

# National inspection of care and support for people with learning disabilities

## Pembrokeshire County Council

June 2016



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## Introduction

This report of an inspection of Pembrokeshire County 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 Pembrokeshire, 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 25 and will also report their findings directly to the Health Board.

The report that follows sets out our findings and recommendations for Pembrokeshire County 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**

Pembrokeshire County Council has a population of approximately 124,000 (2014 mid year estimate).

The authority, using the Daffodil web based social care needs projection system developed for the Welsh Government, estimates that there are 2298 adults with learning disabilities living in the County Borough. There are 768 adults with learning disabilities known to the authority (81 aged 65 or over), of whom 561 are or have been active cases.

In September 2015 there were 768 adults with learning disabilities known to the authority, 81 of whom were aged sixty five or over. Of the total number of adults with learning disabilities known to the authority, 561 people were currently active cases or had been active cases in the past. There were 197 people described as 'active cases' - that is, open to a care manager; 172 described as 'review only' or 'open to review'; and 192 were closed.

The 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 £43,276.

### **The Health Board**

Community health learning disability services in Pembrokeshire were provided by Hywel Dda University Health Board. At the time of our review, there was a multidisciplinary health team which consisted of a team leader, a consultant psychiatrist, a specialist occupational therapist, two occupational therapy technicians, two highly specialist speech and language therapists, a physiotherapist three community nurses (one specifically for transition from child to adult services), and a communication support worker. The health team was located with local authority staff to form the community learning disability team (CLDT).

The health team could also access a dedicated Positive Behavioural Intervention and Support team (PBIS) which consisted of a specialist clinical psychologist, two psychology assistants and two senior behavioural practitioners.

Learning disability health services fell under the Mental Health and Learning Disability Directorate within the health board.

## Summary of Findings – Local Authority

- 1.1. The local authority recognises that improvement is needed across the board in the care and support that it provides for people with learning disabilities. Inspectors concluded that the service had, until very recently, been given a low priority and had lost direction in the face of competing demands on the local authority. A reorganisation of structures and posts within social services was underway during the inspection, with a number of key posts filled by individuals new to the position, the authority, or both. These changes reflect an understanding of the need for change, but had not yet had a significant impact on performance or outcomes for people. Inspectors heard enthusiasm and good ideas from key members of staff for re shaping services and delivering better outcomes for people with learning disabilities and their parents or carers. There are some very early signs of progress. While this is positive, optimism about future prospects will only come when the authority delivers significant, and in some examples urgent, improvements in every aspect of both the help provided and the leadership and governance that should support the service.
  
- 1.2. There is no coherent or explicit local strategy or plan for the development of care and support for people with learning disabilities in Pembrokeshire. A regional statement of intent, developed in partnership with neighbouring authorities and the health board in 2014, provides a broad base for planning, but has not led to significant local progress. The partnership between health and social services is weak. While inspectors saw some good examples of joint work between health and social services staff at the front line, more generally there was evidence of a difficult history of co working. This was particularly the case in respect of cooperation about strategic issues locally, including planning in support of people with more complex needs. There is little consistent gathering of information about people's needs through systematic reviews. There is also a lack of joint reviewing where there are jointly funded packages of care. At an individual level the local authority has shown a commitment to hearing the voice of people through its support for advocacy and self advocacy with, for example, some good work with people using day services. At a strategic level, however, there is poor engagement with people who use services and with parents and carers in the development of ideas and plans for the future of services. There are plans to produce a market position statement for learning disability services (a similar statement for older people's services is already underway) and the work of the accommodation and efficiencies team is evidence of an

effort to be more consistent, systematic and purposeful in the approach to the business. While this is positive, much more needs to be done to develop a shared and agreed way forward in which people and their relatives are enabled to express their views and wishes about current and future needs.

- 1.3. The community team for people with learning disabilities was being reinforced; however the basic disciplines of assessment, planning and review are not currently delivered in a systematic, coherent or efficient manner. This means that the local authority cannot be confident about the quality of the care and support provided. Neither can it be sure that people consistently get the right help at the right time, in the right place, at the right cost. While the case sample examined by inspectors was small, it provided evidence of overdue reviews and outdated care plans. Inspectors were concerned about the quality of safeguarding practice and recording systems in two of the 20 cases that they examined. There were also examples of good and innovative practice. A relatively stable and experienced staff group in day services have skills in providing a person centred approach tailored to individual need – even within the confines of a traditional, building based service. The authority is doing relatively well in the uptake of direct payments and inspectors saw an impressive example of this in the case sample. Inspectors also met some talented care management staff who want to do a good job. Unfortunately, these examples are not typical of the service as a whole. The systems and processes for providing people with information, advice and support that they need are patchy. The overall picture is of a service that has suffered from a lack of leadership, direction and the investment of time, energy and resources needed to support good outcomes for people with learning disabilities.
- 1.4. While the authority has embraced the model of supported living for people with learning disabilities, the quality of the arrangements was found to be variable. It included examples where the landlord of a supported accommodation scheme is also the provider of the care and support. This is poor practice, not least because it means that people may have a lack of choice about who they live with and there is no clear separation of tenancy rights from the provision of care and support.
- 1.5. The arrangements for leadership and governance in the authority have, to date, not achieved a clear vision for care and support for people with learning disabilities, developed in partnership with people and stakeholders that is focussed on outcomes. Senior managers and other leaders must also accept final responsibility for the deficits in



