Arolygiaeth Gofal Cymru
Care Inspectorate Wales

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Healthcare Inspectorate Wales

Inspection of Older Adults Services
Isle of Anglesey County Council

October 2019

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

 WG39071 Digital ISBN 978-1-83933-266-1

Contents

Background

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.

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.

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.

The principles of the act are:

- Support for people who have care and support needs to achieve **well-being.**
- **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.

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.

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.

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.

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

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.

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.

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
- Operational
- Strategic

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.

Well-being	
Strengths	Communication with people who approach Isle of Anglesey County Council (IOACC) for support is respectful and strengths based, it is often collaborative, and mostly built upon an equal relationship. IOACC adult services consistently strive to keep people at the heart of their duties. The local authority dedicates significant time and resources into 'place shaping' and supporting the growth of community resources and resilience. From this work it has identified it needs to review support available to people with dementia.
Priorities for improvement	Ensure a prudent approach to use of resources directly translates into people getting the right response at the right time. This includes ensuring team structures and roles make best use of social work skills, supervision and improving the quality and consistency of social work recording. Ensure team managers have the capacity to respond to all duties within their job descriptions. Ensure complex safeguarding concerns do not lose momentum and remain unresolved. Maximise opportunities presented through the regional safeguarding board to ensure partner agencies are held to account for safeguarding people at risk, within their services.
People – voice and choice	
Strengths	The local authority benefits from the leadership of the chief executive and leader of the council. Both have a strong grasp of strategic direction and are able to hold informed discussions about operational services. They are ambitious for services and the prosperity of Isle of Anglesey. Most people have their voices heard in their assessment of needs for care and support.

Priorities for improvement	The local authority must ensure that the capacity of carers to provide care is sustainable and that they comply with their general duty to promote the well-being of the carer and the person cared for. The quality of mental capacity assessments should be improved in line with the Mental Capacity Act (MCA) 2005 to ensure they are fit for purpose and the most vulnerable people have their voices heard. Managers will need to ensure practitioner recording is up to date and accessible in line with professional expectations.
Partnerships, integration and co-production drives service delivery	
Strengths	We found operational services are mostly working well together to support people to remain at home for as long as possible with support. Communication is good and services are creatively mixed and matched to meet individual needs. There is mostly good joint working at management level. Many managers across health and social care recognise the limitations of their current joint working and have ambitions to improve.
Priorities for Improvement	Partnership working must move beyond projects that are funded through Welsh Government initiatives and inject urgency into developing sustainable services, not least to reduce pressure on front line staff. Managers need to ensure staff have a greater understanding of project priorities and progress. Local authority and key strategic partners need to ensure their ambitions for services are aligned with Welsh Ministers drive towards integrated and sustainable services. Focused upon delivering outcomes people and communities want to achieve.
Prevention and early intervention	
Strengths	Prevention is firmly on the agenda in IOACC. There are many positive examples of practitioners providing and arranging care and support for people in their communities to prevent them reaching crisis. The local authority contributes resources to encouraging communities to build resilience and reduce reliance on statutory bodies.
Priorities for improvement	Managers are aware they need to ensure closer compliance with the SSWBA in the following areas:

	• The eligibility criteria must not be used as a tool to require individuals to demonstrate they have exhausted every other possible avenue of support before becoming eligible for local authority assistance. • determination of eligibility for care and support must drive service response. • finances must not be taken into account as part of an eligibility assessment, a separate financial assessment should be completed once eligibility has been determined. Ensure the reablement service is utilised to maximise benefit for people who need to use it while also making best use of the resource. Ensure the reablement service has sufficient professional support to underpin a positive approach to risk and deliver positive outcomes for people with a wider range of needs.

1. Well-being

Findings: Communication with people who approach IOACC for support is respectful and strengths based, it is often collaborative, and mostly built upon an equal relationship.

Social workers are completing tasks which could be completed by people who are less qualified while some tasks which do need qualified social work support are being delayed. We found there is scope to amend this approach to ensure it is more consistent with a prudent approach to managing resources and delivering sustainable services.

The local authority continues to make significant efforts to build community capacity and resilience with a level of success.

Safeguarding services are mostly effective and timely, we found the service could benefit from adhering more tightly to prescribed processes as well as ensuring team managers have capacity within their roles to manage safeguarding.

