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CSSIW

Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Inspection of *Adult* Services

Ceredigion County Council

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Contents

Introduction

Care and Social Services Inspectorate Wales (CSSIW) undertook a pilot inspection of adult services in Ceredigion County Council in October 2016. The purpose of the pilot inspection was to enable CSSIW to test and learn from a revised approach to local authority inspection. The new methodology introduced a greater emphasis on understanding the extent to which the delivery of social services improves outcomes for people in need of care and support.

The inspection was focused upon testing the ability of our revised inspection tools to evaluate outcomes for adults and their carers that access the local authority for information, advice, assistance including early intervention and prevention support. Alongside this focus, we also took account of what the authority understood about its own performance and the difference it was making for the people it was seeking to help, support and protect.

The inspection took place during a time of significant change: the implementation of the Social Services and Wellbeing (Wales) Act in April 2014; and the introduction of a new electronic recording system - the Wales Community Care Information System (WCCIS).

Nevertheless the authority actively contributed to the review of our tools as part of the assessment of their own performance. They were positive about using the preparation for inspection as a further opportunity to take stock of their progress despite the recent introduction of new ways of working in the authority.

The recommendations contained within this report are intended to assist the authority and its partners in their continuing improvement.

Overview of findings

Ceredigion County Council has a transformation programme in place to begin changing its services to meet the challenges of financial sustainability and the implementation of the Social Services and Wellbeing (Wales) Act 2014. The Act, implemented from April 2016, places a duty on local authorities to establish, deliver and maintain a service for providing citizens in its area with information, advice and assistance relating to care and support for adults and support for carers. The authority recognises that communities require support and encouragement to enable them to become more self resilient and less reliant upon statutory services.

The authority's transformation programme includes a new operating model. This will increase the focus on prevention and provide citizens with access to information and advice in order that they can help themselves. The model also includes the option of proportionate and comprehensive assessments that may lead to the provision of care and support. The authority has started to collaborate with the local health board and some partners in the third sector to develop alternative delivery models.

Tangible outcomes from this work, however, are limited. The authority must harness further independent and third sector support to achieve its vision.

The director communicates effectively across the service and corporate colleagues, elected members and staff all understood and were committed to the vision. The transformation programme is high level at present, with some supporting detail. The coordination of specific work streams with implementation dates and actions to support the high level goals is now needed. This will continue to engage staff in the planned service change.

We found variation in the quality of the responses received by some people seeking information, advice and assistance through the social services contact centre. Customer survey results were positive showing that some people were satisfied that their requests were met. Safeguarding contacts received a quick and comprehensive response. However, some carers experienced delays in response and the help given did not meet their required outcome.

We found the authority was committed to providing advocates to support people, however there were no arrangements in place to secure provision beyond this financial year.

Some information contained in the National Eligibility and Assessment Tool was detailed and we saw examples of comprehensive assessments and good social work to help people to achieve outcomes. However, some records did not capture 'what mattered', did not include the assessment outcome and, on occasion, appeared task rather than person centred.

Safeguarding documentation included details of how risk was assessed and managed. This included challenging other partners about how risks were managed. Other assessments, however, did not include an assessment of risk to aid the prioritisation of response.

Some safeguarding recordings were not up to date and formal supervision was not regularly provided to the safeguarding staff. Managerial oversight and quality assurance was limited.

Staff are supported through regular learning and development opportunities. Staff spoken with were knowledgeable, positive and committed to meeting outcomes for people and this needs to be better evidenced through clear recording within the assessment process. Staff were committed to implementing the authority's new operating model and vision of the future for Ceredigion's citizens.

Recommendations

	Recommendation	Key dimension
1.	Engage with a broad range of third sector agencies to help develop a variety of preventative services for citizens.	Access
2.	Develop a plan to meet the requirements to offer and provide advocates in line with the Act.	Access
3.	Review and improve the timeliness and approach used to provide information and assessments for carers.	Assessment
4.	Develop and implement an effective quality assurance process for assessments.	Assessment
5.	Ensure the assessment includes a record of any risks to effectively determine the proportionality of the response and any care and support required.	Assessment
6.	Review the timeliness of recording in the adult safeguarding team and provide a report of how any required improvement will be achieved.	Safeguarding & protection
7.	Develop a plan to increase safeguarding prevention opportunities, including training and support for any forthcoming internal or external information, advice and assistance services that may support the authority in delivering its preventative agenda.	Safeguarding & protection
8.	Implement the supervision policy to ensure staff are supported to maintain high standards during periods of change.	Leadership, management & governance
9.	Strengthen a work stream to foster relationships with the independent and third sector to accelerate the development of community resources to compliment the authority's new operating model	Leadership, management & governance

The authority's response to any recommendations made will be followed up by the CSSIW Area Manager during the Engagement and Performance Review meetings scheduled throughout the year.

