



CABINET MEETING

4.00 PM WEDNESDAY, 7TH OCTOBER, 2020

BACKGROUND PAPERS

Please note that this supplement only contains background papers that have been provided by the responsible departments.

Anyone requiring information should contact the Democratic Services Department on (01685) 725203 or democratic@merthyr.gov.uk

4. Care Inspectorate Wales Performance Review
April 2019 to March 2020
To consider report of the Chief Officer Social Services **3 - 8**

5. Inspection Report – Ty Bargoed Newydd
To consider report of the Chief Officer Social Services **9 - 22**

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Lisa Curtis-Jones
Director of Social Services
Civic Centre
Castle Street
Merthyr Tydfil
CF47 8AN

Date: 03 August 2020

Dear Lisa Curtis-Jones,

Care Inspectorate Wales (CIW) Local Authority Performance Review April 2019 - March 2020

The code of practice for review of local authority social services in April 2019 outlines our intention to write and publish an annual letter for local authorities which will:

- provide feedback on inspection and performance evaluation activity completed by us during the year
- report on progress the local authority has made in implementing recommendations from inspections and/or child and adult practice reviews
- outline our forward work programme

This letter summarises our review of Merthyr Tydfil County Borough Council's performance in carrying out its statutory social services functions from April 2019 - March 2020.

We acknowledge, that due to the unprecedented circumstances relating to COVID-19 we were unable to complete the annual performance review meeting.

However, we believe that there remains significant benefit in identifying and drawing the attention of the local authority and its partners, to the areas of both strengths and improvements required. The letter is intended to assist the local authority and its partners to continually improve.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

It follows the four principles of the Social Services and Well-being (Wales) Act 2014 and our increasingly collaborative and strengths based approach to supporting improvement.

The content of this letter is informed by the performance evaluation activity undertaken by the inspectorate during the course of the year. This activity included:

- national inspection: Prevention & Promotion of Independence for Older Adults Living in the Community (September 2019)
- focused activity (children's services): 26 July 2019 and 5 August 2019
- practice & performance review meeting (adults services): 06 August 2019
- practice & performance review meeting (children's services): 08 August 2019

During the course of the year we have been in discussions with you during all of the activity listed above, and as such, the content of our annual performance letter is an accurate reflection of our ongoing findings which we have consistently shared with you.

Summary of strengths and areas for improvement in line with principles of the 2014 Act

Well-being

Due to escalating budgetary pressures, Merthyr Tydfil County Borough Council requested support from Welsh Government. In summer 2019 a package of support was agreed under section 28 of the Local Government (Wales) Act 2009. Subsequently an Improvement and Assurance Board with independent external members was convened. The overall purpose of the Board is to assist the Leader in driving forward required change and improvement. At time of writing, the Board is continuing to perform an assurance role and is assessing ongoing progress.

There is some evidence of good outcomes being achieved for people and their families in the local authority. Our inspection and engagement work with social services, that included talking to people, indicates that staff are committed to providing responsive services that are underpinned by strength based approaches. We found that people with complex needs can expect to be supported to live at home for as long as possible, with a focus on promoting their independence and ensuring they receive the right service at the right time.

Concerns about social services are characterised by lack of capacity. Annual cuts in budgets coupled with reduced staffing levels, particularly at principle officer level, have left social services vulnerable in terms of ensuring delivery of safe and consistent well-being outcomes for people. Lack of strategic capacity also challenges social services to play a full role in regional partnership work and the ability to drive through strategic changes at necessary scale and pace. Risks to maintaining adequate service delivery has been exacerbated in children's services by the recent departure of the experienced head of service without permanent replacement to this vacancy.

Despite successfully reducing the projected overspend for 2019-2020 the nature of social services, remains demand led. Corporate support for making difficult budgetary decisions to meet statutory provision is not always sufficiently robust. Morale amongst senior officers is low.

People

People's views were sought during the planning and reconfiguration of services. Families were involved in developing the specification for revised care leaving services and planning for early help services was co-produced. Dementia Care Matters were also commissioned to undertake a strategic review of day services for people with dementia which included stakeholder engagement sessions and focus groups with representatives from the sector and families and friends. Key issues and priorities were identified for inclusion in the regional dementia action plan 2019-2022.