The involvement of carers in the safeguarding process is variable and more work is required to ensure carers perspective is accommodated, as appropriate, and can usefully contribute to the safeguarding of the cared for.

Managers could make greater use of the North Wales regional safeguarding board to escalate and maintain statutory partners' focus upon unresolved systemic safeguarding concerns.

Individual level:

1.1. Many people who contacted IOACC for support received a timely response to their needs. Conversations between practitioners and people who approached IOACC for care and support were respectful.

1.2. People received responses from practitioners who were committed to delivering quality services. A person who had benefited from the support of a social worker told us "if more people in the world were like them, it would be a better place, they respond quickly".

1.3. Most people received a timely response to their safeguarding concerns. People mostly had their voices heard and had their well-being respected by practitioners and safeguarding managers who were offering support.

Operational level:

1.4. We saw how a 'can do' person centred approach by confident team managers found solutions to safeguard people who were at risk of abuse or neglect.

1.5. Case notes revealed discussions between practitioners and managers querying next steps in safeguarding process. On these occasions we did not find people
to be unsafe, however, we did find the process could have been streamlined for everyone involved through a timely, well focused strategy meeting.

1.6. The competing demands on team managers meant their ability to be lead decision makers for safeguarding cases was sometimes compromised. Senior managers will want to assure themselves team managers' workload is manageable in this operating model.

1.7. Some social workers told us they felt pressured by heavy caseloads, we reviewed one 'high' case load and found it contained a mix of complexity and activity. Some of the cases were very active, some had no activity for months and some were referrals for tasks that did not require the skills of a qualified social worker to complete. The types of competing work waiting for social work response included: waiting for a care home placement of choice, wanting to change a care home of choice, annual reviews for people settled in care homes and approval of minor changes in packages of care.

1.8. Social workers juggling these types of competing priorities resulted in some people waiting a month for their first appointment with a social worker. These same people may also have spent time on the team manager's list, awaiting allocation. Although we found some people were facing unhelpful delays we did not find anyone left at risk or unsafe.

1.9. We reviewed a number of cases on the team managers waiting allocation list. We questioned why some people were on the list and were told they were on the 'wrong list'. This is not indicative of good process management but we did not find anyone who was at risk or currently unsafe. We noted staff vacancies were a contributing factor with some vacancies now filled.

1.10. All health and social care staff we spoke to were aware of community agents and utilised them to signpost people towards community activities and community support. They told us how the community agents were having a positive effect on reducing loneliness and assisting prevention of ill health.

1.11. Practitioners told us they had already identified a lack of services for people living with dementia, particularly people with early onset dementia. This gap in services corresponds with the gap identified by local people.

1.12. The local authority told us it recognised the importance of accessible housing to the well-being of people generally and the well-being of people with dementia. We saw evidence of the local authority actively seeking to address accommodation options for older people by revising how they utilise sheltered housing and developing Extra Care schemes.

1.13. People living in the Llangefni extra care scheme told us how pleased they were “with their environment and how lucky they felt to be able to move into the scheme”. Some people told us the accommodation was ideal for people who use wheelchairs. They also told us it was not so good for people with dementia, as there were no activities on the floor allocated for people living with dementia. They were disappointed in this and hoped it would improve. We discussed this
with local authority managers and found them receptive and honest about the need to give this more thought.

1.14 Practitioners shared with us their clear views on areas for improvement, these included: More team meetings with updates on projects and plans. Tighter line management to improve recording and response times. Earlier interventions to reduce caseloads. Less repetitive forms. More engagement with people who have complex needs. More opportunities for people with early onset dementia. Improved consideration of what works and what does not and the need to develop baselines and decide what success looks like.

1.15 Many practitioners told us the department was doing many things well including; respect and value for people as individuals, caring, consulting with people and trying to give everyone a voice; access to counselling; regular supervisions; flexible working and working with professionals from other agencies.

Strategic level:

1.16 We read IOACC’s older peoples strategy which showed ambition and a direction of travel. We saw it followed up by ‘place shaping’ work and heard from many people about the increase in community groups and community activities on the island, including a number of community hubs. One community group had a minibus and transported people to appointments, another that operated a day centre for people with dementia, charging £25 per day for the service. The local authority is managing changes in own service delivery with mixed success. Local authority practitioners told us they valued their managers but it felt like ‘one project after another’ and pilot initiatives never reached conclusion. They explained they were not clear why weekend working was continued for local authority social workers and occupational therapists when weekend working for GPs and pharmacies had not begun.