Key dimension 1: Access - information, advice and assistance (IAA), early intervention and prevention.

What we expect to see

The authority works with partner organisations to develop, understand, coordinate keep up to date and make best use of statutory, voluntary and private sector information, assistance and advice resources available in their area. All people have access to comprehensive information about services and get prompt advice and support, including information about their eligibility and what they can expect by way of response from the service. Arrangements are effective in delaying or preventing the need for care and support. People area aware of and can easily make use of key points for contact. The service listens to people. Effective sign posting and referring provides people with choice about support and services available in their locality, particularly preventative services. Access arrangements to statutory social services provision are understood by partners and the people engaging with the service and are operating effectively.

What we found

1.1. The contact centre service acts as a single point of access and is a gateway into the authority's social care services that has been in place for a number of years. Contacts made 'out of office hours' are supported by the Careline service commissioned by the authority and an 'out of office hours' social work team Partners had a clear understanding of the role of the contact centre and were universally positive about its performance in successfully signposting people. Case files reviewed showed referral routes were used appropriately. Safeguarding contacts had been quickly highlighted to the adult safeguarding team and an immediate and positive social work response occurred.

1.2. Performance information generated from the new Wales Community Care Information System (WCCIS) system recorded 3357 calls relating to adults received between 1 April and 31 August 2016. Over 1,100 of these calls resulted in the provision of information or simple advice before the call was concluded. Approximately 2,000 of these enquiries became a 'request for support' and were responded to by the authority's Targeted Intervention Service and Planned Care and Support services. Additionally the contact centre dealt with a large number of calls (2,556) regarding blue badges – this function is shortly moving from social services to the corporate services customer care team.

1.3. The 'out of office hours' service said that they are effectively supported by the Careline service that is commissioned by the authority to respond to calls from the public. Approximately 100 calls a month from professionals and citizens are handled by Careline. Careline staff have received SSWB (Wales) Act and

Safeguarding training and were said to pass an adequate level of detail to enable the 'out of hours' team to make decisions about the need for an emergency response or follow up the next day. Careline currently telephone the 'out of office hours' staff and provide a follow up email record as there is no shared record system. They do not complete an assessment document.

1.4. Contact centre staff ask people 'what matters to them' and score the level of need between 1 and 4 based on the authority's Continuum of Care guidance. This score is recorded in the email that accompanies the initial assessment to the area teams for allocation. In the initial assessments viewed by inspectors the score was not routinely recorded; this may result in a potential for repeated questioning of people about their level of need and should be addressed.

1.5. We were told that the authority's Service Request Panel considers how well barriers and solutions to overcome them have been considered alongside opportunities for redirecting people to suitable alternative approaches or services before authorising costs. Feedback was said to be passed back to those completing assessments. However a more proactive approach with further guidance for staff and a more structured quality assurance of the assessments should take place.

1.6. Thresholds for providing information, advice and assistance appeared to be inconsistently applied and were not necessarily linked to the preventative agenda. Thresholds were not formally reviewed by the manager.

1.7. The quality of response was inconsistent in relation to carers. In one case a request for carer's package was responded to immediately. In another case a carer described a lack of information, advice and support provided to him and the frustration he experienced as a consequence. His wife, also a carer, experienced a real impact on her ability to work, but was not offered a carers assessment.

1.8. Many staff we spoke with also referred to their own role in providing information and advice as part of their work. The Targeted Intervention Service provide short term support and advice and often signpost to other organisations. Teams that provide planned care and support on a longer term basis including learning disability and mental health services also described a role in ongoing provision of information and advice to promote and maintain independence.

1.9. Staff in the adult safeguarding team described their key function as responding to protection matters, but highlighted their preventative role. We saw that preventative discussion took place with professionals; however we

saw limited evidence of direct discussion with people in the sample we reviewed.