performance at the front line. It is positive that the authority recognises the need for change and senior officers explained that they are on an improvement journey. Inspectors concluded, however, that the authority needs to be clearer with stakeholders and with itself about the milestones on that journey and the measures of success. Currently there is a lack of clear and trusted channels of communication to engage with people; with parents and carers; and with providers of care and support services. There is work underway with Pembrokeshire People First at an individual and project level and there are also plans to revive the currently moribund Carers' Forum. The Mid and West Wales Collaborative (The Collaborative) may prove to be an engine for change and improvement, but these are still early days, and the authority is not yet able to articulate the vision for itself within that overarching collaborative framework. There is no champion for people with learning disability at a member level and scrutiny of social services has not included a consideration of services for people with learning disabilities for a long time. There are several recent developments that have the potential to bring about sustained improvement. These include the changes underway to develop commissioning processes and practice; new management arrangements at head of service and team manager level; and the work of the accommodation and efficiencies team. An action plan for improvement of services was given to inspectors on the last day of the inspection. Leaders need to build on these developments and pick up the pace of change dramatically if they are to serve the interests of people with learning disabilities more effectively now and in the years ahead.

## Summary of findings – The Health Board

- 1.6. Overall we found examples of noteworthy and innovative practice. For example, primary care staff worked relentlessly to increase awareness of learning disability in secondary care, through visiting the hospitals to promote and highlight the use of the learning disability care bundles<sup>1</sup>. There was an ongoing awareness raising within GP services with staff visiting GP practices with a person with learning disabilities so that the service could be evaluated from a person living with the disabilities' perspective. The speech and language team (SALT) had also developed a new assessment tool which the health board had agreed to use.
- 1.7. There are also excellent examples of preventative health services for people with learning disabilities, such as, people being placed on the positive behaviour intervention and support pathway to prevent placement breakdown and the team had intervened to support and teach positive behaviour techniques to staff. This supported the care staff at the placements and the outcomes were positive with a more confident and consistent staff team who better understood the person, which prevented a change of placement or emergency move. 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 some people's needs, particularly for people with learning disabilities who have offended or who are at risk of offending or those with complex respite needs. The health board needs to understand the needs of its adult learning disabilities population in order to plan services in Pembrokeshire that meet people's needs.
- 1.8. 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. There was good collaboration with service users and the Pembrokeshire People First voluntary sector. Staff faced barriers to meeting people's individual needs, for example, due to a lack of specific service provision in the area to meet one person's very

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<sup>1</sup> Learning disability care bundles help health boards and trusts to be consistently alert to, and to respond to, the needs of people with learning disabilities, and their families and carers when they access general hospital services.

complex needs and behaviour that challenged. Health and social care staff worked together to devise a bespoke package with initially intense input on a community level, resulting in very good outcomes for the person. We were told that referral to psychology services was delayed due to long waiting lists. There were also on going IT problems with staff confirming that it was easier to speak with colleagues prior to an assessment rather than try and navigate the historical paper notes. We were told that the IT systems were being changed in January 2016. However this will be a read only system; will not allow all staff to input data and will not cover the disciplines who still maintain paper notes.

- 1.9. Inspectors found that historically there had been a succession of interim staff in senior posts but this had changed in the last eighteen months, subsequently there were some newly established clinical governance structures in place. The health board agreed, in the light of some cases that we discussed, there was a need to improve their governance structures and develop a framework that allowed lessons to be learned and improvements to be made based on this learning.
- 1.10. We were assured that health and local authority staff had plans in place to address future needs for the population on a community and service level. However, we found that although some consultation had taken place around strategy, staff felt disconnected from higher levels of management within the health board.

## **Recommendations – The Local Authority**

- 2.1. The local authority should build on the regional statement of intent to develop a Pembrokeshire-specific vision and strategy for care and support for people with learning disabilities.

People with learning disabilities and their parents and carers should be invited and supported to contribute to a conversation about the shape of future service models.

- 2.2. A commissioning strategy for care and support for people with learning disabilities should be developed in partnership with the health board, based on a wide ranging analysis of need and focussed on collaborative and innovative solutions.

- 2.3. The local authority should assure itself that its 'Operational Learning Disability Action Plan 2015/16' will drive urgent improvements in the timeliness, outcome focus and overall quality of assessment care planning and review for people with learning disabilities.

- 2.4. The local authority should ensure that the 'Operational Learning Disability Action Plan 2015/16' has the support and involvement of both staff and members and is underpinned by project management; quality assurance processes; and visible leadership by senior managers that drive progress.

- 2.5. The local authority should closely monitor the success of its 'Integrated Safeguarding Action Plan' and ensure that the quality of safeguarding practice is affording people with learning disabilities protection from abuse and neglect.

- 2.6. The local authority should identify all placements for people where there is no separation between the landlord and care provider functions; it should then develop a timetable action plan for ensuring that the human rights, voice and choice of tenants are protected.

- 2.7. The local authority should review its overview and scrutiny arrangements to ensure that members are able to monitor the performance of care and support for people with learning disabilities.

Members of the authority should consider appointing a champion of care and support for people with learning disabilities.

## **Recommendations – The Health Board**

- 2.8. The health board must ensure that the specific challenges highlighted in Pembrokeshire are considered in the future planning of service provision including services for:
- appropriate emergency placements
  - appropriate repatriation services
  - appropriate forensic services
  - respite care
  - appropriate services for people with challenging / complex needs.
- 2.9. The health board should work with the local authority to identify better ways of working with a view to improving commissioning processes, where appropriate.
- 2.10. The health board needs to ensure that feedback is captured and acted upon in a way that provides an ongoing and continuous view of performance and demonstrates learning and improvement.
- 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 ensure that IT systems for health staff are fit for purpose and support staff to effectively carry out their roles.

