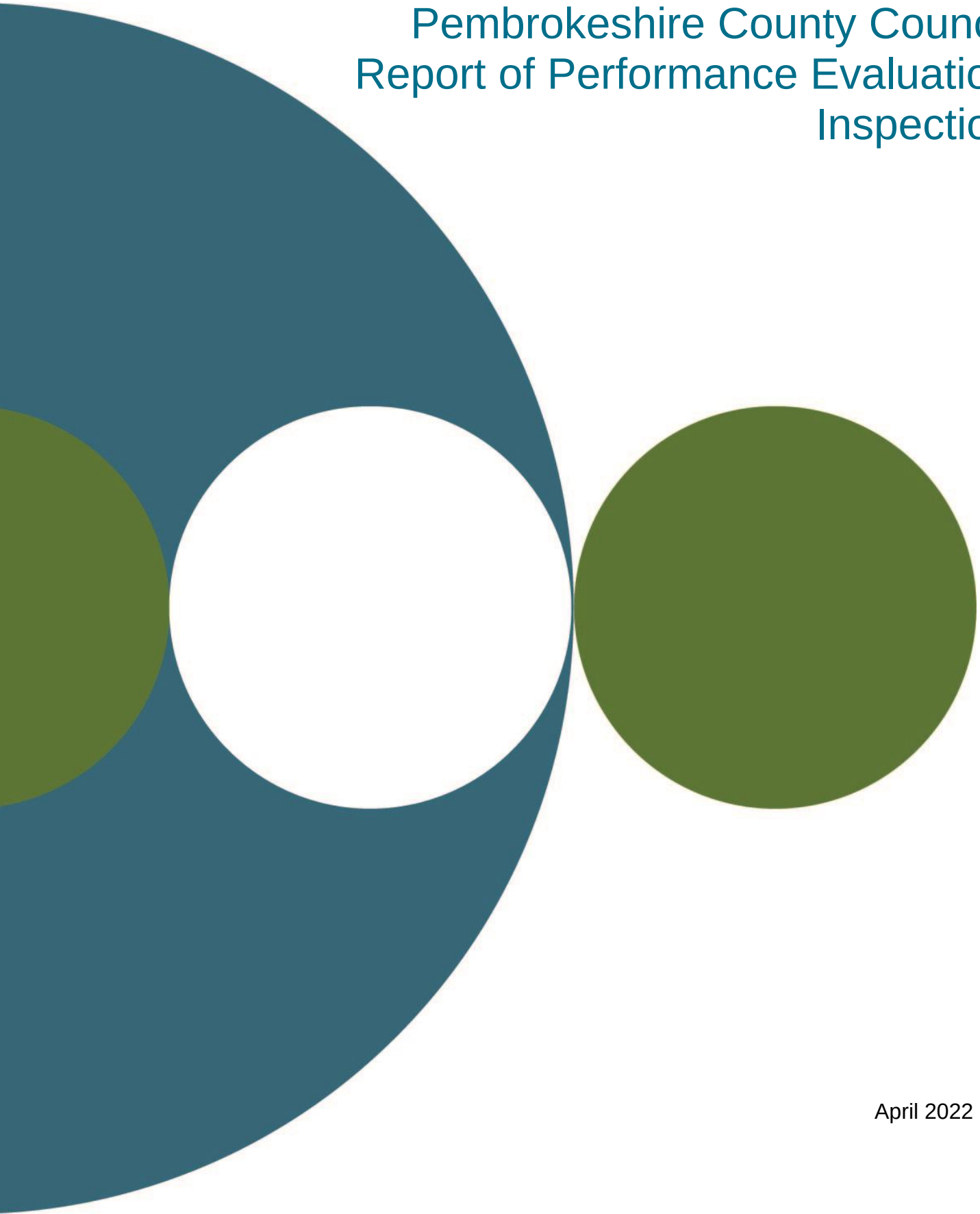
Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Pembrokeshire County Council
Report of Performance Evaluation Inspection



April 2022

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

 W45277 Digital ISBN 978-1-80364-271-0

Introduction

Care Inspectorate Wales (CIW) undertook an inspection of adult and children's services in Pembrokeshire County Council (Pembrokeshire CC) in March and April 2022.