1.10. Contact centre staff had attended training alongside social workers in relation to the SSWB (Wales) Act, advocacy and safeguarding and have commenced the level 4 Information, Advice and Assistance Award. Staff reported receiving good informal support for their work with their supervisor working alongside them with some entries seen in assessments indicating staff had sought and received guidance. The frequency of formal supervision and appraisal has been affected by capacity issues and has not been carried out in line with the authority's supervision policy. The authority anticipates that capacity issues will ease with the forthcoming realignment of some functions between social services and corporate services e.g. moving blue badge administration. Staff reported good support during the implementation of WCCIS.

1.11. Third sector facilitators sit alongside contact centre staff once a fortnight to share their knowledge of local community group activities. This may address some comments we received concerning a need for enhanced knowledge for staff working in the contact centre and any future third sector prevention service to ensure people are signposted to the agency that can best help them.

1.12. Staff in the authority were positive about the contact centre although we did receive some comments about a need for an improvement in the quality of information provided to duty workers who sometimes needed to follow up to obtain more detail. Good levels of satisfaction were noted from the customer surveys the authority sent to every tenth caller. Positive comments for the first two quarters in 2016 included:

"Very helpful response by a lady who helped me to understand clearly what I needed to do and then posted to me all the forms etc. I received it very quickly with clear instructions on them" and "I could feel the smile of goodwill at the end of the phone."

1.13. The authority recognises that access to information, advice and assistance may be challenged by the rural nature of the county and officers in social services are talking to corporate communication colleagues about solutions. The authority's website is about to be reviewed by some of the authority's standing citizen consultation groups.

1.14. A number of people we spoke to during the inspection expressed concern about the coordination of multiple information services, asking how will citizens navigate to find a service that will best help them? We heard about Infoengine the third sector web resource and the future DEWIS website which will be the principal information portal and self help tool for the citizens in the

county. In addition to the social service contact centre, the corporate customer care centre and the service under development the 'third sector prevention alliance' also provide information. There may be implications for duplication, maintaining up to date information on resources and their availability, and/ or risk of contradictory information. Some people we spoke to were not aware of the single point of contact and instead would ring current or previous staff involved in helping them. The authority will need to and strengthen their communication strategy to prevent people being passed between contact points and having to describe what matters to them on more than one occasion.

1.15. The authority provides information bilingually. All contact centre and 'out of office hours' staff are Welsh speakers. The authority encourages the use of welsh speakers and where needed, the job specification will require a commitment to learn and use Welsh within two years. Welsh language skills in existing teams are considered when allocating staff and students. However records viewed in WCCIS had not consistently recorded language preference, therefore it was not clear whether the 'active offer' is made. Staff were aware of language needs of particular communities and gave an example of having used Polish translation services.

1.16. Staff interviewed during the inspection frequently referred to using advocacy, and reported no difficulty in securing advocates. However arrangements for provision beyond this financial year were unclear. A short term advocacy contract has been extended as an interim measure and support is currently secured using spot contracts or promoting the use of informal advocacy offered by the third sector often through drop in services. The authority have identified they require a more robust approach to meet the requirements of the Act, responding to the challenges of the rural nature of the county and cost.

1.17. The quality of responses provided to carers seeking information and advice was mixed. Some case files we saw and some people we spoke to about their experience of the contact centre were not satisfied with information and advice provided. Other people said they had good information and advice from the authority's carers unit. The increase in the number of carers known to the authority and registered with general practitioners was said to be as a result of the carers aware e-learning training that is now mandatory for staff in the authority and work carried out with local general practitioner surgeries in collaboration with the local health board.

1.18. The carers unit supports the Carers Alliance bringing together a range of third sector and health partners to ensure a universal approach to supporting carers. Carers gave their view that coordination of the breadth of third sector

agencies and how they can help was complex and could be more targeted to help them to better navigate to secure help. We were told that not all agencies are part of the Carers Alliance. Carers gave an example of the 'jigsaw publication' that had positively streamlined information for them.

1.19. We saw some examples of the authority's work with partners to develop preventative approaches. A regular multi agency information sharing meeting takes place in the south of the county with general practitioners and discussion with third sector partners has focussed on increasing cooperation. The authority hosted two autumn workshops to explore commissioning and collaborating to design new ways of working. Whilst third sector partners understand the current financial climate of the authority they are critical of the current commissioning model which makes use of short term contracts which they stated do not support sustainability and longer term development of preventative services.

