

Inspection of Older Adults Services Bridgend County Borough Council

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Background

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

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

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

The principles of the Act are:

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

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

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

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

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

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

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

We (CIW and HIW) focused upon the experiences 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 or receive personalised services, for example in the person's own home.

We also considered the times when older adults experienced, or would have benefited from, joint working between Local Authority services and Health Board services.

We evaluated the quality of the service within the parameters of the four underpinning principles of the SSWBA (as listed above) and considered their application in practice at three levels:

- Individual
- Operational
- Strategic

We are always mindful of expectations as outlined in the SSWBA codes of practice:

- 'What matters' – outcome focused
- Impact – focus on outcome not process
- Rights based approach – MCA
- Control – relationships
- Timely
- Accessible
- Proportionate – sustainability
- Strengths based
- Preventative
- Well planned and managed
- Well led
- Efficient and effective / Prudent healthcare
- Positive risk and defensible practice
- The combination of evidence-based practice grounded in knowledge, with finely balanced professional judgement

Strengths and priorities for improvement

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

Well-being	
Strengths	<p>There is a clear vision for adult social care that is well articulated across social care, Bridgend County Borough Council (BCBC) and partner agencies.</p> <p>There are examples of pro-active good practice, for example the Transformation and Review Team</p> <p>Individual practice is person-centred and outcome focussed. Assessments and care and support plans were good, evidencing the views and wishes of people.</p>
Priorities for improvement	<p>Reablement and enablement is not always available when people need it, which delays the achievement of people's outcomes.</p> <p>BCBC should review its practice for sending people information to self-fund care where reablement/ enablement services are not available to ensure this is in line with legislation.</p> <p>BCBC should ensure arrangements in extra care are responsive to the wishes of tenants and allow them to meet their personal outcomes.</p> <p>BCBC should continue to look at how it organises domiciliary care and any other steps to achieve more capacity to respond to people's individual needs and wishes for care they receive.</p>
People – voice and choice	
Strengths	<p>BCBC engages well with people to inform and shape service developments.</p> <p>The positivity and commitment of staff individually and within teams to facilitate improvements in people's lives was a noteworthy feature of BCBC adult social care. Staff feel supported by managers.</p> <p>The voice and choice of people is heard and responded to.</p>

	Practice to establish whether people have mental capacity to make specific decisions and where necessary to make best interest decisions on their behalf is robust.
Priorities for improvement	<p>Delays for people accessing certain services impacts on meeting their identified needs at the earliest opportunity.</p> <p>BCBC should ensure the active offer to provide services in Welsh is operational.</p> <p>Improvements are required in consistency and recording of staff supervision.</p> <p>BCBC will wish to ensure there is sufficiency of individual managers to supervise and oversee those for whom they are responsible.</p>
Partnerships, integration and co-production drives service delivery	
Strengths	<p>There is good integrated health and social care delivery within BCBC adult services that benefits people through quick decision-making and a joined up approach.</p> <p>There are early positive indications of new regional working with local authorities and under the new health board arrangements. BCBC adult services are improvement focussed and has a range of plans to further develop integrated services.</p>
Priorities for Improvement	<p>Ensure structure and transfer processes within short term teams maximises timely help available to people. Case holding practice must be subject to appropriate management oversight and expedites 'flow' through the system to allow more people to receive help at the right time.</p> <p>Improved commonality of approach with mental health and hospital ward staff to improve joined up services for people. Discharge arrangements at the Princess of Wales hospital require improvement to ensure older people's health and well-being does not deteriorate due to unnecessarily extended periods of hospital admission.</p> <p>Production of revised BCBC medication policy to ensure care workers help people to take medication safely and practice is consistent.</p>
Prevention and early intervention	
Strengths	<p>There is strong support for the vision in adult social care understanding of financial challenges by the chief executive and cabinet member, which aids strategic planning.</p> <p>There is a good range of community groups within BCBC of particular interest to older people. Health and social services</p>