1.17 It is recognised as one of the first weekend working projects in North Wales that has sustained beyond a number of pilot weeks. However, staff are not yet confident this change in working pattern was delivering improvements in services for people while they felt it did cause added stress for them and their ability to manage work life balance. Further evaluation will be important.

1.18 Health practitioners were not generally as complimentary about the support they received, they told us health managers were often not visible when challenges arose, and they were not complimentary about being 'managed' via email.

1.19 We noted a high number of safeguarding concerns from a local dementia assessment unit. We went to the unit, while we did not see anyone at risk or unsafe we did notice people, who were unwell, not usefully engaged. Speaking to staff it became apparent there were ongoing issues of concern in the unit including management of safeguarding, staff shortages and staff skill mix.

1.20 We saw people with a range of needs admitted to the unit from as far away as mid Wales. People who were English speaking had been admitted into a predominantly Welsh speaking environment. This means people who were already vulnerable were further isolated. Families told us it was difficult for them to visit and offer support and we considered this isolation increases the risk of safeguarding issues going unreported.

1.21 Managers made us aware of an action plan to improve provision in the unit. We are concerned at the length of time this situation has existed. More work and greater urgency is required to ensure people who are admitted to the unit receive support from suitably qualified staff in a therapeutic environment. Healthcare Inspectorate Wales will continue monitoring of this service.

2. People – voice and choice.

Findings: The local authority is working towards the presumption that adults are best placed to judge their own well-being. However, we received a mixed response when we asked people about their voices being heard and their receiving the support they needed.

An advocacy contract is in place, however, we are not confident the need for advocacy is offered to enable people to fully participate in assessments.

The quality of professional recording in case flies varies considerably from inadequate to very good.

Mental capacity assessments are mostly inadequate. Managers acknowledge further work is required to bring them up to an acceptable standard.

Individual level:

2.1. Some people were offered very traditional services. One person told us "they are all lovely, kind people but they don't listen to what I'm telling them, they keep offering me things but not what I know I need".

2.2. Some people had their voices heard at first point of contact but then waited a long time for a social worker appointment or reablement services. This meant these services were not always timely and opportunities for early intervention may have been missed.

Operational level:

2.3. Advocacy services are provided via a contract commissioned jointly with Gwynedd Council. Workers in Single Point of Access (SPoA) told us they knew of the importance of advocacy and it was available. However, we found limited evidence of advocacy being offered and could not be confident the need for formal advocacy was routinely considered.

2.4. We considered mental capacity assessments to be mostly inadequate. The content was often insufficient and lacked the necessary evidence to demonstrate whether a person has mental capacity to make specific decisions or not. There was a lack of evidence in records to demonstrate how and why the social worker deemed people to lack capacity.

2.5. Managers told us they were aware mental capacity assessments were not to the standard required and have commissioned training from a specialist provider to improve practice.

2.6. The quality of assessments of need for care and support were mixed. Some were strengths based, others were not. We saw some assessments where the section for the social worker to provide their professional judgement consisted of a list of behaviours the individual either demonstrated or did not demonstrate, often written in the negative. For example; 'she had no challenging behaviour'. The social worker told us this was a response to demand from care home managers, who wanted a better understanding of the person's needs.

2.7. We also saw an assessment that recorded "Mrs. Z will need ongoing care and support to enable her to reach her outcome, which is to be supported with her personal care and hygiene needs". Generic statements of this type are not unusual and while have some merit, are not sufficient to demonstrate the individuals needs and strengths have been the topic of a meaningful conversation. Neither do they ensure the personal outcomes the individual wants to achieve will be the focus of the support provided. Some assessments had insufficient record of the person's voice and did not record the outcomes people wanted to achieve. These are quality issues managers need to address.

2.8. The quality of practitioner's file recording varies considerably from inadequate to good. Some case files had insufficient notes to gain an understanding of current circumstances. We spoke to managers about a number of these files and were reassured work was up to date and people were in receipt of services they needed.