1.20. We saw that the development of prevention services was limited to a focus on the third sector prevention alliance to be operated by five agencies. Details of a proposed date of operation, interface with the existing contact centre and corporate customer services along with links to the remainder of third sector agencies and community groups were still to be finalised. There has been no citizen engagement in the development of the forthcoming third sector prevention alliance service to date.

1.21. We saw that population needs analysis and local market position analysis has commenced and should be further developed. The analysis highlighted the presence of a significant number of varied third sector groups operating in Ceredigion that the authority may wish to consider targeting for future collaborative projects.

Summary of findings

- All staff spoken with were well trained and confident in their ability to provide information, advice and assistance, including those working in the contact centre. Staff were able to identify and respond quickly to safeguarding matters. The variation in the quality of information provided by the contact centre appears to affect the ability for some people to access support at times when needed. The arrangements for the provision of timely information for carers should be reviewed as we found that some carers waited months to receive basic information and as a result have continued to struggle and occasionally have needed to make their own arrangements. The authority has promoted the carers aware e-learning training package however further discussion about practical application within social work teams may be beneficial to help meet individual need.

- Whilst it was clear that some people have been listened to and survey responses highlight satisfaction with the contact centre, the authority recognises further work is needed to embed a consistent, person centred approach that balances a detailed account of what matters for people with a proportionate response. Staff interviewed frequently spoke of people they serve in a person centred manner, however this was not consistently recorded in documentation seen.

- There is some evidence that basic recording at the first point of contact leads to more limited responses that may not always be satisfactory. Simple recording is said, on occasions, to require duty officers who receive the allocations to make further contact to gain more information.

- We heard of some concerns about clarity of the roles of additional access points such as the corporate customer centre and the future third sector prevention alliance service. The authority needs to ensure that citizens, people and their carers do not need to tell their story and explain what matters to them on multiple occasions. This has the potential to jeopardise the authority principles and values statement “to ensure that people who come to us for care and support and treatment only have to give the information about their needs once”.

Recommendations

- Engage with a broad range of third sector agencies to help develop a variety of preventative services for citizens.
- Develop a plan to meet the requirements to offer and provide advocates in line with the Act.

Key dimension 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. 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 including those with parental responsibility. This is in so far as is reasonable practicable and consistent with promoting their wellbeing and safety and that of others. Assessments provide a clear understanding of what will happen next. 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.

What we found

2.1. Most staff said they had had good access to internal and external learning and development opportunities and felt supported in their day to day work by their immediate line managers. Area teams visited were mainly positive and appeared to have a balanced mix of newly qualified staff, experienced staff and students.

2.2. Staff had received training in the completion of the new National Eligibility Assessment Tool. Managerial oversight of quality was limited. We saw two examples where assessments were appropriate and timely; one triggered by a safeguarding referral and another by a general practitioner. Timeliness of occupational therapy assessments was variable, with some delays seen; staff told us waiting times were 6-8 weeks. Staff reported their ability to respond quickly and carry out assessments in the Targeted Intervention Service and in the South Team had been impacted by staff shortages.

2.3. The National Eligibility Assessment Tool supports a proportionate response to presenting needs and risk. However, while some assessments seen were comprehensively completed, others were not written in a way that recognises people as equal partners within the assessment. The voice of individuals was not always apparent. Some assessments were task, not person centred. Some appeared limited in identifying things that really matter to people, the barriers to achieving those goals and how to overcome them.

2.4. We noted some recording in the new National Assessment and Eligibility Tool used by the authority contained limited details against the five principles required to be discussed during an assessment:

- the person's circumstances;
- their personal outcomes;
- barriers to achieving those outcome;
- risks to the person or others if those outcomes are not achieved; and
- the person's strengths and capabilities.

2.5. Of the cases viewed some were proportionately completed assessments, however more detail would have added value and perhaps saved further work in the future. In one assessment an issue affecting an individual was recorded in case notes but not identified as a barrier to improved wellbeing; opportunity to find solutions to overcome this barrier may have assisted independence in the longer term.

2.6. Assessment tools were not always completed comprehensively by all staff contributing to the assessment; we saw examples where an assessment tool commenced by contact centre staff that indicated further assessment was required did not contain any outcomes after further assessments were completed. A record of the result of that assessment was found as a separate recording in WCCIS and needed to be extracted from case notes. There is some information held on paper files that is not necessarily reflected on the electronic system.

