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Inspection of Older Adults Carmarthenshire County Council

August 2019

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

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Background

1. The Social Services and Well-being (Wales) Act 2014 (SSWBA) has been in force for almost three years. The Act is the legal framework that brings together and modernises social services law in Wales.

2. The Act while being a huge challenge has been widely welcomed across the sector as a force for good, bringing substantial and considered opportunities for change at a time of increasing demand, changing expectations and reduced resources.

3. The Act imposes duties on local authorities, health boards and Welsh Ministers that requires them to work to promote the well-being of those who need care and support, and carers who need support.

4. The principles of the act are:

   - Support for people who have care and support needs to achieve **well-being.**
   - **People** are at the heart of the new system by giving them an equal say in the support they receive.
   - **Partnership and co-operation** drives service delivery.
   - Services will promote the **prevention** of escalating need and the right help is available at the right time.

5. Welsh Government has followed up the SSWBA with ‘A Healthier Wales’. A strategic plan developed in response to a Parliamentary Review of the Long Term Future of Health and Social Care.

6. A Healthier Wales explains the ambition of bringing health and social care services together, so that they are designed and delivered around the needs and preferences of individuals, with a much greater emphasis on keeping people healthy and promoting well-being. A Healthier Wales describes how a seamless whole system approach to health and social care should be seamlessly co-ordinated.

7. Ministers have recorded the importance of having confidence and ambition in the sector to delivering results. In response we have developed our approach to inspection with a focus on collaboration and strengths with the intention of supporting innovation and driving improvement.

8. This inspection is led by Care Inspectorate Wales (CIW) and delivered in collaboration with Healthcare Inspectorate Wales (HIW).

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

1. The purpose of this inspection was to explore how well the local authority with its partners is promoting independence and preventing escalating needs for older adults. The inspection identified where progress has been made in giving effect to the Act and where improvements are required.

2. We (CIW and HIW) focused upon the experience of older adults as they come into contact with and move through social care services up until the time they may need to enter a care home. We also considered the times when they experienced, or would have benefited from, joint working between Local Authority services and Health Board services.

3. We evaluated the quality of the service within the parameters of the four underpinning principles of the Social Services and Well-being Act (as listed above) and considered their application in practice at three levels:
    - Individual
    - Organisational
    - Strategic

4. We are always mindful of expectations as outlined in the SSWBA codes of practice:
    - What matters – outcome focused
    - Impact –focus on outcome not process
    - Rights based approach – Mental Capacity Assessments
    - Control – relationships
    - Timely
    - Accessible
    - Proportionate – sustainability
    - Strengths based
    - Preventative
    - Well planned and managed
    - Well led
    - Efficient and effective / Prudent healthcare
    - Positive risk and defensible practice
    - The combination of evidence-based practice grounded in knowledge, with finely balanced professional judgement

Strengths and Priorities for Improvement

CIW and HIW draw the local authority and local health board's attention to strengths and areas for improvement. We expect strengths to be acknowledged, celebrated and used as opportunities upon which to build. We expect priorities for improvement to result in specific actions by the local authority and local health board to deliver improved outcomes for people in the local authority area in line with requirements of legislation and good practice guidance.

Wellbeing	
Strengths	Social workers and partners recognise adults are the best people to judge their own wellbeing. The local authority is able to demonstrate a good understanding of its own strengths and areas for development, good performance data is available across service areas. Different professional disciplines work effectively together to support well-being and independence. Safeguarding practice across a multi-disciplinary group is collaborative, there are good working relationships at strategic and operational levels. We identified a proactive approach to the well-being of Carmarthenshire County Council (CCC) staff. Communication across the organisation is strong, leaders prioritise how information is disseminated.
Priorities for improvement	Ensure managers record oversight of work on the IT record management system. Ensure qualitative performance information is gathered across the directorate and this provides opportunity for learning across the service. Ensure personal outcomes recorded represent a personal narrative of what is important to people.
People – voice and choice	
Strengths	People who lack mental capacity can be confident assessment and decision making is made in the best interests of the individual. There is an active approach to enabling people to receive a service in the language of their choice. CCC has an understanding of the learning and development needs of the workforce and has a programme to address those needs. Staff are offered integrated health and social care training. Staff feel supported by the management group. CCC learns from the compliments and complaints it receives.
Priorities for improvement	Ensure a sufficient range of services to carers is available across the local authority. Ensure carers are aware of available support services. Ensure a consistent consideration of the right to formal advocacy

