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

Inspection of Adult Services
Powys County Council

May 2018

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

 WG34853 Digital ISBN 978-1-78937-159-8

Contents

Introduction

Care Inspectorate Wales' (CIW) approach to inspection, engagement and performance review of local authority social services reflects the requirements of the Social Services and Well-Being (Wales) Act 2014 (SSWBA) associated with national well-being outcomes and quality standards issued in codes of practice by Welsh Government. Our inspection methodology emphasises engagement with people[1], including a clear focus on the extent to which services respect people's dignity, promote independence and are provided to Welsh-speaking people in their language of choice.

CIW undertook an inspection of adult social services in Powys County Council (PCC) during January 2018. This inspection was prompted by concerns raised by service users, members of the public, Assembly Members and issues we identified in our inspection of Powys children's services during July 2017.

This inspection looked at how adults, their families and carers access information advice and assistance services and are supported by care and support services. We focused on the extent to which people were signposted or diverted into early help or preventative provision and are supported to stay safe and maintain well-being and independence. We also focused on people's pathways into care and support services, with a specific focus on arrangements for adults at risk of harm or abuse.

Inspectors evaluated the quality of practice, decision making and multi-agency work in respect of the contribution made to the quality of outcomes achieved for people in need of assistance, care and support and/or protection.

This inspection also focused on determining whether the arrangements for leadership, management and governance provide a clear framework for effective safeguarding and service delivery in respect of people in need of help, care, support and/or protection.

The methodology (see appendix 1) used to undertake the inspection included a review of relevant policies, procedures and performance information; case file reviews; and interviews and focus groups with staff, managers, professionals from partner agencies and elected members. Where possible, inspectors talked to service users, their families and carers.

Inspectors were pleased to note senior managers accept our findings and have committed themselves to achieving the necessary improvements.

[1] The use of the term people throughout this report denotes variously and inclusively reference to adult service users (including potential and ex-service users) and their families and/or their carers.

Overview

We saw evidence that some people received good care and support from PCC, high staff morale and a commitment to improving services accompanied by an increase in resources. Urgent safeguarding referrals were dealt with swiftly and effectively. We also saw unacceptable inconsistencies in safeguarding practice and delays in people's journeys from first contacting PCC for assistance to receiving care, support or protection. These delays and inconsistencies have led CIW to have significant concerns about the ability of the local authority to ensure people living in Powys receive the care, support or protection they need in order to maximise their well-being and achieve good outcomes. Substantial improvements are required.

CIW's critical report into the local authority's children's services in July 2017 raised a number of wider issues about the leadership, management and governance arrangements of PCC. An Improvement Board was established with assistance from Welsh Government and the Welsh Local Government Association to support and monitor the progress of improvement. Prior to our inspection fieldwork, PCC had proactively sought to include its adult services improvement plan into the remit of the Improvement Board and had instigated changes to the membership and remit of this board. Subsequently an independently chaired Improvement and Assurance Board has been established with a revised terms of reference to oversee and coordinate the delivery of improvement at a corporate level and across social services.

Recent developments (April 2018) such as the broadened remit of the Improvement and Assurance Board, coupled with the appointment of a permanent statutory director of social services, should mitigate the risks inherent in the issues highlighted in this inspection report, and drive the improvements required to ensure positive outcomes for adults in need of care or support and their carers in Powys.

Access

The high number of abandoned calls by people attempting to contact Powys People Direct (PPD) means a significant number of people do not get consistent access to timely information, advice and support. Opportunities for people to have their voices heard are being missed, as are opportunities to prevent the need for further care and support.

Oversight and management of process and procedures are not sufficiently robust to support efficient work flows. Repeat calls from the public and partners and long waiting times to have calls answered are creating frustration for many people. Incomplete and inappropriate referrals from professionals are creating extra work for PPD staff. This is causing an avoidable drain on resources and preventing the service from reaching its full potential.

PPD has been under-resourced for a lengthy period. Although vacancies have recently been filled, including the crucial specialist social worker post, the level of experience and stability within the team remains fragile. As a service PPD is insufficiently understood, regarded and embedded into the wider health and social care system.

Assessment

Not all geographic areas of Powys have suitable arrangements in place for assessing need and determining people's eligibility for care and support or for assessing the support needs of carers. This means some people are waiting too long for assessment and support. Some of these delays are very significant. They have a negative impact on people, their carers and families and create a burden on other parts of the social and healthcare system.

Some people in Powys benefit from proportionate and strengths based assessments of their care and support needs. There was also evidence of involvement of people and their carers and families in the co-production of some assessments.

Overall we found insufficient recognition of the role managers need to perform in managing quality and workflows. This contributed to unacceptable delays both in allocation of work and between allocation and commencement of work. This means opportunities to prevent escalation of need are being missed, and some people are left more vulnerable than they need to be.

Care & support

There are many good quality care and support plans in Powys; most demonstrate positive engagement with people. Some could be improved with a renewed focus on strengths as outlined in the SSWBA.

We found the requirement to undertake reviews is often missed and this has a direct impact on the ability of people to have their voices heard and ensure services offered are a good use of resources.

Too many people were waiting an excessive amount of time for care and support to begin. Delays were having a negative effect on people and requirements under the SSWBA to promote independence, choice and well-being were not being met. The delays were also having a negative impact on other services in the health and social care system. Timely opportunities were not always taken to help people build upon their own strengths and capabilities and develop their ability to overcome barriers.

There was some noteworthy co-operation between frontline health and social care staff and a range of voluntary sector and community groups in Powys that made a good contribution to the health and wellbeing of residents in the county. However, it is not yet clear how the local authority's transformation programme intends to address current gaps in care and support services, or what plans were in place to ensure the voluntary and community sector can become more sustainable.

Safeguarding

Safeguarding referrals that explicitly articulated and clearly identified risks received a robust, timely response. In these cases there was evidence of intelligent working and well written comprehensive record keeping.

