Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Care and Social Services Inspectorate Wales

National inspection of care and support for people with learning disabilities

Gwynedd Council

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Copies of all reports, when published, are available on our website or by contacting us:

In writing:

CSSIW National Office
Government Buildings
Rhydycar
Merthyr Tydfil
CF48 1UZ

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 7900 126
Email: cssiw@wales.gsi.gov.uk
Website: www.cssiw.org.uk

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Website: www.hiw.org.uk

Joint Inspectorate Website: www.inspectionwales.com

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Contents

13.
Introduction

This report of an inspection of Gwynedd Council is part of a national inspection of care and support for adults with learning disabilities. The purpose of the inspection is to assess the success of local authority social services in achieving the outcomes that matter to people. It will do this by assessing the efficiency, quality and safety of the care and support provided for adults with learning disabilities. It will identify those factors that drive good outcomes for people as well as the barriers to progress.

The national inspection includes detailed fieldwork in six local authorities in Wales, including Gwynedd, and an individual report for each of the six authorities will be published at the same time. We have also produced an overview report for Wales that draws on all the information available to the inspectorate, including a national survey of all 22 local authorities in Wales. The reports can be found on our website

We have worked closely with All Wales People First Wales and the All Wales Forum of Parents and Carers throughout the national inspection in an effort to engage productively with people and with carers who are affected by the issues discussed. Further detail about our engagement with people and carers can be found in the overview report.

Inspectors from Healthcare Inspectorate Wales (HIW) joined us for part of the inspection to assist with the consideration of the efficacy of the partnership between social services and health. HIW have outlined their findings at page 24 and will also report their findings directly to the Health Board.

The report that follows sets out our findings and recommendations for Gwynedd Council. Our intention is firstly, to provide information to the public about the performance of local authority social services; and secondly, to support improvement in the care and support provided for people with learning disabilities.

Context

The Local Authority

Gwynedd Council has a population of approximately 122,000 (2014 mid year estimate).

In September 2015 the local authority estimates that there were 2340 adults with learning disabilities living in Gwynedd. There were 567 adults on the authority's learning disability register of whom 243 were 'active cases' open to a care manager; 232 people who were 'open to review' and 92 people who were closed cases. In the year leading up to March 2015 there had been 47 new referrals.

Between 2010-11 and 2015-16 there has been a 7% increase in the number of people on the learning disability register. Of those people over 65 years of age there were 61 people in September 2015 known to the local authority which was an increase of 18% from 2010-11.

The local authority estimates that its average expenditure per person per year for people with learning disabilities receiving a service during the period April 1 2014 to 31 March 2015 was £23,600.

Context

The Health Board

Community health learning disability services in Gwynedd were provided through Betsi Cadwaladr University Health Board and fitted into tiers one and two of their learning disability service model. At tier one, the Health Liaison Team were involved with health promotion. At tier two, health staff worked alongside local authority staff within the community learning disability team. Community learning disability team health staff were based in three sites across Gwynedd; in Arfon (Caernarfon), in Dwyfor (Pwllheli) and in Meirionnydd (Dolgellau). Local authority staff were co-located with health staff at each location.

There was a multidisciplinary health team which consisted of a health team leader, speech and language therapists, community nurses, health care assistant, physiotherapists, clinical psychologists and a consultant psychiatrist. The health team could also access the following services for people with learning disabilities:

- Complex needs service
- Occupational therapy (not specialist learning disability)

Health services focussed on four priority areas: forensics, profound and multiple learning disabilities, challenging behaviour and mental health. Learning disability health services fell under the mental health and learning disability division within the health board.

Summary of Findings – The Local Authority

1.1. The authority restructured its social services department in 2014 creating the new post - Head of Adults Health and Wellbeing. In March 2015 an interim head of service took up responsibility for adults health and wellbeing and during 2015 two senior managers were recruited to the new structure. The two senior manager posts were not filled at the time of the inspection in February 2016. Although there were arrangements to cover these posts the absence of the substantive post holders during much of the preceding year had significantly affected the leadership capacity and support for the service.

1.2. The authority has been implementing its operating approach 'Ffordd Gwynedd' which aims to put people at the centre of the council's work and efficiently deliver what is important to them. The leadership team's initial priority for change has been services for older people and adults with physical disabilities. Modernising services for adults with learning disabilities has not been a priority.

1.3. There is good joint working between health and social services at an operational level. However this is not the case a senior strategic level. There are no regular meetings at a senior level to make progress with the joint service and no shared vision regarding future direction and development. There is however support within the authority for improving the learning disabilities service with the cabinet member with portfolio responsibility for the service. They are highly engaged and supportive of the need to modernise the service and the need to do this jointly with the health service. Residential and day services for people with learning disabilities are provided from the Frondeg site in Caernarfon. The authority agreed in January 2016 to make a significant capital investment of £3.18 million to develop the site to improve these services.

1.4. The quality of practice in the protection of vulnerable adults was deemed to be reasonable in the cases we saw. However we were not confident that there was clarity regarding the roles and responsibilities of officers and in quality assurance arrangements. This is an area to which the Director of Social Services should give urgent attention.

1.5. Assessments and reviews were not always updated and the authority cannot be sure that people consistently get the right help at the right

time, in the right place, at the right cost. While the number of cases we saw was small it provided some evidence of reviews not being done within the year. We saw examples of good work with individuals, for example there was effective working with Betsi Cadwaladr University Health Board and examples of good practice, particularly in providing positive behavioural support. Some people using day care services received highly person centred care, reflecting the benefits of the authority's investment in active support training.

1.6. People generally get coordinated services that make sense to them, but this was not always the case. We saw good examples of person centred practice. However there were also some instances where progression for individuals was slow. Care mangers were dedicated and had developed a positive relationship with people, carers and colleagues. This was a consistent message in the inspection and the quality of the authority's learning disability services is primarily dependent on the work of the area teams.

1.7. The authority has a learning disability commissioning plan (2011-16), but progress in implementing this has been piecemeal rather than part of a determined and wide ranging improvement drive. The authority has made some progress in the development of services such as the development of modern accommodation in Pant yr Eithin, following an agreement for developing the Frondeg site and the development of practice in the Cynllun Cymunedol Arfon scheme. There has been work with independent providers but this has been limited by the absence of a developed commissioning plan and market analysis and a recent draft commissioning plan had not been developed with key stakeholders. The development of services was not found to be based on a thorough understanding of need or on wide engagement with people, parents / carers, and front line staff. The authority needs to develop more consistent and systematic ways of understanding needs and developing services through a dialogue with people, providers, families and partners. There is a need to improve the coordination between the front line services and commissioning and contracting functions. We saw enthusiasm, energy and hard work within the learning disability services in Gwynedd. There is a need to build on this with strong leadership, a need to create a vision, communicate, engage and implement an improvement plan.

Summary of findings – The Health Board

1.8. There are excellent examples of preventative health services for people with learning disabilities, for example the Health Liaison Team, which includes a dedicated mental health liaison nurse working to improve the experiences of people with learning disabilities using mental health services. Staff had a good understanding of people's needs on an individual level and worked to plan people's future services in partnership with them and their families. However, there is a lack of appropriate service provision in the area to meet people's needs, particularly those people with complex needs. The health board needs to understand the needs of its adult learning disabilities population in order to plan services in Gwynedd that meet people's needs.

1.9. Overall, health and social care staff work well together in providing information, advice, assistance, assessment and care planning to people with learning disabilities. Inspectors found timely and appropriate health and multidisciplinary interventions, assessments and referrals by health and social care staff working together on shared outcomes for people. Staff faced barriers to meeting people's individual needs. For example, due to the reduction in therapies and lack of appropriate service provision but worked together to come up with creative solutions for people. Inspectors heard about challenges in accessing specific equipment in a timely way and challenges around the application of the continuing health care funding process. There was a need for the health team to gather feedback from people with learning disabilities and their carers about the services they provided.

1.10. Inspectors found that there were well established clinical governance structures in place including clinical interest groups. However, therapies, psychology and psychiatry staff were all supervised outside the division by supervisors who did not specialise in learning disabilities. Inspectors asked the health board to review this to ensure staff have access to appropriate, specialist clinical supervision where needed. Inspectors found that the communication between the health board management staff and frontline staff also needed to be improved.

1.11. Although there were good examples of joint working, this was not supported by a clear vision for care and support for people with learning disabilities. Following our inspection in nearby Conwy in November 2015 staff were working to create stability in the division by reviewing the

organisational structure and recruiting staff to key posts. The health board needs to engage with people with learning disabilities and their families as well as staff, in setting a direction for future services.

Recommendations – The Local Authority

2.1. The local authority should give a higher priority to meeting the needs of people with learning disabilities. Leadership is needed to provide direction for improvement, professional support for staff and wide ranging engagement with stakeholders.

2.2 The local authority should establish channels of communication to achieve meaningful engagement with people, families and carers - using advocacy services as needed.

2.3. Strategic planning with health colleagues is needed to develop long term aspirations and plans. A joint commissioning strategy should be developed between health and social services based on an analysis of need.

2.4. The local authority should develop and improve its communication with providers of services, involving them in the construction of a market position statement and in discussions about a joint commissioning strategy with health.

2.5. The local authority should review its arrangements for adult safeguarding ensuring that there is clarity regarding roles and responsibilities and quality assurance arrangements.

2.6. The local authority should review the way in which it safeguards the rights of people where their liberty is being deprived to ensure that human rights are properly supported and protected.

2.7. The local authority needs to ensure appropriate performance management and professional advice is in place to support the workforce.

Recommendations – The Health Board

2.8. The health board must ensure that it plans, resources and manages performance and value for money for learning disability services. Specifically, the health board must ensure that it gathers relevant data and information with a view to planning service provision that can clearly demonstrate how it is meeting the needs (and planning to meet the future needs) of the current learning disability population.

2.9. The health board must ensure that the specific challenges highlighted in Gwynedd are considered in the future planning of service provision including services for:

- people with challenging behaviour
- people with complex needs
- respite
- services for younger people with learning disabilities requiring nursing care
- older people with learning disabilities
- people with autism

2.10. The health board must ensure that health teams are gathering, acting on and learning from people's feedback in order to improve services.

2.11. The health board should ensure that staff on the frontline feel connected and engaged with the health board's vision by improving communication and information flow.

2.12. The health board should work with the local authority to identify better ways of working with a view to improving continuing health care processes, where appropriate. The health board should ensure that staff teams have sufficient training and have consistent, clear information about making continuing health care applications.

2.13. The health board should work with the local authority to, where appropriate, ensure people are offered equipment that meets their assessed needs in a timely way.

2.14. The health board should review supervision arrangements for staff within the division to ensure all staff have access to appropriate, specialist clinical supervision where needed.