	<p>have invested in posts to connect people to these resources. We found good early intervention to prevent escalation of need. There are robust safeguarding procedures and good preventative work undertaken with specific groups of vulnerable people.</p> <p>There are indications of creative use of direct payments. The mobile response service for people using the alarm system is an example of good practice.</p> <p>BCBC take a proactive approach by ensuring people have anticipatory or contingency planning in place.</p>
<p>Priorities for improvement</p>	<p>Ensure practitioners are confident they have access to current and comprehensive information on community activities. BCBC should improve on consistent signposting, quality assurance and ensuring sufficiency of ongoing staffing in the Common Access Point (CAP).</p> <p>BCBC must ensure all 15 minute calls in domiciliary care meet legislative requirements and address any concerns of provider agencies.</p> <p>BCBC should seek to involve people subject to safeguarding processes or their families as much as possible.</p> <p>BCBC must ensure sufficient support to carers who need a short break from caring responsibilities.</p>

1. Well-being

Findings:

Overall, assessments and care and support plans were good, evidencing the views and wishes of people and their self-identified personal well-being outcomes.

The vision for adult social care is very well embedded in Bridgend County Borough Council (BCBC) and is consistent with SSWBA. Significant and successful efforts have been made to ensure individual practice is person-centred and outcome focussed.

The Transformation and Review Team is pro-active and responsive.

Reablement and enablement is not always available when people need it, which delays the achievement of people's outcomes.

BCBC should review its practice for sending people information to self-fund care when reablement/enablement services are not available to ensure this is in line with legislation.

Domiciliary care is under pressure of demand.

BCBC has established Extra Care facilities to promote greater independence for those requiring care and support. We expect BCBC to ensure arrangements meet the wishes of tenants.

Evidence at the individual level:

- 1.1. Overall, we found the quality of assessments and care and support planning for people was good. Practitioners were fully aware of the requirements to produce assessment and care and support plans based on outcomes identified by the individual. The care and support plan began with the assumption the individual is best placed to know what was required for their own well-being. We saw instances where the social care practitioner co-ordinated a complex multi-agency response to support a person's wishes to return home. Sometimes, detail on assessments did not reflect the consideration of options that informed people's wishes; although we were reassured, these discussions had taken place.
- 1.2. Assessments and care and support plans showed variation in completeness between individual workers. We found instances where a person's religion or cultural identity was not recorded or considered in the overall assessment. Some practitioners did not obtain current health information when reviewing care and support plans and we could not be confident packages of care accurately reflected people's care needs due to the potential for changing health conditions. In some instances, we saw

opportunity for more rigorous review by line managers, which supported improvement.

- 1.3. Some people were receiving more care and support than was outlined in their care and support plan. The providers of domiciliary care told us care and support plans did not always match what people said they wanted. Providers had raised this with managers in BCBC, who will wish to continue to monitor concerns and ensure the service meets the needs and wishes of individuals.

Evidence at operational level:

- 1.4. Team managers and deputies hold budgetary responsibilities, which allowed changes to people's packages of care to be agreed swiftly at team level. This meant people could quickly receive an extra domiciliary call, for example, when this was required to meet an increase in need.
- 1.5. Senior managers were clear they expect social work staff to directly engage with people to help them facilitate change and not simply co-ordinate the provision of services. This reflects the culture change outlined in the SSWBA.
- 1.6. There were significant waiting lists for some people in the short-term teams within the Community Response Team (CRT): specifically Bridgestart and reablement. There was also a waiting list for some therapies in the Community Independence and Well-being Team (CIWT). Frontline staff were very positive as to the quality of these services but were mindful of the impact on people when services were not available at the time they were most needed.
- 1.7. When enablement or reablement services were not immediately available, we were told by staff and saw evidence in files, that people were sent details of self-funded domiciliary care. Short-term enablement/reablement services are free. Expecting people to self-fund while waiting for these services, and prior to a financial assessment of their ability to pay, was not part of the charging policy of the authority. The local authority should review this practice to ensure it is in line with legislation.
- 1.8. BCBC had added value to the traditional model of a review team. The Transformation and Review team had a proactive approach appreciated by all those to whom we spoke. Initial reviews of people receiving care packages were undertaken at the earliest opportunity to ensure people were satisfied and receiving the most appropriate care. People needing urgent reviews received a very timely response and practitioners embodied the outcome-focused approach. The team also contributed good practice examples to inform the improvement agenda across adult services, and provided support to colleagues in other teams.