However, not all safeguarding referrals received a timely, proportionate and where appropriate well coordinated multi-agency response. There was a backlog of safeguarding work at screening and enquiry stages and an insufficient focus on multi-agency safeguarding discussions and meetings.

Adult safeguarding procedures were not sufficiently well embedded in Powys. This meant some vulnerable people did not always receive timely support nor gain the benefit of wider multi-agency professional experience from those who were best placed to support them and ensure their voices are heard.

Management oversight of the quality and timeliness of safeguarding was insufficiently robust. Data presented by managers was confused and incomplete and did not demonstrate how the service was meeting the requirements of the SSWBA.

Leadership, management & governance

Senior managers and elected members held a shared vision for improving safeguarding and for promoting services that supported people to lead independent lifestyles. They had also sought to strengthen commitment to effectively promote people's safety and wellbeing through increased investment in adult services. Delivery of this vision will require sustained corporate and political support to secure the improvements required.

Neither performance management arrangements nor quality assurance mechanisms were sufficiently well embedded to provide a thorough understanding of the difference that help, care and support and/or protection was making for people. Senior leaders need to improve their knowledge about performance to enable them to discharge their responsibilities more effectively.

High level plans, including joint plans, need to be translated into tangible action plans for the delivery of good quality and well integrated services. Strategies should be better disseminated throughout the workforce and more effectively implemented alongside partners. The authority needs to build on the relationships it has with partner agencies to ensure shared ownership of the direction for adult services, and also the operational drive needed to improve services and outcomes for people.

Recruitment and retention of the adult social services workforce presents some significant challenges. However, inspectors noted that advertisements to fill operational vacancies had been placed and the commitment of staff who have shown resilience and professionalism whilst coping with many changes. Managers, including senior managers, were seen as accessible but there needs to be stronger oversight of practice, more frequent and better quality staff supervision.

Recommendations

The recommendations below identify the key areas where post-inspection improvement and development work should be focused. They are intended to assist Powys County Council and its partners in their continuing improvement.

As a priority:

1. Senior leaders within the local authority must continue to provide strong political and corporate support for adult services to ensure service improvements are prioritised and sustained with pace.

2. The local authority must ensure all safeguarding enquiries are undertaken within statutory timescales to ensure all adults at risk of harm or abuse are adequately protected.

3. An assurance mechanism should be implemented immediately to ensure a clear management oversight and understanding of demand, capacity and prioritisation of workflow within the adult safeguarding system.

4. The local authority should strengthen the existing adult services improvement plan to ensure specific, clear and time-bound actions to improve access arrangements. This should include objectives to ensure sufficient management and staff capacity, contingency and expertise is in place to manage demand and to support good quality and timely decision making.

5. The local authority should urgently improve systems to ensure the management and prioritisation of allocation, assessment and service delivery to prevent delays in people receiving services.

6. A robust workforce strategy should be produced to include short, medium and long term plans for recruitment and retention of the adult services workforce. Permanent appointments are required in key posts to provide resilience and stability within the service.

Over the next 12 months:

7. Senior managers should refresh and re-invigorate their commitment to regional and local safeguarding arrangements.

8. Effective, multi-agency quality assurance systems, education and training arrangements should be established to ensure the quality of referrals to PPD are consistently aligned with the requirements of the SSWBA.

9. The quality of assessments and care plans must be improved to ensure they are consistently of a good quality, with a clear focus on well-being outcomes, risks, and risk mitigation ensuring clear timescales and accountabilities for actions.

10. The local authority should improve performance and/or contract management arrangements to inform their evaluation of the effectiveness of commissioned services to ensure people referred to community support services are not subject to drift and delay.

11. The quality, consistency and timeliness of record keeping must be improved; all staff and managers must ensure records are of good quality, up to date and systematically stored.

12. Performance management and quality assurance arrangements, including scrutiny of service demand and routine auditing of the quality of practice, needs to be embedded so that elected members and managers at all levels have timely, appropriate and accurate performance and quality information.

13. Senior managers and elected members should maintain an up-to-date understanding of the complexities and risks involved in delivering adult services, underpinned by accurate, timely performance management information, to assure themselves, partners, staff and communities that their responsibilities are discharged to maximum effect.

14. The local authority, jointly with partners, should take steps to ensure the speed of transformation is accelerated and undertaken in a way that fully engages staff and supports the meaningful involvement of service users and carers.

15. The local authority must strengthen the oversight of their response to complaints to improve reporting and analysis and ensure there is a mechanism to capture lessons learned.

16. Senior managers should take steps to improve the frequency and consistency of supervision for front line staff.

Next steps

CIW will expect PCC to review and revise the improvement plan for adult social services in response to this report's recommendations within 20 days of publication. The improvement plan will be monitored during our programme of inspection engagement and performance review throughout 2018/19.

Due to the significant concerns identified in this inspection, consideration will be given to undertaking a re-inspection of Powys adult services within 12–18 months from the publication of this report.

1. Access arrangements

What we expect to see
The local authority works with partner organisations to provide timely access to information, advice and assistance which enables people and their carers to determine the outcomes they wish to achieve and consider how best to manage their wellbeing. Effective signposting and referring provides people with choice about support and services available in their locality, particularly preventative services. Information about eligibility for care and support services is available. Arrangements are effective in delaying or preventing the need for care and support. The service listens to people, it begins with and maintains a focus on what matters to them. Access arrangements to statutory social services provision are understood by partners and the people engaging with the service and are operating effectively.

Context

Powys People Direct (PPD) has been the single point of access (SPOA) for adult services since April 2015. The team is geographically centralised in Llandrindod Wells. PPD performs a number of key functions including accepting initial enquires and referrals; providing a range of local information and advice to callers; and connecting callers to teams across the service.

PPD is managed by a senior manager who also has responsibility for safeguarding arrangements across the county. The team consists of 12 contact officers, who have relevant experience in housing, advice services and community support. The contact officers are supported by a team leader, a post that was newly created in October 2017. There is a specialist social worker post in the team which has been vacant for several months. Three (2.5 full time equivalent) safeguarding designated lead managers (DLM) are situated in the same room as the contact officers.