## **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. The help that people receive generally does not rest on an up to date understanding of their need for care and support. People are not consistently placed at the centre of care planning and more needs to be done to ensure that care and support is delivered in a way which values and helps people to contribute to and understand their care. While inspectors both noted and heard about some good responses from individual practitioners, these were not typical of the service as a whole. Family members and other carers described poor communication between social services and health. The content of case files examined by inspectors tended to be poorly formed, missing detail about the substance of care plans and, for the most part, lacked the views and opinions of the person concerned. There was, overall, a lack of focus on outcomes and some staff noted that they had not received training about an outcome focussed approach. Both care management and external provider staff spoke of IT systems being a barrier to sharing information across health and social services. The social services record system was itself fragmented which meant that inspectors found it difficult, at times, to understand what had been done and when. These technical features reflect an underlying deficit in the oversight and quality assurance of the service.
- 3.2. There are signs that the authority is taking steps to become more consistent and systematic in the way that it understands need and develops services in response. The panel system provides a mechanism for sharing information about people's needs on a multiagency basis that highlights trends, pressure points and service deficiencies. There are plans to develop a market position statement for learning disability services – a similar exercise for services for older people is underway. Different aspects of commissioning activity have been brought together into a hub to ensure greater consistency and to improve communication across commissioning and contract management functions. Resources for quality assurance have been increased; and there are plans to further develop the brokerage service to oversee respite care. Unfortunately, much of what is described is planned, aspirational or embryonic. Those

developments that are established, e.g. the panel system, are less effective than they could be because of the absence of an overarching strategy that drives improvement across all aspects of care and support for people with learning disabilities.

- 3.3. Support for people to receive help through the medium of the Welsh language is patchy. In one example, an individual whose first language was Welsh (and clearly enjoyed speaking it) had little opportunity to do so with the staff who supported her at her accommodation, or in the day service that she used every day. In another example, day service staff were able to respond well to a person's wish to speak Welsh. Language and communication needs were not well represented in the files examined by inspectors and, more generally, the lack of any case file audit process makes it difficult for the authority to track its success in making an active offer to respond to people's language of need. The recruitment of staff who can speak Welsh was perceived as a difficult issue when the authority is already struggling to attract suitably qualified personnel. More positively, there is an active approach taken to More than Just Words, with a data base of staff within social care services who can speak Welsh, and a Welsh speaking care ambassador.
- 3.4. There is no explicit accommodation strategy for people with learning disabilities and little sense that the local authority has effective processes in place that will enable it to predict demand, plan for the future and deliver sustainable and preventative solutions. The Collaborative and its regional statement of intent have the potential to provide a sound basis for progress, but have had only marginal impact in Pembrokeshire. The accommodation and efficiencies team, which as part of its work is reviewing residential and supported living placements for people with learning disabilities in Pembrokeshire, is having a positive impact. Its work, however, needs to be supported by arrangements for care management and reviews that are effective in collating information, assessing need and tracking outcomes. This is discussed more fully in the following section.

## **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 authority is not delivering information, advice, assistance and care planning to a consistently acceptable standard. Consequently it cannot be confident about the quality of outcomes for people. Inspectors saw some examples of a person centred approach by staff, including staff working for external providers, and noted some good and even excellent outcomes for individuals. These were, however, the minority; most of the case files examined showed at least some aspects of practice that was either poor or required improvement.



## Case examples

**Person A** lives in an extra care scheme where she is supported by care staff employed by an independent provider. One of her friends (and former co tenant elsewhere) lives next door. She also attends a local authority day service for older people every week day. On balance, the face to face help provided for person A was well coordinated and probably made sense to the person. The senior carer in the day services had a good knowledge of person A and described a person centred approach. There had been no care manager involvement for a long time. There was no assessment of need or care plan on file, but there was reference to a plan having been completed five years previously. A review had been completed in March 2015. This noted person A's comments that she did not want to live in the extra care scheme any more because of the heat in summer, not being able to feed the birds and because other people did not speak to her, but it was not possible to determine how this information had informed the way help was provided.

**Person B** lives in a supported living scheme with two co tenants. Inspectors felt that there had been an over reliance by the authority on the provider doing the right thing for him. There was evidence of enabling social contacts to be maintained, for example with a relative in France via Skype, and the person had a good level of positive community presence. The care and support provided for person B, however, was not formally reviewed by the authority for more than two years between 2013 (when a major adult protection incident was investigated) and July 2015. It appeared that the emotional impact of the adult protection investigation remained acute for person B and that more needed to be done to address this and to ensure that the provider delivered care and support that was person centred. (The case file contained notes concerning a completely unrelated individual.)

4.3. As of 30<sup>th</sup> September 2015, there were 129 reviews that were overdue, i.e. outstanding for a year or more. This amounts to 35% of the cases that were described by the authority as either 'active', 'review only', or 'open to review.'

