Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Performance Evaluation Inspection of Wrexham County Borough Council's Adults and Children's Services

June 2022

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

Care Inspectorate Wales (CIW) undertook an inspection of children's and adults services in Wrexham County Borough Council (WCBC) in June 2022.

The purpose of this inspection was to review the local authority's performance in exercising its social services duties and functions in line with legislation, on behalf of Welsh Ministers. We seek to answer the following questions aligned under the principles of the Social Services and Well-being (Wales) Act 2014 (The Act).

1. **People – voice and control**
   How well is the local authority ensuring all people are equal partners who have voice, choice and control over their lives and can achieve what matters to them?

   How well is the local authority ensuring that the workforce is sufficient in numbers, suitably skilled, experienced, and supported?

2. **Prevention**
   How well is the local authority ensuring the need for care and support is minimised, and the escalation of need is prevented whilst ensuring that the best possible outcomes for people are achieved?

   How responsive is the local authority to people's changing circumstances?

3. **Well-being**
   How well is the local authority ensuring that people are protected and safeguarded from abuse, neglect and any other types of harm?

4. **Partnership**
   How well is the local authority able to assure themselves effective partnerships are in place to commission and deliver fully integrated, high quality, sustainable outcomes for people?

   How well do strategic plans influence practice and development within the service?

This inspection focused on the effectiveness of local authority services and arrangements to help and protect people. The scope of the inspection included both adult

and children's services:

- evaluation of the experience and outcomes people achieve through their contact with services
- evidence of the local authority and partners having learnt lessons from recent experiences and plans for service developments and improvement
- consideration of how the local authority manages opportunity and risk in its planning and delivery of social care at individual, operational and strategic levels

1. Summary

1.1 As with many local authorities across Wales WCBC has and continues to experience challenges in relation to children's social services and adult social care. Many of the pressures experienced in WCBC reflect the context of recovering from the Covid pandemic including high levels of demand and increased complexity of people's need. Critical workforce deficits in relation to social work recruitment, retention, and staff absence, has resulted in the loss of experienced staff and a competitive market for, and an over reliance on, newly qualified and agency social workers. It is recognised that the pandemic has also amplified pre-existing service stress points such as the availability of community domiciliary support and occupational therapy.

1.2 We identified considerable service deficits and concerns regarding the ability of WCBC children's services to meet its statutory responsibilities to promote and protect the well-being of vulnerable children and families in November 2019. The service has been subject to CIW performance monitoring arrangements since that time. Our inspection of children's services in November 2021 identified areas requiring ongoing improvement and these findings have informed the current inspection.

1.3 Since 2021 the local authority has continued to implement its Accelerated Improvement Board action plan developed to drive the change needed to improve the consistency and quality of children's services in WCBC. We found some progress has been made resulting in developments to practice and better outcomes for children. Senior leaders, managers and politicians are firmly committed and actively working to bring about positive change and are realistic regarding the ongoing actions and resources required to establish a compliant and ambitious child-focused service that promotes the well-being of children

1.4 The successful appointment to senior management posts has helped to create the momentum needed to begin the change of culture in children's services required to raise service expectations and standards. The Senior Head of Children's service has a clear line of sight on operational issues and is well placed to move the service forward with the ongoing support of the Director of Social Services.

1.5 The local authority has acted to reconfigure some of its services with the creation of a

Family Intervention Team aimed at managing all children in receipt of care and support plans freeing capacity for other teams to concentrate on early intervention, child protection and/or court proceedings. WCBC has recently commissioned a managed team of agency social workers to provide additional support to those teams experiencing the most pressure, namely Family Support Team (FST) and Assessment and Intervention Team (AIT). The use of agency staff to fill vacancies has helped to minimise service disruption however some children and families still do not have an allocated or consistent social worker.

1.6 The local authority responds well to immediate safeguarding concerns but safeguarding practice following the initial intervention stage needs to be strengthened. Despite some acknowledged areas of progress, children and young people are not sufficiently at the centre of all practice. We saw evidence of professionals in the safeguarding team working effectively with colleagues from the local health board and the police, as well as wider local authority teams, to protect both adults and children at risk.

1.7 The local authority has developed a clear strategic vision for children services which is due to be shared, with partners. Inspectors found that current practice remains inconsistent pace of improvement needs to be maintained and opportunities to accelerate taken where this allows for sustainable change There remain key areas where action is still needed to ensure the local authority is consistently meeting its statutory responsibilities and making a tangible difference for children, young people, and their families. The local authority must continue to take decisive action to deliver the required improvements and to ensure sustainable and responsive services.