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

1. **People - voice and control**

   How well the local authority is assessing the needs of an individual for care and support (including adults and children at risk of abuse or neglect), or support in the case of a carer?

2. **Prevention**

   How well the local authority is keeping under review care and support plans for people, including where it is necessary to meet the person's needs in order to protect the person from abuse or neglect?

3. **Well-being**

   How well the local authority is keeping people safe and promoting well-being in relation to fulfilling statutory responsibilities?

4. **Partnership and Integration**

   How well the local authority is meeting the needs for care and support (including those in need of protection) and how this is impacting on outcomes for people?

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

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

Summary

Pembrokeshire CC has been experiencing a challenging social care context in common with other local authorities across Wales; with increased volume and complexity across the service coupled with a workforce supply challenge. This is evident in staff responses across our inspection activity, meeting the demands of high workload. The current staffing situation is having an adverse impact on workers' ability to promote the well-being of children and adults.

At the end of 2021 the vacancy position in children's services meant there was concern about fulfilling statutory responsibilities and a critical response plan was developed. In adult services the challenges presented by the shortage of domiciliary support services (DSS) is clearly having an impact on the delivery of care and support. A workforce development plan is in place and there are early indications this is helping to improve the situation.

The local authority can respond to immediate safeguarding needs and crisis but there is delay and drift evident in some situations as qualified from the sample of files reviewed. This means people's outcomes are not always met in a timely manner.

We saw some excellent examples of staff engagement with people living in complex circumstances. Staff told us, however, about the difficult everyday challenges to support people in their choice, care and well-being needs due to lack of resources. The biggest areas of concern expressed by managers of adult services are the waiting list for assessment and overdue reviews. We found insufficient capacity to keep pace with demand.

Due to pressures in staffing, the local authority is not able to capitalise on opportunities to support the preventative agenda in a way which reduces demand on care and support services. There are examples where DSS are not available, and people have no choice but to move into a care home for interim periods even though their preference may be to receive care and support at home.

Although there are excellent operational examples of services working together, effective partnerships across the local authority, health board and partners are not always in place to commission and deliver fully integrated, high quality, sustainable outcomes for certain groups of adults, such as autistic people and people living with a mental health condition. There are significant gaps in some service areas. There is minimal evidence of a shared understanding and of mutual cooperation across services for adults in some areas.

The local authority has a significant challenge to ensure sufficiency of good placements that are matched to the needs of children looked after (CLA), particularly those young people with complex and traumatic backgrounds. Work is being undertaken both locally and regionally to improve this position.

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

The quality of risk assessment in children's services was variable. A re-focus on risk assessment is required to ensure a coherent account about children's circumstances underpins professional judgement. Assessments should ensure past and present factors are considered to identify future risks to a child or young person.

Key findings and evidence

We present some key findings and evidence below in line with the four principles of The Act. Improvements required in previous CIW reports may also appear in this report to emphasise their relevance and importance at this time. However, previous requirements for improvements, which remain outstanding but not referred to in this report, remain relevant and are not negated by omission here.

People

Strengths:

In adult services, for many people, their voices are heard, and many achieve self-identified positive outcomes. Staff complete 'pen pictures' for people and this gives a real sense of the person with strengths identified. Many people said social services were helpful and they were treated with dignity and respect by practitioners.

Some informal carers remained resilient, despite the reduced support they could receive during the pandemic, and said they were happy with support. Our conversations with these carers illustrated positive experiences, interspersed with feedback about delay in care and support and lack of care workers. They and the cared for person had been able to utilise a range of service options; day provision, direct payments and respite were evident.

We found direct payments being utilised positively and saw examples of personal assistants (PAs) working with people whose needs were complex. It was reassuring to hear they will have access to the local authority learning and development programme in the future.

We saw some positive examples of adults being offered advocacy which was delivered by Dewis Centre for Independent Living.

The voice of the child is variable in care and support planning, with the best examples demonstrating carefully considered pen pictures of a child's history, preferences, and outcomes. We found some examples of child centred practice using tools such as the "three houses" to aid communication. Some records are written accurately in the words of the young person which is commendable as it can more accurately represent the individual's views.