*"I meet my social worker for my annual review every 2/3 years. Clearly they are not prioritising me"*

*"I had a social worker in London. When I moved to Pembrokeshire 5 years ago I hoped I would get one here. I have tried all ways, but not been given one. So I don't have a professional to turn to for help."*

Focus group participants

- 4.4. While there have been historical issues about competence and performance in the Community Team for Learning Disability (CTLD), it would be a mistake for the authority to conclude that this is the main reason for the deficits in performance. Rather, inspectors concluded that care managers and others have not been well served by systems, processes and leadership in recent years. The duty system in the CTLD appeared to be used as a proxy allocation system so that, for example, responsibility for a review would be passed to one duty officer who then might arrange a meeting for the next time they were on duty, or set it up for a time when another duty officer would deliver it. This is unlikely to be an efficient or effective way to tackling the overdue reviews. Similarly, the duty system was being used to manage requests for respite care, with care managers taking responsibility for authorising the booking. Finally, care managers had responsibility for undertaking financial assessments – this is not necessarily inappropriate but was clearly felt by staff to be burdensome. Taken together, these features of the care manager role personified a reactive approach to the job. Responsibility and accountability for this should rest with managers and leaders rather than with those at the front line.
- 4.5. There were encouraging signs of recognition of the need for change and some action in response. These include a plan to expand the brokerage team and for it to assume responsibility for respite care bookings; additional staff to tackle the need for reviews and re assessments; and, in the longer term, the development of a review team as part of wider restructuring of adult services. The CTLD has a new team manager and a new senior practitioner; both of whom had already identified the need for improvement and had good ideas about the changes required. It is important that they receive support and encouragement at a more senior level as they make the improvements that are needed. There is enthusiasm for the development of direct payments and as the case example outlined below demonstrates, staff in the authority are capable of overseeing positive outcomes for people.

### Case example

**Person C** is a young person who has a severe learning disability, epilepsy and physical disabilities. She lives with family and receives additional care from a small team of support workers recruited and trained by parents, who organise the care and support. While the assessment and care plan needed updating there was support from a social worker who had been allocated to the case in October 2015. A positive behavioural support plan is in place and there was support from an assistant psychologist. There was a clear costing available for the care and support provided which includes help from the Independent Living Fund, Direct Payments and a respite care package.

*“I am quite happy with the council. I receive direct payments; it would be a different story if these ended. I pay for a personal assistant who does understand and help me.”*

Focus group participant

- 4.6. The systems and processes for providing people with information about support that they are entitled to and advice on how to get them are either poor or patchy. There is no current user friendly information for people with learning disabilities about the work of the community team or more generally about what the authority can do to support them. While inspectors acknowledge that this may have existed in the past, its absence in 2015 is very disappointing and a concern.
- 4.7. People have a voice and are encouraged to express their views through self advocacy groups delivered in day services, and through advocacy services commissioned from Dewis CIL. It is encouraging that in one case examined by inspectors the person knew the identity of his advocate and how to contact him. However, there were other more typical examples where the voice of the person was neglected or marginalised. These include a review being organised for a time when the person concerned was absent on another activity and another where a person expressed a poor view of the help they received, but no action was taken in response. More generally the arrangements for assessment, planning and review were not doing a good job in facilitating and representing the voice of the person.
- 4.8. Inspectors met individual carers through their case tracking interviews and in two group sessions: one that was specifically established in

respect of the inspection; and in another that arose as a consequence of the authority's announcement of its consultation on proposed changes to day services. There were some positive comments about the work of individual care managers and a more general appreciation of the work of day service staff. Less positively, a strong and consistent message about difficulty in determining who to contact for help in the authority emerged from a wide range of evidence. Carers also spoke of the lack of reviews and the 'cursory' nature of some reviews when they did occur. This was coupled with concerns about the lack of visibility of senior managers. Inspectors found some good examples of carers' assessments, but for the most part there appeared to be a lack of up to date carers assessments carried out on a systematic basis. At a more strategic level there was no active carers' forum for parents and carers of people with a learning disability and the more generic carers' forum was moribund. There were plans to revive the latter; a carers' newsletter (not specifically for carers of people with learning disabilities) continues to be produced three times a year; and the carers' officer is considering new ways of reaching out to parents and carers of people with learning disabilities.

- 4.9. The inspection found examples of staff with a good value base who were appreciated by people with learning disabilities and their parents or carers. While turnover of care managers appeared relatively high, the staff group in day services was fairly stable and this appeared to be a positive feature for the people using the service. Inspectors met individual staff at all levels, both employed by the authority or in the independent sector, who were striving to deliver a good quality service. New managers and project leaders were full of ideas for change and improvement. These positive features were coupled, however, with a more negative theme concerning a perceived lack of support by senior managers for those working at the front line. Individuals described a feeling of disempowerment from lack of consultation about changes to the service or progress/plans for filling vacancies. Some talked of an autocratic style of management. It is too early in the 'change journey' for the local authority for inspectors to conclude that these features are entirely historical. Overall, if the local authority wants its staff to consistently respect and value the people they help and support, then it needs to do more to do the same for them.
- 4.10. The authority's arrangements for adult protection and safeguarding had experienced significant disruption and uncertainty during 2014 and 2015. The post of adult safeguarding coordinator was vacant during the inspection and has not been filled on a permanent basis since 2013. There have been difficulties and delays filling vacancies in the

safeguarding team. Changes to structures occurred between June and September 2015, with the integration of children and adult safeguarding into one safeguarding 'hub'. A service manager with responsibility for the quality assurance of safeguarding has recently been appointed as has an 'adult and children safeguarding manager'. The head of children's services assumed responsibility for safeguarding services for both adult and children in the summer of 2015. The head of service and service manager have produced an 'Integrated Safeguarding Action Plan' running from June 2015 – March 2016, which includes the goal of *Better outcomes for adults and children*. Inspectors were told that there had been a "tough time getting people [staff] on the change journey." Plans are underway to introduce the 'Signs of Safety' approach to safeguarding (more common in services for children) to practitioners.