Summary of findings

1.1. People who need information, advice and assistance can contact PPD by telephone, email or post. The local authority website also provides the same information about adult services as well as signposting people to information, advice and support from other agencies, including the third sector. All information is available bilingually and telephone callers are offered a service in Welsh or English prior to being connected. There are no specific arrangements in place to support enquirers/referrers with sensory loss.

1.2. Between October and December 2017 the average waiting time for calls to PPD to be answered varied between 3.33 and 4.45 minutes. Many callers waited significantly longer. During our observation of PPD, inspectors saw calls go unanswered for as long as 20–25 minutes. We were also told by carers and partners that they sometimes have to wait 20 minutes to have their calls answered. Many partners expressed frustration with the difficulties and time delays they experienced when attempting to discuss referrals with

PPD. Data held by the authority indicates that a high proportion of calls were abandoned.

Table 1: Proportion of incoming call to PPD abandoned Oct – Dec 2017

	Incoming calls	Abandoned calls	% abandoned calls
Oct 2017	3422	943	27.6
Nov 2017	3496	1314	37.6
Dec 2017	2411	1053	43.8

1.3. The lack of capacity within the service to handle new calls and take referrals indicates people are not always getting timely access to the information, advice and assistance they need. Whilst we found no evidence to suggest otherwise, we cannot rule out that opportunities to protect vulnerable individuals are also being missed.

1.4. PPD staff told us they receive a high proportion of repeat callers because the enquirer/referrer has not received a response from the team or service they have been forwarded to. This was borne out by partner agencies who also expressed frustration that they did not receive feedback about the referrals they had made and were often unaware how, if at all, these had been progressed.

1.5. Duplication of work uses up resources available in the team and reduces capacity to take calls, undertake meaningful conversations and produce necessary case-recording. Lengthy delays in responding to calls also created stress and anger for people and partners attempting to access information or services, and increased their frustration with staff when they did eventually make contact.

1.6. The generic referral form on the website is lengthy, cumbersome and difficult to navigate; it is particularly unsuitable for professionals who, as a consequence, tell us they make more telephone referrals than they need to. The authority acknowledged the need to redesign a version of the referral form that is both more accessible and fit for purpose for all users.

1.7. The full impact of the poor telephone response rates and the unwieldiness of the online form on people attempting to access information and/or services is impossible to objectively quantify. At best a significant amount of people's time is wasted; at worst it is possible that potential safeguarding concerns are not responded to.

1.8. Although contact officer vacancies have recently been filled, the proportion of inexperienced staff amongst this cohort remains high. Also at the time of our field work there was significant lack of experienced social work capacity within PPD. The specialist social work post remained vacant. There had been some contingency cover for the specialist social worker vacancy, but these arrangements have been unsatisfactory and inconsistent.

1.9. We found there was inadequate social work expertise available within the team to ensure contact officers received support to make rapid evaluations of complex referrals, or to make timely responses to referrers. The limited support and direction for contact officers has also led to referral information being forwarded to functional teams which lacked detail and was variable in quality.

1.10. Despite on-going workload pressures, contact officers told us their morale is high. Contact officers have received consistent training to support them to undertake their role. Contact officers have received safeguarding training and the senior manager is confident in their capability to recognise safeguarding referrals and to respond appropriately by handing these off rapidly to the DLMs for on-going enquiries.

1.11. Some contact officers had received limited “what matters conversations” training and some PPD staff could articulate a good understanding of the requirement to elicit people’s desired outcomes. However, they also told us the pressure of calls waiting often prevents them spending sufficient time undertaking “what matters conversations”. This practice is, as yet, insufficiently well-embedded in PPD.

1.12. It is recognised by the senior manager that because of the pressures on the service, contact officers have not always received supervision to a consistently high standard. Nevertheless, contact officers tell us they are well supported by their team leader who acknowledges deficits within the service and is keen to make improvements.

1.13. PPD staff and managers told us the quality of many referrals received from other partners is poor. They cite a lack of appreciation and understanding from partners of the SSWBA. As a consequence contact officers spend excessive time verifying and clarifying information which reduces their capacity to undertake key activities more directly aimed at supporting people.

1.14. Contact officers confidently use directories and online resources to support sharing information and signposting people to relevant services. However, we heard from staff in locality teams that due to the centralised nature of PPD, contact officers are often less familiar with local provision and this can be detrimental to the advice they are able to offer people who could benefit from access to relevant provision within their own communities. To address this, community connectors have been jointly commissioned by PCC and Powys Teaching Health Board (PTHB), employed by Powys Association of Voluntary Services (PAVO) to work across the county to assist people to access local facilities within their own communities. As this service gathers momentum, it is anticipated more people will benefit from their local knowledge and expertise.

1.15. It was positive that the authority provides and commissions a range of preventative services including reablement services, befriending, transport,

respite and self-help services. However, inspectors were concerned about inconsistent capacity and contingency planning to ensure community based services were consistently able to meet demand and complexity of need. People were not reliably being offered timely assistance and as a result opportunities to support reablement and to maintain independence were too often missed.

1.16. Evidence from complaints and testimony from partners, service users and carers indicated that delays in access arrangements were contributing to the distress felt by people at times when they are at their most vulnerable. These delays also represent a missed opportunity on the part of the adult health and social care sector to reduce further demands on services.

1.17. Overall, we found management oversight of the quality and timeliness of access arrangements was insufficiently robust in terms of challenge and quality control. We did not see evidence of escalation of the issues to senior managers nor did we see pro-active attempts by senior managers to introduce effective contingencies to alleviate pressures within PPD.

1.18. We did find strengths in PPD such as the dedication and enthusiasm of the workforce who despite on-going pressure continued to provide to the best of their ability. However, as PPD is the “front door” to Powys adult services it is of concern to inspectors that it has been operating with significant deficits for a lengthy period. We recognised that PCC had recently (January 2018) commissioned and internal review of the PPD service and senior managers acknowledged awareness of many of our findings. We are concerned by the lack of dedicated, clear and time-bound objectives within the adult services improvement plan with respect to access arrangements and the apparent lack of urgency from senior management to address the problems.