There are examples of practitioners working consistently and collaboratively with children; one young person said they had the same social worker for many years and they "*know me really well*" and were "*always at the end of the phone*" when needed.

We saw many examples of children being referred to advocacy and the benefits this brings in developing care and support. There are good links between Tros Gynnal Plant, social workers, and commissioners.

Practitioners we spoke with were mainly positive about the support received from managers. The workforce was striving relentlessly to support vulnerable people, but it was clear demand was outstripping available resource. Senior managers have sight of front-line practice, albeit their capacity to respond across all areas of the organisation is a challenge given so many pressures in various areas.

Staff are receiving regular supervision; this was functional, and task focused rather than reflective. A strengths-based approach to supervision was evident, more so in adult than children's services. Supervision records also reflected the workload pressure experienced by staff.

Several factors have impacted on recruitment and retention in children's services; some staff said the terms and conditions offered by neighbouring local authorities were more favourable. The local authority has a workforce plan in place which aims to ensure it has an effective and appropriately skilled workforce able to meet demand. A focus on 'growing our own' social workers through sponsorship of formal qualification is already in place and is fundamental to helping to address the problem going forward.

What needs to improve:

People are mainly involved in co-production of care and support but delay in helping people meet their outcomes is a significant concern. This was mostly due to the inevitable consequence of high demand and lack of available resource to respond promptly. We expect the local authority to continue to monitor and review their workforce plan.

It was sometimes difficult to identify how carers' needs were being considered, or evidence of an explicit offer of an assessment. We saw some positive practice in combined assessments where views of relatives/carers were incorporated. Staff referred to the strain carers were experiencing through the pandemic and the reduced service provision, notably the limited respite care available. We found delays in responses and assessments being undertaken when carers asked for help. The local authority should ensure the offer of a carer assessment is timely and unambiguous.

Potential barriers to accessing services could be better anticipated to provide people with as much opportunity as possible to meaningfully participate. Our findings indicate the local authority needs to do more to be reassured all practitioners understand the importance of a service being delivered in people's first choice language. For example, an assessment identified a person's first language as Welsh, but it was not clear they were offered the opportunity to talk with a Welsh speaking member of staff or be provided with written information in Welsh. For this same person, it was positive that the need for a Welsh language mental capacity assessment was later identified, albeit this was not considered until after the person had commenced respite care.

Feedback from people with a learning disability (kindly collated via Pembrokeshire People First) corroborated several key areas identified via other inspection activity. One key area was access to services, whereby many people said getting in contact with social care through the main telephone contact line could be prolonged. People said social workers used to be more accessible. Making contact in a crisis was a particular worry and they suggested there should be a dedicated social care line.

In children's services, supervision was mostly regular but requires improvement in relation to well-being support, learning and development. Workload conversations were also too brief with minimal evidence of reflective conversation. This means opportunity to support practice development may be missing and the quality of service provided to families impacted.

There was disappointment that requests for additional capacity to improve service delivery across adult and children's services had not been supported by the council.

In children's services, some development is required to co-produce care and support plans. Improvement is needed in using plainer language with clear explanation of what is expected of parents and carers to make changes. A clearer focus to the narrative in care and support plans would help engagement with parents. One example is avoiding phrases such as *parent to prioritise needs of the children* as this is too imprecise and can lead to misinterpretation. Plans also tended to be instructive and service led, rather than a meaningful narrative for parents to clearly understand and focus. We are aware more training in this practice area is planned.

Prevention

Strengths:

People we spoke with were positive about the local authority's approach to prevention and a service infrastructure that helped development of community-based support in the pandemic period. This area was not a focus for this inspection, but we saw increasing access to services such as community connectors and social enterprises.

There are examples of services able to respond promptly to meet a certain level of need despite high demand; the Occupational Therapy (OT) Reablement service is responsive and delivering care and support to help people return or remain in their homes. Reablement practitioners adjust care and support over time to compensate for the lack of other support such as DSS. This flexibility is a positive response to supporting people but means the capacity to deliver ongoing reablement itself can be impacted.

