sufficient, skilled, safe and focused workforce to</p>

	<p>promote the wellbeing of people with care and support needs and prevent people reaching crisis. Involve the voluntary and independent sector.</p>
<p>Partnerships, integration and co-production drives service delivery</p>	
<p>Strengths</p>	<p>Positive progress has been made in developing safeguarding to ensure practitioners work with people as partners, balancing least restrictive options with choice, and duty to safeguard, recognising people's strengths and their contributions to their own wellbeing. Reported 'good working relationships' between statutory agencies.</p> <p>There are examples of innovation and 'good' projects, many of which are well developed and offer opportunity to build.</p>
<p>Priorities for Improvement</p>	<p>Local authority and local health board as key partners maximise the benefits of 'good' working relationships to provide a step change in pace of development of an agreed model of locality working/co located services with a focus on prevention and early intervention.</p> <p>Move beyond vision statements and 'good projects' to a clear understanding of what a system of sustainable outcome focused services will look like in practice in Wrexham. Underpin with good local governance to support trust and confidence.</p>
<p>Prevention and early intervention</p>	
<p>Strengths</p>	<p>Staff from across health and social care reflected a can do and will do approach, staff were professional and dedicated to their focus of doing the best they can for people.</p> <p>The interim director of social services enjoys significant support from senior officers across the authority, who were keen and able to demonstrate the link between their roles in housing, economy and finance and the social care agenda.</p>
<p>Priorities for improvement</p>	<p>Local authority and local health board to develop a joint approach to the review and provision of third and independent sector early intervention and prevention services (including community agents) to improve the range and coordination of services that reduce isolation and support people to remain independent.</p> <p>Local authority and local health board make better use of the Population Needs Assessment process. Continue to work with statutory and voluntary sector partners to identify local need and gaps in preventative services, transform individual projects into sustainable services that promote independence and prevent hospital admission for a reason other than clinical need.</p>

1. Wellbeing

Findings: Older adults can be increasingly confident they will maintain their autonomy as the local authority can demonstrate good progress in working with the presumption that the adult is best placed to judge their own well-being. Carers can not be as confident their wellbeing outcomes are considered to the same extent nor always reflected in the support they are offered.

The framework of management oversight and audit is inadequate to enable managers to have clear sight of operational performance and workflow in their areas of responsibility. This results in managers acting down to assure themselves of quality while also trying to balance their competing strategic responsibilities.

The local authority through its self-evaluation was able to reflect a good understanding of its own strengths, areas of challenge and areas for improvement. This self awareness enables senior officers to respond appropriately to challenges that are both chronic and at times acute due to increasingly lean structures and undiminished demand. The pressures on staff are evident and impacting upon sickness levels. The potential benefits of agile and flexible working are yet to be realised.

Evidence at the individual level:

- 1.1. People can be confident there is evidence in file records that the importance of beginning with the presumption the adult is best placed to judge their own well-being is generally understood and applied in practice.
- 1.2. People can expect to have the outcomes they want to achieve recorded in their own words and we saw people supported to consider risks and make decisions that suited them.
- 1.3. We saw some opportunities to support carers were missed and the outcomes they wanted to achieve not routinely recorded. Some carers told us they had experienced an improvement in the last year.
- 1.4. People cannot be confident what matters to them will be captured in hospital and passed on to social services. Although we saw the 'what matters' assessment template completed by health staff, too often we saw it used only as a means of onward referral 'of work' between services rather than a means of ensuring the outcomes the person wanted to achieve remained the focus of ongoing support. On one occasion we saw 'what mattered' to an elderly gentleman recorded as 'MDT referral'. The application of what matters could be further informed and supported through joint learning between Health and Social Care staff in the use of what matters. The lack of an Integrated IT system did not act to assist staff in communication flows.