2. Assessment

What we expect to see
All people entitled to an assessment of their care and support needs receive one in their preferred language. All carers who appear to have support needs are offered carers needs assessment, regardless of the type of care provided, their financial means or the level of support that may be needed. People experience a timely assessment of their needs which promotes their independence and ability to exercise choice. Assessments have regard to the personal outcomes and views, wishes and feelings of the person subject of the assessment and that of relevant others. This is in so far as is reasonably practicable and consistent with promoting their wellbeing and safety and that of others. Assessments provide a clear understanding of what will happen next and result in a plan relevant to identified needs. Recommended actions, designed to achieve the outcomes that matter to people, are identified and include all those that can be met through community based or preventative services as well as specialist provision.

Context

Assessments of care and support needs and support for carers are undertaken by staff within functional teams (Older People, Disability and Mental Health) based at five main locations across the county. Requests for assessment are forwarded to the teams from PPD and work is allocated from within the functional teams. The majority of assessments of care and support needs and support for carers are undertaken by social workers, although this work is supplemented and supported by specialist workers such as Occupational Therapists (OT) and Approved Mental Health Professionals (AMHP).

Summary of findings

2.1. We found a mixed picture in respect of the quality of referral information received from PPD. Some referrals assisted prioritisation and allocation of assessment work; others did not. PPD contact officers told us they did not always have time to liaise with partners to improve on referral information initially provided. Inspectors noted personal information as required by the national minimum core data set[2] was populated in the vast majority of case files reviewed.

2.2. Despite the availability of clear process guidance we found variation in practice for transferring work between PPD and functional teams. We were told about poor communication between teams with some information from enquiries being received piecemeal by team managers rather than as a consolidated referral.

[2] Common baseline for information collection for all assessments across Wales: *Code of Practice on assessing the needs of individuals*, issued under Section 145 of the Social Services and Well-being (Wales) Act 2014

2.3. Amongst other factors, such as demand and capacity issues in PPD, interrupted work flow was often attributed to staff and managers' differing understanding of methods for entering referrals/allocations onto and retrieving them from the Welsh Community Care Information System (WCCIS). Staff told us training in the use of WCCIS had been incomplete and much of their learning was through trial and error. Some new staff had not received training on WCCIS at all. Our review of case-files evidenced many inconsistencies in the use of WCCIS.

2.4. We found unacceptable delays in the allocation of work and also between allocation and commencement of assessment. Lengths of delays varied considerably across Powys. While some teams provided both timely allocation and assessment, others did not.

2.5. We saw many cases where people waited over one month for an assessment and a significant minority of people who waited much longer than this. We have particular concerns about delays in allocation for mental health and sensory loss services as well as delays in commencing assessments by services for older people and occupational therapy in the south of the county. Delays such as these can have a severe impact on people's well-being, independence and/or safety.

2.6. We did not see any evidence within case files that people were supported or signposted to other services during these delays. Neither were we reassured that waiting times were always informed by a systematic approach to prioritisation. We saw little evidence of the constructive use of available performance information to support management oversight and prioritisation of waiting times.

2.7. Delays in allocation of work in functional teams also created additional pressure on PPD as people and professionals chase-up/re-refer. Staff from functional teams informed us they attempt to keep people informed about delays by letter and phone calls once allocation has taken place, but due to pressure of work this is not always possible.

2.8. Last year, aware of the backlog of assessments, senior managers commissioned a private agency to undertake some assessments. Whilst this had limited impact in addressing people's need for care and support, managers drew on learning and further work was commissioned with clearer expectations leading to improved effectiveness. Nevertheless, some of the commissioned assessments were not strengths-based and required more work to comply with the SSWBA.

2.9. Inspectors noted proposed changes to the service structure, including the introduction of assistant team managers and proposals for increased social work staffing in older people's teams, with the purpose of building resilience and providing additional support. However, inspectors question the lack of pace with which these changes are being progressed and urge rapid completion of the recruitment process to fill vacant posts across the county.

2.10. Generally we found staff undertaking assessment work had been appropriately trained and were confident in their ability to recognise and take appropriate action in respect of safeguarding issues. Most staff had received an introduction to the SSWBA and a significant cohort received “what matters conversations” or ”progression model” training. Some staff had also undertaken the ”what matters train the trainer” course and there is a plan to use these staff to cascade this training more widely.

2.11. The majority of staff we spoke to could clearly articulate differences in the way they approached assessment now compared to before implementation of the SSWBA. Team managers told us they had observed an overall improvement in quality of assessments since the implementation of this training.

2.12. We found the quality of assessments was variable. We saw some good assessments that were proportionate, strength-based and demonstrated engagement with people. We also saw evidence of ”what matters conversations” having taken place with a focus on people being supported to identify their own well-being outcomes. Generally, the service users we spoke to said they had felt involved in the assessment process.

2.13. Finalised assessment documents are not routinely shared with people. Inspectors noted this is more likely to happen in teams where there is effective business support for social workers in place.

2.14. We also saw evidence of some positive joint working between health and social care staff to support assessments; for example reablement teams, development of the virtual wards scheme and multi-agency working at hospitals in Welshpool and Shrewsbury.

2.15. We found some assessments would have benefitted from a more explicit risk analysis, clearer contingency planning and a more overt explanation of eligibility decisions. Evidence from our case file review also suggests assessment of service users’ finances alongside an explanation of relevant service charges was not always carried out when it should have been.

2.16. We also found a variable approach to undertaking carers’ assessments. Some assessors missed the opportunity to identify family members as carers and did not offer assessments. We saw one example of a failure to identify a young carer. Some carers told us their perception was that social workers were too busy and did not have capacity to undertake an assessment of their needs. Others said they felt they needed to chase and fight hard for their own support needs to be recognised.