- 1.9. BCBC was increasing its number of occupational therapists to review people whose domiciliary care was delivered by two care workers. We saw good examples of people being introduced at their own pace to new equipment and care practices to allow for just a single care worker. This may be less intrusive for the individual and represent the best use of limited resources.
- 1.10. BCBC has legal responsibility for arranging social work and provider services to people held in Her Majesty's Prison (HMP) Parc and at the time of inspection, there were 40 older people in receipt of care and support. Some people had dementia and there was a clear challenge in responding to individual needs that is being considered across the secure estate.

Evidence at strategic level:

- 1.11. The vision for adult social care was particularly well developed in BCBC and articulated consistently in an easily accessible way. The vision was appropriately person-centred; outcome focussed and drew heavily on the value of preventative community resources. We found it was well understood throughout the social care workforce, with frontline staff particularly focused and astute to the vision of BCBC. An internal board and work streams promoted and monitored culture change from the SSWBA (although established prior to the Act).
- 1.12. The director is supported by strong corporate relationships within BCBC. The director has had to find considerable budget savings in recent years and this was clearly a pressure across all aspects of service. We were told councillors understand savings made are in the context of rising demand for services for older people. We have seen senior managers use digital stories and traditional strategic documents to ensure accessible communication to a wide audience, including elected members.
- 1.13. As in the majority of Welsh local authorities, there were substantial pressures on capacity within domiciliary care in BCBC that resulted in delays in some people receiving services. BCBC operate a traditional 'time and task' commissioning model of domiciliary care. 'Call banding' had recently been introduced and senior managers should evaluate the impact of this on people receiving services. BCBC was in the early stages of considering a more substantial change to commissioning practice that would increase flexibility and choice for people.
- 1.14. Due to falling demand for residential care, BCBC had reduced its care home provision and established three Extra Care facilities. We spoke to a tenant who was very positive about their level of independence they could maintain in Extra Care, while receiving the support needed. This facility was in the same building as a care home and there was an inclusive approach involving all people in activities and communal living areas. We

expect BCBC to ensure this approach maximises levels of independence achieved for tenants, meets their wishes and expectations and that tenants are specifically consulted on activities they would like.

- 1.15. The Housing department managed applications for disabled facilities grants (DFG). Systemic barriers had resulted in substantial delays for people and a streamlined approach was being established. An occupational therapist had been employed and cleared the backlog of applications. Housing officials we spoke with were confident the process was now improved and delays would not increase again.

2. People – voice and choice

Findings:

People felt they had been asked ‘what matters’ to them and that their voice and choices had been heard. Practice to establish if people have the mental capacity to make decisions and to make decisions on their behalf is robust.

The positivity and commitment of staff individually and within teams to facilitate improvements in people’s lives was a noteworthy feature of BCBC adult social care. Staff feel supported by managers.

Delays for people accessing certain services impacts on meeting their identified needs at the earliest opportunity.

BCBC should ensure the active offer to provide services in Welsh is operational.

Improvements are required in consistency and recording of staff supervision.

BCBC will wish to ensure there is sufficiency of individual managers to supervise and oversee those for whom they are responsible.

BCBC engages well with people to inform and shape service developments and there is commitment to this approach at the most senior levels.

Evidence at individual level:

- 2.1. People who responded to our survey and with whom we spoke were generally positive about their contact with individual social care practitioners. People felt they had been treated with respect and believed practitioners wanted to hear their views and wishes. Responses were more divergent as to how useful people found services or support provided. Delays in receiving services impacted on people’s sense of choice and self-determination.
- 2.2. Case files evidenced people had been asked ‘what matters’ to them and most assessments reflected good practice, were written in the first person or gave detailed information on what the person wished to achieve.
- 2.3. Despite evidence of co-production, people were not routinely offered a copy of their assessment. We expect managers to reinforce people’s rights to the outcome of their assessments. We found the format of the assessment could be more accessible to people and less repetitive and BCBC should consider this with partners.
- 2.4. The local authority had commissioned new arrangements for advocacy on a regional basis. Staff were clear formal advocacy was offered when appropriate, but this was not always well recorded in case files. Consequently, we remain unclear whether advocacy was considered at the earliest opportunity to enable the person to participate in their assessment.