2.7. Performance data viewed indicated the authority has improved the number of carers assessments offered (95%) and completed (43%) above the Wales average. 87% of assessments resulted in services being provided. There has been an increase in the number of carers known to the authority and the number of carers registered with General Practitioners which was said to be as a result of the work of the carers unit. We saw two examples of comprehensive carers assessment and other examples of delays in carers having an assessment, despite need having been identified including a risk to a carers ability to continue to provide care. In one case where a carer had requested an assessment there was a delay before the carers information was provided and a further delay after the person had confirmed they still wished to have a carers assessment (as requested by the authority). The person was then placed on a waiting list. A further delay occurred of over three months before a copy of the assessment document was sent out.

2.8. Carers assessments viewed did not always record what matters in detail. Some carers told us they had experienced difficulty in accessing carers' assessments from the Community Mental Health Team and one case reviewed showed a delay in the provision of an assessment by this team.

2.9. Although the service request panel reviews assessments alongside the request form and often provides verbal feedback to social workers, the authority recognises there is no quality assurance process for the new assessment process. A joint appointment for a quality assurance manager has been made by the authority and its health partner and the authority envisages the post holder will design a plan to address this.

2.10. We saw some examples that assessments did not appropriately address the issue of risk and staff frequently did not factor this in to determine the proportionality of response.

2.11. We saw good use of risk assessments in relation to safeguarding including appropriate referral to and engagement in the process of Multi Agency Risk Assessment Conferencing.

2.12. Cases viewed generally showed good information sharing took place during assessments and in response to safeguarding matters.

Summary of findings

We saw some examples where good outcomes had been achieved for people through effective social work practice and partnership working. It was not always apparent, however, how people's wishes and feelings were represented in the process. The challenge for the authority is to achieve a balance between proportionality of assessment and recording and the detailed evidence needed to support ongoing work with people. Further training, support and evaluation should focus on these issues. Management oversight of the new assessment approach and the inclusion of risk assessment to help determine the response required was not robust. We saw variation in response to support for carers. The authority will wish to consider quality assurance mechanisms to support staff to capture what matters to people.

Recommendations

- Review and improve the timeliness and approach used to provide information and assessments for carers.
- Develop and implement a quality assurance process for assessments.
- Ensure the assessment includes a record of any risks to effectively determine the proportionality of the response and any care and support required.

Key dimension 4: safeguarding and protection

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 urgent, well-coordinated multi-agency responses. People are not left in unsafe or dangerous environments.

4.1. We saw examples of effective multiagency safeguarding taking place. There are clear arrangements between the adult safeguarding team and other internal authority departments including the 'out of office hours' service. Cases viewed demonstrated effective liaison between children and adult services.

4.2. There are well-defined arrangements with local and regional external partners for operational and strategic safeguarding matters. Hywel Dda University Health Board and the Dyfed Powys Police Service described positive working relationships with the authority including engagement in discussion and provision of advice. Evidence seen during this inspection about operational practice showed good multiagency responses to adult at risk reports and joint work in relation to the resulting enquiry and/ or investigation.

4.3. Multi agency working varies across the region in relation to preventative practice. Ceredigion's practice differs from other local authorities in the same police service area; the authority screen all domestic abuse incidents that have been dealt with by police and sent to the authority for information only as part of their automatic notification process. The adult safeguarding team assess all notifications they receive to identify any need for assessment for care and support or additional safeguarding preventative measures. While this has increased the demand upon the authority's adult safeguarding team, there was no analysis available as to the effectiveness of this approach to early intervention, There was, for example, no record of the number of automatic notification cases reviewed by the team that went on to have further assessments or safeguarding intervention by the local authority.

4.4. We saw that all adult at risk reports are referred to the contact centre and efficiently transferred to the safeguarding team duty officer and onwards for allocation to other internal teams. Staff report a more consistent application of thresholds since the introduction of central screening by the safeguarding team. While the authority responds promptly, reduced capacity across a number of social work teams has resulted in an increase to the workload of the safeguarding team with an impact on the timeliness of case recording. A locum social worker was providing some capacity at the time of the inspection however, a number of cases reviewed showed record entries described as "retrospective". Discussion with the safeguarding manager confirmed that not all recordings were up to date albeit some outstanding recordings were said to

be about quality review prior to case closure. This poses an immediate risk to people who need care and support and others involved if information sought by other staff, including staff working 'out of office hours' is not up to date. Recording practice requires improvement.