1.8In Adult services most people's voices are heard. However, we also found some gaps in social work practice where outcomes are not fully considered and documented, and the impact of being a carer is not always recognised. A lack of professional curiosity, analysis and recording means people may not always be getting the quality of services they are entitled to.

1.9 Due to the pressures on direct care provision, the local authority is unable to capitalise on opportunities to maximise people's independence and prevent escalation in their needs. We found examples of people being unable to access the care they require and having to move into a care home for an undetermined length of time. This is clearly having a negative impact on people and on the morale of staff who are assessing people fully in the knowledge there is no care available. There are also waiting lists for occupational therapy assessments which have been long standing.

1.10 There are many positive examples of operational partnership working, including multi-disciplinary forums for decision making about practice. We are aware separation from health in the community mental health teams is underway with the community wellbeing team created to focus on a more holistic model of wellbeing. Support groups are being developed in conjunction with third sector partners. The

impact of this on the people in WCBC, and on partnership working, will need to be evaluated.

1.11 Whilst recognising some challenges are being experienced across Wales, further work is required in adult services as has been implemented in children's services to ensure strategic and operational developments are focused on ensuring people can receive the right service at the right time and in the right place as well as ensuring practitioners are consistently working to the principles of the Act. We are aware both Chief Executive and Director recognise the areas which require improvement and are currently recruiting a senior head of adult service to focus on strengthening and bring stability of services for the benefit of adults who need care and/or support.

Key findings and evidence – Children's Services

We present our key findings and evidence below in line with the four principles of the 2014 Act. Improvements required in previous CIW reports may also appear in the report to emphasise their relevance and importance at this time.

2. Principle: People

Strengths:

2.1 Ensuring there is a stable, sufficient, and suitably skilled and experienced workforce remains a challenge in some areas. However, senior managers, including the Head of Service, have been proactive in producing a Risk Management plan to address the significant lack of staffing.

2.2 Practitioners recognise the importance of ensuring children's voices are heard. We saw some examples in social care records where language, communication and level of emotional and developmental maturity was considered and explored to obtain/facilitate views of children.

2.3 Some children have benefitted from opportunities to develop relationships with their social worker. We saw some good examples of direct work to establish children's wishes and feelings. Staff spoken with were confident in this area of work and told us the importance of direct work is recognised and valued.

2.4 The local authority is proactive in the promotion of the active offer of advocacy. Young people spoken with, and information contained within social care records, evidenced it gives regard to the rights of children to be offered independent professional advocacy. The recent creation of the Family Intervention Team and the introduction of a 'managed team' is valued by staff and viewed as enabling targeted preventative work to be undertaken with children and young people. This increased capacity should also enable staff to maintain a better focus on care and support planning.

2.5 Workforce well-being, recruitment and retention is a key priority for the local authority. It has identified and is acting on issues raised by staff regarding current pay scales and working conditions and is reviewing administrative support for teams, with the aim of stabilising and supporting the workforce. The local authority views this as business-critical, underpinning both its ability to meet its statutory responsibilities and to secure and sustain improvements. Some staff and managers told us how moving all teams into new premisses has improved staff morale, communication and joint working between teams and partner agencies.

2.6 The local authority is currently expanding its approach to recruitment and retention with a focus on 'grow your own' social workers through sponsorship of formal qualifications and the offer of practice learning opportunities for social work students studying at Glyndwr University. This is fundamental to helping address recruitment issues.

2.7 The local authority has taken action to increase capacity of front-line managers through the development of the assistant team manager role to strengthen supervision and operational managerial oversight. Most staff who completed our staff survey stated they were supported to do their job (89%), with 72% stating their workload was manageable.

2.8 Staff interviewed told us that they felt confident that there is a more open and ambitious culture in the local authority. Both staff and partner agencies praised the availability of senior managers. Staff told us they felt valued by managers who recognised and tried to manage their work pressures and cared about their wellbeing.

2.9 Work has commenced to strengthen quality assurance including regular performance meetings held with team managers and Head of Service to look at monitoring reports for each team. The local authority has introduced a quality assurance approach to identify areas for improvement and build on positive practice.