2.15. The health board must ensure they engage with people with learning disabilities, carers and staff, in setting the vision and direction of the service.

Findings – The Local Authority

Key Question 1

How well does the local authority understand the need for care and support for people with learning disabilities, including support for carers and the development of preventative services, in its area?

3.1. People generally get the help they need, when they need it, in the way that they want it. Help is mostly well coordinated by social services and its partners on a case by case basis. The co-location of health and social services staff, a joint allocation meeting, and the ability of community nurses and therapists to use the social services case recording system have contributed to achieving this coordinated service.

3.2. At the front line social services, health and service providers work well together to anticipate and respond to future needs. For example, health practitioners described that two to three years ago they saw an increase in the prevalence of dementia in people with learning disabilities and arranged appropriate training for the services providing care for people.

3.3. The personal commitment, professionalism and skills of individual staff and managers has helped to create a service that has a strong value and practice base that demonstrates a commitment to the voice of people with learning disabilities. Staff were respectful of the views and opinions of people and we saw excellent examples of staff supporting people to express their views and feelings.

3.4. People, families, carers and providers do not have a clear understanding of the next stages for the development of care and support services. We were told that the authority's projects were identified under the headings of day services, support services, respite care, supported accommodation, Continuing Health Care and adult placement. There are work programmes proposed for each work stream and a project team meets on a monthly basis to monitor progress. This was not widely understood within the authority or by people, families, care workers and providers.

3.5. The authority has a learning disability commissioning plan (2011-16) with reasonable analysis of need and projections about future need. However in the past five years little work has been done to update this plan. Some work has been progressed but this has been piecemeal rather than part of a determined and wide ranging improvement drive. Accommodation and development of community based options have been developed. Respite

care and the partnership development of day services have not been similarly progressed. A recent draft commissioning plan developed shortly before the inspection fieldwork had been developed without discussion with key stakeholders.

3.6. The authority needs to develop more consistent and systematic ways to understand people's needs in the community in order to develop services. *Raise*, the authority's electronic case recording system, has not been able to gather information about individual needs in order to inform commissioning activity and the authority is moving towards using a new electronic recording system. There does not appear to be a system where information gathered from meetings and reviews about individual people is systematically collated to inform a county level needs assessment. Care managers/social workers complete a monthly data return identifying increases and decreases in packages of care and other quantitative data. There has been some mapping within the service of older carers, but the absence of a strong link between this and case work illustrates the gap between operational staff and planning. The assessment of need should to be completed with health colleagues and these arrangements are not in place. Information and understanding from health and social care practitioners needs to be fed into this analysis. The absence of a needs analysis affects the ability to plan; develop preventative services; and to meet the future needs of people, and their carers. This limits the ability to evaluate changes in need, contingency plans and the impact on services.

3.7. There is evidence to demonstrate that some consultation work has been well executed regarding individual service developments and that information has been cascaded in a clear manner, as seen in the Frondeg site development. Partnership working is inhibited by the absence of a future direction for the service that has been communicated to people, families and key stakeholders. Some providers spoke of individual officers working in 'silos' with a lack of co-ordination between the different council offices and functions such as commissioning and children's services. The absence of a strategy and plans for some services has left some people uncertain and anxious about their future care and support.

3.8. The authority has a robust Welsh language policy and in the main employs bilingual staff. The authority has been active in delivering on the "More than just words" agenda with a needs assessment and includes Welsh language in its contracts with providers. The authority performs strongly in providing people with an 'active offer' of assessment and services in Welsh. For example, we saw that people have an active offer of assessment by a Welsh speaking care managers. We also saw many third sector services and council services where there was a clear active offer. The position was weaker in the provision of more

specialised care services. We saw cases where first language Welsh speaking people were placed in care settings where English was the main language and their needs were clearly not met. Some providers reported no difficulty in recruiting Welsh speaking staff, while others particularly at the south of the county found this to be a considerable challenge.

Key Question 2

How effective is the local authority in providing information, advice, assistance, assessment and care planning that achieves positive outcomes and which respects people with learning disabilities as full citizens, equal in status and value to other citizens of the same age?

4.1. Inspectors examined 20 case files and followed through with a detailed examination of the experience of eight people from that sample. The evidence from this activity was considered alongside performance information and evidence from interviews and documentation.

4.2. The provision of information and advice needs improvement with more consistent web based communication. There is limited information available about support and opportunities on the local authority's website and information and families said that advice is provided by the care manager and local councillors. Although care managers are responsive to enquiries from families, information is not consistently shared. Care workers and carers described that they were unaware of some information and developments.

4.3. The assessment of individual needs for people in the case sample was relatively good - they were timely and of a good standard. The authority is aware of changes coming from the Social Services and Wellbeing (Wales) Act and care managers are including the "What Matters" conversations as part of their work, this conversation is part of the new assessment process that considers what is important to the individual. The wider principles of the act are still to be fully implemented. We saw specialist social work assessments resulting in some impressive examples of person centred care plans and good positive behavioural support plans.

4.4. On an individual basis within care planning it is evident that people are encouraged to express their views and opinions and that care managers listen and respect them. In the case files we reviewed and the visits we undertook, we saw evidence of a respectful, value driven approach from staff that encouraged the participation of people. Care managers spoke informatively about the people using the service and demonstrated that they knew peoples' preferences; they spoke with admiration of peoples' skills and abilities and of their achievements. Family attendance and opinions at reviews are also actively sought. The advocacy service is available to support people and health professionals described that the advocacy services were excellent.

4.5. Consultation work has developed recently and the consultation officer spoke of the department's Consultation strategy and provided evidence of the feedback from an engagement exercise about the various proposals for change. However the authority has not established regular mechanisms to listen to peoples' views and opinions making full use of the advocacy service. An area for improvement is in more wide ranging work with people to engage them in a conversation about decisions and proposals about the future shape of services,

4.6. The authority needs to continue to improve the timeliness of its reviews. At the time of the inspection of the 402 people who should have had their circumstances reviewed in the previous 12 months, 332 (82.6%) had been completed. We were told by providers that while recent reviews have been timely, performance had not been so good in the past. Most people in the case sample had experienced timely annual reviews, with additional reviews being used to consider changes in circumstances.

4.7. The quality of the reviews we saw was good. There is generally good multidisciplinary involvement in reviews with many held regularly with plentiful information. Health professionals said reviews and assessments worked well, were well organised with reports and notes. Further multi disciplinary team meetings were also held as needed. Practitioners said that generally discussions around funding do not delay the provision of care but there are examples of where this has happened.

4.8. The use of volunteering opportunities and work is important for people and should meet the individual's needs. We saw people who worked within the day services for many hours a week for little or no financial reward. Providers also told us that there had previously been limited emphasis on developing paid employment opportunities for people. It is important to review the outcomes of work activities to ensure that people's rights are protected and their independence maximised.

4.9. We saw person centred services providing good person centred care. The outcomes for people are generally good, but some more traditional services were lacking aspiration and personalised plans.

4.10. There is strong evidence of practice that developed a preventative approach and promoted independence. For example the authority has successfully introduced positive behavioural Support and active support models. Practitioners have developed the use of these approaches to prevent the need for more intensive interventions. Care managers do as much as possible to promote independence by ensuring that people in

transition to adult services' are provided with aproportionate packages of support. The authority's practice reflects a commitment to prevention, but is also driven by an awareness of the need to minimise cost. Respite services were described as being reviewed and these were identified numerous times by carers and families as being absent / weak.

Service example

Cynllun Cymunedol Arfon Community Link service is a day service spread across a number of small sites working with 25 people with profound disabilities and complex needs. Although the fabric of some of the buildings was poor the quality of work was good. Attention had been paid to individual positive behaviour support plans which were in place for all people with active support being ensured through quality assurance and data collection about engagement by individuals. There was clear evidence of the support leading to reductions in incidents of challenging behaviour and this was illustrated in weekly reports. The positive outcomes achieved were seen to be highly motivating for staff. The management and staff team were highly motivated, enthusiastic and value driven. This was a demonstration of good leadership in a service achieving a high quality public service.

The training was also provided to external providers and the impact was evaluated through direct observation of the implementation of practice by providers. To further embed the practice there was ongoing support and mentoring including observation and modelling.

4.11. Care managers and providers spoke positively about the multidisciplinary active support training and it being reinforced in practice. We saw examples of positive behaviour support plans detailing slow triggers, fast triggers, and 'respect' approaches for physical intervention and breakaway techniques. We also saw good practice in other areas such as best interest meetings giving full and balanced discussions and decisions. Appropriate personal relationships were also seen to be sensitively considered and supported with appropriate use of advocates with clearly presented views and involvement of people.

4.12. People do get help that is planned round their personal circumstances and needs. This tends to be from a range of existing services with limited mechanisms to develop new services. One care manager stated that one person wanted to join a walking group but none were available in his area. The care manager did not know how to address this or the most suitable person to speak to. We saw some cases of people living for years in

residential homes where their needs were not met. There were plans to move the people closer to their families and to more suitable arrangements. In these cases the care managers and their managers were identifying opportunities for the people to move as a result of vacancies arising in other care settings rather than services being developed to meet individual need. Plans did not, therefore, always start with a focus on individual need. There was an absence of coordinated planning that included the resources in the community, the third sector, and the authority's wider resources.

4.13. There were however, clear examples of some services being designed to build on individual strengths and meet individual need. There was significant input by the health service in assessment and planning of the cases we saw. Health professionals gave us examples of end of life care where the individual died according to their plan in their own home.

Case example

Person A has a strong and positive community presence. The care manager had been active in involving individuals in creating a network of support that helped to safeguard person A. This included the local corner shopkeeper who helps with daily purchases of cigarettes and groceries and the local pubs where both landlords and customers keep a caring watch over the service user. The plan focused on individual need and promoted independence.

Person B wanted to attend work experience but suffered from agoraphobia. Following an assessment and plan a third sector provider undertook daily visits to support the person. Taking a step by step approach getting ready, going to the front door, going to the path, going to the road over many months progress was made. The person did attend the work experience and the work to achieve this took a year and three months.

4.14. On March 31, 2015, there were 36 people with learning disabilities receiving direct payments. We saw cases where direct payments worked for people and their families. However other people did have difficulty in recruiting staff and direct payments were not a viable option for them. The use and promotion of direct payments to meet need and support carers was inconsistent. The arrangements were described as very bureaucratic and inefficient, with payments frozen if not used regularly. The arrangements were described by one provider as being "demeaning, keeping people tethered". Work has been done in the co-production with carers and providers on a new direct payment policy and the authority needs to implement this.