2.9. However, 'missing' or incomplete file notes makes it extremely difficult for others to provide support in the absence of the key worker. Managers will need to ensure practitioner recording is up to date and accessible in line with their policies and expectations.

2.10. We are not confident people always receive a positive response when their voices are heard. A carer requested respite support for his wife and it was suggested to the carer he pay privately or have a Direct Payment to purchase a personal assistant. The carer did not know anyone to ask to be a personal assistant and we did not find any evidence of him being told about the advocacy service set up to help people find personal assistants.

2.11. The carers' assessments we saw were adequate or good, however we are not confident they always translated into care and support as often as they should or that assessors fully recognised the stress carers were facing in undertaking their caring duties.

2.12. Care providers told us the involvement of carers had improved but many carers did not live on the island and they did not know what was available. We were told Carers Outreach provide a useful service and useful carer information booklet that is consistently available to all carers.

2.13. Health practitioners told us they are embracing the principle of “what matters” to the patient in their patient assessments. However, we found limited evidence of this within their documentation. We understand that there is a further piece of work pending which will involve support for hospital-based staff on use of *What Matters* documentation on admission.

2.14. Most staff are first language Welsh and confident in working bilingually to meet the needs of the population. The ease with which many practitioners are able and willing to transition smoothly between languages is a significant strength.

Strategic level:

2.15. There is an IOACC social services SPoA and an IOA voluntary sector SPoA. We were told the social services SPoA was being used by IOA residents to contact a wide range of council services not linked to social services. We did not pursue this matter, managers may want to explore why this is happening.

2.16. We heard many positive comments about voluntary services, SPoA, community groups, hubs and link workers. However, we also heard about people passed between one SPoA and the other before getting the response they needed. Managers will want to ensure the range of positive services on offer are not undermined by misunderstanding and poor communication.

2.17. The leader of the council provides strong leadership and clear direction. She has a thorough understanding of strategic issues and a knowledge of operational detail expected of someone in her role. We found evidence of positive communication between the lead member and members from across the political spectrum in IOACC. Meetings with members were positive and their active involvement in the running of the council was evidently encouraged and supported.

2.18. Members have a limited but useful understanding of the challenges facing adult services and the concerns of carers. They have an awareness of the challenges faced in managing the budget in the face of increasing pressures. Practical steps have already been taken to ensure members increase their understanding of adult social services to the same level as their understanding of children’s services.

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

Findings: We found operational services mostly working well together to support people to remain at home for as long as possible. Communication is good between practitioners and services are creatively mixed and matched to meet people's needs.

The move to patch based commissioning has not been without its challenges. However, people are experiencing positive benefits from the change in commissioning model.

There are many positive examples of partnership work on the IOA. Practitioners from health and social care are mainly positive about the move to community resource teams. Key Strategic partners need to ensure the focus of service delivery is people and communities to ensure 'care closer to home' can become a reality.

Firmer plans and quality improvements are required to support the move to community resource teams (crt's). Inspectors are concerned the move to crt's alone will not address the majority of current operational challenges.

We found the Mon planning group to have been in existence for a many years. Many relationships within the group are clearly well developed and effective. Some fine tuning is required to ensure this group fits with the wider planning for health and social care on Anglesey.

Individual level:

3.1. There are many positive examples on IOA of people getting the support they needed at the right time.

3.2. We saw many people have benefited from good communication between the local authority, hospital practitioners and the district nurse. Good links into the Night Owls service ensured services wrapped around people to keep them supported at home.

3.3. People who approach IOACC for information, advice and assistance were not always treated as equal partners in the development of their care and support. Some people faced significant challenges in accessing services to which they may have been entitled. The local authority must ensure people are given the information and advice they need at the time they need it to be able to exercise their rights to services that may prevent them from reaching crisis.

Operational level:

3.4. There is much anticipation and discussion about the move into community resource teams. We found most practitioners to be mainly positive about the initiative and believe it will improve service delivery for people and remove duplication for them. Staff told us anxiety could be reduced through increased communication.

3.5. We found good evidence of positive communication and collaboration between different agencies, family and third sector all clearly focused upon putting people at the centre of their work. We saw evidence of pooled funding supporting a husband and wife to stay together within their family home.