What needs to improve:

2.10 Some children and families were not allocated to a social worker in a timely way and too many children had experienced changes of social worker. This has an impact on both the family's willingness to engage with the service and the trust of children and families in professionals. The local authority must ensure a sufficient, qualified, and competent workforce to meet its statutory duties.

2.11 Social care records did not evidence that an allocated social worker routinely maintained regular contact /visits to children who had a care and support plan in place, in some example's visits were undertaken by duty workers or an unqualified worker. This may result in a lack of clarity regarding the purposefulness of the visit other than monitoring. Managers must ensure staff visiting families have a clear appreciation of the situation including presenting risks and that the purpose of the visit is meaningful to all involved and meets statutory requirements.

2.12 During the last inspection we identified the need to improve the quality of social work practice across all social work teams. The current workforce situation continues to place significant pressure on managers and staff who are working incredibly hard to meet demand and are often working long hours. We heard how some practitioners are concerned that high caseloads due to lack of staff impact on their ability to have the required oversight and focus on outcomes and safety of people. Whilst there was evidence of improving management oversight this remains variable. Managers must maintain effective oversight of workloads, workflow, and the quality of practice.

2.13 Workloads for some social workers affect their ability to spend focused time with children. Engagement with families lays the foundations for effective direct work which helps social workers understand children's views and experiences. Not all children have been helped to understand their life history and the rationale for decisions made about them. Social workers told us that they would always seek to support and work collaboratively with children and families, but demand is often outstripping the available resource. Managers must ensure caseloads are manageable; and managers and practitioners must have capacity to complete their work, form professional relationships and work in partnership with children and families.

2.14 Further work is required to help ensure people consistently feel listened to and feel they are treated with dignity and respect. We received 84 responses to our people survey (people receiving services or their representatives. 45% felt they were 'rarely' or 'never' listened to.

2.15 Opportunities for children's views to be consistently sought and appropriately recorded need to be strengthened. We found the quality of recording in capturing the voice of the child and their lived experience was too variable. The written records seen did not always include how the social worker used the information provided by the child to inform decision making and planning. The language used often reflecting organisational outcomes rather than those of the child, though it was positive managers had themselves identified this as an area for improvement.

2.16 Whilst some social care records were up to date, we still saw examples of gaps in recording that adversely impacted on the understanding of the child's journey. There were several instances identified where a social worker had left the local authority without completing a record of their visits and this had resulted in children and families having to repeat information as well as undermining understanding of risk resulting in a drift in progress. Managers must ensure all social care records are updated by staff prior to leaving the local authority.

2.17 Practitioners told us the need to constantly prioritise their work and the requirements of the electronic system adversely impacted on the timely completion of the required social care records. Practitioners need adequate opportunities and support to enable them to consistently record quality information in a timely manner. Management oversight systems must ensure effective monitoring of adherence to

policies and procedures and timescales in relation to statutory requirements and recording.

2.18 The quality of formal supervision across teams remains an area for improvement. Supervision is generally timely, team managers told us they have systems to monitor this. Further progress is needed to ensure that supervision provides social workers with time to reflect on the progress they are making for individual children, and also, to provide workers with the support and added direction needed in line with their experience. Supervision records do not always do justice to the quality of supervisory discussions reported by social workers, or the quality of work seen by inspectors.

2.19 Whilst it is positive that there is a comprehensive training programme in place, given the workforce pressures there is a risk training may not be prioritised by practitioners. Therefore, it is important systems are in place to ensure staff are suitably knowledgeable and skilled to undertake the tasks they perform, and they are provided with opportunities/capacity to undertake ongoing professional development, reflect, and embed learning.

3. Principle: Prevention

Strengths:

3.1 Senior leaders, managers and politicians have understood the importance of early help and preventative services. They recognise the significance of early intervention in ensuring children and families receive the support they need at an early stage before situations reach crisis point. We saw a focus on ensuring services are sufficient, sustainable and of consistent good quality to promote good outcomes for children and families

3.2 Decision-making in the Single Point of Access team (SPOA) is mostly prompt. Children's histories and previous local authority involvement are considered well by social workers when analysing initial information. Improvement was noted regarding the application of thresholds between early intervention and children's social care being more appropriately applied

3.3 Practitioners and managers spoke highly about the wealth and range of support services available to work with children and families in WCBC including the Wrexham Family Information Service (WFIS) and Together Achieving Change (TAC) as well as support from education especially the work undertaken by the Looked After Children's Education Coordinator. We saw examples of how preventative services had assisted families by supporting them with parenting, providing advice on practical strategies and relationships. Despite high level of demand, waiting lists are minimal and we were told services were generally able to respond promptly to meet need. In one example we saw how the outcomes for a young person and their family were directly improved through the intervention from the Multi Systemic Therapy Team which has been developed in partnership with Betsi Cadwaladr University Health Board (BCUHB) and Flintshire County Council.