	as outlined in Part 10 Code of Practice (Advocacy). Ensure there is a consistent approach to explanation of and opportunity for people being offered Direct Payments.
Partnerships, integration and co-production drives service delivery	
Strengths	There are many examples of collaborative thinking and working by health and social care managers. There are new joint initiatives and evolving services in the local authority which are focused on meeting people's well-being outcomes. Integrated posts provide good opportunity for shared understanding and collaborative working. There is good information sharing across multi-agency working. There is cohesive leadership within the community directorate, with heads of service working well together. CCC and Hywel Dda University Health Board (HDUHB) work collaboratively and responsively to support independence at times of acute ill-health.
Priorities for Improvement	Ensure there is equity of services across all areas of the county.
Prevention and early intervention	
Strengths	Health and social care staff work collaboratively towards a shared vision of addressing the needs of people in the community, with a developing focus on prevention and promotion of independence. Operational working between diverse disciplines is effective in some areas, supported by co-location of staff. Some excellent initiatives are being driven to support communities to be more resilient in meeting the increasing needs of older people in the population.
Priorities for improvement	Establish and embed preventative working across communities throughout the county. Continue to connect communities to services through engagement with people and partners to help prevent escalation of need. The local authority should reassure itself people contacting Delta Information Advice and Assistance (IAA) service are provided with appropriate information and advice.

1. Wellbeing

Findings: Practitioners, managers, partners and staff from other departments within the local authority can articulate the shift of culture resulting from the SSWBA and generally recognise strengths and areas for improvement. This has resulted in a shared culture focused on addressing the well-being of people.

CCC staff responses to a CIW survey are positive with regards to support from managers and peers and workload management. We found, however, some staff experienced challenges due to vacancies including social workers and occupational therapists (OTs). These challenges were compounded due to undiminished demand and increased complexity. We found peer support was highly valued by staff and co-location with different disciplines provided good opportunity to share knowledge and expertise.

We found practice was characterised by compassionate practitioners working well to identify what matters to the person. People routinely told us they were satisfied with the services that had helped them. We found multi-disciplinary responses and a shared sense of purpose working together across professional groups. This enabled prompt and effective responses at critical times for people.

We found common understanding across key agencies, notably between health, social care and police. This means people can be confident their safety and well-being is thoroughly considered by a multi-agency group. Staff, senior managers and partners we spoke to told us safeguarding practice had improved significantly over the last two years.

Evidence at the individual level:

1.1 The quality of the assessments and care and support plans we reviewed captured what was important to people, were outcome focused and strength based. Eligibility criteria was used and consistently applied. Service delivery plans produced by the internal domiciliary support service detailed peoples' preferences.

1.2 We found where '*What Matters'* conversations and personal outcomes were recorded, these would be improved if they included the words and phrases representing specific personal outcomes used by the person. Whilst staff understood and promoted the principle the adult is best placed to judge their own well-being, most of the written records examined did not capture the individual's wishes in their own words. Domiciliary support providers told us care and support plans they received from the local authority sometimes did not reflect precise individual outcomes. Some of the best examples of what matters to the individual were seen in the reablement assessments, which whilst functional, captured the individual's goals and objectives in their own words.

1.3 We identified uncertainty amongst some staff we interviewed who were unclear, following the receipt of a referral, whether IAA staff had started an assessment or were collating information. The use of one form used by many staff covering a number of activities (such as assessment and review) compounded the issue. From review of files inspectors noted a significant number of reassessments in a short period regarding amendment of care packages. We did not see this adversely

impacting on peoples' well-being, but it made clarity in information and decision making problematic to follow.

1.4 We found first reviews of care and support plans were undertaken after six weeks but these were difficult to locate given the above issue. We found elements of a review being captured as an updated care and support plan, and on occasions it was difficult to confirm who had contributed to the review. CCC report that overall 90 % reviews are undertaken within the required time.

1.5 We did not see evidence of the local authority monitoring progress in achieving outcomes in the file records we reviewed. This means on an individual and service basis (and in the absence of scheduled qualitative auditing), the local authority cannot be assured interventions are clearly helping people to meet their personal outcomes and opportunity for wider learning is missed.