The local authority is aware of, and monitors, waiting lists across adult service areas and have commissioned an external organisation to help address assessment backlogs. The best reviews of care and support plans provided clear insight into people's individual circumstances and represented an understanding of the person's circumstances and outcomes important to the person.

We recognised services working together to promote a universal offer of support and a culture of prevention and early intervention in early years to reduce demand in other service areas. A strategic priority was to ensure 'right service at the right time'.

Lead staff for Team Around the Family (TAF) and education safeguarding provide a conduit between schools and the local authority and partners. We found good information exchange processes in place; for example, we heard about Operation Encompass, an effective partnership between police and schools with the aim of all incidents of domestic abuse being shared with schools. This provides an opportunity to work with families at an early stage. We also saw some good child-centred practice through TAF workers.

There are Emotional Literacy Support Assistant (ELSA) trained staff in all schools and others have received training in emotional and trauma informed practice. There are opportunities for staff to achieve a trauma informed diploma. The local authority is optimistic this approach will see a positive impact in the years to come.

Generally, we identified prompt responses to presenting concerns about children. The local authority has strengths in its child protection conference and Independent Reviewing Officers (IROs) resource. Reviews for children, both through child protection conference and CLA procedures were mostly positive. The IROs and conference chairpersons were also undertaking mid-point reviews and we could see follow up on outstanding issues with specific actions agreed.

What needs to improve:

The local authority should re-focus on how it can promptly address presenting need across the social care system. At present the local authority is having to rate adult services referrals in terms of urgency, which means some people are not assessed in a timely manner. When reviews are not taking place, there is also risk of people's changing needs not being addressed and resulting in care and support being provided that does not meet their needs. Inevitably, this leads to an escalation of people's needs and a deterioration in their circumstances, requiring more intensive intervention later.

Lack of timely response, delays with assessment, reviewing, care and support planning and communication were reasons why some people were unhappy with the service they received from adult services.

Despite a positive approach to prevention and early intervention in children's services, opportunities to prevent escalation of need is a challenge for the local authority given the persistently high volume of referrals along with the complexity of needs and risk to children. We found staff workload inevitability high, challenges to how best to prioritise work and the efficient transition of files across teams.

Some assessments of risk overlooked risk indicators. There was a lack of professional curiosity, missed opportunities to thoroughly explore risk, including historical concerns. Although it is important to work optimistically with families, it is also essential to recognise past behaviour can be a predictor of future behaviours. Improvements in risk analysis of domestic abuse circumstances requires particular

focus where practitioners should have reflective conversations with managers about risk indicators. When files are closed, there should be robust contingency plans in place to enable prompt response to relapse and risk of repeat harm.

Many children are being seen and core groups convened, but there is delay and sparse detail in some safety plans. We found there were crucial gaps in visits to see some children and core groups not evident. These are critical elements of the child protection system and must be addressed. This is a particular challenge when practice can be pressed and was a factor where progress in care and support planning was not always clearly recorded.

We found the local authority's approach to quality assurance has been impacted by the pandemic as other areas have taken priority. It is timely for the local authority to reinvigorate its approach to provide reassurance people are receiving care and support that is safe, effective, and responsive. The approach to quality assurance should be supported by leaders.

Partnership and Integration

Strengths:

Generally, opportunities for partnership working are positively exploited at an operational level. We saw evidence of cooperation in areas of hospital discharge and in adult safeguarding. The joint discharge team and Information, Advice and Assistance (IAA) service are particularly positive examples, with close collaboration among Occupational Therapists (OTs), physiotherapists, and social workers. Inter-professional communication and contribution to the care and support planning process were evident. The Integrated Care team was established to help keep people within their own homes by providing a range of health and care support. In this area we saw evidence of how good partnership working can make a difference to improved outcomes for people.

Feedback from partners was mainly positive in relation to inter-agency working. Dyfed Powys Police representatives and providers said the local authority was generally responsive with good communication evident. Some providers said the provider forum was improving and support in relation to workforce challenges was very positive.