Generally, people are able to communicate in their language of choice. However, the provision of the active offer of Welsh is not always recorded on casefiles to evidence that this was taking place.

The local authority continues to be challenged by the registration requirements for domiciliary care workers. At time of writing a significant number of domiciliary care staff working within the authority still needed to register, as required with Social Care Wales.

We continue to monitor the implementation of Deprivation of Liberty Safeguards (DoLS) which has identified the local authority, in common with many others in Wales, is unable to assure itself people's human rights are not being breached by being deprived of their liberty unlawfully. Our joint national report on DoLS will be issued in due course.

Prevention

Merthyr Tydfil County Borough Council has continued its journey toward remodelling early help and prevention services. The Early Help Hub was launched in October 2019, initially to other professionals and then to families. This incorporates Information, Advice and Assistance, Family Information Service, Team Around the Family Co-ordinator and services for Young Carers. This Hub also signposts to universal services. Alongside this for adults, GP support officers and community coordinators are in place and people in hospital can expect to get a timely response from the Staywell@home initiative to help them return home.

Increasing staffing capacity at the front door remains challenging for the local authority. Senior managers need to continue to ensure that recruitment and retention of staff is sufficient to meet demands of the service and that practitioners undertaking assessments are suitably qualified and appropriately supervised. We identified a need for managers to ensure 'what matters' conversations are fully embedded in practice to ensure that specific personal outcomes people want to achieve are always identified and recorded. During our focused activity in children's services we found that there were some improvements in the quality of assessments since the last inspection. These improvements had taken place following a detailed improvement plan by senior managers who demonstrated a commitment to ongoing development.

The local authority placed a child in unregistered arrangements for a period of time as there was no suitable alternative placement available. The local authority has demonstrated a focus on meeting the particular needs of the individual in their care, and have kept CIW informed of developments throughout. This situation has subsequently been rectified.

During 2018 our programme of work focused on care experienced children and young people. The national [report](#) is published on our website. Key findings highlight areas for improvement in respect of profile, sufficiency, practice, partnerships, stability, governance and corporate parenting. Many of the areas we have identified for improvement continue to be considered by Welsh Government's Ministerial Advisory Group on improving outcomes for care experienced children and young people and we also hope local authorities will consider their own contribution to addressing these findings. We will monitor with interest the development of much needed commissioning and market position strategy to map future demand for services and help shape the market.

In December 2019 we wrote to all local authorities asking for information about The Public Accounts Committee report following their enquiry into care experienced children, specifically recommendation five concerning the effectiveness and frequency of end of placement reviews. We did not receive a formal response from Merthyr Tydfil County Borough Council and therefore request again that you advise us and confirm assurance of your practice in such reviews. For example, are disruption meetings or placement breakdown meetings held and how is learning from such reviews / meetings embedded within practice?

Partnerships

Regional arrangements are undergoing significant change. As the newly constituted Cwm Taf Morgannwg has been operating shadow arrangements, for example in relation to regional partnership and safeguarding boards, 2019-2020 has been a transitional year. The dynamic of regional working is therefore changing. Notwithstanding some budgetary challenges, including Integrated Care Funding (ICF) remaining separate until April 2020, the new partnership is making progress on transformation arrangements for safeguarding priorities and the development of a new regional approach to carers. The changes have been broadly welcomed by Merthyr Tydfil County Borough Council and opportunities for learning different approaches, such as incorporating early help into the MASH, are being actively explored. During 2020-2021 there will be a need for further alignment and embedding new ways of working. The local authority is also committed to working with neighbouring local authorities especially Rhondda Cynon Taf with whom they share DoLS and workforce planning responsibilities.

Partnership working across the region has remained innovative with clear commitment to integrated service delivery. Initiatives designed to make the best use of resources and promote well-being such as Staywell@home and Valley's Life projects are examples of partnership arrangements that capitalise on positive strategic and operational working relationships between health and social care services. Joint planning is also underway to further expand the Staywell@home services to include pre-admission services and to broaden some dementia extra care services to a wider cohort of adult service users. We recommend strengthening links between the local authority, third sector organisations, community coordinators and general practitioner support workers, in order to further improve outcomes for people.

CIW Performance Review Plan for 2020-2021

Our scheduled thematic inspection programme for adult services 2019-2020 is focused on prevention and promoting independence for older adults in the community and, for

children's services the focus is on prevention, partnerships and experiences of disabled children. Due to the current emergency situation relating to COVID-19 we have paused the publication of our older adults report and paused all activity relating to the disabled children's review. We will advise you in due course when we envisage recommencing our inspections.