Evidence at operational level:

- 1.5. We saw and were told a small number of referrals made by professionals were delayed and later chased up by family members/friends when people deteriorated. On some occasions we saw these 'reminders' resulted in the need for urgent responses because people were reaching crisis point. We cannot conclude these people received a timely response to identified need.
- 1.6. There was mixed evidence of practitioners understanding of wellbeing as crucial to the success of any offer of support. At times, we saw creative support packages and the positive involvement of family and carers. At other times, we saw people waited for services without any offer of support or consideration of alternatives while they waited. We saw and were told delays without support caused distress.
- 1.7. Assessment documentation guides practitioners to focus on 'what matters' to people and the national well-being outcomes to be achieved. We found completion of documentation by practitioners inconsistent, national outcomes were identified but they were not routinely translated into individual personal outcomes to be achieved.
- 1.8. There is a team of social workers in 'the front door' to Wrexham social services, we were told having professionals at the front door aims to ensure people receive the right information, advice and assistance at the first point of contact and reduces 'failure demand'.
- 1.9. However, we found a 'what matters' conversation is not routinely undertaken before referrals from health are passed to other teams. This then contributes to a waiting list in Team for Older People where people can then wait, sometimes unnecessarily, for allocation to a social worker in the team. We found some of the people waiting did not require a qualified social worker to meet their needs.
- 1.10. We heard how the development of the waiting list increased the pressure felt by social workers in the Team for Older People. Pressure turned to annoyance when social workers opened referrals that could have been more easily and more quickly resolved without the requirement for intervention by a qualified social worker.
- 1.11. We understand some of the social work time in 'the front door' is used to support people who would have fallen between 'traditional services' pre implementation of the SSWBA. This was because they required social work support but did not traditionally meet eligibility for any one service area.

- 1.12. Occupational therapists carried out robust functional assessments, leading to positive outcomes for people. However, due to the nature of the assessment templates it was not always clear how the assessment and provision of support had helped to achieve what mattered to the person. On occasions we saw comments at the end of the assessments refer to 'what matters' or 'the outcome the person wanted to achieve'; from this we could not conclude the outcomes the person had wanted to achieve had been central to the process.
- 1.13. We saw some assessments to be 'traditional' focusing on needs, process and current availability of services rather than 'what matters' to the person and outcome they want to achieve. We saw day care added to a package of care without clear understanding of personal outcomes to be achieved. There is a need to ensure all practitioners are working in accordance with the principles of the SSWBA 2014 and recording 'what matters' and outcome rather than process.
- 1.14. We found people waiting for domiciliary care was impacting on the accessibility of Reablement Team services because people who had completed periods of reablement could not always move on to a domiciliary care service. This resulted in the support of the Reablement Team not being available to some who people who could benefit.
- 1.15. We saw a very small number of cases where people were receiving 15 minute calls to help with personal care and preparation for bed. The local authority should assure itself all calls uphold dignity, respect and wellbeing particularly when personal care is delivered in such a short time allowing so little opportunity for respectful human interaction. We also saw a number of cases of people delayed in hospital. We understood these deficits were also due to lack of availability of domiciliary care.
- 1.16. We found good understanding and application of 'What matters' and wellbeing in the safeguarding team. We found the team very focused on providing timely solutions that matter to people, promotes their independence; and ensured they considered the risks they faced were reasonable for them.
- 1.17. We found a 'can do' problem solving approach in many areas of services and particularly in the safeguarding team where their motto of 'move it on or move it up' meant all referrals not completed within 30 days were brought to the attention of the service manager. This is proportionate management oversight, which positively contributed to people receiving a timely response and practitioners increasing confidence in their abilities.

- 1.18. Supervision files and staff survey revealed variability in both quality and quantity of supervision sessions offered. Some supervision notes were seen to be comprehensive and some very limited. We did note the vast majority of staff we spoke to told us they felt very well supported and they found senior managers accessible and 'ready to listen'. They consistently told us of good peer support.
- 1.19. Newly qualified social workers told us about support during first year in practice. Including protected caseloads, formal training courses and opportunities to shadow and learn from experienced practitioners. This feedback was not consistently good; some people were concerned about the level of formal support and feedback available to newly qualified social workers.
- 1.20. There were 90 people on the waiting list to be allocated to the Team for Older People. Of those we saw we concluded one did need to be given higher priority and could not conclude the others were appropriately prioritised to achieve the most proportionate or timely response to achieve required outcomes. We concluded management of the waiting list and workflow linked to what matters conversations inadequate and requires immediate attention.