4.15. We saw that the outcomes during transition arrangements from children's to adult services were good for people; however families told us that this was not consistently the case. Some families were unhappy with the outcomes while others families had successful transition arrangements. When speaking to a group of care managers they told us parental expectations are not always met during transition and providers of services could sometimes create expectations that were not sustainable and did not promote independence. The local authority has developed guidance regarding the transition from children's to adult services, with information about people being shared with adult services from the age of 14 and regular transition forum meetings are held to discuss the young people going through transition. The health staff involved said that the transitions forum worked well, but some day service providers said that they were not effectively informed or involved in the process. In a tracked case we saw challenging work around transition to adulthood had been handled well with timely assessments, reviews and plans. We also saw other good transition plans in place.

4.16. We saw practice that promoted independence in living arrangements, work and transport. We saw that people's presence and profile in the community was considered and promoted. We saw people being valued and well known in their communities and within professional circles. There was a strong sense of working together to ensure that lives were enriched and that wellbeing was promoted. There were clear outcomes specified for people including the ability to maintain positive community presence, maintain their own housing tenancy and live safely and independently.

4.17. The evidence from the inspection is that there is effective practice safeguarding people from abuse and neglect, but the arrangements for the leadership, governance and quality assurance for adult safeguarding were unclear. This heightens the risks and the authority has identified that improvement is needed. The improvements the authority identified within the adult safeguarding process include:

- the making and recording of decisions and outcomes in strategy meetings;
- inform and involve families and carers of safeguarding activity and outcomes;
- supervision and quality assurance; and
- clarity of governance roles and responsibilities.

4.18. There is some effective interagency working in safeguarding with timely responses by the authority to safeguarding issues. It was reported that the care managers told us that they found difficulty in progressing complex safeguarding cases such as when individuals don't have mental capacity and this was an area where professional leadership could be improved. Providers could readily access safeguarding training but were not involved in wider safeguarding.

4.19. There has been a significant increase in the number of Deprivation of Liberty Safeguards (DoLS) applications after the Cheshire West judgement. We saw cases were DoLS were in place to safeguard people's rights. The authority has 13 best interest assessors and a work programme to prioritise the assessments on the waiting list. During the inspection we also became aware of liberty being restricted in the use of locked doors in day services and supported living services. The authority needs to keep arrangements that deprive liberty under close review.

4.20. People benefit from a positive relationship with care managers and enthusiastically described the support they received. Most families reported that care managers communicated well with them and got things done and some families said that their care managers were "brilliant" and that there had been longstanding positive relationships. We heard how these trusting relationships had been developed over time and had enabled good communication.

4.21. We saw evidence of carers being offered carers assessments and often declining the assessment. Carers were positive about the support they received and many were in contact with the Carers Outreach service. Carers generally appreciated the reliable and consistent support from the care managers in the community team and spoke highly of some of these relationships. This was partly due to the way in which cases 'closed to review' are managed, which enabled people to contact their previous care managers directly and effectively pick up where they left off. Families were positive about their relationships with care managers praised them and said that they did what they said they would do.

4.22. Families were critical of the communication they received from the authority about developments in the service and that there were no regular meetings or direct communication. Carers said repeatedly that they were not informed of opportunities or consulted on they type of help that they may need.

4.23. The multi disciplinary team worked effectively to support people. We saw examples of swift action being taken to safeguard people when it was not

safe for them to remain living independently and good use of people's community contacts to play a safeguarding role. The input of the psychiatrist was to be seen in the cases and provided leadership in managing risks and promoting wellbeing.

Key Question 3

To what extent have the arrangements for leadership and governance in the local authority delivered a clear vision for care and support for people with learning disabilities, aimed at improving outcomes, and which has the support an involvement of partners – including people with learning disabilities and carers

5.1. The absence of the two senior managers in Adult Services and the substantive service sanager have had a significant impact on the quality of the evidence available to inspectors about the leadership and governance for the service.

5.2. Frontline staff within the authority have no clear understanding of how the care and support for people with learning disabilities will be improved in the coming years. Care managers felt ill informed regarding developments and not being prepared for the future. There is no clear and effectively communicated direction from senior managers in terms of prioritising projects and giving regular guidance. We were told that staff supervision and appraisal does not regularly occur. A training needs analysis is carried out and training was seen to be available to support professional development. Staff work plans and targets did not appear to fit in with or contribute to an overall plan for the service. Improvements in the services have primarily been the result of the effort of individuals. While individuals in the staff team were highly motivated and wanted to provide a responsive high quality service, staff and managers consistently described feeling alienated by the approach to the management of change at a senior level. Senior management have communicated the vision and direction an example of this is was in a staff conference. A care manager said that in the conference "we were all told that if we didn't want to be on the journey of change then we could get off at the next station. The frustration is that we feel that we have been working in an outcome focussed, preventative fashion for many years in learning disability services."

5.3. The workforce has a number of care managers on temporary contracts and has not recruited to vacancies on a permanent basis. These arrangements were not the result of an active decision by the leadership

team instead highlighting a gap between leadership and recruitment practice.

5.4. The principles of the Social Services and Wellbeing Act need to be included in the vision and plans. There is no specific plan to develop the relationship with providers and this is a key part in changing the way services will be provided in the future. Providers said that there had been no regular and effective dialogue explaining the future direction of the service. The absence of an effective commissioning strategy and market place analysis has frustrated an effective dialogue. The authority said that it was renewing its procurement practices which may result in improvements. Some providers have felt that case reviews had aimed to reduce the cost of care packages and they have not appreciated the need to provide individual person centred support. The piecemeal reduction in individual care packages has in some cases had significantly affected providers' financial stability and ability to plan. Other providers have been quicker to understand the intentions of the council and the need to provide a more progressive service.

5.5. The practice we saw promoted the rights and entitlements of people with learning disabilities. The authority's staff have good relationships with people, treating them respectfully and protecting their rights and entitlements. People in some services receive good person centred care promoting individual needs, but this is not consistently to be seen in all services. However care managers and managers said that there was a lack of processional advice available to them to support with complex cases and decision making. Also care managers said that applications for Continuing Health Care funding of packages of support for people with learning disabilities are handled differently to those for older people and the criteria and level of challenge to decision making takes longer.

5.6. During the inspection we met with a group of people with learning disabilities as the authority had effectively worked with advocacy services and arranged attendance of 20 people who were effectively supported to contribute to the meeting. The people were mostly positive about the help received although some were also profoundly upset about the decision to close the Manton day service. The people who work at the Manton day service heard in September 2015 that the services would be closing and their parents, and carers and the advocacy service had not been informed of this decision. The authority subsequently decided to postpone the decision regarding the closure of the service. These events caused and continue to cause distress to people who use the service and during the inspection parents and carers referred frequently to the anxiety and associated behaviour such as disturbed sleep and repeated questioning.

5.7. In January 2016 the authority decided to transfer the Frondeg site to a housing association partner to work in partnership to develop new modern purpose built accommodation for adults with learning disabilities. Presently, day and residential services are provided from the site and these will continue until the new accommodation is ready which will take at least three to four years to design and build. The authority has said that it will engage a focus group of people to contribute to the development and design.

5.8. There has been consultation and engagement work regarding the Frondeg development and this played an important part in the council decision making. The council produced an information pack and questionnaire for people who used services and their families asking what provisions they would wish to see provided. The consultation began in September and finished at the end of October 2015. There were paper and on line questionnaires, and face to face meetings and information was provided in the press and via social media.

5.9. The local authority needs to establish trusted channels of communication with people, their carers and families. A wide ranging plan for engagement is needed that moves beyond a service focussed approach and includes meaningful engagement with users, carers and the advocacy service at an early stage of planning.

5.10. A comprehensive quality assurance operational plan was drafted in August 2015 however little evidence of quality assurance was seen in practice. The authority's use of its electronic complaints management system 'Respond' is developing and improving timeliness of responses and improving learning. The department manages a complaints procedure and data demonstrates that it is responding within timescales. There is evidence to show that local resolution stage is working well. The customer care officer is currently working on identifying actions from the lessons learnt and linking the resulting learning or changes to the complaint, to close the circle regarding the issue. Managers within the learning disabilities service are seen to be responsive to complaints issues. For example, following complaints about the termination of a mini bus service to a place of work for people the council responded to the issue by influencing the usual bus company to pass the place of work as part of its normal route. Complaints are increasingly receiving resolution close to the issue at hand and there are now very few second stage complaints - none in the last seven months.

5.11. The local authority needs to build on the services and strengths that it has in supporting people with learning disabilities. In doing so, they can provide strong leadership with a direction for improvement, professional support for staff and wide ranging engagement with stakeholders.

Next steps

The local authority is required to produce an improvement plan in response to the recommendations from the inspection. While the plan is the responsibility of the local authority, it should be available to CSSIW as soon as possible after the publication of the report.

We will monitor progress with the improvement plan through our usual programme of business meetings and engagement activity in the local authority. Where necessary, additional follow-up activity will be discussed and arranged with the local authority.

Findings - The Health Board

Healthcare Inspectorate Wales (HIW) undertook fieldwork in order to form a view of the role of the health board in the effective provision of services for people with learning disabilities.

Summary of inspection

We tracked four cases that were jointly funded between health and social care by reviewing case records, interviewing key professionals involved and meeting with people and their families. We interviewed health staff both on the frontline and management staff within the health board. We held a focus group attended by community nurses, speech and language therapist, clinical psychologists, health care assistant, members of the health liaison team, psychiatrist, student nurse and team manager. The health board and local authority also carried out a presentation on how they worked together to achieve positive outcomes for people.

Key Question 1

How well does the health board understand the need for care and support for people with learning disabilities, including support for carers and the development of preventative services it its area?

6.1. We saw excellent examples of preventative health services working in practice for people with learning disabilities to promote awareness, best practice and ensure people's care and support was well coordinated. We saw examples where staff from the complex needs service intervened to try to prevent the breakdown of people's support and provided long term input to a family in one case, when the person with learning disabilities needed support from consistent staff. There was also a dedicated health liaison team consisting of 13 staff, including input from people with learning disabilities, who worked on health promotion and awareness in a range of areas including primary and secondary care and mental health. Some examples included work around good discharge planning, promoting hospital passports and learning disability care bundles in hospitals to help staff to support people with learning disabilities according to best practice principles and the promotion of annual health checks. There was also a dedicated mental health liaison nurse for learning disabilities who was working on a range of initiatives to improve the experiences of people with learning disabilities who also used mental health services. For example, through the production of accessible information on the Mental Health Act and staff training. The work of this team was an area of noteworthy practice.

6.2. Through case tracking we found that people received timely and appropriate health and social care assessments and interventions. Case management was well coordinated with the most appropriate professional taking on the role of case manager, this being the health professional in some cases. In one case we saw that both local authority and health staff became involved early enough to be able to jointly coordinate services that would meet the young person's complex needs. In this case there had been difficulties in finding respite care that could work with the person who demonstrated behaviours that could challenge. The team had to work jointly in a creative way to set up a bespoke respite service for the person.