1.6 We were satisfied assistant team managers had oversight of the work undertaken in their teams. Some practitioners said they communicated via email with their line manager to review and approve care plans and assessments, however, this was not recorded on the IT record management system. We were unable to see evidence of line manager's rationale to support complex decisions. We were told by staff supervision was taking place, however, records of these discussions relating to people's care and support were not logged on the IT record management system. This means the rationale to important decisions will not be found on the person's file records. Managers told us they wanted team members to exercise autonomy in their work with older people, however, there is a need for improved recording of discussions and decisions made on the person's electronic record.

Evidence at operational level:

1.7 The pressures on the service at the time of the inspection were apparent due to staff absences and vacancies across teams and level of demand. In some areas the service was overly reliant on staff's willingness to work over hours and managers were concerned about the impact on morale. Whilst the local authority has retained a number of very experienced and loyal staff, most teams had varying levels of vacancies or absences, which affected the resilience of the service. The local authority recognised the importance of improving recruitment processes to support the service and staff.

1.8 CCC recognised the shortage of care staff in some areas of the county and were actively recruiting to their domiciliary support service. The impact of the shortage of care provision in some locations was illustrated in a file we reviewed which highlighted difficulties accessing care for a person living with vascular dementia in an isolated rural location. This situation was resolved as the domiciliary support agency located a worker with a 4 x 4 vehicle.

1.9 Most staff we interviewed were positive about their jobs and talked enthusiastically about their work. The CIW staff survey (267 responses) recorded approximately 90% of staff felt supported by their managers and colleagues to do their job. Eighty per cent said their workload was manageable. This can be partly attributed to supervision being provided to staff and line management support being

available. We reviewed supervision files and found the quality of supervision records varied. We noted recording about people's circumstances had little evidence of analysis and records were task focused. Supervision records showed consideration was given to staff development and well-being.

1.10 We found managers had a good level of knowledge and understanding of the needs of people supported by their team members. This was evident in the Hospital Working List meeting we observed when the manager demonstrated an in depth knowledge of a high number of people being considered for discharge packages of care and support.

1.11 We identified a proactive approach to the well-being of CCC staff; regular well-being fairs are held which include advice on healthy eating and smoking cessation. There are two well-being co-ordinator posts. Staff told us about a good Occupational Health service, with people seen very quickly.

1.12 We received positive responses from newly qualified social workers. They told us about support during their first year in practice in CCC; a protected workload of twenty cases, opportunity to attend formal training courses, peer support groups and opportunities to shadow and learn from experienced practitioners.

1.13 Health and social care staff working in the Community Resource Teams (CRTs) told us co-location had helped them understand each other's roles. They said this had worked well particularly when responding to emergencies. Social care staff commented it was helpful in sharing responsibility for planning responses. Staff also reported working in hubs (locality focused teams working within each CRT) worked well because staff got to know an area and community resources available to meet people's needs.

1.14 The short-term duty arrangements in the CRTs have recently been reconfigured to enable referrals that progress beyond the duty desk (i.e. those that require allocation) to remain if possible with the worker on duty that day. Whilst this has a positive impact as people do not have to repeat their information, social workers told us staff shortages as well as the complexity and level of demand can make this approach challenging. Staff told us managers were approachable and responsive and would reallocate work as needed but vacancies meant teams were often under pressure.

1.15 We saw how strengths and what matters to a person is explored by the short term duty workers and heard positive examples of where more information was needed. We were told this may be undertaken via a conference call with the person and included OT and District Nurse to help determine the most appropriate response. People were directed to preventative services if possible. The short-term duty desk had access to Dewis information system, a falls nurse and visual and hearing impairment officers located in each of the CRTs. Teams had also undertaken their own research on local providers. Staff knowledge about the preventative services such as community connector / community prescriber's role was variable. This was partly related to services developing at different rates across the county.

1.16 We found that the vision for reablement was forward thinking and well led by strategic and operational managers. The reablement service has been refocused around “what is important to you.” From file records reviewed we saw people’s goals being outcome focused and wide ranging to fit in with people’s lifestyles.

1.17 The Releasing Time to Care Project was an OT led programme which had a dual approach of increasing people’s independence and targeting resources. It involves reviewing packages of long-term domiciliary support to assess whether double handed support is necessary, or whether it could be reduced to single handed support. This has a dual benefit of focusing on the dignity and independence of the individual and releasing resources. We were told this has reduced the number of double handed calls by 20% over two years from 340 to 270, against an overall rising demand. From file reviews it was evident OT led assessment focusing on double handed support were thorough, balanced and represented people’s best interest.