3.6. However, we also saw evidence of how a disagreement between professionals about the need for an assessment and who should undertake the assessment was protracted, with agencies adopting fixed 'do nothing' positions. The focus on the vulnerable person and carer was lost. This left the carer under significant pressure for some considerable time, undertaking daily tasks statutory services had a duty to provide or commission.

3.7. In some areas of the island we found social workers and district nurses have worked in teams for many years, they know each other well and support each other. They attend link multi-disciplinary team meetings. Teams explained they have confidence in each other and do their best to work together. They told us it was helpful to have social workers and occupational therapists available at weekends to help support vulnerable people and prevent hospital admission.

3.8. We were told by individuals, carers and practitioners about the pressure on community psychiatric nurses and the positive work of Mon Enhanced Care team and their positive contribution to keeping more people supported at home and preventing admission to hospital.

3.9. Practitioners spoke with some pride about how they worked together to keep people at home. We heard from care providers how they work well together to ensure care calls are shared when necessary. They told us about sharing resources and training and how this contributed to working relationships.

3.10. Transfers of care from hospital to domiciliary agencies is driven by a new contractual agreement stipulating providers must begin delivering care within 48 hours. People told us this is working well. However they also told us the local authority reablement service did have a waiting list and this did cause delay to people being discharged from hospital. Managers told us they are aware of the delays, the delay is evident in the local authority's own self-evaluation and they will be addressing this delay as a priority.

3.11. Independent domiciliary care providers told us they have managed to start care delivery within the 48 hours but it has been a struggle. The biggest challenges and delays are arranging care for people who have complex needs. However, they reported a very positive partnership with the Health Board who provide specialist training both at the start of a new package of care and follow up training. Care providers told us their partnership with Ysbyty Gwynedd staff was “brilliant when someone needs peg feeding”.

3.12. We heard how the positive support from health practitioners makes care staff feel valued and they told us they were confident about accepting hospital discharges at weekends; if training has been provided and people are safe.

3.13. The move to patch based commissioning created some initial operational challenges. Most of these challenges have been overcome and the positive benefits of the new patch based approach are being realised. We heard how people highly value the greater consistency of provider. People told us knowing who is going to provide personal care is important. We heard how having a patch has allowed one company to calculate what their workload is likely to be and they have been able to give defined contracts to their staff. We were told this has helped staff retention as pay and conditions have improved.

3.14. The number of people in receipt of direct payments on the island is low. Managers will want to ensure social workers are confident in offering direct payments, and that people’s choice on how they receive care and support, and who they receive that care and support from, is not unnecessarily limited by the local authority commissioning intentions and social work practice.

Strategic level:

3.15. Independent care providers told us the challenges in achieving outcome focused assessments have improved but not when people are being discharged from hospital. They described the new commissioning framework as a battle between outcomes and a very prescriptive system of hours. They described a culture change that has begun but has a long way to go before people receive the service as intended by the SSWBA.

3.16. Senior health and social care managers are confident and encouraged by their success in moving to patch based commissioning. They report a good relationship with domiciliary care providers. They acknowledge the challenges and are confident the benefits of the new model outweigh the deficits of the past. Most notably in reducing the numbers of people awaiting a care package to support their discharge from hospital.

3.17. The new domiciliary contract contains provision for the same care provider to continue when someone meets criteria for Continuing Health Care Funding. This is a thoughtful approach to providing consistency of care for people

during a period where their health and well-being is declining. This is a good example of strategic planning delivering positive outcomes for people

3.18. There are other positive strategic projects to support local authority and key strategic partners assertions of positive partnership working, including a joint enhanced dementia service in a care home with the Health Board. A community psychiatric nurse is linked to the unit to bolster skills and knowledge within the service. Managers recognise there is need and opportunity to improve the offer of support to carers of people with dementia who are not residents of the care home.

3.19. Strategic partners acknowledge joint commissioning is mainly shaped by new pockets of funding from Welsh Government. In particular, the Integrated Care Fund, was recognised as a significant driver for partnership working.

3.20. We heard mixed messages about the process for development of a new clinical commissioning strategy for North Wales. BCUHB reassures the work has not yet progressed, discussion is beginning at point of underpinning principles and a programme of work will be agreed with partners from the outset. Improved joint working before documents reach draft stage is welcomed as a positive way to build trust, improve integrated working, deliver sustainable public services and ensure the focus of service delivery remains on the people who need to use the services.