The responses we received from partner organisations in relation to children's services was mainly positive, they said there were productive working relationships between social care teams and partners. This was corroborated in other inspection activity where we found good information sharing via police, schools, and internal teams. There was mainly good multi-agency attendance and shared contributions at CLA reviews, core groups and child protection conferences. Multi-agency information was shared at strategy discussions and recommendations were clearly recorded.

What needs to improve:

Senior managers across the local authority and health board must work together to resolve concerns identified in relation to faltering partnerships at strategic levels in

some areas. This should involve collaborative conversations leading to agreed solutions and a shared understanding of thresholds and access to services.

We found resources being withdrawn from shared agreement between the health board and local authority which jointly supported care and support services, without clear communication. Notwithstanding the funding challenges experienced by organisations and competing demands, this illustrates a lack of common understanding between organisations about the needs of people.

We found this created tension across operational practice. In one example relating to hospital discharge, there was disagreement between social care and health staff in the scoring of the nursing checklist to determine whether the person required support from a care home with nursing. There was a delay in the person being discharged from hospital while the agencies resolved this.

There were some difficulties recognised in working jointly with health colleagues in the Community Mental Health Teams (CMHTs). Thresholds for access to services were perceived as high; social care staff said even in crisis there was limited support available when risks of harm were high. Care packages were being managed from the generic managed care teams rather than the CMHTs. This means at times, people have two sets of assessments and support on two separate Information Technology (IT) systems. Similarly, we found some examples of health (hospital) records relating to mental capacity not shared with social care practitioners. This means that post hospital discharge, essential information required to review people's circumstances is not available.

The importance of health led services to promote and protect the welfare and safety of adults who become vulnerable or at risk at any time was an issue consistently highlighted during this inspection. There were examples where the support of specialist services for autistic people, learning disability and mental health was not accessible or took too long to access. The integrated autism team is a diagnostic led service, but thereafter there is minimal follow up support to ensure people's needs are being met following a diagnosis.

Minimal specialist support was a source of frustration for practitioners and, for some individuals with complex needs, this meant their needs were not being assessed. This is a critical situation that must be resolved as some vulnerable adults are being left isolated and at risk of their needs escalating.

The local authority must work with partners to ensure it is compliant with the Statutory Code of Practice on the Delivery of Autism Services. We were told an integrated autism steering group was being reinvigorated and training on autism had been publicised over the last few months.

We expect the local authority to work with partners to address critical gaps in other service areas, including specialist areas such as sensory and speech and language assessments. Support for children's emotional and mental health was also very limited; Child and Adolescent Mental Health (CAMHS) support was described by staff as providing an advisory rather than a delivery role. They also said the relationship between the local authority and CAMHS was challenging to a point

where conversations about meeting needs of vulnerable children were fractious. Feedback from practitioners indicated some health services were able to provide an assessment, but ongoing work was negligible.

Transition between children's and adult's services was a problematic area, particularly for young people with complex and continuing health care needs. We found gaps in service provision at age 17/18 years and over. We saw examples of people's needs escalating consequently and being drawn into criminality. For care leavers, some personal advisors were taking on a role that should have been fulfilled via adult services.

Well-being

Strengths:

In the context of escalating demand, and resource struggling to meet this demand, we found the local authority mostly exercises its functions under the Social Services and Well-being (Wales) Act 2014 and makes a positive contribution to the well-being of people who need care and support and carers who need support.

The voice of the person and their views in the safeguarding context are generally well represented. This is supported by a data base template for capturing strengths and risk-based information by examining 'what is working well, what are we worried about and what needs to happen'.

During our last formal inspection activity in 2020, we commented on practitioner analysis and summary on adult services files was mainly clear and focused, a finding repeated for this 2022 inspection. We found there was a good balance of information which provided a sense the practitioner had focused on understanding the lived experiences for people.

Adult safeguarding processes are mainly adhered to and understood by social workers. In promoting safety at an individual level, we found practitioners seeking out the person's wishes and feelings. We saw some excellent examples of practitioner analysis and rationale recorded that evidenced an understanding of what was required to help people meet their personal outcomes.