4.11. The evidence from the inspection is that the changes to structures, posts and philosophy are yet to have a significant positive impact on outcomes for adults with learning disabilities. Inspectors referred two cases back to the local authority because of the quality of safeguarding practice as recorded in case files or as explained by practitioners in interviews. In these cases there was no or only limited evidence as to how safeguarding concerns had been followed up. In another case, in which inspectors' concerns were not sufficient to merit a referral back to the authority, there was still insufficient explicit recording about the outcome from an adult protection investigation. The absence of an overt quality assurance process for adult safeguarding (which mirrors a similar deficit for care management generally) only compounds the risk to the safety of vulnerable people arising from poor practice. While there were 33 adult safeguarding strategy meetings for people with learning disabilities held in 2014-15 there were no case conferences. To a degree, the paucity of case conferences reflects a more general nationwide pattern. Nevertheless, it is still of concern that there was a complete absence of a formal and structured opportunity through the case conference process to review the outcome from an investigation; agree an adult protection plan; and potentially involve the person at risk themselves.

4.12. Along with other authorities in Wales, Pembrokeshire is under pressure from a rise in applications to authorise deprivation of liberty safeguards. This is largely a consequence of the 'Cheshire West' judgement which gave clarity about the definition of a deprivation of liberty. At the time of the inspection the authority had 167 people described as 'pending' an assessment for a potential deprivation. Ten of this number were people with learning disabilities; this figure seems low in comparison with the total number of people known to the authority. Responsibility for the

oversight of the safeguards rested with the team manager for mental health services. The authority needs to ensure that there are good arrangements to facilitate collation, cross referencing and analysis of information across its separate arrangements for the management of the deprivation of liberty safeguards, adult safeguarding and contract monitoring. Putting these in place is likely to assist the identification of further potential deprivations of liberty for people with learning disabilities.

- 4.13. Inspectors acknowledge that the local authority is attempting to reorganise and re energise its approach to adult safeguarding. A senior manager commented that in 12 months time they would be able to “describe a good model”. Providers reported a mixed experience. Some commented on good practice and rapid response while others were concerned about delays in bringing investigations to a conclusion. At the moment, inspectors concluded that more needs to be done to monitor outcomes from adult protection concerns and assure the quality of safeguarding practice. The challenge for the local authority is particularly acute because of the wider context for the shortcomings in adult protection. Poor performance in relation to reviews; deficits in the contract monitoring process (discussed in the next section); and a lack of local strategic direction in recent times – are not a sound basis for adult protection. Consequently, the authority will need to work very hard to ensure that its ‘Integrated Safeguarding Action Plan’ and its ‘Operational Learning Disability Action Plan’, which are the responsibility of different heads of service, are properly aligned.

### 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 regional statement of intent produced by the Mid and West Wales Health and Social Care Regional Collaborative Learning Disabilities Partnership (2014) contains a vision and model of care described as a 'progression model'. It defines the model as:

*A person centred developmental approach that seeks to help an individual achieve their aspirations for independent living.*

- 5.2. To date this has not been translated into a Pembrokeshire specific strategy or action plan. Indeed, the statement of intent notes the "further work" is needed, not least to gain an understanding from people who use services and their carers or families about their response to the proposed model. The authority has experienced significant changes at all levels of social services during the last two years, and this has inevitably had an impact on progress. There have been four different Heads of Adult Services with responsibility for services for people with learning disabilities in the 12 months from November 2014. There is some indication that the changes had begun to settle down, with a permanent appointment made to the head of service position and a new team manager in post for the community team. The director of social services has begun work with the new management team to develop the vision and values for the work of the department. There are plans for an all directorate day in February 2016 to engage the wider staff group in shaping that vision. While these developments and plans are positive, the absence of a clear vision for care and support for people with learning disabilities in Pembrokeshire has held back progress. The absence of this outward facing vision needs to be set alongside the failure, until very recently, to engage with the wider staff group about the visions and values of the department. Taken together, this is a mixture that is likely to explain the sense of detachment and distance from the authority that inspectors encountered from both people who use services and staff.
- 5.3. It is clear that some people with learning disabilities in Pembrokeshire are helped to secure their rights and entitlements. Inspectors saw

examples of people participating in activities in their local community, living in age appropriate accommodation and taking part in valued social activities. There are two major challenges for the local authority as it attempts to build on this good work for individuals. Firstly, the lack of a systematic and effective approach to assessment, care planning and review means that people are not consistently helped to secure their rights in a timely fashion. This means that while some people do well in the support they receive, others are neglected for extended periods of time with much responsibility left to others, including external providers. Secondly, promoting the rights and entitlements of people with learning disabilities can be compromised by the historical model of accommodation and support for people with learning disabilities in Pembrokeshire. Inspectors noted, for example, more than one situation where an individual with a tenancy also received care and support from their landlord. Care managers confirmed that these were not isolated examples. The extent to which these arrangements constitute real tenancies for the individual concerned is, at the least, questionable. One of the tests of a genuine tenancy is the extent to which the tenant has control over who supports them and how they are supported. The authority should ensure that it considers this test, alongside other considerations, as its care managers review care plans and as its contract monitoring team engages with providers.



## Case examples

**Person D** grew up outside of Pembrokeshire and moved to the area in 2002. There was an assessment on file, dated Aug 2014, which was well written, comprehensive and did a reasonable job of representing the voice of the person. An up to date care plan had been reviewed in November 2015, but had not yet been written up. There were some positive outcomes for person D, including a voluntary work placement which also provided him with informal counselling and guidance about his lifestyle. He spoke positively about the help provided by the social worker. He moved from residential care to supported living in 2013 with the same provider continuing to provide both his accommodation and his care and support. An email on file from social services in another local authority (where he lived up until 2002), noted that, "there will need to be a discussion about balancing the two roles of being both landlord and providing tenancy/domiciliary support". This did not appear to have happened. Person D mentioned to inspectors that his landlord was offering him another flat, in the same block, that was more expensive than his current accommodation. The weekly net cost of the package of support was £1,146. The authority had no contract with the provider for this package, but was engaged with "protracted" negotiations with the provider through the work of the accommodation and efficiencies team.