2.17. Where assessments of the person cared for did take account of carers, they did not result in offers of support for carers often enough. The impact of this being in some cases carers became unwell themselves and additional demands were made on services as a result.

2.18. The quality of case recording throughout the assessment process was inadequate to identify how the case was being progressed. In a small number of case files, assessments were incorrectly stored on WCCIS. Consequently, duty staff or new staff taking over a case were hampered from swiftly understanding needs and risks. This was of particular significance for some teams given the high level of churn within their workforce.

2.19. Overall, we found management oversight of the quality and timeliness of assessment was insufficiently robust. Whilst we did see some evidence in individual case notes of oversight, this was limited and lacked rigour in respect of challenge and quality control.

3. Care & support

What we expect to see
People experience timely and effective multi-agency care, support, help and protection to meet assessed need. People using services are supported through co produced care and support plans which promote their independence, choice and wellbeing, help keep them safe and reflect the outcomes that are important to them. People are helped to build on their strengths and capabilities and develop their ability to overcome barriers to wellbeing.

Context

Care and support for adults and support for carers is provided by staff based within functional teams (Older People, Disability and Mental Health) located at five main sites across the county. The Reablement service is managed as a countywide provision with service delivery organised from four locations across the county.

The local authority commissions domiciliary care services from various providers across the county with approximately 9% provided by the local authority's in-house service. Numerous, often very local, voluntary groups and services around the county provide support to people.

Summary of findings

3.1. In the majority of cases we reviewed, where a care and support plan was in place, plans were good quality. Most plans reflected people's preferences and demonstrated their engagement in the plan's production. Most service users and carers we spoke to told us they felt involved in planning, and the services they received were appropriate and promoted their safety and well-being.

3.2. Contrary to the aims of the SSWBA, not all plans were sufficiently strengths-based and many focused disproportionately on service user needs at the expense of well-being outcomes to be achieved. We recognise this is a difficult balance to achieve and inspectors saw some examples of care and support services being effectively delivered with identified outcomes within plans being met.

3.3. Service users were not always provided with copies of their care plans and their agreement of their plans was not generally recorded.

3.4. We also found areas of the county where there are delays of several weeks before assessments translate into the delivery of care and support. On one date in January 2018 there were 46 people in the community who had been assessed as needing either reablement or domiciliary care services, all of whom were waiting for their service to commence. A further 12 people were delayed in hospital waiting for a home care package to commence. Frequently the impact of these delays has a significant negative impact on service users, whose health and well-being may deteriorate, and on their

families who are caused undue stress that may impact on their own wellbeing.

3.5. Whilst we saw some good evidence of responsive reassessment or reviews of care plans in light of changing circumstances, we did not see evidence of timely scheduled reviews. Neither did we see evidence that outcomes were always updated when a review had taken place. Staff told us that whilst challenging generally they found their caseloads manageable although this often did not include sufficient capacity to review and update care plans as frequently as required. .

3.6. We found only limited systematic management oversight and prioritisation of waiting lists and work load. Despite team managers' having the facility to review the volume of people waiting for care packages on their desktop dashboards, this management responsibility was not seen as a priority. The reason given was insufficient time and insufficient staff to allocate work to.

3.7. We did not see evidence of team managers escalating concerns about lack of capacity, or senior managers pro-actively requesting reports about pressure points within the system. This lack of information exchange limited capacity to rapidly mitigate immediate difficulties, and impacts negatively on planning and commissioning future service provision.

3.8. Many partners and service providers described difficulties in contacting and communicating with social workers and other staff either directly or via PPD. Some staff were reported to be unresponsive in respect of confirming care and support arrangements for people. The lack of response was often attributed to the demands of high workloads and technology rather than lack of commitment, but nevertheless poor communication between partners too often resulted in further delays in people receiving care and support.

3.9. Equally we found evidence of good communication and co-operation between health and social care staff. Examples were given of joint work which improved communication between professionals and outcomes for people, such as direct telephone consultations between clinical lead nurses and service managers; teleconferences held three times a week to share health and social care information concerning reablement allocations; and a pilot integrated health and social care team in the south of the county. Learning from these good examples needs to be shared more widely across health and social care services in the county.

3.10. Despite having staff designated carers' champions within functional teams, we saw little evidence of consistent support for carers. Feedback from carers suggested access to and regularity of support was very much dependent on the individual knowledge, commitment and experience of workers and was inconsistent as a consequence.

3.11. Some carers were benefiting from support offered by Credu, the main organisation commissioned by the authority to support carers. The Credu service was described as very good by a number of carers we spoke to. We

also observed a Credu worker make good use of a “what matters conversation” to help resolve a challenging situation that arose during the inspection.

3.12. We saw significant take-up of Direct Payments with some positive examples of people using the opportunity to tailor care and support to meet their specific circumstances. We were told there has been an improvement in the delivery of Direct Payments.

3.13. We found some evidence of wider community support services, often provided locally by the third sector, making a very positive difference to people’s lives. However these services, whilst robust in some parts of the county, were more fragmented in others. People told us in some areas community services are just not available or operational when they are needed. It was acknowledged by community connectors that now their service is established there is scope for further work to address gaps in services. More consistent and tailored support is required to enable voluntary and community services to reach a point where they become comprehensive and sustainable.

3.14. The authority would benefit from a more systematic approach to quality assurance and monitoring arrangements of community services that includes the quality of decision making and feedback from people using services. There was an absence of good quality performance information to assist the authority to make informed judgements about the effectiveness of commissioned and “in-house” services, or to evaluate the value for money each were providing.

3.15. Third sector providers were generally positive about the support they received from senior managers. However, they did comment on their frustration with the lack of timely communication about future funding arrangements to enable them to manage their staffing commitments and their budgets effectively.

3.16. Overall, we found management oversight of the quality and timeliness of care planning was insufficiently robust in terms of challenge and quality control. Whilst we did see some limited evidence in case notes of discussions between managers and practitioners, these did not provide assurance of adequate oversight across caseloads.