- 2.5. The sample of mental capacity assessments we reviewed were good or excellent. Two social workers in the older people's mental health team were trained as approved mental health professionals (AMHPs). We saw thorough and robust processes to ensure decisions were taken in people's best interests when people lacked capacity to make the decision themselves. Greater clarification would be provided by reinforcing processes within safeguarding in managing referrals for people who may not have capacity to consent to the referral.
- 2.6. Overwhelmingly, staff who responded to our survey felt supported by colleagues and managers and 80% of staff regarded their workload as manageable. Managers should continue to oversee workloads, as there were indications this was variable across teams. Staff identified a number of areas for improvements, but this was within the context of a strong sense of teamwork, enthusiasm and pride in the job they were doing. Many areas identified aligned with our findings.
- 2.7. Most staff were complimentary about the guidance and strategic direction of senior managers. The positivity and commitment of staff individually and within teams to facilitate improvements in people's lives was a noteworthy feature of BCBC adult social care.

Evidence at operational level:

- 2.8. There were difficulties in recruiting staff in some professions; limited resource of occupational therapists was contributing to long waiting time for people in some circumstances. Vacancies in key roles in the Common Access point (CAP) were being addressed, but there had been opportunity to do so at an earlier stage to minimise the negative impact on service.
- 2.9. Senior managers had worked hard to produce budget savings without reducing the front line workforce. A lean senior management structure meant a substantial span of control for some managers. BCBC should assure the structure provides sufficient managerial oversight, challenge and quality assurance.
- 2.10. While the majority of frontline staff were content with the frequency of case supervision, there were significant gaps and poor recording in the sample we reviewed. Compliance with BCBC's policy on regularity of supervision was variable across teams. We did not find evidence of the policy requirement to enter case management decisions onto people's files, important to ensure transparency and accountability. Consistent and well-recorded staff supervision should be a priority for improvement.
- 2.11. At the time of inspection, there were no Welsh speakers in the CAP and arrangements to provide a service in Welsh were not completely clear.

BCBC should review their delivery of the active offer to ensure compliance with legislation.

- 2.12. BCBC responds in a positive and timely manner when people make complaints about adult social services. Most complaints were resolved at the first level of the complaints process. Learning from complaints was embedded within the local authority.

Evidence at strategic level:

- 2.13. BCBC had recently completed an extensive consultation with carers and other stakeholders to establish a new service. At the time of inspection, a council wide public consultation was open on people's priorities in the context of restricted budgets. There were plans for further consultation and BCBC had made arrangements for people to be supported in expressing their views. We found the director and chief executive were committed to public engagement exercises to inform and shape service developments and the chief executive outlined steps they were going to take to improve the public engagement strategy in the next 12 months.
- 2.14. Senior managers were concerned about a high level of staff sickness, which had endured and was reflected in some other directorates across the council. Managers were developing an increased emphasis on staff well-being, in conjunction with the operation of the corporate sickness policy, aimed at reducing absences. Several staff described receiving personal support from managers, which they clearly appreciated.

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

Findings:

There is good integrated health and social care delivery within BCBC adult services that benefits people through quick decision-making and a joined up approach.

There is good practice in improving links with GP practices and/or hubs that can be developed further.

Improved commonality of approach with mental health and ward staff would be of further benefit to people.

The range of short terms teams is complex and does not maximise help available to people. Case holding practice and transfer arrangements between teams requires more consistency. Improvements are needed to ensure clarity in roles and responsibilities of practitioners, including transfer arrangements between teams to increase the flow of people through the system as intended.