4.5. Case review and discussion with staff highlighted clear links between the authority's complaint and safeguarding services and there are plans to consolidate this with a joint protocol. Delays in the duty to report being exercised by health were noted, whereby safeguarding matters had not been immediately identified when they were contained in complaints about health services that health had received and were investigating.

4.6. The manager is located with the safeguarding team and is able to provide regular advice which aids consistency of thresholds; this is valued by staff in the authority and partners. Informal support is available for staff in the safeguarding team and staff report good access to relevant learning and development to support their work; Social Services and Wellbeing (Wales) Act, best interest assessor, mental capacity and adult protection support officer sessions are examples of training undertaken. The authority is considering a three month rolling secondment into the safeguarding team. The benefits of this skill exchange will need to be balanced with the manager's capacity to provide the secondee with a positive learning opportunity given the current demand upon the team.

4.7. Formal supervision and appraisal for the safeguarding manager and staff in the safeguarding team has not taken place. This must be addressed as a matter of urgency.

4.8. Some safeguarding training has been provided in the authority and further sessions are planned; a mechanism for refresher training is being considered. A training recording system was said to provide better oversight of the number of staff who have undertaken safeguarding training. Safeguarding training is provided for Elected Members who scrutinise the authority's work. The manager recognises there is more to do in training the wider social care workforce to enable the authority is to fulfil its prevention role. This will be essential for the third sector prevention alliance.

4.9. The ability to carry out preventative work is limited and affects the authority's ability to minimise risk effectively. Some Hywel Dda Health Board nursing staff carry out safeguarding investigations as part of the multiagency safeguarding process where appropriate, however some cases reviewed highlighted significant delays in investigations being completed by health. Difficulties in identifying capacity in health to undertake investigations leads to delays in the safeguarding process. We saw examples where the authority had challenged health partners around such delays and around risk management measures for

staff who had been alleged to have harmed people. However, there was no evidence that strategic influence has been exerted to effect sustainable improvements in operational safeguarding matters directly affecting people.

4.10. Case files showed that the authority had been proactive in referring a case for a Multi Agency Risk Assessment Conferences (MARAC) to minimise future risk.

4.11. There are no formal alert systems for repeat 'adult at risk' reports, rather discussion between staff in the safeguarding team and the contact centre highlights repeat contacts. There were no chronologies readily available to support staff, however the authority have recently started case recording on the Welsh Community Care Integrated System (WCCIS) which could provide opportunity to explore how significant events could be drawn together to show peoples safeguarding experiences.

4.12. The authority recognises that the involvement of adults in the safeguarding process is inconsistent. There was limited evidence in cases reviewed that people know what will happen next or are involved in the safeguarding process. There was limited evidence of protection plans or care and support plans with adult at risk protection measures in the small sample of case files reviewed. We saw some evidence of discussion with adults and/ or their carers and some adults are invited to attend their own case conference; case review showed some people were invited and declined, others did attend. The authority described how meetings are adapted to help people participate. We did not see examples of the use of advocacy in the cases reviewed, however staff across the authority frequently referred to the offer of advocacy to aid full participation.

4.13. Performance management information showed that in 2015/16 Ceredigion recorded that 100% of adult at risk referrals completed had resulted in the risk being managed and we saw that the authority responded comprehensively in the cases we reviewed. However the manager advised that some cases for 2016/17 have been only concluded in part and left open. Many cases were awaiting final review and closure and therefore quality assurance was incomplete.

Summary of findings

- The authority uses appropriate safeguarding strategies to respond to adult at risk reports and enquiries through the adult safeguarding team and staff across the adult service department. Staff spoke positively about the support and advice provided by the safeguarding team. There are effective arrangements in place, with good multi agency discussion and information sharing during enquiry and investigation stages. The assessment of domestic abuse notifications whilst increasing demand on the team may provide opportunities to intervene early and should be evaluated. Good practice was seen in the small

sample of cases reviewed, however this was overshadowed by a lack of capacity in the safeguarding team resulting in limited preventative work, retrospective recording and cases not having been quality assured/ closed in a timely manner. This undermines the delivery of a comprehensive safeguarding service. Involving people in the safeguarding process was inconsistent and could be improved. The authority has plans to increase its role in safeguarding prevention through education and to increase support for those involved in carrying out the designated lead manager and investigating officer roles. The authority now needs to work towards implementation in a planned timeframe.