6.3. In all of the cases we reviewed we found that staff had a good understanding of people's needs and worked to plan people's future services in partnership with them and their families. In three out of four cases however, a lack of appropriate service provision in the area to meet people's needs, meant that there had been disruption or delays to people's care and support. For example, in one case, the person with

learning disabilities who was under 65 years but needed nursing care had to go out of county for a placement, away from their family, because of a lack of nursing homes registered for people with learning disabilities. There were challenges in service provision meeting people's needs particularly for those with challenging behaviour, complex needs, younger people with learning disabilities requiring nursing care and those people requiring respite care.

6.4. There were some isolated examples of good planning happening in health services on a more strategic level. For example, management staff were making changes to team configurations to ensure the appropriate skill mix. Based on the outcome of a review of the service, more health care assistants and band 5 nurses were being employed. The health board had also committed to training nurses in dialectical behavioural therapy (DBT) which had come about as a result of anticipating the future needs of those people currently going through transition.

6.5. However we found that overall planning on a strategic level had not been proactive and had not involved people with learning disabilities and their carers. Staff told us there was not a system in place for overall monitoring of needs and outcomes of the adult learning disability population to support future planning and commissioning. There had also been a lack of management stability within the Division to take planning forward due to key posts within the service being interim. Following our inspection in nearby Conwy in November 2015, the health board provided us with assurance, through an improvement plan, that there was a plan in place to recruit to permanent posts within the Mental Health and Learning Disability Division in order to progress with more strategic planning.

6.6. Overall this meant that there were some excellent examples of preventative work with people with learning disabilities and care coordination, anticipating people's future needs on the frontline. Following our inspection in Conwy, we were also assured on a strategic level that there was a focus on recruiting to permanent posts to create the stability to take plans for the service forward. However the health board needs to prioritise building up a detailed understanding of the current needs of the population of adults with learning disabilities in the Gwynedd area in order to be able to effectively plan.

Key Question 2

How effective is the health board in providing information, advice, assistance, assessment and care planning that achieves positive outcomes and which respects people with learning disabilities as full citizens, equal in status and value to other citizens of the same age?

7.1. Overall, we found a staff team who were passionate and committed to achieving the best outcomes for people with learning disabilities. In the cases we tracked, we found that health staff worked well together in providing information, advice, assistance, assessment and care planning to people with learning disabilities. Families we spoke with made positive comments about their relationships with health staff.

7.2. However, health staff faced barriers to meeting people's individual needs. For example, access to therapies such as speech and language therapy, occupational therapy and physiotherapy had reduced over recent years with occupational therapy services now being provided by generic, rather than specialist, learning disability occupational therapists. We also heard about a reduction in hours provided by the complex needs service which no longer offered out of office hours provision. Staff told us this had changed the kind of assessments the complex needs service were able to undertake with people with learning disabilities. There was also less Welsh language provision available in the health team as opposed to the local authority, with a particular gap being noted in psychology. Staff told us several community nurses spoke Welsh and they could use Welsh speakers across the local authority and health team to provide translation services when required. Overall this meant that the current working environment provided challenges to staff in meeting people's individual needs.

7.3. One carer told us about the frustrations they had faced in trying to find support staff with the appropriate skills to work with their loved one who could demonstrate behaviour that challenged. This was confirmed through further case tracking where we saw that in three of the four cases there had been a lack of appropriate service provision in the area to meet people's needs leading to disruption and delays. We have asked the health board to make improvements to service planning and provision under key question one. We saw that in all cases health and local authority staff had worked together to come up with creative solutions where there was a lack of appropriate service provision. For example, there was a lack of appropriate respite placements to meet one young person's physical health needs and challenging behaviour. The multidisciplinary team had therefore started to make arrangements to trial

respite in a day service placement; an environment that was familiar to the person. This demonstrated that both health and local authority staff felt empowered to work together to identify creative solutions and were committed to meeting people's needs despite the challenges they faced.

7.4. Case tracking revealed that people received a variety of multi professional assessments and interventions based on their individual needs. We saw evidence of timely and appropriate health and multidisciplinary interventions, assessments and referrals by health and social care staff working together on shared outcomes for people. The health team provided training to enable staff to meet people's individual needs, for example, the Complex Needs Service had been involved in carrying out behavioural assessments and speech and language therapy staff told us about work they did in training staff to meet people's individual communication needs.

7.5. We saw that people were encouraged to express their views and preferences over decisions that affected their lives on an individual level. We heard that the health liaison team gathered feedback about their services and psychology staff were developing an accessible questionnaire. However, the health team did not gather feedback about the services they provided as a whole team, from people with learning disabilities and their carers. The health team must ensure they are responding to people's feedback and experiences to improve their services.

7.6. The health board had recently invested in resources for the safeguarding team and health staff were clear about their responsibilities in reporting potential harm or abuse. The health board had a system in place for monitoring safeguarding concerns that came from community teams, for potential themes and trends, with a view to taking action or making improvements.

7.7. Following a focus group and further discussions with staff we identified that improvements were needed in the communication between health board management staff and frontline staff to ensure staff felt valued in their roles and felt engaged with the health board's priorities.

Key Question 3

To what extent have the arrangements for leadership and governance in the health board delivered a clear vision for care and support for people with learning disabilities, aimed at improving outcomes, and which has the support and involvement of partners – including people with learning disabilities and carers?

7.8. Overall we found the vision for learning disability services to be unclear within health and was instead based upon trust and informal arrangements. There was no current strategy for learning disability services and key posts within the health board were interim. However since the last inspection in November 2015, we were assured that work was happening to recruit permanent staff into key posts to give the stability to take plans forward.

7.9. In the four cases we reviewed people experienced care and support across health and social care that was well coordinated and demonstrated effective partnerships between social services, health, the wider multidisciplinary team and support providers. There were barriers to joint working due to staff working across a large geographical area, but informal discussions still happened to enable staff to gain up to date information about people's needs on a more informal basis. We found issues in relation to IT systems which meant that joint working was not supported by effective systems. For example, there were two separate IT systems; one for health and one for the local authority with not all staff using these systems consistently or being able to access them. This meant that the IT systems did not provide an accessible overall view of the person's needs without further investigation by health and local authority staff. Health board management staff told us that a review of the IT issues across learning disabilities services had been immediately commissioned with a view to making improvements.

7.10. Staff told us about the challenges and pressures placed on the team of increasing numbers of continuing health care applications. In the funding examples we saw, this did not affect outcomes for people with learning disabilities but the process of reaching these outcomes left the team feeling demoralised and created difficulties in managing families' expectations of services. We also heard that there could be difficulties and delays in accessing specific pieces of equipment.

7.11. We saw that staff worked to secure people's rights on an individual level and the health liaison team were key in promoting the rights of people with learning disabilities in secondary care, primary care and mental health settings. We saw appropriate use of the Mental Capacity Act in individual cases. However, through case tracking we saw that the lack of service provision in the area for people with complex needs meant that this impacted on their rights because they were not always able to be as fully active and independent as people of a similar age, or there were delays in people being able to access appropriate services. The team were dedicated to working together to come up with creative solutions in these cases. However staff were not able to demonstrate on a strategic level how they were working jointly to overcome these challenges. A joint commissioning proposal had been drawn up but this had not yet been signed or agreed upon as a way to advance strategic joint planning and commissioning.

7.12. The North Wales Learning Disability Regional Partnership provided a forum for health, the local authority and other partners to come together to discuss joint work. However, joint working on a strategic level was informal and there had not been the stability within senior health management for effective partnership working with local authority staff at this level of joint service development. The lack of close monitoring of the spend, needs and plan for learning disability health services meant that we could not be assured that stable plans were in place to continue with arrangements that were informal and based upon 'goodwill'. Following our last inspection the health board were able to demonstrate that they were beginning to recruit permanently to key posts. A review of the organisational structure within the division was underway. The Director of Nursing post had been appointed and posts for the Medical Director and Director of Mental Health were being advertised. This meant that staff were working to create stability within the division in order to move joint work and service planning forward.

7.13. We heard that there were well established clinical governance structures in place. For example, there were clinical interest groups which staff told us were well attended, to promote best practice. Staff also told us that groups such as the professional nurse forum for learning disabilities was also re-starting. However, therapies, psychology and psychiatry staff were all supervised outside the division by supervisors who did not specialise in learning disabilities. Staff told us that supervisors did not always have the specialist understanding of learning disabilities to provide them with the most appropriate clinical guidance and that this could also lead to inconsistencies in how initiatives were implemented, with guidance outside the division sometimes conflicting with guidance within the division.

7.14. A strategy group had recently been disbanded and was in the process of being reformed so that the necessary time and resources could be used to put a clear strategy in place. There were examples whereby people were consulted and involved in service development such as through involvement in the new strategy group. However there was not a structured system in place within the health board for consulting with service users on a formal basis.

7.15. Health team staff felt unclear about the vision of the service and disconnected from higher levels of management within the health board. There was a lack of a clear vision for the future of learning disability health services at a time when there were a number of challenges facing staff on the frontline, for example, a reduction in therapies, a need for succession planning and a lack of service provision to meet the needs of the adult population of people with learning disabilities. There is a need for the health board to engage both people with learning disabilities and staff teams in setting the future direction, vision and strategy for learning disability services.

Next steps

The health board is required to complete an improvement plan to address the key findings from the inspection and submit this to Healthcare Inspectorate Wales (HIW) within two weeks of the publication of this report.

The health board improvement plan should clearly state when and how the findings identified will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/units within the wider organisation.

The actions taken by the health board in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the health board's improvement plan remain outstanding and/or in progress, the health board should provide HIW with updates, to confirm when these have been addressed.

Methodology

Survey and Self Assessment

The local authority completed a data survey and self assessment in advance of the fieldwork stage of the inspection. The information from both was used to shape the detailed lines of enquiry for the inspection. It will also be used to inform the national overview report for Wales.

Routine inspections of regulated services

These included additional lines of enquiry linked to the key questions for the national inspection.

Contribution from All Wales People First Wales and the All Wales Forum of Parents and Carers

Both organisations undertook work with their members and others to consider the key questions for the inspection and report back to the inspectorate.

Fieldwork

The inspection team were on site in Gwynedd for seven days spread across two weeks in February 2016. The first week focussed on the experiences of people and their carers and of staff working in the delivery of care and support. The second week considered issues of leadership and governance (including partnership work) and the success of the local authority in shaping services to achieve good outcomes for people. Activities during the fieldwork included:

- Case tracking – inspectors considered 20 selected cases and explored 8 of those in further detail with people, carers, care managers and others.

- Interviews – inspectors conducted a number of group and individual interviews with staff, elected members and partners.

- Observation - inspectors together with HIW listened to a presentation by the authority and the health board on their work together in support of people with learning disabilities.