3.17. Along with workforce issues particularly in the south of the county, many staff and managers cited the rurality of the county as the main cause of the limited capacity of some services; attitudes were often stoic and accepting of these limitations. Whilst these are clearly challenging and important factors which may impede service delivery, they are not unique to Powys. More innovative solutions, contingency planning and workforce resilience are urgently required to alleviate the pressures on services.

4. Safeguarding

What we expect to see
Effective local safeguarding strategies combine both preventative and protective elements. Where people are experiencing or are at risk of abuse, neglect or harm, they receive timely, proportionate and well-coordinated multi-agency responses. Actions arising from risk management or protection plans are successful in reducing actual or potential risk. People are not left unsupported in unsafe or dangerous environments. Policies and procedures in relation to safeguarding and protection are well understood and embedded and contribute to a timely and proportionate response to presenting concerns. The local authority and its partners sponsor a learning culture where change to and improvement of professional performance and agency behaviours can be explored in an open and constructive manner.

Context

Powys adult protection team consists of 2.5 DLMs based in PPD alongside contact officers, specialist social worker and appointeeship/deputyship officer and deprivation of liberty (DoLS) coordinator. All staff report to the contact and safeguarding senior manager. Team managers and senior practitioners in functional teams also undertake the DLM role on an “as and when” basis. The role of the adult protection team is to manage and oversee the majority of safeguarding referrals.

PCC is a member of Collaborative Working and Maintaining Partnership in Adult Safeguarding (CWMPAS), the Mid and West Wales Regional Safeguarding Adults Board.

Summary of findings

4.1. All safeguarding referrals are routed through PPD. The majority of referrals come from professionals and/or providers, using a pre-designated format (VA1); these are received by contact officers and are passed immediately to the adult protection team. Concerns are also reported by the public.

4.2. Where there were obvious indicators of risk, contact officers passed these immediately to the adult protection team for a response. However, when risks were less obvious, contact officers were less confident and needed more support. Although contact officers reported that generally DLMs were readily accessible to provide such support, in their absence this support has not been consistently available to them. This has been exacerbated by the specialist social worker vacancy.

4.3. We were reassured that urgent and obvious referrals received a timely and robust response but some safeguarding decisions are not timely. We did not see evidence of a systematic process for allocation of safeguarding work, either within the adult protection team or throughout the dispersed cohort of DLMs. We found delays of up to a month between a referral being made and action being taken. More work is required before we can have confidence

that between receipt of referral and appropriate response all adults at risk are adequately protected.

4.4. We were told that both an increase in volume of inappropriate/incomplete referrals and lack of clarity of process was hindering timely management of safeguarding referrals. We found the lack of clarity around screening of referrals in PPD, and lack of capacity within other social care teams to undertake the DLM role, also contributed to delays.

4.5. Feedback was not routinely provided to partners who made safeguarding referrals. Partners chasing safeguarding referrals created further demand on PPD.

4.6. We were not confident that strategy discussions and meetings were always timely nor that all relevant partners were involved. However, from the small sample of meetings we reviewed, we found the standard of recording was good and relevant actions shared with those involved. We also saw examples of good timely work by a DLM which successfully addressed repeat episodes of poor care that was putting a service user at risk.

4.7. The adult protection team benefits from the experience of a range of professionals. However, there is a lack of professional social work perspective and operational social work experience in the team. This means responses can be too narrow in focus and opportunities to improve situations for people missed.

4.8. Understanding the difference between incidents of poor care and actual or potential risk of harm or abuse was not sufficiently developed amongst partners, providers or consistently within the adult protection team. As a result, inappropriate referrals were placing additional demands on the service. Inspectors recognised the contribution that the current development of an “Adults At Risk Threshold” document led by the regional safeguarding board should have on alleviating these issues. Nevertheless, more work to educate partners and providers to improve their understanding of safeguarding thresholds would have a positive impact on demand.

4.9. We found the adult protection team somewhat detached from other teams. The lack of a robust process for notifying and involving case holders in safeguarding referrals is to the detriment of the integrity of the safeguarding process and the detriment of the service user who should be receiving timely support from a care coordinator who knows them best.

4.10. Where there were safeguarding concerns about an individual without a current allocated care coordinator (review only), the way in which WCCIS raised electronic alerts was not effective and therefore presented a missed opportunity to meet the duty to offer a review or reassessment to someone who appears to be in need. The lack of connection between safeguarding and functional teams suggests the requirement to include safeguarding actions into care and support plans is also being missed.

4.11. Management oversight of the quality and timeliness of safeguarding is insufficiently robust. Despite the availability of team caseload within the WCCIS management dashboard we did not see robust use of this facility (or any other) by senior managers, to ensure equitable workloads, quality assurance or management of workflow.

4.12. Performance data was incomplete and lacked context. Managers were not able to explain the strengths and weaknesses within the process or the progress of cases through the service. Work is required to ensure managers fully understand the steps within the safeguarding process and to more effectively identify where pressure points are impacting on the quality of safeguarding outcomes for people.

4.13. PCC's commitment to the regional adult safeguarding board has been variable. At an operational level there has been positive engagement by Powys staff in the development of relevant policies and guidance documents. However, attendance at the board by senior managers has been inconsistent and the requirement to submit relevant data to the board has not been complied with for the last two quarters. A similar lack of attendance at the local operation safeguarding group was also noted by partners and inspectors and was acknowledged by managers.

4.14. Lack of commitment at the most senior level to regional safeguarding arrangements has impacted negatively on the focus and prioritisation given to the protection of people at risk across the county at the corporate level. Combined with the failure to submit required data, poor attendance has reduced the support and understanding of best practice that the regional arrangement provides.

5. Leadership, management & governance

Direction of services

What we expect to see
Leadership, management and governance arrangements comply with statutory guidance and together establish an effective strategy for the delivery of good quality services that effectively promote wellbeing and support people to achieve the outcomes that matter for them. Meeting people's needs and the delivery of quality services are a clear focus for councillors, managers and staff. Services are well-led, direction is clear and the leadership of change is strong. Roles and responsibilities throughout the organisation are clear. The authority works with partners to deliver help, care and support for people and fulfils its corporate parenting responsibilities. Involvement of local people is effective. Leaders, managers and elected members have sufficient knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively.