BCBC works well with commissioned domiciliary care agencies. BCBC should expedite its revised medication policy.

BCBC adult services are improvement focussed and plans to introduce seven-day services for people requiring care and leaving hospital.

Discharge arrangements at the Princess of Wales hospital is an area for improvement.

BCBC has worked hard to minimise the impact of changed health board boundaries and continues to do so. There are early positive indications of new regional working with local authorities.

An area for improvement is the extension of the shared electronic case management system to all health staff.

BCBC should continue to consider sustainability of services funded through short-term grants.

Evidence at individual level:

- 3.1. Overall, we could identify the benefit to the person of integrated health and social care arrangements. Immediate opportunities for multi-disciplinary communication, particularly with specialist health professionals, largely resulted in people receiving the right help at the right time.

- 3.2. We were told communication between adult services, primary mental health and the 'drugs for dementia' team required improvement. Practitioners in adult services were not up to date on the person's involvement with mental health and the joined up approach was not fully developed in this part of the health service.

Evidence at operational level:

- 3.3. Many teams were integrated and senior manager posts were funded by the health board and BCBC. Post holders managed health and BCBC budgets, which allowed for quicker decision-making. Staff from health disciplines in integrated teams fully embraced the SSWBA. Practitioners sought early advice from colleagues across professional disciplines, and were looking forward to physiotherapists, speech and language therapists and more occupational therapists joining integrated network teams. Where staff in teams remained separately employed by the health board and BCBC, they were co-located and evidence was that they functioned similarly to integrated teams.
- 3.4. We attended several multi-disciplinary meetings with the integrated network teams and the older people's mental health team. We saw arrangements to deliver well-co-ordinated help and support, particularly across social work, district nursing and occupational therapy. District nurses were trained in assessing people's wider needs, so a social worker was not always required. Professionals across disciplines provided a good sharing of expertise. Senior managers were considering the composition of teams to ensure the right balance of professional disciplines.
- 3.5. Hospital ward staff, particularly on specialist wards, did not share the common approach of social care and health in the integrated teams. This is an area for further improvement. BCBC was working to develop a clearer pathway with community mental health services for those with dementia/complex needs. Senior managers in health recognised these issues.
- 3.6. There were weekly meetings to discuss people ready for discharge from hospital, or due to be. The meetings were well attended by multi-disciplinary professionals. The director recognised discharge arrangements at the Princess of Wales hospital could be improved and saw an impact of the change in health board boundaries this year. We were assured refreshed discharge guidance for ward staff was to be issued.
- 3.7. The Acute Clinical Team (ACT) could evidence it was reducing hospital admissions by providing medical care for people at home. At the time of inspection, ACT was providing care to over 30 people. Perhaps because of increased referrals, the service was not always able to respond as rapidly as intended.
- 3.8. We found the range of short-term teams unclear. We were not assured this structure maximises capacity of the workforce due to the specificity of

staff roles. Staff in the CAP were spending time negotiating the appropriate team to which to transfer a referral. Practitioners told us there was a lack of clarity in the eligibility criteria of teams that acted as a barrier to referral.

- 3.9. Transfer points between one team and others were blurred in practice. Practitioners were retaining people on their caseloads for considerable periods when the person's needs no longer fitted the criteria for that team. Staff told us this was to minimise the number of changes in practitioner for people and/or to alleviate the workload for other teams. While informed by good intentions, this practice impeded management oversight and created blockages as it worked against the flow of people through teams. Transfer arrangements should be improved, defined and supported by transfer summaries and/or meetings. Senior managers plan to review and streamline the CRT structure, delayed due to changes of health board boundaries. This is a priority area for improvement.
- 3.10. Managers of domiciliary care agencies were less confident about medication practices because BCBC's policy had not been reviewed for several years. Senior managers were drafting a new policy and timely publication of this will confirm expectations of safe practice. Generally, BCBC maintained good communication with commissioned domiciliary care providers via regular meetings and regular contract monitoring visits.
- 3.11. There were improved connections between social care and primary care in some areas of BCBC; social workers were attached to some GP surgeries and some GPs participated in multi-disciplinary meetings. A preventative service had linked with GP surgeries and hubs to provide floating tenancy support and general support as part of the Supporting People programme.