1.18 CCC has a suite of performance data it captures systematically. We found performance management was given a high profile through regular team reporting and performance meetings. CCC’s approach to quality assurance would be improved if it gave higher profile to qualitative data, for example developing a regular audit schedule. Some social workers and managers had commented referrals passed through to their team from the IAA service could have been better diverted to a service that would meet their need rather than to a statutory team. An audit of referrals being passed through to locality teams would provide improved insight and learning in this area.

1.19 We considered safeguarding practice to be well led by senior managers and operationally supported by the safeguarding team. Senior managers have worked hard over the last two years to ensure multi–agency safeguarding practice is focused on risk and needs of vulnerable people whilst also addressing specific concerns about alleged perpetrators. We recognised good communication between social care staff and partners, notably with key agencies, police and health staff.

1.20 From the review of file records we identified appropriate decisions and actions being made in response to safeguarding referrals. We found an organised approach to safeguarding. For example the safeguarding team works to clusters of care homes to ensure knowledge and oversight of any safeguarding issues. We also noted close working with the internal commissioning team and regular meetings ensured effective communication and systematic approaches to protecting vulnerable people.

1.21 The latest local authority survey was conducted between November 2018 and January 2019 to collect people’s views in respect of the care and support they received. Responses recorded 83% of respondents stated they felt safe from any kind of abuse, physical harm or from falling both inside and outside of their home.

Evidence at strategic level:

1.22 We found strategic arrangements were in place to plan the delivery of preventative commissioned services across the region. The Regional Partnership Board (RPB) is working to eight key principles including prevention, integrated

commissioning, carers and dementia. The RPB links to the West Wales Commissioning and Prevention Programme Board, which has strategic multi-agency membership.
1.23 We saw good examples of work being driven by the Regional Safeguarding Board and its sub management groups. CCC led the development of the Regional Adult Safeguarding Threshold Guidance Document which was introduced in 2018. We found professionals were aware of the document and they told us this had helped a shared understanding across professional groups about risk to vulnerable adults. Work was in progress in relation to developing wider dissemination of learning from Adult and Child Practice Reviews and Multi-Agency Professional Forums across the region.

1.24 We found commitment from members of the scrutiny committee who had attended specific training in safeguarding, corporate parenting, Shared Lives and Dementia Friendly communities.

1.25 A communication procedure for adult social care has been implemented in CCC. The purpose of this is to provide guidelines and instructions for communicating to all adult social care staff with the aim of promoting consistent practice and providing opportunity for staff to communicate back to senior management. Our findings indicated communication across the workforce is a high priority for senior managers. Staff told us about information being provided through written correspondence, staff meetings and forums.

2. People – voice and choice.

Findings: Through review of care and support records and talking to people receiving services we were satisfied people's views were taken into account. When people lacked capacity to understand issues significant to them we found social workers provided robust assessments that accurately represented the person's situation.
People were actively supported in their use of Welsh language. Some staff mentioned this as a reason for working in CCC. We found evidence services were made available through the medium of Welsh as far as possible to enable people to be supported in the language of their first choice.
We found an evolving approach to peoples' needs being met in the community at the earliest possible stage. We found examples of innovative services, but mainly established and more traditional approaches to meet care and support needs.

Evidence at individual level:

2.1 We found carers were involved in the planning of carers' services. For example the West Wales Carers Development Group (WWCDG) is a priority work area of the Regional Partnership Board. It has convened a series of workshops and produced a delivery plan. A 2018/19 Delivery Plan proposed by WWCDG forms part of the West Wales Area Plan.

2.2 We found services available to carers such as replacement care (hours utilised for someone to sit with the cared for person in their own home or to take them out enabling the carer to have a break but remain at home). The local authority provided assurance that it has a robust information service commissioned through Crossroads Sir Gar and that it was continuing to review and improve its information services for carers and users, however some carers spoken to were not aware of the range of services available. We noted the West Wales Care Partnership needs assessment identifies a number of gaps and areas for improvement in respect of the experience and outcomes for carers. This may have been difficult to address locally as a commissioning officer for carers post has been vacant since last year. Some staff interviewed told us they were alert and responsive to carers needs, however, they identified the range of services available varied across the county and they did not always know what was available.