Acknowledgements

We would like to thank the people with learning disabilities who contributed to the inspection; parents and carers, staff and managers of Gwynedd Council, staff and managers of the health board, the service providers and partner organisations (including the third sector) for their time, cooperation and contributions to this inspection.

Contents

Introduction

This report of an inspection of Gwynedd Council is part of a national inspection of care and support for adults with learning disabilities. The purpose of the inspection is to assess the success of local authority social services in achieving the outcomes that matter to people. It will do this by assessing the efficiency, quality and safety of the care and support provided for adults with learning disabilities. It will identify those factors that drive good outcomes for people as well as the barriers to progress.

The national inspection includes detailed fieldwork in six local authorities in Wales, including Gwynedd, and an individual report for each of the six authorities will be published at the same time. We have also produced an overview report for Wales that draws on all the information available to the inspectorate, including a national survey of all 22 local authorities in Wales. The reports can be found on our website

We have worked closely with All Wales People First Wales and the All Wales Forum of Parents and Carers throughout the national inspection in an effort to engage productively with people and with carers who are affected by the issues discussed. Further detail about our engagement with people and carers can be found in the overview report.

Inspectors from Healthcare Inspectorate Wales (HIW) joined us for part of the inspection to assist with the consideration of the efficacy of the partnership between social services and health. HIW have outlined their findings at page 24 and will also report their findings directly to the Health Board.

The report that follows sets out our findings and recommendations for Gwynedd Council. Our intention is firstly, to provide information to the public about the performance of local authority social services; and secondly, to support improvement in the care and support provided for people with learning disabilities.

Context

The Local Authority

Gwynedd Council has a population of approximately 122,000 (2014 mid year estimate).

In September 2015 the local authority estimates that there were 2340 adults with learning disabilities living in Gwynedd. There were 567 adults on the authority's learning disability register of whom 243 were 'active cases' open to a care manager; 232 people who were 'open to review' and 92 people who were closed cases. In the year leading up to March 2015 there had been 47 new referrals.

Between 2010-11 and 2015-16 there has been a 7% increase in the number of people on the learning disability register. Of those people over 65 years of age there were 61 people in September 2015 known to the local authority which was an increase of 18% from 2010-11.

The local authority estimates that its average expenditure per person per year for people with learning disabilities receiving a service during the period April 1 2014 to 31 March 2015 was £23,600.

Context

The Health Board

Community health learning disability services in Gwynedd were provided through Betsi Cadwaladr University Health Board and fitted into tiers one and two of their learning disability service model. At tier one, the Health Liaison Team were involved with health promotion. At tier two, health staff worked alongside local authority staff within the community learning disability team. Community learning disability team health staff were based in three sites across Gwynedd; in Arfon (Caernarfon), in Dwyfor (Pwllheli) and in Meirionnydd (Dolgellau). Local authority staff were co-located with health staff at each location.

There was a multidisciplinary health team which consisted of a health team leader, speech and language therapists, community nurses, health care assistant, physiotherapists, clinical psychologists and a consultant psychiatrist. The health team could also access the following services for people with learning disabilities:

- Complex needs service
- Occupational therapy (not specialist learning disability)

Health services focussed on four priority areas: forensics, profound and multiple learning disabilities, challenging behaviour and mental health. Learning disability health services fell under the mental health and learning disability division within the health board.

Summary of Findings – The Local Authority

1.1. The authority restructured its social services department in 2014 creating the new post - Head of Adults Health and Wellbeing. In March 2015 an interim head of service took up responsibility for adults health and wellbeing and during 2015 two senior managers were recruited to the new structure. The two senior manager posts were not filled at the time of the inspection in February 2016. Although there were arrangements to cover these posts the absence of the substantive post holders during much of the preceding year had significantly affected the leadership capacity and support for the service.

1.2. The authority has been implementing its operating approach 'Ffordd Gwynedd' which aims to put people at the centre of the council's work and efficiently deliver what is important to them. The leadership team's initial priority for change has been services for older people and adults with physical disabilities. Modernising services for adults with learning disabilities has not been a priority.

1.3. There is good joint working between health and social services at an operational level. However this is not the case a senior strategic level. There are no regular meetings at a senior level to make progress with the joint service and no shared vision regarding future direction and development. There is however support within the authority for improving the learning disabilities service with the cabinet member with portfolio responsibility for the service. They are highly engaged and supportive of the need to modernise the service and the need to do this jointly with the health service. Residential and day services for people with learning disabilities are provided from the Frondeg site in Caernarfon. The authority agreed in January 2016 to make a significant capital investment of £3.18 million to develop the site to improve these services.

1.4. The quality of practice in the protection of vulnerable adults was deemed to be reasonable in the cases we saw. However we were not confident that there was clarity regarding the roles and responsibilities of officers and in quality assurance arrangements. This is an area to which the Director of Social Services should give urgent attention.

1.5. Assessments and reviews were not always updated and the authority cannot be sure that people consistently get the right help at the right

time, in the right place, at the right cost. While the number of cases we saw was small it provided some evidence of reviews not being done within the year. We saw examples of good work with individuals, for example there was effective working with Betsi Cadwaladr University Health Board and examples of good practice, particularly in providing positive behavioural support. Some people using day care services received highly person centred care, reflecting the benefits of the authority's investment in active support training.

1.6. People generally get coordinated services that make sense to them, but this was not always the case. We saw good examples of person centred practice. However there were also some instances where progression for individuals was slow. Care mangers were dedicated and had developed a positive relationship with people, carers and colleagues. This was a consistent message in the inspection and the quality of the authority's learning disability services is primarily dependent on the work of the area teams.

1.7. The authority has a learning disability commissioning plan (2011-16), but progress in implementing this has been piecemeal rather than part of a determined and wide ranging improvement drive. The authority has made some progress in the development of services such as the development of modern accommodation in Pant yr Eithin, following an agreement for developing the Frondeg site and the development of practice in the Cynllun Cymunedol Arfon scheme. There has been work with independent providers but this has been limited by the absence of a developed commissioning plan and market analysis and a recent draft commissioning plan had not been developed with key stakeholders. The development of services was not found to be based on a thorough understanding of need or on wide engagement with people, parents / carers, and front line staff. The authority needs to develop more consistent and systematic ways of understanding needs and developing services through a dialogue with people, providers, families and partners. There is a need to improve the coordination between the front line services and commissioning and contracting functions. We saw enthusiasm, energy and hard work within the learning disability services in Gwynedd. There is a need to build on this with strong leadership, a need to create a vision, communicate, engage and implement an improvement plan.

Summary of findings – The Health Board

1.8. There are excellent examples of preventative health services for people with learning disabilities, for example the Health Liaison Team, which includes a dedicated mental health liaison nurse working to improve the experiences of people with learning disabilities using mental health services. Staff had a good understanding of people's needs on an individual level and worked to plan people's future services in partnership with them and their families. However, there is a lack of appropriate service provision in the area to meet people's needs, particularly those people with complex needs. The health board needs to understand the needs of its adult learning disabilities population in order to plan services in Gwynedd that meet people's needs.

1.9. Overall, health and social care staff work well together in providing information, advice, assistance, assessment and care planning to people with learning disabilities. Inspectors found timely and appropriate health and multidisciplinary interventions, assessments and referrals by health and social care staff working together on shared outcomes for people. Staff faced barriers to meeting people's individual needs. For example, due to the reduction in therapies and lack of appropriate service provision but worked together to come up with creative solutions for people. Inspectors heard about challenges in accessing specific equipment in a timely way and challenges around the application of the continuing health care funding process. There was a need for the health team to gather feedback from people with learning disabilities and their carers about the services they provided.

1.10. Inspectors found that there were well established clinical governance structures in place including clinical interest groups. However, therapies, psychology and psychiatry staff were all supervised outside the division by supervisors who did not specialise in learning disabilities. Inspectors asked the health board to review this to ensure staff have access to appropriate, specialist clinical supervision where needed. Inspectors found that the communication between the health board management staff and frontline staff also needed to be improved.

1.11. Although there were good examples of joint working, this was not supported by a clear vision for care and support for people with learning disabilities. Following our inspection in nearby Conwy in November 2015 staff were working to create stability in the division by reviewing the

organisational structure and recruiting staff to key posts. The health board needs to engage with people with learning disabilities and their families as well as staff, in setting a direction for future services.

Recommendations – The Local Authority

2.1. The local authority should give a higher priority to meeting the needs of people with learning disabilities. Leadership is needed to provide direction for improvement, professional support for staff and wide ranging engagement with stakeholders.

2.2 The local authority should establish channels of communication to achieve meaningful engagement with people, families and carers - using advocacy services as needed.

2.3. Strategic planning with health colleagues is needed to develop long term aspirations and plans. A joint commissioning strategy should be developed between health and social services based on an analysis of need.

2.4. The local authority should develop and improve its communication with providers of services, involving them in the construction of a market position statement and in discussions about a joint commissioning strategy with health.

2.5. The local authority should review its arrangements for adult safeguarding ensuring that there is clarity regarding roles and responsibilities and quality assurance arrangements.

2.6. The local authority should review the way in which it safeguards the rights of people where their liberty is being deprived to ensure that human rights are properly supported and protected.

2.7. The local authority needs to ensure appropriate performance management and professional advice is in place to support the workforce.

Recommendations – The Health Board

2.8. The health board must ensure that it plans, resources and manages performance and value for money for learning disability services. Specifically, the health board must ensure that it gathers relevant data and information with a view to planning service provision that can clearly demonstrate how it is meeting the needs (and planning to meet the future needs) of the current learning disability population.

2.9. The health board must ensure that the specific challenges highlighted in Gwynedd are considered in the future planning of service provision including services for:

- people with challenging behaviour
- people with complex needs
- respite
- services for younger people with learning disabilities requiring nursing care
- older people with learning disabilities
- people with autism

2.10. The health board must ensure that health teams are gathering, acting on and learning from people's feedback in order to improve services.

2.11. The health board should ensure that staff on the frontline feel connected and engaged with the health board's vision by improving communication and information flow.

2.12. The health board should work with the local authority to identify better ways of working with a view to improving continuing health care processes, where appropriate. The health board should ensure that staff teams have sufficient training and have consistent, clear information about making continuing health care applications.

2.13. The health board should work with the local authority to, where appropriate, ensure people are offered equipment that meets their assessed needs in a timely way.

2.14. The health board should review supervision arrangements for staff within the division to ensure all staff have access to appropriate, specialist clinical supervision where needed.

2.15. The health board must ensure they engage with people with learning disabilities, carers and staff, in setting the vision and direction of the service.

Findings – The Local Authority

Key Question 1

How well does the local authority understand the need for care and support for people with learning disabilities, including support for carers and the development of preventative services, in its area?