Evidence at strategic level:

- 1.21. We met with staff from Human Resources who told us their priorities include absence management and recruitment. We heard about how new approaches to recruitment have been successful in appointing staff to the new extra care scheme.
- 1.22. We heard conflicting messages from managers and practitioners about flexible working and work life balance. We heard about practitioners having to make daily requests to work from home and an expectation of only one day a week worked from home. We found flexible and agile working not as advanced as some other local authorities.
- 1.23. We also heard the availability of mobile phones is limited and parking an ongoing problem near offices for staff who have to come in and out of offices more than once during the day. This means that optimum working conditions for social care staff is not in place and the environment is not conducive to allow staff to make best use of their time and work effectively with people.
- 1.24. The pressures on the service at the time of the inspection were evident due to high levels of staff absences and level of demand. We saw senior managers pulled between demands of operational services and setting strategic direction for teams. While we saw some good evidence of audit we did not find evidence of a systematic audit framework that enables senior managers to have a clear

line of sight on demand, workflow and quality; without involving them in undertaking significant work themselves. This means the local authority cannot be reassured resources are being used prudently and positive outcomes are consistently delivered across the service.

- 1.25. Senior leaders from across the council were able to demonstrate how their roles and functions fitted into the requirements of the SSWBA. Colleagues in Housing, Economy and Finance were all able to demonstrate links to the work of social services and the direct impact of their roles on outcomes for people.

2. People – voice and choice.

Findings: Many people can expect to be offered ‘What matters’ conversations and people who lack mental capacity can be confident assessments and best interest decisions ensure their voices are heard. People can also expect to be offered formal advocacy should they need it and informal advocates are regularly heard. Deficits in the domiciliary care market mean people cannot be confident they will always maintain control and receive timely and proportionate responses. People cannot routinely expect to be offered direct payments to enable them to maintain control over their own care and support.

Managers have driven considerable changes in safeguarding services. New policies, procedures and practice have improved the focus on voice and choice and supported practitioners to deliver a timelier, proportionate and more sustainable service. Timely and specific oversight and audit of safeguarding ensures consistent quality of delivery. This learning could be extended to other service areas.

There is positive engagement between staff and managers; they share a good level of knowledge, dedication and professionalism. The challenges faced due to sickness absences and workflow are evident and already a source of discussion in the local authority as the inspection began. Leaders ensured adequate interim plans were in place to keep people safe and manage workload.

Evidence at individual level:

- 2.1. We saw and were told people do have their voices heard and choices respected. Recording of what matters conversations is often adequate and sometimes good. More work is required to ensure it is consistently good.
- 2.2. People can expect to be supported through formal advocacy once an agreement is reached that advocacy is needed. People who have informal advocacy can expect their advocate to be readily involved in assessment process and the planning and delivery of services.
- 2.3. People who lack mental capacity to make significant decisions are supported by social workers who are competent to carry out mental capacity assessments. We saw support was provided to enable people to make their own decisions.
- 2.4. We saw more work is required to ensure records of assessment include outcome of assessment and any advice or guidance given on the assessment and eligibility tool. This applies to those needs that are to be met through the provision of care and support and those met through community based or preventative services.

Evidence at operational level:

- 2.5. Through discussion and in file records we heard and saw a robust understanding in adult services of the need to balance protection with the rights of the adult. Particularly for those who are most vulnerable. Mental capacity assessments are mostly undertaken to a good standard. The knowledge and skills to undertake these assessments to a high standard are evident in the service.
- 2.6. Recording of mental capacity assessments is generally good and could be further improved by verbatim recording of the questions asked and detail of efforts made to support people to have their voices heard. Mental capacity assessment documentation must not be allowed to drift into a retrospective brief summary sheet, omitting key stages and details. Management oversight and audit should be highlighting omissions to ensure legal rights of individuals are not diminished.
- 2.7. We saw the new outcome focused advocacy contract is in place, and includes provision for eligible older people. The local authority needs to ensure people requesting advice and support, for whom eligibility is not yet established, are enabled to have their voices heard.
- 2.8. We did see cases where lack of timeliness in communication was impacting upon peoples abilities to make informed choices. We saw people moving into residential care where their financial position was not clearly understood and family were left picking up unexpected ongoing bills. The local authority should satisfy itself about the timeliness of financial assessment and financial information passed to families who may become responsible for ongoing charges.
- 2.9. The local authority has put resources into the development of DEWIS web directory and there is some evidence of it being used effectively. However there is scope for it to be used more widely, for example health practitioners based in the hospital told us they didn't always know what was available in the community. Voluntary sector representatives told us they felt opportunities were missed to provide alternative solutions to traditional domiciliary care and their services were under used.
- 2.10. The local authority recognises not all older people will have access to technology. Community Agents assist by ensuring people in communities receive the community newsletter and information leaflets. Posters and leaflets are also used. We saw cases where older people had referred themselves to services using the details found in the newsletter.