3.4 Developments in the fostering service are a good example of the local authority responding creatively to some of the challenges it faces. The creation of three fostering HUBS, additional support workers, post, and face – to face support groups for foster carers demonstrates an innovative use of resources.

3.5 The number of looked after children remains stable. Performance indicators suggest the local authority is working hard to support children to remain within their families, where safe and appropriate. We heard about the local authority's focus and success in discharging care orders securing children's permanency plans through Special Guardianship Orders (SGOs) with carers supported by a dedicated team.

What needs to improve:

3.6 Whilst recognising the national challenges which are impacting on Wrexham CBC further work is required by senior managers to ensure their strategic and operational developments are focussed on ensuring people can receive the right service at the right time and in the right place as well as ensuring practitioners are consistently working to the 2014 Act.

3.7 The challenges in workforce recruitment and retention continues to impact on the local authority's ability to identify, assess and support as early as possible the families who require intervention. While the local authority was responding to immediate safeguarding needs, we found some delay and drift in some situations. This means people's outcomes are not always being met in a timely manner. For example, staff described their frustration that lack of staffing sometimes resulted in involvement being closed too soon resulting in children and families being re-referred for support.

3.8 Whilst the use of chronologies and genograms have improved since our last inspection, further work is required to ensure consistency and quality of this work. This is particularly important given the current turnover in the workforce and the importance of workers understanding the child's journey.

3.9 Practice continues to be inconsistent in assessments addressing all five areas of assessment set out in the 2014 Act. Whilst some good assessments were seen others contained limited information, were not sufficiently strength based and lacked clear professional analysis including presenting risks. The records did not routinely capture or demonstrate the level of professional curiosity needed to ensure the right level of ongoing intervention was identified to support the child and family

3.10 The 'What Matters' conversations although undertaken are not well recorded, the best seen included the child's own words. The practice described by staff was more reassuring however generally the language used in the written record was not child friendly. Staff told us that the electronic record templates are not conducive to capturing strength-based outcome focused information. They would welcome the opportunity to contribute to any future system changes.

4. Principle: Well-being

Strengths:

4.1 When concerns for children are referred to the SPOA Service, the response is timely, and we saw examples of appropriate decisions made to escalate reported issues to child protection investigations.

4.2 Strategy discussions and meetings are generally timely. Appropriate information is shared to inform decision-making. Subsequent child protection enquiries aid the decision-making about next steps. The template for the strategy meetings provides helpful prompts but the record does not always capture the rationale for decision making. A lack of police availability had created delays for some children but there is now agreement to pilot police and education staff within the SPOA.

4.3 The local authority's recent responses have included the introduction of a new threshold policy to support the consistency of prompt decision making and a new trauma informed, solution focused practice model. Senior managers are currently embedding internal performance and quality assurance systems to inform both current service delivery and continuous improvements. An increase in the capacity of Independent Safeguarding Reviewing Officers (ISRO's) will support this agenda.

4.4 The local authority is looking to improve the child's permanency journey and have appointed a new lead for early permanence with responsibility for reviewing policies, mapping, and tracking the journey of children and improving staff training, with the aim of achieving the more proportionate use of orders.

4.5 The local authority benefits from an increased establishment of confident and competent independent reviewing and safeguarding officers who positively challenge and escalate poor practice. The oversight of IRSO was evident on children's records. Team Managers spoke of appreciating the quality assurance afforded by the ISRO's. This was an area of improvement from the previous inspection.

4.6 Children's services practitioners understand their role and responsibilities within the organisation in contributing to safeguarding and promoting the well-being of children, but vacancies and workloads are compromising their capacity to achieve this.

What needs to improve:

4.7 Safeguarding practice following the initial intervention stage is often more fragmented with crucial elements of risk evaluation missing. The quality of risk assessment in children's services was variable. A re-focus on risk assessment is required to ensure a coherent and updated account of children's circumstances to underpin professional judgements.