Evidence at strategic level:

- 3.12. Changes in health board boundaries in April 2019 required substantial strategic planning for senior managers in BCBC over the last 12-18 months and new strategic relationships had been negotiated. All those we spoke with acknowledged a setback to 'seamless' pathways for older people. However, leaders were confident matters would be resolved and we could see joint efforts to do so. We saw no evidence of systemic failure. Health managers valued the positive engagement by BCBC and noted an open and 'can do' attitude. They welcomed the integrated social care teams and the focus on prevention.
- 3.13. BCBC had gained additional funding to employ more staff within its Better at Home service, which supports people on discharge from hospital. At the time of inspection, there were no services in place to allow for weekend discharges for people needing care at home. BCBC wants to progress to a seven day model to allow people to leave hospital earlier.
- 3.14. The change in health board boundaries also resulted in new regional arrangements between local authorities. BCBC became part of the Cwm Taf Morgannwg region with Rhondda Cynon Taf and Merthyr Tydfil. New

regional partners were positive about the contribution of BCBC. Senior managers in BCBC were clear they would continue to progress on their priority areas but welcomed collaboration with regional partners and new opportunities for shared learning.

- 3.15. Staff in integrated teams used a common electronic case file management system (WCCIS). The intention had been for the health board to move over to this system entirely, but this was delayed due to the health board changes. At the time of inspection, there was restricted access to health information. The lack of a shared system did not support readily accessible oversight of professional involvement in individual cases or support BCBC's clear commitment to integrated working.
- 3.16. Leaders in health and social care were aware of the challenge to ensure the sustainability of service developments established with time-limited funding. This is a national issue.
- 3.17. There were plans to improve joint commissioning between social services and housing to streamline systems and improve efficiencies. Housing managers described recent improvements in support to homeless people, including an example of innovative practice.

4. Prevention and early intervention

Findings:

BCBC take a proactive approach by ensuring people have anticipatory or contingency planning in place.

There is a range of community groups within BCBC of particular interest to older people. BCBC is relatively advanced in its focus on early intervention and community services to prevent escalation of need. The chief executive and cabinet member are well sighted on the vision and challenges of adult social care and the importance of community preventative services within this.

BCBC and the health board have invested in posts to connect people to community resources.

Practitioners are not confident of access to current information on resources. Practitioners do not always include or sufficiently consider the uptake of community groups as part of people's care and support plans.

The CAP is a priority area for improvement, including consistent signposting, quality assurance and ensuring sufficiency of ongoing staffing.

BCBC maintains constructive relationships with domiciliary care providers. BCBC must ensure compliance with legislation in relation to each 15 minute call undertaken.

There are robust safeguarding procedures in BCBC, although improvements could be made in the involvement of people and their families in the process. There is good preventative work undertaken with specific groups of vulnerable people. There are indications of creative use of direct payments.

The mobile response service for people using the alarm system is an example of good practice.

Carers are concerned about the lack of resource for planned breaks from caring responsibilities. BCBC must ensure sufficient support to carers and where this involves development of additional options, it should ensure these become available in as short a timescale as possible.

Evidence at individual level:

- 4.1. BCBC had invested in contingency and anticipatory care planning. We recognised this as an example of good practice as it allowed individuals and families to be reassured as to what would happen if their current care arrangements broke down or their health and well-being deteriorated. This planning is designed to alleviate crises.

- 4.2. We visited a number of groups providing prevention and well-being activities, including a community hub that was open seven days a week and hosted a range of community groups and a day service for older people. People using services told us that they could continue to take part in activities that mattered to them most as individuals. This included attending the hairdresser and the betting shop. We attended a music session, an 'olympage' group (where older people take part in physical activities), tai chi for older people and a dementia cafe. We heard of an inter-generational experience involving children from a play scheme joining in olympage activities with older people.
- 4.3. All groups were well-attended and provided opportunities for socialising in addition to the activity itself. As an example of the impact of such activities, we noted a person who was assessed at reduced risk of falling because of the strengthening exercises undertaken in classes. Community connectors worked with individuals to identify appropriate local activities and supported initial attendance.
- 4.4. From our review of people's files, we saw evidence of people engaging in groups and receiving services that provided social opportunities, supported recovery and enabled people to continue living in their own homes. Practitioners did not always include community activities in people's care and support plans as a means of meeting well-being outcomes, which they should.