**Person E** has a moderate to severe learning disability with challenging behaviours. She receives 24 hour care and supervision in a care home. In addition she gets 30 hours 1:1 support every week, which was put in place in October 2006. She requires full support for her personal care needs, and support with continence. She requires support with all aspects of daily living, and support to take medication. She is unaware of personal safety issues and her movements are restricted in the community owing to her behaviours. The care home manages her finances and acts as appointee for her benefits. The package of care is joint funded with Health. There appeared to have been an adult protection investigation or referral in 2011, but there were no details on file provided or on the electronic care management system. There was a request for advice/intervention from the Positive Behavioural Intervention service in October 2014, but there was no record of this having been delivered. The last care plan on file was dated October 2014 and the last assessment was undertaken in 2013. There was no information on file about the outcomes, costs or value for money from Person E's care package.

- 5.4. The authority needs to do more to build up clear and trusted channels of communication with people with learning disabilities and with parents and carers. Pembrokeshire People First and the Dewis project are actively involving people on an individual basis as do staff in day services. What is missing is a strategy of engagement with stakeholders, including providers of care and support, to ensure that they are consulted on significant aspects of service delivery. This is a critical shortfall which will undermine the local authority's efforts to manage change and development – not least in response to declining budgets. While inspectors were on site, the local authority began a public consultation about changes to day services for people with learning disabilities. The changes could involve the closure of a day centre in Tenby and prompted vociferously expressed concern from a group of parents and carers. Parents and carers told inspectors that some of their relatives first heard about the proposal for their day service through local radio on the minibus that provides some with transport to and from the centre. Inspectors did not explore this issue in detail during the inspection. Nevertheless, it is noteworthy that, while the paper submitted to Cabinet about the proposal placed it in the context of a completed “review of current day services”, this, presumably, more wide ranging and strategic piece of work is not referenced further in the paper.
- 5.5. The local authority needs to make improvements to collaborative multi agency working within an integrated framework with Health. The regional collaborative have plans in place that could translate to more effective multi agency working. Leaders in both social services and health spoke of realigning activity with a clear focus on multi agency working. Discussions with staff at all levels demonstrated a commitment to this. Efforts to rebuild the community team in partnership with colleagues in health were well underway and inspectors acknowledge that staff at the front line have sought to work effectively together, even in difficult times. Towards the end of the inspection the authority made available a draft commissioning work plan for 2015 – 2017 for adult services. This contains four values and principles that include ‘Collaboration’. The challenge for the authority is to show the leadership, commitment and perseverance to turn this and other ambitions into action that results in tangible improvement in outcomes for people with learning disabilities.

## **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**

Health 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 focus groups attended by community nurses, speech and language therapist, clinical psychologists, health care assistant, members of the positive behaviour intervention and support (PBIS) team, psychiatrist and the 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 in its area?**

- 6.1. Overall we were assured that planning on an individual level was effective and we found, through case tracking, that people received appropriate health and social care assessments and interventions with well coordinated case management. The most appropriate professional took on the role of case manager, this being the health professional in some cases. There were good examples of multidisciplinary working and case coordination with appropriate health care interventions, assessments and referrals by health and social care staff, working together on shared outcomes for people. 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.
- 6.2. Staff told us about some innovative bespoke packages which had been created and there were plans to explore new ways of joint funding/commissioning for individual packages. Case tracking and discussions with staff revealed how well health and social care frontline staff (in the last year) worked together around shared outcomes for people and planning ahead to meet people's potential future needs. For example, in one case we reviewed, there was a lack of service provision in the area to meet one person's very complex needs and behaviour that challenged. Health and social care staff worked together to devise a bespoke package with initially intense input on a community level, resulting in very good outcomes for the person.
- 6.3. We discussed repatriation (bringing people placed out of county back to Pembrokeshire) and were told of instances where people had returned to the health board but the packages of care had not been established and in one instance the person remains in a residential unit some years after the return. We discussed this with senior management, who agreed it was not best practice and that they were already looking to develop a bespoke package for this individual.
- 6.4. Although many of these interventions were when people were at a point of crisis, we found that there were positive outcomes for people receiving services. The health board needs to become pro-active in its planning of individual services.
- 6.5 With regard to service on a community level we found that areas of improvement had been identified and developments were already in

place. For instance there were no health liaison nurses employed, however a bid for funding had been submitted to the health board to enable development of these posts. The health board needs to ensure that this important role is progressed to ensure people are supported to receive and access appropriate care in a timely manner. Despite this when we spoke with a patient, we were told that the social worker and carers were active in preventative work and ensured attendance for annual health checks with the GP, consultant reviews and dental checks.