4.8 The quality of care and support plans seen was variable. While most describe the reasons and triggers that led to the need for the plan, they did not always cover the

risks or maintain a sufficient focus on the child's experience. The plans seen were not always specific about what needed to change or what positive change looks like. This makes it difficult for parents and others to own the plan and understand what is expected of them and to assess progress within the child's timescales. Co-produced solutions were not currently evident in the social care records reviewed. We saw examples where children and families would have benefitted from practitioners undertaking more consistent critical thinking about the potential for harm, contingency plans, and the availability of wider support.

4.9 There was evidence ISROs were raising management alerts appropriately, particularly on cases were there was a gap in allocation. However, such issues were not always resolved in a timely way. Examples were raised regarding case conference reports not always being available to families prior to review protection conference, and also a lack of social work attendance at meetings that resulted in their cancellation creating the potential for plans to drift. Some concerns were identified that due to staffing issues the ISRO had become the most consistent professional for some children and families.

4.10 Work to improve recording practice in relation to sibling groups was yet to make a difference. The extensive blending of sibling information seen on the case records remains a significant impediment to identifying and understanding the unique characteristics, needs, strengths and experience of each child. The extent to which information is cut and pasted from one file to another meant that the individual voice of the child often became lost. In some examples, including child protection, we found an over reliance on the adults' views and needs. Managers must ensure recording policy and practice in relation to sibling groups needs is reviewed and improvements are made to ensure the strengths and or support of each child are easier to identify within the social care record.

5. Principle: Partnership and Integration

Strengths:

5.1 The response received from partner organisations in relation to children's services was mainly positive. Partners described recent improvements in culture within children's social services, with improved open communication, a willingness to listen and take ownership and address issues.

5.2 We heard how children services senior managers had been proactive in developing a threshold tool for decision making and in implementing escalation procedures so disagreements can be addressed immediately in the best interest of the child or young person.

5.3 Children in need of immediate protection receive a prompt response from social workers that helps to keep them safe. This is enhanced by the support from partners, who understand and apply thresholds appropriately.

What needs to improve:

5.4 Whilst there is a strong commitment to effective partnership, partners and providers described how staff turnover and a lack of social work continuity was still adversely impacting on communication with children's service and that this impeded effective care and support planning.

5.5 Engagement with health services continues to be a challenge in SPOA and accessing services for children and young people who need support with their mental health (CAMHS). We were informed of a three-year waiting list for an assessment with no alternative services available. We are aware these issues have been raised between both services Chief Executives for solutions.

Key findings and evidence: Adult services.

6. Principle: People

Strengths:

6.1 In adult services, for most people, their voices are heard and well reflected in care and support planning. The best care plans evidence clear recording which details the outcomes being worked towards and specialist social care assessments prompt a clear narrative about people's circumstances. Advocates are offered and available to assist people with important decisions effecting their lives. The staff survey strongly reflected the view that promoting the voice of adults and carers is a strength in WCBC.

6.2 We saw direct payments routinely offered and utilised positively, with examples of personal assistants (PA's) working appropriately with people whose needs were complex. A strength noted in our previous performance evaluation inspection in 2020 is the consideration of a person's mental capacity to make decisions. Positively, this continues to be embedded in practice and used at appropriate times to inform care planning decisions. Most people who responded to our survey said they were treated with respect by the local authority most of the time.

What needs to improve:

6.3 We saw frequent examples of people and carers experiencing significant and unacceptable delay when requesting support. Repeatedly we heard how the lack of domiciliary support is impacting on people's outcomes and the ability of the local authority to support people to remain or regain independence. People are unable to access the care services they require, and in some instances are moving into what are known as ''convalescence homes'' for an undetermined length of time until a care service to support them at home can be sourced. We heard an example of a person waiting over twelve months in a home for one care call per day which raises concerns about how lack of service provision is impacting on people's human rights, their ability to exercise choice, and how people's needs are reviewed.

6.4 Practitioners told us they are at times in the demoralising position of completing assessments fully in the knowledge of possibly not being able meet the outcome of providing the right care and support. They highlighted frustrations about the increasing reliance on residential placements or carers having to 'make do' until packages of care can be sourced. These findings were supported by our people survey which indicated people are aware of the lack of resource in the county. We recognise the work undertaken by the local authority to explore other options such as developing Micro commissioning models. However, the local authority must ensure strategic and operational developments are focussed on ensuring people are receiving the right care and support, in the right place and at the right time.