- 2.11. We heard about the efficacy of Community Agents and saw an evaluation report. We heard from leaders and practitioners that some are ‘fantastic they communicate and respond promptly. They have skills proportionate to the tasks and they listen to people’. We heard how allowing the service to grow organically from the bottom up was a deliberate concerted approach to enabling local people to shape services to meet need in their local communities.
- 2.12. Practitioners and managers told us consultation had preceded remodelling of services for older people. Some day care has been decommissioned and a Shared Lives service developed. In house residential respite has been decommissioned and respite that is more flexible is being developed. Carers told us they would welcome more flexible respite.
- 2.13. This work needs to be embedded in practice as we saw day care added to packages of care without clear explanation of how this would contribute to wellbeing outcomes. We saw some people in Extra care were also accessing external day care. This means the local authority is paying twice for care rather than supporting people to access the local community or other tailored support in the scheme.
- 2.14. There is clear Direct Payment Operational Guidance for staff. This includes information on legislative context, principles, eligibility, appropriate use of direct payments and financial accountability. However, we did not see evidence of practitioners routinely promoting Direct Payment when eligible care and support needs or support needs in case of Carers were identified.
- 2.15. Practitioners told us there is a reluctance to recommend direct payments as there are insufficient providers available, so predominantly traditional packages of care and support are provided. Staff also told us it is difficult to set up an account and not ideal for 65+ and those with dementia. This narrow focus and understanding suggests people are not routinely offered the choices that should be available to them under the SSWBA.
- 2.16. We were told Carers Direct Payment, are available typically up to £200 (higher if required) for carers to spend on anything they feel will support them in their caring role. We did see evidence of these payments being processed. Carers can apply directly via the adult social care webpages, via their social worker or NEWCIS. There is evidence of 20 Carer direct payments awarded between August and end October 2018. This is notable practice although numbers are not high.

Evidence at strategic level:

- 2.17. We saw and heard about mostly positive engagement between staff and managers and they share a good level of knowledge, dedication and professionalism. Challenges were evident during the inspection due to high sickness absence requiring people to 'act up or act down'. These challenges are acutely felt due to increasingly lean structures and undiminished demand.
- 2.18. Complaints are managed corporately. Corporate services provide audit of timeliness and identify themes. An annual report is taken to scrutiny and the number of complaints are reported as being low. Communication and timeliness are an ongoing source of complaint in many local authorities including Wrexham and are frequently recognised as a challenge to practitioners with high workloads who are managing complex situations.
- 2.19. Increasing numbers of complaints are managed at first stage once brought to the attention of managers. This underpins the importance of people being heard and receiving responses appropriate to what matters to them. Resolution of most complaints with a conversation suggests human error and misunderstanding to be the basis of most.

3. Partnership and integration - Co-operation drives service delivery.

Findings: People can expect to have more equal relationships with social workers and their strengths and abilities considered as positive resources upon which to draw. Some people can expect to be able to access support from local 'Community Agents'. This project is a positive example of local innovation and demonstrates a willingness by the local authority to build community capacity and move towards a new relationship between service providers and people who use services. Despite reported positive working relationships between partner organisations in Wrexham, people cannot be confident they will be supported by a team of social care and health professionals who routinely work together to ensure they receive timely support. Projects underpinned by joint working with health colleagues are slow to become established. Pockets of good innovative practice are predominantly led by single agencies. 'Good projects' too often remain 'good projects' and the opportunities to deliver sustainable integrated services not maximised. Care Closer to Home, Discharge to Assess, an Integrated Single Point of Access and remodelling of the role of community hospitals are all much-discussed models of supporting people outside acute hospitals whose benefits are yet to be realised in Wrexham. Organisational vision statements require more work to produce a shared understanding of what preventative sustainable services could look like in practice in Wrexham.