When people had an allocated worker, we saw some exceptional working with people with complex needs such as autism. We saw examples of prompt access to OT assessment and services being delivered through this route.

We found mainly timely responses in promoting the immediate safety of children and young people. We found evidence of positive practice in responding to young people who were at risk of exploitation; use of a risk assessment and review process to understand and manage high risk situations. The multi-agency child exploitation meetings (MACE) provide a positive approach to oversight of children and young people at risk of being exploited.

What needs to improve:

Further work is required to ensure people's safety is not compromised by ensuring there is clear analysis with a rationale which is consistently fully evidenced based. Furthermore, it is essential the local authority consider both direct risks to individuals as well as other people who may be at risk from perpetrators of abuse and neglect.

Adult practitioner analysis and depth of critical thinking was variable. For example, for one person there was only brief reference to a risk of falls, without deeper consideration of the full extent of the risk.

The local authority should ensure adequate resources are available to manage adult safeguarding activity. Although referrals were screened and immediate safety issues responded to in a timely manner in adult services, the volume and increasing scope of safeguarding work was notable. For example, the increasing demand of court of protection work. To manage demand, we were told strategy meetings were held as an exception and conferences not held. These are key elements of safeguarding procedures and omissions that should be revised by the local authority.

On some occasions adults were being diverted to be supported by prevention services without an assessment of eligible needs being undertaken. The Local Authority must offer an assessment to people when they appear to have eligible care and support needs, and if this offer is accepted, ensure this is undertaken.

For autistic people, and people who required specialist support for learning disability and mental health, accessing services was a significant concern. We heard about an adult who had recently received an autism diagnosis but was not referred on or signposted to social care. People told us autistic people should receive more pro-active support. They said people can 'fall through the cracks' and this was corroborated across our inspection activity. The local authority should do more focused work with autistic people and people with a learning disability to understand their perspectives and experiences.

There was delay noted in responding to the needs of some children and young people and missed opportunities to undertake earlier assessments that could have prevented escalation of need. The local authority must ensure children and young people receive an assessment when they appear to have eligible care and support needs.

Some key elements of the child protection system are subject to delay; with statutory visits and core groups lapsed or not recorded. Consequently, care and support protection plans are not being updated and we could not be assured well-being and safety was being adequately addressed.

In relation to care experienced children living outside of Wales, the local authority has consistently commissioned an England based provider operating services without registration. The local authority has used this provider given the paucity of suitable placements both locally and in Wales and the ability of the provider to respond promptly when urgent admissions to care are required. Some of these young people have complex needs and require specialist placement. Others,

however, have been admitted to these placements solely because of a lack of an alternative placement.

The local authority is considering enhancing their contract and commissioning quality assurance arrangements for this provider. This must be prioritised. It is reassuring the local authority have plans to improve placement sufficiency to specifically address this concern. Corporate support will be essential to the success of these plans.

The pattern of commissioning unregulated services is a significant concern as we cannot be confident about standards and safety. For example, staff fitness checks being carried out and safety and suitability of accommodation. This group of young people also reside a significant distance from their local area, which is an issue for young people's identity and security and means oversight and case management is exceptionally challenging. We also have concern for the quality of care and support for these young people. We could not identify any education provision and addressing health needs was significantly delayed for some.

The young people were generally satisfied with these arrangements, they were seen by practitioners in line with statutory expectations, and IROs provided oversight and challenge through the CLA reviewing process.

In relation to missing children, we saw information sharing from the police in referral form and attachments. We did not, however, explicitly see safe return home interviews (undertaken by Llamau). This means we are not assured critical information about risk is being appropriately shared across agencies. Closer working with Llamau to address this concern is required.

Next Steps

CIW expect Pembrokeshire CC to consider the areas identified for improvement and take appropriate action to address and improve these areas. CIW will monitor progress through its ongoing engagement activity with the local authority.

Methodology

Fieldwork

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

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

We interviewed a range of local authority employees.

We interviewed a range of partner organisations, representing both statutory and third sector.

We reviewed a sample of staff supervision files.

We reviewed supporting documentation sent to CIW for the purpose of the inspection.

We administered surveys to staff, partner organisations and people.

Acknowledgements

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