6.5 From the records reviewed it was difficult for us to identify unambiguous offers of carers assessments or support for carers. Practitioners recognised the pressure on carers made more acute by ongoing waiting lists and lack of domiciliary care, but it was unclear how this translated into offers of support for carers. An area for improvement in our previous inspection was meeting carers needs and explicitly offering carers assessments in line with statutory duties. The local authority has developed a lead carers role and this role must ensure this improvement is prioritised.

6.6 Senior managers must have a consistent clear line of sight on front line practice and workflow. We are not assured the system for rating the waiting lists by urgency and managerial focus alone can safely prioritise the vast number of people waiting for care or support in some areas of need, such as occupational therapy assessment. There needs to be capacity at a strategic level to develop a vision for adult services which can drive forward improvement informed by high quality data audits and quality assurance. Leaders must further develop quality assurance systems and performance information in adults as they have done in children's services.

7. Principle: Prevention

Strengths:

7.1 The broader area of prevention was not a particular focus for this inspection, but we did hear about initiatives to support people to live independently. We saw examples of Community Catalysts supporting the development of micro-enterprises across Wrexham. The aim is to increase the number and range of domiciliary care and support options available to people and carers through the creative use of direct payments. A further example is 'Bridging the Gap' (BTG) run by North East Wales Carers Information Service (NEWCIS) which provides a respite scheme providing carers with a short period of rest from their caring role. Whilst these initiatives are welcomed by people, we heard demand often outstrips capacity.

7.2 Community Resource Teams (CRT) provide integrated health and social care services to all people within a given locality. Practitioners told us about positive

experiences of working in partnership with CRT. We heard examples of swift responses to maximise people's independence and prevent hospital admissions.

7.3 Despite the high demand and waiting lists for occupational therapy assessments we saw some examples of the service's ability to respond promptly. This included provision of some equipment to promote people's independence enabling them to remain living in their own home for longer.

7.4 We heard about plans regarding the Wrexham Wellbeing Hub to enable access to health and social care information and services within a range of accessible facilities including three changing spaces facilities. The Hub which is due to be operational in the autumn is aiming to enable citizens and their informal carers improved access to services and facilities.

What needs to improve:

7.5 Timelines of occupational therapy assessments and support was an area identified as requiring improvement during our previous performance evaluation inspection in 2020. Despite examples of effective OT interventions, the provision of assessment and adaptations is sometimes significantly delayed and contrary to the wider preventative agenda. We saw how the reablement team has a waiting list and are oversubscribed. There is also limited access to community options for people who require more support such as 'step up beds' as these are being used for people who are unable to be supported in their own homes with packages of domiciliary care. Senior managers must ensure waiting lists are reduced and a sustainable model of delivery is embedded to assist people to live independently.

7.6 There is a backlog of annual reviews of people's needs which risks their changing needs not being addressed. The local authority must improve the timeliness of reviews of care and support plans as it is missing an opportunity to assure itself people are receiving the right care and support at the right time.

7.7 Lack of timely review may lead to an escalation in people's needs and more intensive support later. We read about a person contacting the department three times for an assessment since March and still awaiting allocation. Delay at initial contact was a theme identified in some of the responses to our people's survey. We heard from senior managers, there are plans to redesign the front door service with a focus on prevention. This will include developing the role of social care assessors to be able to undertake low level occupational therapy tasks. The local authority must ensure all practitioners undertaking assessments are suitably skilled, trained, and supported in undertaking assessments.

7.8 Many of the "what matters conversations" are driven by the need for referrals or processes to progress rather than genuine consideration of what is important to the person. For example, in one social care record it was noted 'what matters to me is an OT assessment' with little focus on the outcome to be achieved. The outcome of assessments and consideration of eligibility must be included in all social care

records, including where the provision of care and support will not be met by statutory services.

8. Principle: Well-being

Strengths:

8.1 We saw good examples of effective and timely response to adult safeguarding reports. This view was supported by key partners who told us about the openness, timeliness, and transparency of adult safeguarding. We heard the local authority welcomes suggestions for improvement and is always willing to work in partnership, to support any safeguarding actions needed. In promoting individual safety, we found people's wishes and feelings well represented, and a good balance of information which focused on a person's lived experiences.