2.3 The local authority has introduced a number of initiatives such as carers champions in teams and the introduction of a carers information officer to improve the information carers and professionals have about services. We found carer assessments being offered to carers and these were often declined. We found carer assessments were mainly captured through an assessment combined with the cared for person, and not as an assessment in the carer's own right. We heard there was differing guidance being provided by managers to social workers in different teams about practice in respect of carers assessments. We found these assessments did not always have sufficient focus on the carer's needs and outcomes, although the form does include a question about the carer's willingness to continue to care. This means the carer's role can be underestimated and the needs of the carer and cared for person may not to be fully understood or met. The significance of recording the

impact caring has on the carer's life; the carer's physical, mental and emotional needs, including their ability or willingness to continue to care is essential. If carer's needs are not fully considered then there is potential for escalated care needs.

2.4 We reviewed a number of file records where a safeguarding concern centred upon alleged intra-familial financial abuse. In all these referrals we found social workers talked to the person and assessed capacity and any element of coercion or control, leading to appropriate actions being taken. A social work record of the rationale to decisions was noted on files.

2.5 We reviewed mental capacity assessments and found the standard was good. Records we saw gave clear consideration to people's ability to retain or weigh up information and included verbatim responses and evidence of the reason for the assessment and decision. We read assessments which considered communication methods, and social workers visiting people at different times of the day. We were less confident about the quality of assessments undertaken by health colleagues, this is an issue already identified by social care managers and will need to be addressed with HDUHB.

Evidence at operational level:
2.6 We found CCC was able to provide a bi-lingual service. The Delta IAA service has 90% Welsh speaking staff. Fifty percent of the Learning and Development team are Welsh speaking with training facilitated in Welsh. In-house domiciliary support workers are required to complete level two Welsh language training. Care staff have been provided with Welsh phrase cards to facilitate communication with Welsh speakers. We have noted 91% of respondents to the LA survey confirmed they were able to communicate in their preferred language. In Cwmamman day provision most of the staff speak Welsh which is important for some people who actively attend this service.

2.7 CCC has maintained four day service provision centres across the county to provide support to sustain people with more complex needs living in their own homes. People generally have mobility and or cognitive decline (for example 70% of people who attend Cwmamman day provision). The Day Centres are also used to support carers to have a break along with a socialising opportunity for the individual. In addition, CCC pay for day care in private care homes to enable carers to continue working.
Day provision has changed significantly in recent years; and represents the changing needs of the population with more people having higher levels of dependency. The benefits of this service were illustrated in the example of a person who had been living alone for many years and encouraged to attend the day provision to socialise and improve general wellbeing.

2.8 We found an efficient system for the brokerage of care to older people, and care providers told us the communication with brokerage staff was good. They were less positive about being able to have direct communication with social workers; they said they had to use the IAA service rather than being able to have direct telephone contact with social workers. We found autonomy in managers' authorisation of

services, with higher packages of care requiring authorisation at a higher management level. This system appeared to work well with no recourse to panels.

2.9 CCC domiciliary support staff told us they had good training and support but were concerned about accessing the duty senior carer if they needed advice or assistance. This is important, particularly at times when carers are working alone with vulnerable adults outside office hours. Some staff worked between the extra care schemes and the community if the need was required, which demonstrates a flexible approach to managing demand. We were assured this approach did not compromise capacity to provide safe care at extra care facilities.

2.10 Although we found staff making records of an offer of advocacy, there was a misunderstanding by some staff in relation to which organisation provided advocacy for older people. Eiriol is funded by HDUHB and CCC to provide formal advocacy, but not all staff we interviewed were aware of this. This was reflected in the low number of referrals reported by Eiriol received via health and social care staff. There were concerns reported by Eiriol as short term funding meant there was a high turnover of staff who had left to take up permanent contracts. Clarity will be important as a new regionalised approach to advocacy is developed; Ceredigion County Council will be piloting an independent advocacy service for adults later in 2019.

2.11 We found conflicting information about Direct Payments. File reviews evidenced practitioners had offered direct payments but the take up was not high. This could partly relate to a view that direct payments may not be suitable for older people and the availability of personal assistants (PAs), but may also relate to the quality of the explanation and information provided by practitioners. Social workers said they were always offered, and they all had training about their use. We also found information on the CCC website about direct payments including a fact sheet and people can request an assessment via the website. Some carers, however, reported having only found out about Direct Payments to support them when assisted at reviews by a support worker. One carer said a Direct Payment was offered in respect of her mother, but in a way that put her off. The social worker had said it would involve a lot of work without mentioning support she could have with administration. The local authority has appointed a direct payments project officer who will consider the issue of direct payment take up. We noted a training plan was in place and a review will feed into the training plan.