Evidence at individual level:

3.1 Some people do benefit from repeat visits by social workers who are aiming to develop a professional working relationship built upon co-operation and a shared understanding of 'what matters'.

3.2 People told us there were frequent changes of domiciliary care provider. One person told us she still "felt safe and was treated as a person not a client". She told us she was very grateful for the support that had given her back her independence.

3.3 People told us communication with staff has improved over the past year, they have noticed an improvement in how often phone calls are returned by social workers and a different approach in how services work with them to address 'what matters' and seek timely solutions.

Evidence at operational level:

3.4 There was evidence of a robust auditing system in place for safeguarding cases. The audits are timely and contribute to maintaining quality of work and workflow. We considered there to be merit in extending this approach to mental capacity assessments and more widely to ensure quality continues to rise and is maintained.

- 3.5 There was evidence of the safeguarding team ensuring timely proportionate responses during the enquiries stage. Involving the person, their family and local agencies to deliver joined up solutions and support wellbeing in community settings. In these instances we saw good examples of how services could work in partnership with people and become more sustainable.
- 3.6 We also saw and heard about cases of inappropriate referrals to the Safeguarding Team. One from a nurse that could have been resolved as a discussion between the nurse and the GP. It need not have been a safeguarding referral and unnecessary distress caused to the family avoided. The resources of the safeguarding team could be better used for cases where people do require safeguarding from abuse.
- 3.7 The new safeguarding focus on the person rather than the perpetrator may help to reduce these types of referrals, and the safeguarding team will have a role in making partners aware of the role of safeguarding.
- 3.8 We were told about and saw the clarity with which Wrexham CBC safeguarding team understood their roles, responsibilities and the legislative framework. The local authority continues to take an active role in developing safeguarding agenda at a regional and national level. Officers work well with regional colleagues and the unique contribution brought by Wrexham to this area of work is acknowledged and welcomed.
- 3.9 We heard about co-location of Social Workers/ Social Care Assessors in five District Nursing Hubs, we heard the 'pilot' has been in place since 2016 with some success and lessons learned. From the summary of an evaluation written for social services senior management team it was evident joint working, joint visits and regular joint operational meetings were not taking place as a matter of everyday working.
- 3.10 We reviewed files and spoke to people who were supported by both health and social care practitioners; we found little joint working or sharing of information. We did see a very small number of emails exchanged. We are not confident people are benefitting from joined up services. People are having to repeat personal information, they are not routinely benefitting from professionals joint review of their cases and maximum efficiency is not being achieved.
- 3.11 We did see many small innovative pockets of good joint work where teams were being creative and carrying out their work diligently. Each contributing to the individual's journey in their own way. However, overall, we saw case management was weak as people passed between health and social care services and sometimes between social care teams without a focus upon what

matters to them and with limited continuity. In these instances, we saw the needs of services placed above the needs of people and the outcomes they wanted to achieve.

3.12 We established through interview and records there was good oversight and positive interface and relationship between social services commissioning and independent domiciliary care providers. A robust IT interface and regular liaison was evident. Providers are involved in reviews where appropriate and every Provider has a link Contract Manager to ensure challenges are addressed before becoming critical.

3.13 Independent care providers described an excellent working relationship with commissioners and brokers developed through focus groups.

Evidence at strategic level:

3.14 Wrexham CBC commissions very few services with the local health board. Most jointly commissioned services are those jointly funded by Welsh Government where the requirement of funding is joint working. These include a range of services funded by the Integrated Care Fund (ICF).

3.15 Step up and step down beds are one of the services purchased by the local authority from ICF money. Unfortunately, this project has not translated into increased joint working and system efficiency. We were told the local health board has commissioned more community beds in the area without reference to the commissioning process in the local authority, therefore, we believe an opportunity to develop a sustainable model of commissioning is being missed.