8.2 Practitioners we spoke with said they felt that their well-being is supported by managers. They spoke of a change in management, which had been positive and how, despite the waiting lists, the pressure regarding allocations has eased, resulting in less strain on practitioners. They told us they are all aware of the pressures of the waiting list and the length of time people are waiting for support.

8.3 The local authority offers good mandatory or basic training for social workers, and career progression is actively encouraged. The local authority should consider offering complex or expert social work training more widely. Our staff survey results indicated strong agreement workloads are manageable, and practitioners feel well supported to undertake their roles. We heard from practitioners and managers alike about a sense of unity in the new building – barriers are now gone because people are not dispersed. 'Everyone being there is fantastic'.

What needs to improve:

8.4 Further work is required to ensure the five key elements of assessments are addressed, people's outcomes are captured, and eligibility is addressed in line with statutory guidance. Practitioners told us they are confident outcomes are being considered but this is not well reflected in the social care records seen. Some practice lacks clear analysis or critical thinking and fails to provide an evidence-based rationale for key decisions and actions. The local authority must assure itself all practitioners are working to the four principles of the 2014 Act, and this is consistently reflected in the assessments and the care and support plans.

8.5 Recruitment of occupational therapists and experienced social workers continues to be a challenge for the local authority. To address gaps in the longer term, in common with many other local authorities, WCBC is focusing on developing their existing workforce and offering professional qualifications to 'grow their own'. The

authority must ensure a sufficient, qualified, and competent workforce to meet its statutory duties.

8.6 From the small sample of supervision records reviewed in adult services, supervision is functional, and task orientated rather than reflective. There was a welcome focus on professional development using Continuing Professional Education and Learning (CPEL). The local authority must ensure improvements in the quality of supervision, management oversight and support.

9. Principle: Partnership

Strengths:

9.1 We saw good multiagency practice focused on joint working with different professionals at an operational level. There are regular multi-disciplinary forums to support decision making about practice. Where people's needs increase, we saw evidence of meetings with partners to consider Continuing Healthcare Care (CHC) funding to meet these needs. There are also regular contact with mental health services and close working with health professionals' particularly occupational therapists and physiotherapists to maximise people's independence.

9.2 Providers of adult domiciliary support services spoke positively of being involved through focus groups to discuss ways to address the challenges in recruitment and supporting change. One provider commented the local authority makes them feel valued as a company.

9.3 We heard positive feedback from partners in relation to the support they have received from adult safeguarding team during complex enquiries and investigations. One key partner commented **'**Wrexham have been supportive in relation to ensuring a streamlined approach in processes with North Wales Police and joint working with cases involving commissioned care homes.'

What needs to improve:

9.4 There is some evidence of practitioners developing professional working relationships with people built on co-operation and a shared understanding of what matters. However, the impact of the waiting lists is adding an additional challenge and negatively effects practitioners' abilities to build trusting relationships due to increasing pressures and demand.

9.5 The local authority's reduced ability to respond in a timely manner and provide appropriate interventions to support people is significantly impacting on people and carers outcomes. We heard from one partner how they experience delay accessing support from social workers and how cases are not allocated in a timely way. The local authority has

practitioners based in hospitals who are committed to supporting wards with safe and timely discharges. However , Hospital discharge is a challenging area and managers must continue to ensure the timeliness of referrals from the wards, with sufficient information which enables practitioners to respond in a safe manner to peoples ongoing needs

9.6 Despite some positive practice, partnerships at individual, operational and strategic levels need further development. It is now key for strategic partners to work together to address the ongoing challenges in particular exploring what more can be done together to reduce the number of people waiting for assessments and services. Leaders must find solutions to areas of improvement identified and deliver more seamless services for people in Wrexham.

10. Next Steps

10.1 CIW expect Wrexham County Borough Council to consider the areas identified for improvement and take appropriate action to address and improve these. CIW will monitor progress through its ongoing performance review activity with the local authority.

Methodology

11. Fieldwork

11.1 Most inspection evidence was gathered by reviewing the experiences of people through review and tracking of their social care record. We reviewed over sixty social care records and tracked a minimum of twenty.

11.2 Tracking a person's social care record includes having conversations with the person in receipt of social care services, their family or carers, key worker, the key worker's manager, and other professionals involved.

11.3 We interviewed a range of local authority employees and partner agencies.

12. Acknowledgements

12.1 CIW would like to thank staff, partners and people who gave their time and contributed to this inspection.