Context

Adult services sit within the social services directorate of Powys County Council. The service is led by two heads of service: an operational lead with responsibility for service management and a transformation lead with responsibility for commissioning and change. Both heads of service report directly to the director of social services (DSS). At the time of this inspection, key local authority leadership roles were covered either by acting or interim arrangements. Both the chief executive officer (CEO) and the head of adult services (operational) had been in acting positions since October 2017. The DSS had been in an interim role for a similar period. The post of head of adult services (transformation) was filled by the permanent post-holder.

Summary of findings

5.1. Powys adult services have been subject to frequent changes of management and reliance on interim positions for several years. This lack of stability in crucial leadership roles has had an impact on the authority's capability to both disseminate a clear and consistent vision for adult social services to staff and partners, and to provide safe, reliable and good quality services to citizens.

5.2. We heard consistently from senior managers and elected members that findings from the recent CIW report about children's services had given the local authority cause for concern and the impact on the authority has been substantial.

5.3. Senior managers from across the authority and elected members provided a consensual view that improvements in social services are now the concern of the whole council. It was positive that a corporate safeguarding policy had been introduced and a corporate safeguarding group established.

5.4. Senior managers and elected members met weekly to review any obstacles to improvement and to take stock of progress. We were informed of improved cooperation between departments. Examples included assistance to adult services from housing to undertake a review of the fabric of some residential care facilities; workforce and development to develop and deliver staff training; and business services to improve data analysis. It was anticipated this would result in adult services being more effectively supported to deliver its functions.

5.5. We noted a willingness and commitment to improve adult services. This was evidenced by cabinet approval of the adult services improvement plan and corresponding budgetary uplift.

5.6. However, not all senior mangers or elected members could clearly articulate the changes required to transform services in alignment with the requirements of the SSWBA. Nor did we see strategies for change being effectively shared with staff with staff or effectively implemented alongside or partners.

5.7. We did hear about some changes; for example the implementation of the befriending service and the introduction of community connectors. Also planned change, such as: an increase in extra care provision and step-up/down services, as well as innovative ideas about more effective use of accommodation and housing provision to both strengthen individual independence and to support local community resilience. We also saw evidence of dynamic use of demographic data to model requirements for future residential services. We found it too early to evidence any direct improvements to service delivery as a consequence.

5.8. We found that neither senior managers nor elected members had a comprehensive knowledge of what was happening at the ‘front-line’ and therefore were insufficiently well sighted on how well people were being helped, supported and/or protected. As a consequence senior managers were often too slow to respond to areas of service instability. Both elected members and managers need to improve their knowledge about practice and performance to enable them to discharge their responsibilities more effectively.

5.9. The scrutiny committee members we spoke to understood their challenge role and had a grasp of some relevant issues in social care. However, we found elected members need to develop better mechanisms to understand what is happening in services and to hold senior managers to account. The recently published PCC performance management framework (January 2018) should assist with oversight.

5.10. Quality assurance and performance management arrangements in adult services were not robust. We found management information was not sufficient to systematically provide an up-to-date view of performance.

Neither was performance information routinely used by managers to challenge performance, prioritise the provision of services to manage delays, or to drive improvement in the quality of services people receive.

5.11. Case file auditing by managers across adult services was not compliant with the authority's own quality assurance policy. We found routine auditing was not embedded into core business nor were results from audit used to identify themes and drive improvement. Consequently, neither the use of performance information nor quality assurance monitoring contributed effectively to continuous improvement.

5.12. The authority had recognised a deficiency in this area and had recently taken action to bolster staff capacity to address this. It is too early to know whether additional capacity and the implementation of the new performance management framework will to lead more robust processes to identify and investigate performance issues.

5.13. We found the records kept on complaints indicate the majority of responses received by complainants were not compliant with relevant guidance. Although it was clear in many responses that efforts had been made to resolve issues, we found that the process of investigating complaints was not robust.

5.14. We noted complaints statistics were shared with senior managers for discussion but there was no consistent mechanism for highlighting learning points or for effectively disseminating these to inform service improvement.

Shaping and commissioning of services

What we expect to see
Services are designed and commissioned to improve the outcomes and wellbeing of people, as well as improving the efficiency and effectiveness of service delivery. Service delivery should be focused on:

- improving care and support, ensuring people have more say and control;
- improving outcomes and health and wellbeing;
- providing coordinated, person centered care and support; and
- making more effective use of resources, skills and expertise.

Work with partners in shaping the pattern and delivery of services is informed by the views and experiences of people who use or may need to use services. The local authority should make a full contribution to establishing, managing and developing the regional partnership board with the local health board. Strategic plans are informed by a regional assessment of the wellbeing needs of the local population and are converted into commissioning arrangements which provide safe, quality services and deliver best value. There should be an integrated approach to the development of care and support services, which focus on opportunities for prevention and early intervention, between the local authority, the local health board and wider partners including the development of new models of delivery such as social enterprise and cooperatives. People benefit from services which:

- meet their assessed needs;
- are quality-assured against clear standards;
- are developed in partnership; and
- provide choice.

Summary of findings

5.15. Notwithstanding, effective arrangements for the development of joint high level plans the authority needs to build on the relationships it has with the health board and other partner agencies to ensure a genuinely shared ownership of the strategic direction for adult services, and to support the operational drive needed to improve services and outcomes for people.

5.16. The Regional Partnership Board (RPB) was seen as a vehicle to drive improved partnership working with a view to more integrated working. However, we found the work of the board under-developed and the level of trust required between partners was not yet sufficiently well established to achieve effective results.

5.17. Work completed with partners on population assessment was sound, and together with the Health & Social Care Wellbeing Strategy was providing a platform for the development of future adult services. Some work had already been initiated with partners to develop joint initiatives, such as trials of integrated teams, virtual wards and the deployment of community connectors. In addition, Intermediate Care Funded projects had been established to address emergency home support and falls.