3.1. People generally get the help they need, when they need it, in the way that they want it. Help is mostly well coordinated by social services and its partners on a case by case basis. The co-location of health and social services staff, a joint allocation meeting, and the ability of community nurses and therapists to use the social services case recording system have contributed to achieving this coordinated service.

3.2. At the front line social services, health and service providers work well together to anticipate and respond to future needs. For example, health practitioners described that two to three years ago they saw an increase in the prevalence of dementia in people with learning disabilities and arranged appropriate training for the services providing care for people.

3.3. The personal commitment, professionalism and skills of individual staff and managers has helped to create a service that has a strong value and practice base that demonstrates a commitment to the voice of people with learning disabilities. Staff were respectful of the views and opinions of people and we saw excellent examples of staff supporting people to express their views and feelings.

3.4. People, families, carers and providers do not have a clear understanding of the next stages for the development of care and support services. We were told that the authority's projects were identified under the headings of day services, support services, respite care, supported accommodation, Continuing Health Care and adult placement. There are work programmes proposed for each work stream and a project team meets on a monthly basis to monitor progress. This was not widely understood within the authority or by people, families, care workers and providers.

3.5. The authority has a learning disability commissioning plan (2011-16) with reasonable analysis of need and projections about future need. However in the past five years little work has been done to update this plan. Some work has been progressed but this has been piecemeal rather than part of a determined and wide ranging improvement drive. Accommodation and development of community based options have been developed. Respite

care and the partnership development of day services have not been similarly progressed. A recent draft commissioning plan developed shortly before the inspection fieldwork had been developed without discussion with key stakeholders.

3.6. The authority needs to develop more consistent and systematic ways to understand people's needs in the community in order to develop services. *Raise*, the authority's electronic case recording system, has not been able to gather information about individual needs in order to inform commissioning activity and the authority is moving towards using a new electronic recording system. There does not appear to be a system where information gathered from meetings and reviews about individual people is systematically collated to inform a county level needs assessment. Care managers/social workers complete a monthly data return identifying increases and decreases in packages of care and other quantitative data. There has been some mapping within the service of older carers, but the absence of a strong link between this and case work illustrates the gap between operational staff and planning. The assessment of need should to be completed with health colleagues and these arrangements are not in place. Information and understanding from health and social care practitioners needs to be fed into this analysis. The absence of a needs analysis affects the ability to plan; develop preventative services; and to meet the future needs of people, and their carers. This limits the ability to evaluate changes in need, contingency plans and the impact on services.

3.7. There is evidence to demonstrate that some consultation work has been well executed regarding individual service developments and that information has been cascaded in a clear manner, as seen in the Frondeg site development. Partnership working is inhibited by the absence of a future direction for the service that has been communicated to people, families and key stakeholders. Some providers spoke of individual officers working in 'silos' with a lack of co-ordination between the different council offices and functions such as commissioning and children's services. The absence of a strategy and plans for some services has left some people uncertain and anxious about their future care and support.

3.8. The authority has a robust Welsh language policy and in the main employs bilingual staff. The authority has been active in delivering on the "More than just words" agenda with a needs assessment and includes Welsh language in its contracts with providers. The authority performs strongly in providing people with an 'active offer' of assessment and services in Welsh. For example, we saw that people have an active offer of assessment by a Welsh speaking care managers. We also saw many third sector services and council services where there was a clear active offer. The position was weaker in the provision of more

specialised care services. We saw cases where first language Welsh speaking people were placed in care settings where English was the main language and their needs were clearly not met. Some providers reported no difficulty in recruiting Welsh speaking staff, while others particularly at the south of the county found this to be a considerable challenge.

Key Question 2

How effective is the local authority in providing information, advice, assistance, assessment and care planning that achieves positive outcomes and which respects people with learning disabilities as full citizens, equal in status and value to other citizens of the same age?

4.1. Inspectors examined 20 case files and followed through with a detailed examination of the experience of eight people from that sample. The evidence from this activity was considered alongside performance information and evidence from interviews and documentation.

4.2. The provision of information and advice needs improvement with more consistent web based communication. There is limited information available about support and opportunities on the local authority's website and information and families said that advice is provided by the care manager and local councillors. Although care managers are responsive to enquiries from families, information is not consistently shared. Care workers and carers described that they were unaware of some information and developments.

4.3. The assessment of individual needs for people in the case sample was relatively good - they were timely and of a good standard. The authority is aware of changes coming from the Social Services and Wellbeing (Wales) Act and care managers are including the "What Matters" conversations as part of their work, this conversation is part of the new assessment process that considers what is important to the individual. The wider principles of the act are still to be fully implemented. We saw specialist social work assessments resulting in some impressive examples of person centred care plans and good positive behavioural support plans.

4.4. On an individual basis within care planning it is evident that people are encouraged to express their views and opinions and that care managers listen and respect them. In the case files we reviewed and the visits we undertook, we saw evidence of a respectful, value driven approach from staff that encouraged the participation of people. Care managers spoke informatively about the people using the service and demonstrated that they knew peoples' preferences; they spoke with admiration of peoples' skills and abilities and of their achievements. Family attendance and opinions at reviews are also actively sought. The advocacy service is available to support people and health professionals described that the advocacy services were excellent.

4.5. Consultation work has developed recently and the consultation officer spoke of the department's Consultation strategy and provided evidence of the feedback from an engagement exercise about the various proposals for change. However the authority has not established regular mechanisms to listen to peoples' views and opinions making full use of the advocacy service. An area for improvement is in more wide ranging work with people to engage them in a conversation about decisions and proposals about the future shape of services,

4.6. The authority needs to continue to improve the timeliness of its reviews. At the time of the inspection of the 402 people who should have had their circumstances reviewed in the previous 12 months, 332 (82.6%) had been completed. We were told by providers that while recent reviews have been timely, performance had not been so good in the past. Most people in the case sample had experienced timely annual reviews, with additional reviews being used to consider changes in circumstances.

4.7. The quality of the reviews we saw was good. There is generally good multidisciplinary involvement in reviews with many held regularly with plentiful information. Health professionals said reviews and assessments worked well, were well organised with reports and notes. Further multi disciplinary team meetings were also held as needed. Practitioners said that generally discussions around funding do not delay the provision of care but there are examples of where this has happened.

4.8. The use of volunteering opportunities and work is important for people and should meet the individual's needs. We saw people who worked within the day services for many hours a week for little or no financial reward. Providers also told us that there had previously been limited emphasis on developing paid employment opportunities for people. It is important to review the outcomes of work activities to ensure that people's rights are protected and their independence maximised.

4.9. We saw person centred services providing good person centred care. The outcomes for people are generally good, but some more traditional services were lacking aspiration and personalised plans.

4.10. There is strong evidence of practice that developed a preventative approach and promoted independence. For example the authority has successfully introduced positive behavioural Support and active support models. Practitioners have developed the use of these approaches to prevent the need for more intensive interventions. Care managers do as much as possible to promote independence by ensuring that people in

transition to adult services' are provided with aproportionate packages of support. The authority's practice reflects a commitment to prevention, but is also driven by an awareness of the need to minimise cost. Respite services were described as being reviewed and these were identified numerous times by carers and families as being absent / weak.

Service example

Cynllun Cymunedol Arfon Community Link service is a day service spread across a number of small sites working with 25 people with profound disabilities and complex needs. Although the fabric of some of the buildings was poor the quality of work was good. Attention had been paid to individual positive behaviour support plans which were in place for all people with active support being ensured through quality assurance and data collection about engagement by individuals. There was clear evidence of the support leading to reductions in incidents of challenging behaviour and this was illustrated in weekly reports. The positive outcomes achieved were seen to be highly motivating for staff. The management and staff team were highly motivated, enthusiastic and value driven. This was a demonstration of good leadership in a service achieving a high quality public service.

The training was also provided to external providers and the impact was evaluated through direct observation of the implementation of practice by providers. To further embed the practice there was ongoing support and mentoring including observation and modelling.

4.11. Care managers and providers spoke positively about the multidisciplinary active support training and it being reinforced in practice. We saw examples of positive behaviour support plans detailing slow triggers, fast triggers, and 'respect' approaches for physical intervention and breakaway techniques. We also saw good practice in other areas such as best interest meetings giving full and balanced discussions and decisions. Appropriate personal relationships were also seen to be sensitively considered and supported with appropriate use of advocates with clearly presented views and involvement of people.

4.12. People do get help that is planned round their personal circumstances and needs. This tends to be from a range of existing services with limited mechanisms to develop new services. One care manager stated that one person wanted to join a walking group but none were available in his area. The care manager did not know how to address this or the most suitable person to speak to. We saw some cases of people living for years in

residential homes where their needs were not met. There were plans to move the people closer to their families and to more suitable arrangements. In these cases the care managers and their managers were identifying opportunities for the people to move as a result of vacancies arising in other care settings rather than services being developed to meet individual need. Plans did not, therefore, always start with a focus on individual need. There was an absence of coordinated planning that included the resources in the community, the third sector, and the authority's wider resources.

4.13. There were however, clear examples of some services being designed to build on individual strengths and meet individual need. There was significant input by the health service in assessment and planning of the cases we saw. Health professionals gave us examples of end of life care where the individual died according to their plan in their own home.

Case example

Person A has a strong and positive community presence. The care manager had been active in involving individuals in creating a network of support that helped to safeguard person A. This included the local corner shopkeeper who helps with daily purchases of cigarettes and groceries and the local pubs where both landlords and customers keep a caring watch over the service user. The plan focused on individual need and promoted independence.

Person B wanted to attend work experience but suffered from agoraphobia. Following an assessment and plan a third sector provider undertook daily visits to support the person. Taking a step by step approach getting ready, going to the front door, going to the path, going to the road over many months progress was made. The person did attend the work experience and the work to achieve this took a year and three months.

4.14. On March 31, 2015, there were 36 people with learning disabilities receiving direct payments. We saw cases where direct payments worked for people and their families. However other people did have difficulty in recruiting staff and direct payments were not a viable option for them. The use and promotion of direct payments to meet need and support carers was inconsistent. The arrangements were described as very bureaucratic and inefficient, with payments frozen if not used regularly. The arrangements were described by one provider as being "demeaning, keeping people tethered". Work has been done in the co-production with carers and providers on a new direct payment policy and the authority needs to implement this.

4.15. We saw that the outcomes during transition arrangements from children's to adult services were good for people; however families told us that this was not consistently the case. Some families were unhappy with the outcomes while others families had successful transition arrangements. When speaking to a group of care managers they told us parental expectations are not always met during transition and providers of services could sometimes create expectations that were not sustainable and did not promote independence. The local authority has developed guidance regarding the transition from children's to adult services, with information about people being shared with adult services from the age of 14 and regular transition forum meetings are held to discuss the young people going through transition. The health staff involved said that the transitions forum worked well, but some day service providers said that they were not effectively informed or involved in the process. In a tracked case we saw challenging work around transition to adulthood had been handled well with timely assessments, reviews and plans. We also saw other good transition plans in place.