3.16 Colleagues in the health board told us the lack of availability of domiciliary care in the community was a joint challenge, and directly impacting upon discharges from hospital. However, support is offered between agencies on an ad hoc basis and is not yet subject of a joint plan to remedy as part of a system wide response to develop sustainable services.

3.17 The ICF has provided the opportunity for partners to work together to problem solve and Community Agents are seen by some as one of the successes. The Agents are working closely with primary care teams at cluster levels. The local authority is developing improved process to drive and monitor this work stream.

3.18 The local authority and local health board discuss and make some arrangements to promote co-operation between themselves and relevant partners with a view to promoting the well-being of adults with needs for care and support. However, at both operational and strategic levels we found partnership, integration and sustainability are not enhanced by organisations continuing to

maintain separate meeting schedules and targets. There is duplication, delay and added pressure as people are increasingly asked to attend meetings for their own employer plus additional joint meetings set up to support joint working. Some of the duplication is compounded by regional and national working and needs to be seen as transitional to be worked through.

- 3.19 Senior leaders from health and social care all told us they knew each had vision statements. They were unable to tell us with any level of confidence what was in their partners vision statements apart from broad and brief descriptions of intent. Neither were they confident that there was a clear vision of what sustainable community services could look like in practice in Wrexham. They were not confident their senior managers knew what the phrase sustainable services meant in relation to their own practice, they understood more work is required to develop a joined up approach.
- 3.20 Separate organisations and Welsh Government launching improvement drives that are not directly compatible with one another does not support joint operational working. We saw the new BCUHB hospital discharge improvement drive, although an excellent improvement drive for in-patient care and Hospital Discharge, it does not fully reflect the principles of the SSWBA. Specifically it does not require staff to complete what matters documentation, despite this being a statutory duty on all staff who deliver services under the act, and offering people the smoothest transition out of hospital and back to appropriate support in their own communities.
- 3.21 The Chair of the regional adults safeguarding board, the regional safeguarding coordinator, and representatives from North Wales Police and the BCUHB Health Board all told us about good joint working with Wrexham CBC on safeguarding. They described Wrexham CBC as providing a specific and unique contribution to the agenda and helping to drive improvements regionally.

4. Prevention and early intervention

Findings: Depending upon presenting need some people can expect to receive a positive, timely, 'can do' preventative response. People cannot be confident they will always receive the same timely preventative response when they need domiciliary care, Reablement Service or a review of their care and support needs.

The importance of promoting independence and early intervention in the planning and delivery of service is high priority for the local authority. Assistive technology, falls service, night time response, step up step down beds and extra care are all available. However, the pressures in the local acute hospital are allowed to dictate and overtake, distracting practitioners and senior officers from progressing strategic opportunities for prevention and early intervention.

Wrexham social services presents as a service undergoing a period of substantial change as they move towards a more sustainable approach. The interim Director of Social Services enjoys significant support from senior officers across the local authority who were keen and able to demonstrate the link between their roles in housing, economy and finance and the social care agenda.

Evidence at individual level:

4.1 People do not have access to one integrated single point of access for health and social care in Wrexham. People enter services from a range of 'doors'.

Sometimes the range of 'doors' do not always follow the most direct route and people are signposted or referred to teams without the opportunity to explore and explain 'what matters' to them.

4.2 People can expect to feel supported to remain independent as a result of changes in the safeguarding service. People can expect to receive a timely partnership approach to their concerns that aims to keep them safe and promote their independence.

4.3 People are at home and in hospital waiting for care and support packages to begin or be increased. Sometimes, because hospitals are not the best environment for those who do not need to be there, people can deteriorate while they wait, lose muscle mass, skills and confidence. We saw in case files, and practitioners confirmed, people are in hospital waiting longer than they need because domiciliary care and support is not available in the community to enable them to return home.

Evidence at operational level:

4.4 Local safeguarding procedures developed in the absence of national documents are good, drive a positive 'can do' approach and underpin a focus on the voice and choices of the people and the timely outcomes they want to achieve. We saw issues resolved and two people remain living in the community despite their initially thinking they may need to move into care because they felt unsafe.