5.18. We found only limited evidence that the requirements of the SSWBA were well understood by partners. Information, advice and assistance services were seen too narrowly as a social services responsibility. Further work needs to be undertaken to overcome barriers to improve joint working.

5.19. Senior managers and partners acknowledged they still had much to do to shape their aspirations for transforming adult services into a modern and integrated service. We found the focus to date had been too much on developing high level plans and not enough on action.

5.20. We did not see evidence of a clear and consistent approach to involving the public and commissioned and third sector partners in planning and reviewing of services. However, commissioning and communications managers could describe some consultation exercises that had taken place with the public in respect of the Health and Care Strategy and concerning the future of day centres and accommodation services. Also with providers, for example in respect of the development of a dynamic purchasing system for domiciliary care services.

5.21. It was positive that a social values forum had recently been convened; a group bought together jointly by adult services and PAVO to explore the use of social value based services such as cooperatives and social enterprises. Nevertheless more work is required to achieve a fully cohesive approach to capitalising on the contribution of the third sector to shaping services.

5.22. We did not see evidence of a clear and consistent approach to involving users of services and carers in the planning and reviewing of services. We observed the older people's forum to be mainly a channel for communication outwards from adult services with an ad hoc agenda and without a business programme, although it was reported the group had fed into a project on the remodeling of residential services.

5.23. Although the local authority commissions support for carers from Credu there is no active forum to engage carers in the planning or review of services for carers.

5.24. Communications officers described work underway to develop an adult social care engagement strategy. They also supported attendance by citizen representatives at the RPB and issued an ongoing customer satisfaction survey of domiciliary care services. However, significantly more pro-active work was required to achieve cross-cutting meaningful engagement with people in respect of the contributions they could make to shaping adult services in Powys.

Workforce

What we expect to see
Services are delivered by a suitably qualified, experienced and competent workforce that is able to recognise and respond to need in a timely and effective way. The council is able to ensure that staff and services meet the standards that have been set for them. Services and support improve outcomes for people.

Summary of findings

5.25. It is to the credit of the vast majority of the workforce interviewed during the inspection that despite the many challenges faced by the service, staff are enthusiastic, committed, enjoy working for Powys and their morale is high. This was supported by responses to the staff survey issued by CIW.

5.26. The recruitment and management of the adult social care workforce presents a mixed picture; the workforce in the north of the county is quite stable, but in the south there is significant instability, particularly across social worker, occupational therapy and reablement services.

5.27. We identified a significant vulnerability at middle and senior management tiers of the workforce. This not only impacted on the consistency of management oversight and decision making but also created uncertainty for staff about the direction of travel for the service.

5.28. High sickness/absence rates within adult services had exacerbated pressures within the workforce. Reliance on short-term contracts for agency staff, whilst being a constructive approach to alleviate staff absences had compounded inconsistencies in practice and decision making to the detriment of people receiving services. Many of the complaints seen by inspectors echoed concerns around frequent changes of social worker and poor communication.

5.29. We found formal staff supervision to be inconsistent across the county and between teams. Fewer than half of the social care workforce receives regular monthly supervision. Whilst some staff reported regular, good quality supervision we also saw evidence of very lengthy gaps between episodes of formal supervision for many staff.

5.30. Good peer support was evident and many staff reported that they found their managers accessible and supportive despite challenging workloads.

5.31. There are many training opportunities in adult services, although staff working in less stable parts of the service expressed a view that it is difficult to find the time to attend training when the service is under so much pressure.

5.32. Although work was underway to develop a workforce strategy, at the time of inspection the authority remains hampered in its ability to map the strengths

of its workforce and thereby build a service to meet demand. Strategies for recruitment, retention and succession planning are a priority to ensure future service stability and capacity to deliver the changes necessary to improve outcomes for people.

Methodology

Self assessment

The local authority completed a self assessment in advance of the fieldwork stage of the inspection. The authority was asked to provide evidence against *'what we expect to see'* under each key dimension inspected. The information was used to shape the detailed lines of enquiry for the inspection.

Staff survey

An electronic survey was administered to all staff in Powys adult services seeking their views on a range of issues with respect to the service and their experiences of working within it. 115 staff submitted responses.

Sample selection

We selected a case file sample for case review and tracking from a specification of all referral/enquiries, including safeguarding referrals and assessment work undertaken between 01/09/2017 and 30/11/2017, and all cases that had an ongoing care and support plan which began between 01/10/2016 and 31/12/2016.

Fieldwork

We were on site during the weeks commencing 15th and 29th January 2018[3].

We reviewed 57 cases of which we tracked 30 in more depth. We interviewed 28 allocated case managers (or a delegate [4]); 11 service users and carers; and 5 other professionals who had involvement in the work. We undertook and observation of the work of PPD.

We interviewed a range of local authority staff and managers including senior officers and the chief executive. We also undertook interviews with elected members including the leader of the council, chair of scrutiny and the portfolio lead for adult services. Auditors from Wales Audit Office supported CIW in facilitating a small selection of these meetings.

We interviewed a broad range of partner organisations, representing both statutory and third sector agencies and we attended several service user/carer focus groups.

We looked at all complaints and compliments that were made about adult services between 01/06/2017 and 30/11/2017.

We reviewed a small sample of staff supervision notes where supervision had been undertaken between 01/06/2017 and 30/11/2017.

Inspection Team: Lead Inspector: Bobbie Jones. Supporting Inspectors (CIW): Christine Jones, Denise Moultrie, Richard Leggett and Catherine Poulter. Supporting Inspectors (WAO): Justine Morgan, Colin Davies

[3] Individual team members were on site for additional days during weeks commenting: 22/01/2018 and 05/02/2018

Acknowledgements

CIW would like to thank the people who contributed to the inspection: service users; families and carers; staff and managers of Powys County Council; and service providers and partner organisations (including the independent and third sector) for their time, cooperation and contributions to this inspection.