4.16. We saw practice that promoted independence in living arrangements, work and transport. We saw that people's presence and profile in the community was considered and promoted. We saw people being valued and well known in their communities and within professional circles. There was a strong sense of working together to ensure that lives were enriched and that wellbeing was promoted. There were clear outcomes specified for people including the ability to maintain positive community presence, maintain their own housing tenancy and live safely and independently.

4.17. The evidence from the inspection is that there is effective practice safeguarding people from abuse and neglect, but the arrangements for the leadership, governance and quality assurance for adult safeguarding were unclear. This heightens the risks and the authority has identified that improvement is needed. The improvements the authority identified within the adult safeguarding process include:

- the making and recording of decisions and outcomes in strategy meetings;
- inform and involve families and carers of safeguarding activity and outcomes;
- supervision and quality assurance; and
- clarity of governance roles and responsibilities.

4.18. There is some effective interagency working in safeguarding with timely responses by the authority to safeguarding issues. It was reported that the care managers told us that they found difficulty in progressing complex safeguarding cases such as when individuals don't have mental capacity and this was an area where professional leadership could be improved. Providers could readily access safeguarding training but were not involved in wider safeguarding.

4.19. There has been a significant increase in the number of Deprivation of Liberty Safeguards (DoLS) applications after the Cheshire West judgement. We saw cases were DoLS were in place to safeguard people's rights. The authority has 13 best interest assessors and a work programme to prioritise the assessments on the waiting list. During the inspection we also became aware of liberty being restricted in the use of locked doors in day services and supported living services. The authority needs to keep arrangements that deprive liberty under close review.

4.20. People benefit from a positive relationship with care managers and enthusiastically described the support they received. Most families reported that care managers communicated well with them and got things done and some families said that their care managers were "brilliant" and that there had been longstanding positive relationships. We heard how these trusting relationships had been developed over time and had enabled good communication.

4.21. We saw evidence of carers being offered carers assessments and often declining the assessment. Carers were positive about the support they received and many were in contact with the Carers Outreach service. Carers generally appreciated the reliable and consistent support from the care managers in the community team and spoke highly of some of these relationships. This was partly due to the way in which cases 'closed to review' are managed, which enabled people to contact their previous care managers directly and effectively pick up where they left off. Families were positive about their relationships with care managers praised them and said that they did what they said they would do.

4.22. Families were critical of the communication they received from the authority about developments in the service and that there were no regular meetings or direct communication. Carers said repeatedly that they were not informed of opportunities or consulted on they type of help that they may need.

4.23. The multi disciplinary team worked effectively to support people. We saw examples of swift action being taken to safeguard people when it was not

safe for them to remain living independently and good use of people's community contacts to play a safeguarding role. The input of the psychiatrist was to be seen in the cases and provided leadership in managing risks and promoting wellbeing.

Key Question 3

To what extent have the arrangements for leadership and governance in the local authority delivered a clear vision for care and support for people with learning disabilities, aimed at improving outcomes, and which has the support an involvement of partners – including people with learning disabilities and carers

5.1. The absence of the two senior managers in Adult Services and the substantive service sanager have had a significant impact on the quality of the evidence available to inspectors about the leadership and governance for the service.

5.2. Frontline staff within the authority have no clear understanding of how the care and support for people with learning disabilities will be improved in the coming years. Care managers felt ill informed regarding developments and not being prepared for the future. There is no clear and effectively communicated direction from senior managers in terms of prioritising projects and giving regular guidance. We were told that staff supervision and appraisal does not regularly occur. A training needs analysis is carried out and training was seen to be available to support professional development. Staff work plans and targets did not appear to fit in with or contribute to an overall plan for the service. Improvements in the services have primarily been the result of the effort of individuals. While individuals in the staff team were highly motivated and wanted to provide a responsive high quality service, staff and managers consistently described feeling alienated by the approach to the management of change at a senior level. Senior management have communicated the vision and direction an example of this is was in a staff conference. A care manager said that in the conference "we were all told that if we didn't want to be on the journey of change then we could get off at the next station. The frustration is that we feel that we have been working in an outcome focussed, preventative fashion for many years in learning disability services."

5.3. The workforce has a number of care managers on temporary contracts and has not recruited to vacancies on a permanent basis. These arrangements were not the result of an active decision by the leadership

team instead highlighting a gap between leadership and recruitment practice.

5.4. The principles of the Social Services and Wellbeing Act need to be included in the vision and plans. There is no specific plan to develop the relationship with providers and this is a key part in changing the way services will be provided in the future. Providers said that there had been no regular and effective dialogue explaining the future direction of the service. The absence of an effective commissioning strategy and market place analysis has frustrated an effective dialogue. The authority said that it was renewing its procurement practices which may result in improvements. Some providers have felt that case reviews had aimed to reduce the cost of care packages and they have not appreciated the need to provide individual person centred support. The piecemeal reduction in individual care packages has in some cases had significantly affected providers' financial stability and ability to plan. Other providers have been quicker to understand the intentions of the council and the need to provide a more progressive service.

5.5. The practice we saw promoted the rights and entitlements of people with learning disabilities. The authority's staff have good relationships with people, treating them respectfully and protecting their rights and entitlements. People in some services receive good person centred care promoting individual needs, but this is not consistently to be seen in all services. However care managers and managers said that there was a lack of processional advice available to them to support with complex cases and decision making. Also care managers said that applications for Continuing Health Care funding of packages of support for people with learning disabilities are handled differently to those for older people and the criteria and level of challenge to decision making takes longer.

5.6. During the inspection we met with a group of people with learning disabilities as the authority had effectively worked with advocacy services and arranged attendance of 20 people who were effectively supported to contribute to the meeting. The people were mostly positive about the help received although some were also profoundly upset about the decision to close the Manton day service. The people who work at the Manton day service heard in September 2015 that the services would be closing and their parents, and carers and the advocacy service had not been informed of this decision. The authority subsequently decided to postpone the decision regarding the closure of the service. These events caused and continue to cause distress to people who use the service and during the inspection parents and carers referred frequently to the anxiety and associated behaviour such as disturbed sleep and repeated questioning.

5.7. In January 2016 the authority decided to transfer the Frondeg site to a housing association partner to work in partnership to develop new modern purpose built accommodation for adults with learning disabilities. Presently, day and residential services are provided from the site and these will continue until the new accommodation is ready which will take at least three to four years to design and build. The authority has said that it will engage a focus group of people to contribute to the development and design.

5.8. There has been consultation and engagement work regarding the Frondeg development and this played an important part in the council decision making. The council produced an information pack and questionnaire for people who used services and their families asking what provisions they would wish to see provided. The consultation began in September and finished at the end of October 2015. There were paper and on line questionnaires, and face to face meetings and information was provided in the press and via social media.

5.9. The local authority needs to establish trusted channels of communication with people, their carers and families. A wide ranging plan for engagement is needed that moves beyond a service focussed approach and includes meaningful engagement with users, carers and the advocacy service at an early stage of planning.

5.10. A comprehensive quality assurance operational plan was drafted in August 2015 however little evidence of quality assurance was seen in practice. The authority's use of its electronic complaints management system 'Respond' is developing and improving timeliness of responses and improving learning. The department manages a complaints procedure and data demonstrates that it is responding within timescales. There is evidence to show that local resolution stage is working well. The customer care officer is currently working on identifying actions from the lessons learnt and linking the resulting learning or changes to the complaint, to close the circle regarding the issue. Managers within the learning disabilities service are seen to be responsive to complaints issues. For example, following complaints about the termination of a mini bus service to a place of work for people the council responded to the issue by influencing the usual bus company to pass the place of work as part of its normal route. Complaints are increasingly receiving resolution close to the issue at hand and there are now very few second stage complaints - none in the last seven months.

5.11. The local authority needs to build on the services and strengths that it has in supporting people with learning disabilities. In doing so, they can provide strong leadership with a direction for improvement, professional support for staff and wide ranging engagement with stakeholders.

Next steps

The local authority is required to produce an improvement plan in response to the recommendations from the inspection. While the plan is the responsibility of the local authority, it should be available to CSSIW as soon as possible after the publication of the report.

We will monitor progress with the improvement plan through our usual programme of business meetings and engagement activity in the local authority. Where necessary, additional follow-up activity will be discussed and arranged with the local authority.

Findings - The Health Board

Healthcare Inspectorate Wales (HIW) undertook fieldwork in order to form a view of the role of the health board in the effective provision of services for people with learning disabilities.

Summary of inspection

We tracked four cases that were jointly funded between health and social care by reviewing case records, interviewing key professionals involved and meeting with people and their families. We interviewed health staff both on the frontline and management staff within the health board. We held a focus group attended by community nurses, speech and language therapist, clinical psychologists, health care assistant, members of the health liaison team, psychiatrist, student nurse and team manager. The health board and local authority also carried out a presentation on how they worked together to achieve positive outcomes for people.

Key Question 1

How well does the health board understand the need for care and support for people with learning disabilities, including support for carers and the development of preventative services it its area?

6.1. We saw excellent examples of preventative health services working in practice for people with learning disabilities to promote awareness, best practice and ensure people's care and support was well coordinated. We saw examples where staff from the complex needs service intervened to try to prevent the breakdown of people's support and provided long term input to a family in one case, when the person with learning disabilities needed support from consistent staff. There was also a dedicated health liaison team consisting of 13 staff, including input from people with learning disabilities, who worked on health promotion and awareness in a range of areas including primary and secondary care and mental health. Some examples included work around good discharge planning, promoting hospital passports and learning disability care bundles in hospitals to help staff to support people with learning disabilities according to best practice principles and the promotion of annual health checks. There was also a dedicated mental health liaison nurse for learning disabilities who was working on a range of initiatives to improve the experiences of people with learning disabilities who also used mental health services. For example, through the production of accessible information on the Mental Health Act and staff training. The work of this team was an area of noteworthy practice.

6.2. Through case tracking we found that people received timely and appropriate health and social care assessments and interventions. Case management was well coordinated with the most appropriate professional taking on the role of case manager, this being the health professional in some cases. In one case we saw that both local authority and health staff became involved early enough to be able to jointly coordinate services that would meet the young person's complex needs. In this case there had been difficulties in finding respite care that could work with the person who demonstrated behaviours that could challenge. The team had to work jointly in a creative way to set up a bespoke respite service for the person.