3.21. We were told the strategic leadership and drive to support the move to CRTs is through the Integrated Health and Care Delivery Board reporting directly to Gwynedd and Anglesey Public Services Board. There is a clear programme of work and written project milestones with sessions planned during September in Anglesey involving managers from Health and LA and staff (nurses, therapists, social workers).

3.22. Local authority leaders also expressed their concerns about a lack of targets for community based services and how hospital based targets can drive provision.

3.23. The development of Vulnerability and Risk Management (VARM) policy three years ago has been a local policy practitioners and managers consider to be a success. It was developed out of a response to joint working between police and mental health services for use with section 136. The officers identified a gap in provision for people who don't meet the threshold for MAPPA (Multi Agency public Protection arrangements), MARAC (Multi Agency Risk Assessment Conference) or safeguarding. The group of officers expanded and now includes Welsh Ambulance services, Fire Service, Health Services, Adult Services and the Police. Their focus has grown to include older people as well as those who use community mental health services. This was a positive example of partnership working highlighted to us by the chair of North Wales

regional safeguarding board. He explained consideration is being given to whether the initiative should be rolled out across North Wales.

3.24. Due to its size IOA has only one GP led ‘cluster team’ called Môn. The cluster team has regular meetings and has a mix of operational and strategic topics on its agenda. GP led clusters are a product of health boards planning systems to organise and support local planning and delivery of community services. The paid role of GP cluster lead assumes responsibility for marshalling the energies, knowledge and skills of their colleagues in the cluster to work with a range of agencies to deliver upon local priorities. Consideration needs to be given to how the priorities of the cluster fit within the wider health and social care priorities on the island.

4. Prevention and early intervention

Findings: Prevention is firmly on the agenda in IOACC. There are many positive examples of practitioners providing and arranging care and support for people in their communities to prevent them reaching crisis.

The local authority contributes resources to encouraging communities to build resilience and reduce reliance on statutory bodies.

It is not clear that determination of eligibility for care and support always drives service response. We are not confident practitioners always uphold people's unambiguous rights to assessment and determinations of eligibility or that assessment of eligibility for services is not confused with financial assessment under part 5 of the SSWBA.

An overreliance on the capacity of community resources to meet specific needs is occasionally resulting in some people having to show they have exhausted community options before being offered statutory services.

There is more scope to improve the reablement offer, to reduce the number of people experiencing delays and missed opportunities to maximise their independence.

Individual level:

4.1 Many people have received positive support to maintain their independence and prevent them reaching crisis.

4.2 Increasingly, this support is coming from within their own communities as the local authority continues to encourage local communities to identify local needs and take ownership of their own solutions.

4.3 People have not always been able to access reablement services at the right time for them to maximise their independence.

Operational level:

4.4 It is not clear that determination of eligibility for care and support always drives service response. On occasion practitioners told us if someone is only requesting support with showering, they signpost to the third or private sector where the service can be purchased. On these occasions, it was not clear whether eligibility for services was assessed and financial assessment offered in line with the SSWBA.

4.5 Having clarified with senior managers it appears the practice of signposting people who request support with showering to other services is not in line with

IOACC policy. Further work is needed to ensure practitioners uphold people's unambiguous rights to assessment and determinations of eligibility.

4.6 We were made aware of a dementia day service offered by a community group for £25 per day. We saw people were directed to the service before their right to an assessment was upheld. It is not clear on what basis the local authority was determining care and support needs and meeting their duty to provide proportionate assessments and outcome of assessments. The local authority needs to ensure financial resources are not taken into account in assessments of how people can use their own resources and those available in the community to meet their care and support needs.

4.7 The local authority also has an aligned duty to provide information, advice and assistance to ensure people have access to the right information at the right time. This is to ensure people can make informed decisions about how their care and support needs will be met. We found lack of information, misjudged signposting or arbitrarily limited support does delay people with dementia and their carers receiving support to which they are entitled.

4.8 One carer described how living with dementia was impacting his partners' ability to access community facilities. He was specific about what he needed and why. We found it was nine months before it was agreed he could have the support he originally requested. During the nine months a range of options were suggested and were not suitable. We found his voice was not heard and the well-being of the carer and the cared for, declined during this time.