2.12 Learning and Development opportunities were highly regarded by staff as was the support of the dedicated SSWBA implementation officer who promoted consistency and understanding. We found an inclusive approach to training with joint health and social care training for care staff and training broadly offered out to partner organisations. We consider this important for effective multi-disciplinary working, helping staff's understanding of roles and responsibilities of different disciplines.

Evidence at strategic level:

2.13 There is strategic focus on addressing variability in provision of domiciliary support by changing the balance of in house and independently provided services. This is to ensure sustainability and address some of the inconsistency in provision

across the county. The Releasing Time to Care programme is a strategic approach to deploying resources as effectively as possible.

2.14 CCC has also been working on rebalancing the proportion of domiciliary support provided by in house and by independent providers since last year following a significant provider withdrawing from the market. This is to ensure more stability in provision. A framework agreement for domiciliary support is being redeveloped to take account of lessons learned about outcome focused work and from the Fulfilled Lives project (see paragraph 4.8).

2.15 CCC has an ethos of learning in relation to compliments and complaints. We noted appropriate scrutiny challenge and prompt management of complaints we reviewed. We saw appropriate response from the head of service and recommendations captured and reported. We noted quarterly reports being sent to the directorate and senior management teams and half-yearly reports to scrutiny.

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

Findings: Multi-disciplinary working was generally good. This was promoted through the co-location of staff, multi-agency meetings and joint funded posts. This has resulted in building common understanding and creating improved and more timely response to the needs of people.
There was good leadership provided by health and social care senior managers and strategic activity to develop an understanding of the operational environment and programmes to strengthen communities. There were examples of local and regional multi-agency partnerships to provide strategic direction to harmonise practice and streamline the deployment of resources.
We found preventative multi-disciplinary work at different levels featured prominently throughout our inspection fieldwork. The multi-disciplinary GP cluster meetings worked well in areas. The Transfer of Care Advice & Liaison Service (Tocals) illustrated how groups of professionals can work closely together to promptly support people's independence and avoid hospital admission and unnecessary prolonged stays in hospital.

Evidence at individual level:

3.1 We saw assessments leading to appropriate care and support being implemented to address personal outcomes. Some of these plans were comprehensive in terms of service provision. For example, an older person living alone fell and this prompted a referral for assessment from family, and a visit from a community nurse. The person received a multi-agency response to support his independence in the community.

3.2 We noted the Red Cross provided a valuable home from hospital service for those people who needed non statutory services. They offered short term practical help to assist with day-to-day tasks, emotional support, food preparation, shopping, laundry, light domestic duties, and help with claiming benefits and form filling. These services last for no more than a few weeks but contribute to an important preventative approach in CCC and HDUHB.

3.3 We observed reablement meetings to be focused on the promotion of independence with positive problem solving conversations. Peoples' needs were understood and care was organised to individual need. We found a wide range of services being utilised, for example; physiotherapy, GP and OTs considering equipment which would aid independence.

Evidence at operational level:
3.4 Tocals are dedicated Multi-disciplinary teams (MDT) based at both acute hospital sites in CCC. We found they supported prompt assessment, care and discharge planning for people who were at increased risk of long term reduced level of function as a result of a hospital admissions. At the time of the inspection this service was working with unprecedented demand. We observed how the weekly 'Working List' meeting attended to people's individual needs, with staff from different disciplines

sharing information. The consequence of the process was a combined understanding of the needs of people and shared planning. We observed Tocals working fluently with the reablement team.

3.5 We found tensions existed between some social care and health care staff which was a consequence of different social care and medical models. For example, some health staff commented social care staff did not understand people's changing needs and the requirement for prompt discharge, conversely some social care staff felt health staff sometimes misunderstood the different needs of people being supported in the community. This is an area the local authority has been working on and would benefit from specific focus and monitoring.

3.6 In addition to the Tocals service, another example of progressive relationship building between health and social care staff we found was the GP MDT cluster meetings. These were GP led meetings which were multi-disciplinary, and included social care staff, OT and social prescriber. The meetings demonstrated a shared and inclusive approach to prevention with a focus on addressing older peoples' needs in the community. The approach is established in a number of GP cluster areas and preliminary evaluation has indicated the approach is improving the response to support people's independence and reducing demand on hospital services. It will be encouraging to see this practice embedded across CCC.