Recommendations

- Review the timeliness of recording in the adult safeguarding team and provide a report of how any required improvement will be achieved.
- Develop a plan to increase safeguarding prevention opportunities, including training and support for any forthcoming internal or external information, advice and assistance services that may support the authority in delivering its preventative agenda.

Key dimension 5: Leadership, management and governance

What we expect to see

Leadership, management and governance arrangements together establish an effective strategy for the delivery of good quality services and outcomes for people. Meeting people's needs for quality services are a clear focus for councillors, managers and staff. Services area well-led, direction is clear and the leadership of change is strong. The authority works with partners to deliver help, care and support for people. Services are designed and commissioned to: improved outcomes for individual people; reflect community need; and address key priorities within the local population. 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. 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.

What we found

Direction of services

5.1. The authority has undergone significant restructuring within the last twelve months, with a reduction of posts in the senior management team. Staff changes in this period include a new Director, Head of Service and three Service Managers. In addition some vacancies in the area teams have resulted in resources being stretched across adult services. The director states the restructuring has provided the department with an opportunity to review and implement changes in line with the changing demographics, needs of people and financial challenges.

5.2. The authority has made substantial use of an evaluation undertaken by commercial experts in 2015/16, developing an extensive and challenging transformation programme. The authority aims to embed the ethos of the Social Services and Wellbeing (Wales) Act into practice and create financial opportunities to redesign services to better meet future need and demand in Ceredigion. The director's annual report 2015/16 sets out the vision and values for citizens.

5.3. The rationale for change and the ultimate vision or 'target operating model' was understood by staff spoken with during the inspection. Staff have received information and training regarding the Social Services and Wellbeing (Wales) Act and the director has promoted the implementation of the Act as a corporate responsibility across the authority - this was confirmed by Elected Members. There was limited reference to the Wellbeing of Future Generation (Wales) Act, the principles of which could also compliment the authorities collaborative, long term, preventative approach.

5.4. We saw good evidence that the director communicates regularly with staff; email, letters, workshops and discussion in meetings and notice given about reports and plans being presented to Scrutiny and Cabinet. The authority evaluated its 'Making it Happen' conference to assess baseline and post conference understanding of the vision and found staff were aware and had further increased their understanding. A further conference specifically aimed at practitioners was planned to take place in autumn where commercial experts will help staff to embed new ways of working.

5.5. The transformation programme in place sets high level goals, we saw early planning of work streams and the authority must now confirm the detail of sequencing and prioritising of the transformation activities. Potential risks include the social services transformation interface with other divisions/ directorates that are also reshaping services.

5.6. The authority is working with health partners using intermediate care funding to develop a third sector prevention alliance to provide information and advice prior to people accessing the authority's own social services contact centre – this will be the 'pre-front door' of the authority's new operating model. Additionally, discussions are underway with corporate colleagues who are further developing the corporate customer care centre. A draft communication plan seen requires strengthening to provide clarity around the range and function of multiple contact points to inform and secure engagement of staff and people affected.

5.7. Elected Members understand and work to support the transformation programme. They have attended training and were able to debate the vision with inspectors, "we want to take the public with us", and acknowledged "there is a person at the end of every decision".

5.8. We saw that partnership working takes place at an operational level with some third sector organisations. There are five agencies involved in the proposed third sector prevention alliance service, the project is still in design and so partnership working has yet to be tested. Leadership in this area could be strengthened as the authority will need to engage more broadly with additional third sector services and independent sector partners in order to realise and sustain n their future vision to provide a range of different options for citizens.

5.9. The preventative agenda was said to be benefiting from a recent increase in involvement of public sector services for example the Fire and Rescue Service contributing to the design and development of a community service. Work with health was said to be strengthened resulting in the joint funding of a quality assurance post and a jointly managed third sector 'community facilitator'.

Shaping services

5.10. The authority used satisfactory consultation and engagement with detailed explanation given to citizens for the reasoning and the alternatives when planning revised use of a residential care premises. Elected members described their role as influencing each other to ensure they all promote the authority's vision and support the community to participate for the good of the authority's future ; "assisting outcomes for people in our own wards". Managers and elected members reinforced the "Caru Ceredigion" - 'love Ceredigion' branded message being promoted to create citizen ownership across the county.