- 4.5 We saw good multiagency working focused upon timely hospital discharge by staff co located on the acute hospital site. We saw the service was led by a nurse and included social services and the voluntary sector, we heard how at times creative solutions to individual need were missed as the pressure to support discharge routinely resulted in an offer of domiciliary care which is not always immediately available nor required.
- 4.6 We found staff from across health and social care reflected a can do and will do approach with staff who were professional and dedicated to their focus of doing the best they can for the citizen.
- 4.7 Case files sometimes showed people who need services being transferred between teams based upon adherence to a predefined process. This approach undermines the purpose of 'what matters' conversations and the judgements of professional staff. Some of these people then waited in waiting lists.
- 4.8 We did see evidence of timely and proportionate response by Initial Response Team. This response ensured these individuals received the right service at the right time following referral from primary care.
- 4.9 Initial Response Team (IRT) Managers informed us of their good working relationship with Community Resource Team and primary health care teams. Some health staff told us they thought timeliness could be improved, if, having completed the 'what matters' conversation they could directly send referrals to where they needed to get to rather than through IRT.
- 4.10 We were told about social services occupational therapists going into hospital with the aim of developing health colleagues understanding of risk, assessing for single-handed care and using correct hoists and techniques. We saw a summary of outcomes of this work describing a positive reduction in the assessed need for care and support by hospital occupational therapists. While this project is having some success and we support joint working, it is clear this is not a new issue and therefore it is not clear why community resources are drawn back into hospital, albeit on a project basis, to the detriment of work in the community where there are waiting lists. In collaboration with colleagues from the local health board the local authority should assure themselves this is the best use of local authority resources.
- 4.11 There is a range of services available in Wrexham providing support to individuals to maintain independence and the contribution of occupational therapists to supporting people to maintain their wellbeing is acknowledged. For example through timely provision of equipment and adaptation; and training and support for private providers. There has been investment in telecare basic and

enhanced over a number of years enabling people to successfully manage risk and maintain their independence at home. This project is supported by the falls response service and the night time service. These services are not all routinely found everywhere and do provide examples of services being both responsive and creative in meeting individual needs.

Evidence at strategic level:

- 4.12 We understand the Reablement service is a priority for managers who want to ensure it is being as effective and targeted at those in greatest need where maximum efficiency can be achieved.
- 4.13 We heard there has been work to re-examination and reassess the use of domiciliary care calls lasting less than 15 minutes. This work has led to increased clarity on responsibility for 'medication only' calls and ensuring dignity is respected.
- 4.14 We heard about a focus on workflow that is taking time to progress with sensitivity. Current workflow does not always meet requirements of SSWBA as focus on wellbeing outcomes is missed by a process focus on labels and defined pathways.
- 4.15 We saw and heard the effort to develop a population needs assessment has not yet been maximised. An opportunity to take an overview and develop a joint approach to the review and provision of third and independent sector early intervention and prevention services (including community agents) is still to be grasped.
- 4.16 Cluster based integration with Health has been outlined as a project for development in partnership with health partners. We heard how the recent joint work between the local authority and local health board intends to make use of the Welsh Government Transformation grant and the positivity with which the money and opportunity is being welcomed.

Method

We selected case files for tracking and review from a sample of cases. In total we reviewed 50 case files and followed up on 14 of these with interviews with social workers and family members. We spoke with some people who used the services.

We reviewed 10 mental capacity assessments.

We interviewed a range of local authority employees, elected members, senior officers, director of social services, the interim chief executive and other relevant professionals.

We administered a survey of frontline social care staff.

We reviewed nine staff supervision files and records of supervision. We looked at a sample of three complaints and related information.

We reviewed performance information and a range of relevant local authority documentation.

We interviewed a range of senior officers from the local health board and spoke with operational staff from the local health board.

We interviewed a range of senior officers from statutory organisations and partner agencies from the third sector.

We read relevant policies and procedures.

We observed strategy meetings and allocation meetings.

Welsh Language

English is the main language of the local authority and the inspection was conducted accordingly. We offered translation in co-operation with the local authority. Welsh and Polish are spoken in Wrexham as are a small range of other languages.

Acknowledgements

CIW would like to thank all those who gave their time and contributed to this inspection: individuals and carers, staff, managers, members, partner organisations and other relevant professionals.

This inspection was a 'pilot' of a new approach and we thank everyone who participated for their patience and understanding of any of our shortfalls.