3.7 We noted physiotherapists and OT's were employed by either the local authority or health board and this created tension for some posts where terms and conditions varied across employers. Managers told us going forward the All Wales Health and Social Care Framework would provide improved opportunities for joint training.

3.8 We were told about three clinical psychology posts based in CRTs with the aim of reducing demands on services and maintaining people at home. We were told that recruitment and vacancies had meant the full benefits of this service had not yet been embedded. Staff we interviewed had not utilised the service.

Evidence at strategic level:
3.9 We found CCC worked collaboratively with partners. CCC and HDUHB have a number of integrated management posts and we found this had benefits in improving communication across different disciplines and shared understanding of roles and responsibilities.

3.10 We found cohesive future planning between health and social care and a mapped out vision for transformation of services through a HDUHB led bid for transformation funds. We noted innovative plans for the Llanelli Wellness and Life Science Village which organisations in CCC consider an opportunity to integrate research and development, business, education, primary and social care, leisure and broader wellness initiatives.

3.11 We found the performance framework meetings chaired by the director of communities an opportunity to share cross cutting performance information across

departments. Overall we identified good use of statistical data and a performance framework in place that would be augmented by an improved approach to qualitative information, focusing on key areas.

3.12 We found CCC embraced relationships with the third sector, an example being work with commissioned services such as Crossroads.

4. Prevention and early intervention

Findings: We identified examples of different disciplines working together to support people's independence. People's care and support plans were produced through a process of co-production. We found timely and proportionate responses that resulted in people staying at home at times of crisis.
CCC and HDUHB have invested in services which are responsive to acute poor health. The Tocals service is an example of effective working across disciplines to support people's independence and well-being.
CCC and HDUHB have successfully collaborated on preventative strategies such as GP MDT meetings, social prescribers, dementia friendly communities and the Fulfilled Lives scheme. Through CCC evaluation there is indication these are addressing the needs of people at an earlier stage and preventing needs escalating.

Evidence at individual level:

4.1 The IAA Delta Well Being service is a local authority trading company wholly owned by CCC. The service comprises co-located multi-disciplinary staff and a quality assurance manager supporting trained call handlers to take IAA calls direct from public and professionals whilst supported and advised by local authority professional staff co- located with the call handlers. In addition the trading company provides call handling services across the county for a range of council functions. This was set up in June 2018 and involved the transfer of Carmarthenshire Care Line into the company. The service operates a 24/7 bilingual information, advice and assistance service. We found the Delta service provides a recognised point of access; one referral can trigger a range of services including social services, therapists, preventative services such as telecare and Carmarthenshire United Support Project (CUSP) (see paragraph 4.12). People have the opportunity to discuss and explain what matters to them as part of a proportionate assessment.

4.2 We found some indication from the file records reviewed of peoples' voices being listened to although there was not always evidence of clear actions as a result. We saw people were diverted to a service other than requested and there was delay in referring onto the CRTs. We also found some referrals sent to CRT when they could have been redirected to other social service teams, for example learning disability and mental health or signposted to non-statutory services. This is something CCC should review.

4.3 We noted Delta call handlers treat people with respect and provide people with a mainly positive first point of contact. The call handlers undertake the 'what matters conversation'. Staff within the service reported they were able to resolve many matters speedily without recourse to statutory social service involvement, but our inspection did not find evidence of people being appropriately diverted to other non-statutory assistance. We have noted, however, 79% of respondents to the local authority survey said they had the right information and advice when needing it. CCC needs to assure itself citizens are being provided with the full information relating to community services.

4.4 The links with telecare and assisted technology was considered significant as this enabled people to easily access the service. We considered these services well promoted. The regional partnership will deliver the proposed Spanish model (technology used to support a more joined up and preventative approach, helping people to stay safe) of telecare and support with the local authority trading company Llesiant Delta Wellbeing playing a key role. This proactive preventative approach is an exciting development for CCC.

4.5 We heard a modelling exercise had been undertaken by HDUHB which has evidenced that it could be possible to reduce on average four admissions a day to hospital which would account for a 25% reduction in admissions. As a consequence and to support this, advance plans are in place to locate GPs at Delta.

4.6 CCC has started to promote the Carmarthenshire is Kind initiative implemented following the End Loneliness Campaign. The rationale behind this is to encourage people to think of others in their neighbourhood and undertake acts of kindness thereby building a resilient community. It is too early to be clear how well this will benefit older people, however we noted the initiative has started well through awareness and training sessions being held with community groups.