4.9 Further work is required to support people in accessing community support that can meet their needs. Expecting people supported by social workers or link workers to demonstrate they have exhausted all community options before receiving statutory support to which they are entitled, runs counter to the intention of the SSWBA.

4.10 We saw people made repeat requests for the same support, because the first response was either delayed or had not met their needs. Repeating or incomplete work is contributing to high social work caseloads.

4.11 There is more refinement required to ensure assessment and panel processes are not being used as tools to require individuals and social workers to demonstrate they have exhausted every other avenue of possible support before becoming eligible for local authority assistance.

4.12 Inbuilt delays, protracted processes and 'gatekeeping' are problematic in a model of sustainable social services aimed at early intervention and promoting independence for older people. Overly bureaucratic processes run contrary to the ambition of 'sustainable social services: A Framework for Action and prescribed in the SSWBA.

4.13 We saw many people in IOA have benefited from reablement support and the positive interactions with staff who provide the service. We found a positive, friendly approach centred on responding to people as individuals and meeting their individual needs. We saw more people could benefit from the service.

4.14 Independent providers of domiciliary care told us about providing care for people who miss out on a period of reablement when there is no capacity in the reablement team. We found this is often because there is a waiting list for the reablement service as the service is dominated by people being discharged from hospital with low level needs, requiring convalescence.

4.15 We identified an inherent risk in the substantial evidence we found about reablement support workers leading on reablement with minimal professional support. This is compounded by inconsistent professional contribution to reablement monitoring meetings. We saw people could benefit from improved planning and recording of their progress and outcomes.

4.16 There was evidence of the use of Night Owls and how this flexible service throughout the night is well utilised and can make the difference between people being able to remain at home during a crisis, or having to move into a care or even hospital setting. This is a positive service not widely available elsewhere in Wales.

Strategic level:

4.17 Health staff, at all levels, are aware that hospital is not the best place for older people once their acute illness episode has been resolved. This awareness is changing practice and interventions in the emergency duty medical assessment unit with a focus on reducing admission and length of stay. We were told about a new initiative involving a social worker at the 'front door' to support a seamless care pathway through admission to home. However, this was a new service and the individual currently responds to requests rather than be available within the unit, this is an inbuilt delay.

4.18 We heard mixed messages about the IOA having two SPOA. The third sector SPoA supports the LINC workers who provide support to individuals to link them into community initiatives. LINC has a phone service and someone mapping what is available in the community and maintaining a data base. The local asset co-ordinators use this information. Local asset coordinators are part funded by the GP cluster via a 2 year partnership agreement. We found they make a positive contribution to supporting people to access community initiatives and reduce isolation. Managers will want to ensure people are appropriately referred between third sector and statutory agencies and are not signposted back and forth between the two.

4.19 The local authority has grasped the importance and is utilising a model of community development called 'place shaping'. The model is building social

capital and increasing opportunities for local people to be both providers and users of community resources. The deputy chief executive of the council is leading on the roll out of place shaping.

4.20 There are already some positive outcomes of this work including a day service developed by the third sector and community groups to support people living with dementia. The day service is based in the lounge of a sheltered housing scheme and costs £25 a day. The local authority has no involvement in the running of the scheme. It is unclear why the local authority does not support people who have eligible care and support needs to attend the centre via use of a direct payment.

4.21 The local authority is looking forward to the development of a worker and users co-operative to enable people to pool their Direct Payments. This is in its early stages and an officer to support this has been appointed to help development.

Method

We selected case files for tracking and review from a larger sample of cases. In total we reviewed 40 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.

Visited a carers outreach group, Gwelfor Community Centre, Llangefni Extra Care Scheme and a local health run dementia unit to meet and listen to people who use services.

Reviewed nine mental capacity assessments, seven referrals on team managers awaiting allocation list and briefly reviewed ‘one social workers caseload for level of activity and complexity.

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

Administered a survey of frontline social care staff.

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

Reviewed performance information and a range of relevant local authority documentation.

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

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

Read relevant policies and procedures.

Observed an allocation and a panel meeting.

Welsh Language

Welsh is the main language of the local authority and the inspection was conducted accordingly. We offered translation in co-operation with the local authority.

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.