6.3. In all of the cases we reviewed we found that staff had a good understanding of people's needs and worked to plan people's future services in partnership with them and their families. In three out of four cases however, a lack of appropriate service provision in the area to meet people's needs, meant that there had been disruption or delays to people's care and support. For example, in one case, the person with

learning disabilities who was under 65 years but needed nursing care had to go out of county for a placement, away from their family, because of a lack of nursing homes registered for people with learning disabilities. There were challenges in service provision meeting people's needs particularly for those with challenging behaviour, complex needs, younger people with learning disabilities requiring nursing care and those people requiring respite care.

6.4. There were some isolated examples of good planning happening in health services on a more strategic level. For example, management staff were making changes to team configurations to ensure the appropriate skill mix. Based on the outcome of a review of the service, more health care assistants and band 5 nurses were being employed. The health board had also committed to training nurses in dialectical behavioural therapy (DBT) which had come about as a result of anticipating the future needs of those people currently going through transition.

6.5. However we found that overall planning on a strategic level had not been proactive and had not involved people with learning disabilities and their carers. Staff told us there was not a system in place for overall monitoring of needs and outcomes of the adult learning disability population to support future planning and commissioning. There had also been a lack of management stability within the Division to take planning forward due to key posts within the service being interim. Following our inspection in nearby Conwy in November 2015, the health board provided us with assurance, through an improvement plan, that there was a plan in place to recruit to permanent posts within the Mental Health and Learning Disability Division in order to progress with more strategic planning.

6.6. Overall this meant that there were some excellent examples of preventative work with people with learning disabilities and care coordination, anticipating people's future needs on the frontline. Following our inspection in Conwy, we were also assured on a strategic level that there was a focus on recruiting to permanent posts to create the stability to take plans for the service forward. However the health board needs to prioritise building up a detailed understanding of the current needs of the population of adults with learning disabilities in the Gwynedd area in order to be able to effectively plan.

Key Question 2

How effective is the health board in providing information, advice, assistance, assessment and care planning that achieves positive outcomes and which respects people with learning disabilities as full citizens, equal in status and value to other citizens of the same age?

7.1. Overall, we found a staff team who were passionate and committed to achieving the best outcomes for people with learning disabilities. In the cases we tracked, we found that health staff worked well together in providing information, advice, assistance, assessment and care planning to people with learning disabilities. Families we spoke with made positive comments about their relationships with health staff.

7.2. However, health staff faced barriers to meeting people's individual needs. For example, access to therapies such as speech and language therapy, occupational therapy and physiotherapy had reduced over recent years with occupational therapy services now being provided by generic, rather than specialist, learning disability occupational therapists. We also heard about a reduction in hours provided by the complex needs service which no longer offered out of office hours provision. Staff told us this had changed the kind of assessments the complex needs service were able to undertake with people with learning disabilities. There was also less Welsh language provision available in the health team as opposed to the local authority, with a particular gap being noted in psychology. Staff told us several community nurses spoke Welsh and they could use Welsh speakers across the local authority and health team to provide translation services when required. Overall this meant that the current working environment provided challenges to staff in meeting people's individual needs.

7.3. One carer told us about the frustrations they had faced in trying to find support staff with the appropriate skills to work with their loved one who could demonstrate behaviour that challenged. This was confirmed through further case tracking where we saw that in three of the four cases there had been a lack of appropriate service provision in the area to meet people's needs leading to disruption and delays. We have asked the health board to make improvements to service planning and provision under key question one. We saw that in all cases health and local authority staff had worked together to come up with creative solutions where there was a lack of appropriate service provision. For example, there was a lack of appropriate respite placements to meet one young person's physical health needs and challenging behaviour. The multidisciplinary team had therefore started to make arrangements to trial

respite in a day service placement; an environment that was familiar to the person. This demonstrated that both health and local authority staff felt empowered to work together to identify creative solutions and were committed to meeting people's needs despite the challenges they faced.

7.4. Case tracking revealed that people received a variety of multi professional assessments and interventions based on their individual needs. We saw evidence of timely and appropriate health and multidisciplinary interventions, assessments and referrals by health and social care staff working together on shared outcomes for people. The health team provided training to enable staff to meet people's individual needs, for example, the Complex Needs Service had been involved in carrying out behavioural assessments and speech and language therapy staff told us about work they did in training staff to meet people's individual communication needs.

7.5. We saw that people were encouraged to express their views and preferences over decisions that affected their lives on an individual level. We heard that the health liaison team gathered feedback about their services and psychology staff were developing an accessible questionnaire. However, the health team did not gather feedback about the services they provided as a whole team, from people with learning disabilities and their carers. The health team must ensure they are responding to people's feedback and experiences to improve their services.

7.6. The health board had recently invested in resources for the safeguarding team and health staff were clear about their responsibilities in reporting potential harm or abuse. The health board had a system in place for monitoring safeguarding concerns that came from community teams, for potential themes and trends, with a view to taking action or making improvements.

7.7. Following a focus group and further discussions with staff we identified that improvements were needed in the communication between health board management staff and frontline staff to ensure staff felt valued in their roles and felt engaged with the health board's priorities.

Key Question 3

To what extent have the arrangements for leadership and governance in the health board delivered a clear vision for care and support for people with learning disabilities, aimed at improving outcomes, and which has the support and involvement of partners – including people with learning disabilities and carers?

7.8. Overall we found the vision for learning disability services to be unclear within health and was instead based upon trust and informal arrangements. There was no current strategy for learning disability services and key posts within the health board were interim. However since the last inspection in November 2015, we were assured that work was happening to recruit permanent staff into key posts to give the stability to take plans forward.

7.9. In the four cases we reviewed people experienced care and support across health and social care that was well coordinated and demonstrated effective partnerships between social services, health, the wider multidisciplinary team and support providers. There were barriers to joint working due to staff working across a large geographical area, but informal discussions still happened to enable staff to gain up to date information about people's needs on a more informal basis. We found issues in relation to IT systems which meant that joint working was not supported by effective systems. For example, there were two separate IT systems; one for health and one for the local authority with not all staff using these systems consistently or being able to access them. This meant that the IT systems did not provide an accessible overall view of the person's needs without further investigation by health and local authority staff. Health board management staff told us that a review of the IT issues across learning disabilities services had been immediately commissioned with a view to making improvements.

7.10. Staff told us about the challenges and pressures placed on the team of increasing numbers of continuing health care applications. In the funding examples we saw, this did not affect outcomes for people with learning disabilities but the process of reaching these outcomes left the team feeling demoralised and created difficulties in managing families' expectations of services. We also heard that there could be difficulties and delays in accessing specific pieces of equipment.

7.11. We saw that staff worked to secure people's rights on an individual level and the health liaison team were key in promoting the rights of people with learning disabilities in secondary care, primary care and mental health settings. We saw appropriate use of the Mental Capacity Act in individual cases. However, through case tracking we saw that the lack of service provision in the area for people with complex needs meant that this impacted on their rights because they were not always able to be as fully active and independent as people of a similar age, or there were delays in people being able to access appropriate services. The team were dedicated to working together to come up with creative solutions in these cases. However staff were not able to demonstrate on a strategic level how they were working jointly to overcome these challenges. A joint commissioning proposal had been drawn up but this had not yet been signed or agreed upon as a way to advance strategic joint planning and commissioning.

7.12. The North Wales Learning Disability Regional Partnership provided a forum for health, the local authority and other partners to come together to discuss joint work. However, joint working on a strategic level was informal and there had not been the stability within senior health management for effective partnership working with local authority staff at this level of joint service development. The lack of close monitoring of the spend, needs and plan for learning disability health services meant that we could not be assured that stable plans were in place to continue with arrangements that were informal and based upon 'goodwill'. Following our last inspection the health board were able to demonstrate that they were beginning to recruit permanently to key posts. A review of the organisational structure within the division was underway. The Director of Nursing post had been appointed and posts for the Medical Director and Director of Mental Health were being advertised. This meant that staff were working to create stability within the division in order to move joint work and service planning forward.

7.13. We heard that there were well established clinical governance structures in place. For example, there were clinical interest groups which staff told us were well attended, to promote best practice. Staff also told us that groups such as the professional nurse forum for learning disabilities was also re-starting. However, therapies, psychology and psychiatry staff were all supervised outside the division by supervisors who did not specialise in learning disabilities. Staff told us that supervisors did not always have the specialist understanding of learning disabilities to provide them with the most appropriate clinical guidance and that this could also lead to inconsistencies in how initiatives were implemented, with guidance outside the division sometimes conflicting with guidance within the division.

7.14. A strategy group had recently been disbanded and was in the process of being reformed so that the necessary time and resources could be used to put a clear strategy in place. There were examples whereby people were consulted and involved in service development such as through involvement in the new strategy group. However there was not a structured system in place within the health board for consulting with service users on a formal basis.

7.15. Health team staff felt unclear about the vision of the service and disconnected from higher levels of management within the health board. There was a lack of a clear vision for the future of learning disability health services at a time when there were a number of challenges facing staff on the frontline, for example, a reduction in therapies, a need for succession planning and a lack of service provision to meet the needs of the adult population of people with learning disabilities. There is a need for the health board to engage both people with learning disabilities and staff teams in setting the future direction, vision and strategy for learning disability services.

Next steps

The health board is required to complete an improvement plan to address the key findings from the inspection and submit this to Healthcare Inspectorate Wales (HIW) within two weeks of the publication of this report.

The health board improvement plan should clearly state when and how the findings identified will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/units within the wider organisation.

The actions taken by the health board in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the health board's improvement plan remain outstanding and/or in progress, the health board should provide HIW with updates, to confirm when these have been addressed.

Methodology

Survey and Self Assessment

The local authority completed a data survey and self assessment in advance of the fieldwork stage of the inspection. The information from both was used to shape the detailed lines of enquiry for the inspection. It will also be used to inform the national overview report for Wales.

Routine inspections of regulated services

These included additional lines of enquiry linked to the key questions for the national inspection.

Contribution from All Wales People First Wales and the All Wales Forum of Parents and Carers

Both organisations undertook work with their members and others to consider the key questions for the inspection and report back to the inspectorate.

Fieldwork

The inspection team were on site in Gwynedd for seven days spread across two weeks in February 2016. The first week focussed on the experiences of people and their carers and of staff working in the delivery of care and support. The second week considered issues of leadership and governance (including partnership work) and the success of the local authority in shaping services to achieve good outcomes for people. Activities during the fieldwork included:

- Case tracking – inspectors considered 20 selected cases and explored 8 of those in further detail with people, carers, care managers and others.

- Interviews – inspectors conducted a number of group and individual interviews with staff, elected members and partners.

- Observation - inspectors together with HIW listened to a presentation by the authority and the health board on their work together in support of people with learning disabilities.

Acknowledgements

We would like to thank the people with learning disabilities who contributed to the inspection; parents and carers, staff and managers of Gwynedd Council, staff and managers of the health board, the service providers and partner organisations (including the third sector) for their time, cooperation and contributions to this inspection.