- 6.6. The positive behaviour intervention and support team (PBIS), became involved at appropriate times, with people being placed on a crisis intervention pathway. For example, in all four cases we tracked, people had been placed on the pathway to prevent placement breakdown and the team had intervened to support and teach positive behaviour techniques to staff. This supported the care staff at the placements and the outcomes were positive with a more confident and consistent staff team who better understood the person, which prevented a change of placement or emergency move. We did see that access to psychology services was becoming increasingly difficult with a waiting list for non-crisis intervention.
- 6.7. We were told of occasions where people had been admitted out of hours to mental health units, due to the lack of emergency provision for people with a learning disability who were in a crisis. Staff expressed their concern regarding this, because they were admissions to inappropriate units which could not offer the treatment and support to people with a learning disability. This was discussed at senior management level and assurances were made that this would be a priority.
- 6.8. Community staff told us that they were driving health improvement and awareness for the general learning disability population. For example, increasing awareness of learning disability in secondary care, through visiting the hospitals to promote and highlight the use of the learning disability care bundles<sup>2</sup>. They were also increasing awareness in primary care within GP services by visiting GP practices with a person with learning disabilities so that the service could be evaluated from a person living with the disabilities' perspective and the speech and language team (SALT) had also developed a new assessment tool which the health board had agreed to use. The health board need to ensure that these areas of noteworthy practice continue to develop.

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<sup>2</sup> Learning disability care bundles help health boards and trusts to be consistently alert to, and to respond to, the needs of people with learning disabilities, and their families and carers, when they access general hospital services.

- 6.9. There was an identified transition nurse who had developed good links with the designated learning disability school in the area especially with the special educational needs officer (SENCO). The team and the nurse were concerned that they may be missing some children who are home schooled and this was an area they were exploring.
- 6.10 Staff told us that there were currently a number of offenders with learning disabilities who were inappropriately placed and therefore the health board have developed a forensic pathway<sup>3</sup> and were actively looking at ways to provide more appropriate care and accommodation for offenders, although the team were supporting the current placements and closely monitoring peoples care.
- 6.11. Overall we found that there was a vision to improve service provision to meet the needs of the population. We were assured that health and local authority staff had plans in place to address future needs for the population on a community and service level.
- 6.12. In relation to developing preventative services, we were told of the health board's proposal to tender the running of the local learning disability residential home to the independent sector which would release health board qualified staff who could be developed into a crisis intervention/outreach team. They were also reviewing the in-patient services with a view to restructuring the admission criteria.
- 6.13. There were very limited respite services and we were told the health board were looking for more suitable accommodation with improved facilities based more locally. Currently there was a facility in Llanelli some distance away which was not easily accessible for people from Pembrokeshire.
- 6.14. We saw evidence of the close working arrangements with the voluntary sector Pembrokeshire People First group who are involved in many of the information gathering processes. The health board do not have a patient participation group although there are representatives of the learning disability community in the Pembrokeshire People First group. Staff told us historically there had been a patient experience group but there was a lack of representation from people with learning disability and the group was predominantly represented by people with mental health issues.

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<sup>3</sup> A forensic health care pathway is to ensure that service users are receiving a quality service that is accessible and appropriate to their needs.

6.15. Overall we were satisfied that the health board had identified areas which required improvement and were actively addressing these. However there continues to be some environmental and financial challenges which need to be considered when planning for sustainable future services.



## 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. We were assured that services at individual level were patient centred and had positive outcomes for people because people with learning disabilities and their carers made consistently positive comments about the care and support they had received over the years and overall confirmed they had received the help they needed in the way they wanted it. They were particularly positive about their relationships with health staff and the consistency of involvement with the same health professional over many years. One relative told us that the family were always “kept in the loop” and the same nurse would arrange to attend any hospital reviews with the family. We were told this was important because the family had a single point of contact, they felt supported and were assured that the nurse understood the person’s needs and acted as advocate at all times. 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.
- 7.2. In relation to service delivery by staff we saw that the health team’s documentation was person centred and their approach was inclusive of patients and relatives. We saw that staff both on the frontline and more senior, were very passionate, committed and driven to make changes and improvements.
- 7.3. Staff we interviewed knew their cases well, giving examples of how they had been involved since the person was very young. They also told us they were encouraged to act as advocates for people by challenging decisions, especially in respect of options, choice and values. For example, we heard specific examples of advocacy from speech and language therapy team staff, who challenged decisions in secondary care, including the lack of timely use of best interest meetings. It was evident that health staff were passionate, dedicated, constant and a driving force for change.
- 7.4. We found that health and social care staff worked well together in providing information, advice, assistance, assessment and care planning to people with learning disabilities. We explored access to therapies and through discussion with staff and analysis of documents we found that all therapists were specialised in learning disability and therefore patients received appropriate therapy input specific to their learning disability

needs. We saw excellent examples of multidisciplinary working between community nurses, psychologists, physiotherapists, occupational therapists, speech and language therapists, social workers and support workers. For instance we saw recorded entries in positive behaviour intervention and support files written by community nurses, speech and language therapists, psychology and advocacy services. This showed a sharing of information, assessments and care planning. This also revealed that access to therapies was timely and responsive.

- 7.5. Overall we were satisfied that frontline staff providing care and support were working conscientiously, diligently and respectfully to achieve positive outcomes for people with learning disabilities.
- 7.6. On a strategic health board level we found in regard to communicating with people with learning disabilities in their language of choice, the health board had engaged with the third sector, who were undertaking a patient satisfaction project which also included the need for Welsh services in the area. The health board suggested they would develop services in line with the outcome of the project and the new Welsh language standards. We found that within the health team, staff were available at all levels who could assist with the Welsh language such as a Welsh speaking psychiatrist and nurses. We also used the opportunity to explore other means of communication such as Makaton and were told that all nursing staff were trained as part of the learning disability nurse qualification. However when we met with one person who, according to documentation, communicated using Makaton, we found that health staff had not communicated in this way and the person had lost the skill.
- 7.7. Although we saw evidence of seamless multi disciplinary team work to provide co-ordinated care, there had been some issues with social work colleagues, whereby there had been many agency and interim staff who did not remain in post for long. Subsequently health staff (predominantly nurses) had taken on many areas of their role. The health board had developed documentation to clarify roles and expectations and this had improved working relationships in the last year, although we understood that there remained issues with recruitment and retention of social workers.
- 7.8. With regard to safeguarding adults from abuse, we were told that the health board was currently expanding the safeguarding team. There was a clear pathway for reporting potential cases of abuse via the local authority, although there was also a health board operational policy available. All staff spoken with were clear about their roles and responsibilities and worked closely with local authority staff in instances