Evidence at operational level:

- 4.5. The local association for voluntary organisations was positive about the constructive partnership it had with BCBC.
- 4.6. BCBC provides information, advice and assistance from the CAP. Senior managers were aware of the need to improve the functionality and quality of this service. We regard this as a priority area for improvement. For several months, staff deficits meant people phoning received an answer machine message and had to wait to be phoned back within the day. Referrals passed to case management teams were not always of good quality and secondary screening was taking place in these teams. People were not always signposted to community services at the earliest opportunity. Professionals making referrals often did not receive further information from the CAP. Blockages and complicated eligibility criteria practices between teams added to pressure on the CAP. There was room to improve management oversight and quality assurance within this service.
- 4.7. BCBC and the health board had invested in community connector and community navigator posts. These were viewed as key posts to connect people to activities to reduce isolation and decrease future need for health and social services. These posts also had a role to identify gaps in community services, which would be considered by BCBC and partner

agencies. We saw good practice with the development of links made with GPs.

- 4.8. Social care practitioners in CAP and across teams were not confident in the national Dewis website as they believed it was not up to date. Teams had developed their own files. This practice could minimise the use of current, accurate information and is not an effective use of staff's time. Managers should review this practice. Practitioners require access to accurate information on community resources.
- 4.9. Domiciliary care providers told us they were sometimes asked to assist people to undertake specific tasks within a 15 minute call, which they did not consider achievable. We discussed this with BCBC senior managers and viewed evidence of calls commissioned. This largely supported the BCBC view that short calls were predominantly used to prompt people to take their medication within the context of a larger care package or was the choice of the individual. There are exceptions allowed to legal restrictions on the use of 15 minute calls. Given the discrepancy in views, BCBC should speak with providers and assure itself each 15 minute call is within legislation and meets the need of the person.
- 4.10. BCBC leads on multi-agency safeguarding arrangements (MASH) whereby police, health, social services and other agencies are co-located to speed up and streamline processes for adults at risk. All professionals were positive about the benefits of this arrangement for efficiencies of process and easier information sharing. Adult safeguarding referrals from within social services and the new health board have increased in the last six months. Analysis of the reasons for this had not been explored in any depth. BCBC continued to perform well on national performance indicators in relation to timely safeguarding enquiries and strategy meetings and the police are confident in the robustness of procedures. Professionals outside the MASH were positive about the responsiveness of adult safeguarding.
- 4.11. New national protection procedures are due to be introduced and this will present an opportunity for BCBC to refresh its internal processes. We found BCBC could do more to actively involve the person subject to the safeguarding referral or a family member in the process. Senior managers should refresh their expectations in this regard, to promote the voice and choice of people at the centre of safeguarding.
- 4.12. We noted good practice in a multi-agency group that considers support options for people at risk of self-neglect who are rejecting services. While respecting people's rights to refuse services, BCBC ensured continued attempts were made to engage individuals to offer care and support. There were also daily multi-agency meetings to discuss people at high risk due to domestic abuse. Staff believed co-location in the MASH was a significant benefit to the speed of communication. We also heard of preventative work by the police who have pro-actively recruited older police officers to engage with older people vulnerable to fraud.