Evidence at operational level:

4.7 We found examples of how emphasis on integration across departments and between social care and health had significantly benefited people. An example being the success of the National Exercise Referral Scheme (NERS) which is facilitated by the leisure directorate, usually accessed via GPs, but also runs from the extra care bed schemes.

4.8 We found some innovative services being developed by CCC which demonstrated how commissioning practice is changing. For example, Fulfilled Lives is a project working with home care providers with a focus on the individual living with dementia directing the support they need. The local authority has evaluated a pilot in Llanelli and this has demonstrated people are benefiting from the approach through consistency of the same provider. It is now rolling this service out in other parts of the local authority.

4.9 The ‘MDT’ cluster funded support model is established in some areas of CCC, for example there are now regular MDTs in eight surgeries in the Taf-Towy cluster. We found these working effectively through commitment of different disciplines, sharing information and planning early preventative actions to individual needs. The attendance of social prescribers, health and social care staff enable a rapid response to ensure people can be supported living at home.

4.10 Dementia Friendly Communities is a programme to develop greater awareness of the needs of people with dementia to enable them to access more community provision. We found the approach established in certain areas with a number of local businesses and organisations fully engaged; Laugharne, St Clears and Whitland areas are now self-sufficient. CCC’s approach to developing more resilient communities is a developing area.

4.11 We were told about the work of the visual and the hearing impairment rehabilitation officers focusing on early identification of sensory impairments. They provide advice and practical support on a preventative basis. We identified there is good regional co-operation between organisations supporting people with visual impairments and links to RNIB and other third sector organisations means specialist services are available to people.

4.12 CUSP is a partnership of agencies managed through Red Cross. It is commissioned by CCC to deliver a range of low level ‘non eligible’ support and targets people at risk of losing independence through poor health or increasing frailty. We saw evidence from file records of CUSP services being provided, for example supporting welfare rights and practical support such as shopping. The CUSP service was known to staff as an early intervention network and this was seen in some of the file records reviewed.

4.13 We found various services providing lower level support via Supporting People programme which provides housing related support to help people to live as independently as possible. An example being the locality based floating support open to anyone over sixty years of age who has a housing support need. Nine localities were being provided a service by five service providers. One of the benefits of using locality providers is they will know what services are available locally and can make connections. All Supporting People services were accessible through being registered on Dewis.

4.14 We found examples of changing relationships with providers. CCC is in early discussions with providers to develop existing domiciliary and extra care facilities into a community resource with a focus on providing services via a community hub. This demonstrates a flexible approach to meeting the needs of people in a rural area where traditionally there are limited services. CCC has also been working with Crossroads on developing weekend day services. Again this will involve utilising day provision and sheltered housing complex opening access and providing an improved preventative response.

Evidence at strategic level:

4.15 We identified a strategic approach to planning preventative services across the region as noted at paragraph 1.22. CCC has recently introduced a dedicated lead for prevention at service manager level. This should provide an opportunity to ensure various service strands are drawn together. CCC’s PEIPIL (Prevention, Early Intervention, Promoting Independent Living) strategy outlines an alternative delivery model and a specific approach to community preventative activities. This should also provide opportunity to ensure there is equity of services across the county.

4.16 CCC aim to meet the Welsh Government standards for dementia services. The dementia steering group led by HDUHB provides strategic leadership for dementia services; a CCC locality manager attends the group. CCC has a dementia action group to coordinate the CCC activities. We found this is supported through CCC staff (including leisure), third sector and the lead councillor. We recognised partnership working in addressing the needs of people living with dementia; HDUHB has seven locality keyworkers, a specialist multi-disciplinary team which is consultant led and

400 training licences for dementia care. The priority given to this area by both health and social care is evident.

Method

We selected case files for tracking and review from a sample of cases. In total we reviewed 60 case files and followed up on 16 of these with interviews with social workers and family members. We spoke with some people who used the services and administered a survey for people and carers.

We reviewed 10 mental capacity assessments.

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

We administered a survey of frontline social care staff.

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

We reviewed performance information and a range of relevant local authority documentation, including the local authority's self-evaluation.

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

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

We read relevant policies and procedures.

We observed strategy meetings and allocation meetings.

Welsh Language

English and Welsh are equally spoken in the local authority and the inspection was conducted accordingly, those people who chose to be interviewed in Welsh were offered a Welsh language speaker. We offered translation in co-operation with the local authority. Polish is spoken in CCC as are a small range of other languages.

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