5.11. The authority evaluated the methods used during detailed engagement regarding the future redesign of services in Llandysul and used the lessons learned for consultation with citizens around Cwlch Caron and Awel deg projects.

5.12. The joint funded 'community facilitator' visits the social work teams to help staff build knowledge of community resources available. However the community infrastructure is still growing which poses challenges for staff to identify community resources to which they can refer or signpost citizens as alternative support. Staff told us people receiving a direct payment experienced difficulty in recruiting personal assistants and so it was difficult to promote alternative methods of care and support, there is no plan address this.

5.13. We noted that while the authority is in the early stages of developing their new model we did not see a clear direction to develop this infrastructure beyond the five agencies involved in the third sector preventative alliance. Workshops held recently with the third sector around collaboration and competition should now be linked with population and resource information. The Wales Council Voluntary Association Third Sector Statistical Resource 2014 used by the authority in its market analysis identified 3,433 third sector groups in Ceredigion. Of these, 1,551 local groups were active in Ceredigion with a further 197 regional groups and 1,567 national groups also active in Ceredigion. It is for the authority to harness support to create its community vision accelerating development of alternative products for citizens to help themselves.

Workforce

5.14. We saw a range of polices to support staff that set out the expected operating practice under the Social Services and Wellbeing (Wales) Act. Staff reported they were supported informally with opportunities for learning and development however given the extent of change taking place structured support is essential. Formal supervision and appraisal was inconsistent in some areas depending on workload pressures.

5.15. Performance information is not currently provided to managers in a way that they find helpful. In addition a focus on the management restructuring and the transformation programme appears to have affected managers own monitoring of those they are responsible for. The authority needs to strengthen the arrangements for performance management information.

5.16. Managers spoke of the benefits of some action learning meetings held, which had been successful in providing support for staff. Staff reported they were well supported during the roll out of the Welsh Community Care Information System and by the authority's ongoing commitment to train and equip its workforce.

5.17. Workforce information provided indicated the authority has vacant posts and is using some locums in response to increase their ability to manage the volume of work.

5.18. The authority recognises the need to support staff to move through the changes required to continue to increase staff confidence to help people to develop individual and family resilience. The aim is to empower staff to make decisions at the point when people are at the 'gateway' to care to manage risk proactivity. We saw a commitment from staff spoken with to embedding the new way of working into their practice and the authority are supporting them with opportunities such as the staff conference planned to collectively review progress and further explore implementation.

Summary of findings

- We saw increasing corporate support for adult services. We saw a clear vision shared by the director albeit at a high level at present. Elected Members and all staff spoken with understood and were committed to this vision and the new ways of working under the Social Services and Wellbeing Act. We saw a culture of continuous learning for staff.

- Prioritisation of work streams and clarity of sequencing and timing is now essential along with increased management oversight to evaluate.

- We saw significant impact of the management restructure and extensive transformation programme on assurance of core business such as supervision and appraisal, quality and regularity of case recording, and monitoring and evaluation of significant changes such as the introduction of the National Eligibility and Assessment Tool. The director was aware that "practice has not yet fully changed", acknowledging that training has focussed on "winning hearts and minds" for the new approach and the director has plans to now move forward focusing on evaluation.

Recommendations

- Implement the supervision policy to ensure staff are supported to maintain high standards during periods of change.
- Strengthen a work stream to foster relationships with the independent and third sector to accelerate the development of community resources to compliment the authority's new operating model

Methodology

Self Assessment

The authority completed a self assessment in advance of the fieldwork stage of the inspection. The authority provided 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.

Fieldwork

The inspection team were on site in Ceredigion for five days during a week in October 2016. The inspection focussed on the experience of people and their carers and of staff working in the authority. We also considered issues of leadership and governance (including partnership work) and the success of the authority in shaping services to achieve good outcomes for people. Activities during the fieldwork included:

- Case review – inspectors considered 20 selected cases and explored 7 of those in further detail with people, carers, case managers and others.
- Interviews – inspectors conducted a number of group and individual interviews with people receiving care and support and their family carers, staff, elected members and partners.

Further detail regarding the framework for local authority inspection, engagement and performance review can be viewed here: www.cssiw.org.uk

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