- 4.13. Practitioners told us about difficulties for carers wishing to make advance arrangements for a short stay in a care home for their loved one to allow them to book holidays or attend hospital. Senior managers confirmed there were few reserved beds in care homes for short-term stays and 'block booking' was too expensive. BCBC was planning to develop improved choice and flexibility for carers and their loved ones but in the meantime, it should ensure it is providing sufficient support to carers.
- 4.14. BCBC used short-term funding to establish carer link worker posts in each of the network teams. These posts have raised awareness of carers by other professionals, including making links with GP surgeries. Link workers informed care and support plans and contingency planning.
- 4.15. BCBC had refreshed its approach to direct payments and engaged a new provider to support people wishing to arrange their own care. We heard of some good and creative use of direct payments, including the potential for the pooling of individual's direct payments to purchase a service. BCBC were working closely with the new provider and providing training for practitioners. Finance staff were supporting practitioners by basing themselves in care management teams on regular days. Senior managers had identified a particular goal to increase uptake of direct payments by older people. As with commissioned packages of care, direct payments were agreed at team level, avoiding delays.
- 4.16. BCBC was enthusiastic about the expansion in assistive technology to support people in their home. BCBC had a mobile response service where people could receive direct assistance within 30 minutes and this is good practice.
- 4.17. BCBC had undertaken a lot of work on falls prevention and were about to increase physiotherapist resource to identify those people subject to frequent falls to offer interventions to reduce risk. It was anticipated this would meet individual need and release savings for health and social care.

Evidence at strategic level:

- 4.18. Nursing staff had recently been added to the MASH. It was envisaged they would have an educative role on hospital wards around the duty to report adults at risk. The nurses would also improve speed of access to health information relevant to safeguarding.
- 4.19. We met with the cabinet member with the lead for social services and early help and the chair of two of BCBC's scrutiny committees. Members were well informed and promoted the vision for adult social care. The cabinet member described frequent contact with senior managers and an open relationship. We attended a scrutiny committee, where members considered a paper on community well-being and prevention approaches. There was informed challenge, in line with the role of scrutiny, which

focused on sustainability, equity of service provision and efficacy of services.

- 4.20. The chief executive was committed to the well-being and preventive agenda and ensuring this was developed across all council departments and was well sighted on the plans for service development in adult services. The chief executive was focussed on budget management and was conscious prevention and well-being services are core business for BCBC but are largely dependent on Welsh Government short term funding arrangements.
- 4.21. BCBC commissioned, financially assisted and self-funded a substantial range of diverse activities. Senior managers understood the importance of sustainability, and were considering support options for social enterprises and other groups. Some groups required only small sums of money to continue to operate which could have a significant impact on reducing risk of falls, combating isolation and maintaining physical and mental activity. Some community groups were being established to increase skills and employability.
- 4.22. There was good collaborative working with the sport and cultural provider organisations who supported groups and initiatives under the prevention and well-being agenda. The council has ambition to progress at pace over the next two years, strengthening the relationship with the third sector to increase the range and geographical spread of community opportunities. Senior managers wanted to make improvements to some people's care and support plans by encouraging greater take up of community activities wherever possible. While senior managers were assured community activities were used by people not in receipt of packages of care, they felt more could be done to ensure people continued to participate in the community when other need increased to be eligible for care services.
- 4.23. The 'Super Agers' programme is a partnership between local authorities in the region and the health board and monies were available from a 'healthy and active fund' to facilitate older people to run activities and organise events. There is an ambition to establish 15 hubs across the region where group activities are delivered. A local university is researching the effectiveness of such activities in reducing the need for formal health and social care services, and thereby making financial savings.
- 4.24. BCBC has a traditional commissioning model for private domiciliary care based on care tasks to be undertaken and how long this should take. BCBC was beginning to consider other models intended to be more flexible for the person and the agency. Senior managers were aware this was an area for improvement but explained other service review work needed to be completed first.

Method

We selected case files for tracking and review from a sample of cases. In total we reviewed 58 case files and followed up on 15 of these with interviews with social workers and family members. We spoke with some people who used the services.

We spoke to approximately 30 older people attending community activities and received 23 responses to a survey for older people or their carers.

We reviewed 10 mental capacity assessments.

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

We administered a survey of frontline social care staff and received 122 returns.

We reviewed nine 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.

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 several team meetings and multi-disciplinary meetings.

Welsh language

The inspection was conducted with the active offer of interviews and discussions in Welsh as wished.

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