of potential abuse. Staff were very clear about reporting processes and the actions required to safeguard people in instances of suspected abuse. We discussed the use of the Datix<sup>4</sup> system to collate information specifically for health and found that at present this was not used. This meant that the health board did not have easily available information (specific to health) on safeguarding reports, trends or outcomes. By the completion of our review, the health board had rectified this and were now collating their own data.

7.9. From conversation with staff we were told about the challenges and pressures placed on the team with regards to the new panel process for commissioning care. 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 saw that the lack of some 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.

7.10. We saw that the health board was instrumental in promoting the review of joint funded cases to ensure that people were receiving the right care at the right place at the right time. This work required the engagement of local authority staff in order to take this work forward.

7.11. Overall we were satisfied that the health board was meeting the needs of people with a learning disability in the Pembrokeshire region, although there was a need to become more pro-active in addressing the short falls within the current service.

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<sup>4</sup> Datix is a system for reporting and monitoring health incidents.

### **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?**

- 8.1. In relation to joint working between health and the local authority on an individual case level, we saw that there were clear and trusted channels of communication between people with learning disabilities, their carers and the health board in the development of health services. For example we heard about the Pembrokeshire People First (a third sector group who include people with learning disabilities in their participation work). The group is actively involved in many aspects of health work and planning, such as helping with the patient feedback questionnaires and sitting on the health service board to offer the patient perspective. The commissioning team had reviewed the quality assurance framework to ensure standards were more achievable and user led and were currently developing a strategic provider group. There was also a “Moving On” joint user engagement group which had begun as a service user group but was now more involved in directing development of service provision.
- 8.2. When we looked at individual case documentation, we found that the notes were difficult to navigate because different disciplines had different paper notes. Staff confirmed it was easier to speak with colleagues prior to an assessment rather than try and navigate the historical paper notes. We were told that the IT systems were being changed in January 2016. However this will be a read only system; will not allow all staff to input data and will not cover the disciplines who still maintain paper notes. There was therefore no central set of notes for individual people. We were told of a pilot in Ceredigion for joint health and social care records and that the health board were awaiting the outcome of this pilot before committing to any further changes health board wide.
- 8.3. Interviews with frontline staff revealed that they were unclear about the vision of the service and the structure of “joint” working arrangements between health and the local authority. Although some consultation had taken place around strategy, staff felt disconnected from higher levels of management within the health board. They stated there was a need for further clarity regarding the future vision for learning disability health services. Subsequently, we saw evidence of very good individual work but this was not supported by embedded policies and therefore not

equitable across the Pembrokeshire region. Management confirmed that due to the previously interim nature of some posts in both health and the local authority, strategy and structure of services had been delayed but this had changed in the last 18 months and all current information had recently been made available to staff. Communication between health board management and frontline staff needs to improve to ensure staff feel valued in their roles and are engaged with health board's priorities.

- 8.4. On a strategic level, we were told that at present health services did not monitor the adult population of people with learning disabilities in a systematic way in order to assess the current needs. Therefore, the spend, needs and future plans for learning disability services were unclear. The health board had an integrated medium term plan 2014-2018 in place, however, senior staff acknowledged the plan was progressing more slowly than they had anticipated when the plan was written. This was because of staffing and recruitment reasons which had now been resolved. Slow progress had also been made in joint working with the local authority, which we were told was as a result of instability within the local authority operational structures. However, there was now a significant difference in the willingness and momentum for change, and we found that in the last two years formal arrangements had been implemented to guide joint working and planning. Senior health managers told us that engagement with local authority colleagues had improved and there were regular joint meetings operationally and strategically, which showed a commitment to joint decision making. There was a strategic forward plan which had been agreed by all partners and signed off at a directorate level but not yet at health board level.
- 8.5. The health board and local authority had produced a joint paper which included a statement of intent for regional objectives. The paper set out potential options for reorganising learning disability services across health and social care in the area and included joint strategic priorities for a single customer record, with real time recording; a single point of access; and commissioning with pooled budgets. Both parties were committed to improving services for people receiving care through the development of new commissioning strategies and the integrated service board. For example encouraging development of private and independent services; offering mixed provision of care tailored to the person, which may include traditional and outcome focussed packages and a review of day services. We saw that there was now a regional joint strategic board for learning disabilities; a local joint health and wellbeing commissioning board and an integrated services board. We were told that the creation of sustainability and establishing a long term service

were their joint priorities. We found that there were structures in place and there was clear forward planning between health and the local authority.

The health board agreed, in the light of some cases that we discussed, there was a need to improve their governance structures and develop a framework that allowed lessons to be learned and improvements to be made based on this learning.

### **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 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 be used, also, 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 Forum**

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 Pembrokeshire for seven days spread across two weeks in December 2015. The first week focussed on the experience 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 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 - CSSIW inspectors attended a meeting of the ‘panel’ and 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 Pembrokeshire County Council and Hywel Dda University Health Board; the service providers and partner organisations – including the third sector; for their time, cooperation and contributions to this inspection.