We hope to publish the older adults' national report in due course and want to take this opportunity to thank you for your local authority's contribution to this.

Due to the unforeseen circumstances we find ourselves in, we are currently reviewing and considering our work plan for the remainder of 2020-2021.

CIW worked together with HMI Constabulary (HMICFRS), HMI Probation, Healthcare Inspectorate Wales (HIW) and Estyn to develop a model of joint inspection of child protection arrangements in Wales (JICPA). This approach was piloted during the autumn of 2019. This was a fantastic example of new ways of working across Wales and a real drive towards collaboration and integration in public services.

We continue to work closely with Social Care Wales to support improvement in social care services.

You will note that this letter has been copied to colleagues in Audit Wales, Estyn and HIW. CIW works closely with partner inspectorates to consider the wider corporate perspective in which social services operate, as well as local context for social services performance.

We will publish the final version of this letter on our website.

Yours sincerely



Lou Bushell-Bauers
Head of Local Authority Inspection

Cc.
Audit Wales
HIW
Estyn

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Inspection Report on

Tŷ Bargoed Newydd Residential Home

**Tŷ Bargoed Newydd
Williams Terrace
Treharris
CF46 5HH**

Date Inspection Completed

22 July 2020

Final unpublished report

Final unpublished report

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About Ty Bargoed Newydd Residential Home

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	Merthyr Tydfil County Borough Council Adults and Children's Services
Registered places	32
Language of the service	English
Previous Care Inspectorate Wales inspection	15 August 2019
Type of Inspection	Full
Does this service provide the Welsh Language active offer?	This is a service that provides an 'Active Offer' of the Welsh language. It provides a service that anticipates, identifies and meets the Welsh language and cultural needs of people who use, or may use, the service.

Summary

Tŷ Bargoed Newydd Residential Home is located in Merthyr Tydfil and is operated by Merthyr Tydfil County Borough Council. The Responsible Individual (RI) for the service is Angela Edevane. A manager is also in place to oversee the daily running of the home who is suitably qualified and registered. The home can accommodate up to 32 residents with personal care and/or dementia care needs.

Well-being

People enjoy a good standard of care and support. They feel safe, well cared for and are complimentary of the care workers. People's general emotional and psychological needs are met. The provider is appointing an activities coordinator to give people more opportunities to become occupied and engaged. People access care from the right professionals when they need it. Personal plans need more information regarding how risks are to be managed and reviews need more detail. Systems are in place to ensure the safe management of medication and infection control. The home has relevant policies, but some need reviewing. Processes are in place for protecting people from the risk of harm and abuse. But, staff training is lacking, so people cannot feel confident all care workers will know how to follow those processes correctly.

The home is clean, free of malodours and appropriately maintained. Residents, relatives and a professional we spoke with all shared positive feedback, commenting on the home's cleanliness and presentation. People can personalise their bedrooms and there are suitable facilities and equipment to enable people live safely and well. Management ensure the home's health and safety requirements are met.

Governance and quality monitoring needs improving. The care workers we spoke with shared positive experiences of working at the home. They feel it is well-managed and that they work well together; but we found not all care workers receive regular supervision. Daily handover records are kept which show effective communication between care workers when they change shift. Turnover of care workers is low, which helps promote good continuity for residents. There are deficits in training which need immediate attention. The RI's oversight of the quality and performance of the service needs to improve. This includes obtaining the views of people connected with the service more regularly. The home has clear aims, objectives and relevant policies, but written information needs reviewing.

Care and Support

People receive a good level of care and they access health services when needed. We spoke with people using the service, relatives and a healthcare professional. They all told us the standard of care and support was good. They described care workers as caring and friendly. Turnover of workers is low which promotes good continuity for residents. Care records show people receive appropriate care and support, but mouth care records should be completed more fully to show where people have received support, or where they have met their own needs. Care workers communicate well with each other and with the residents. Relatives experience a warm welcome when they visit. People's general emotional and social needs are met, but there could be more opportunities for people to become occupied and stimulated. The provider is addressing this through the appointment of an activities coordinator.

People have individual care plans, but reviews are basic and guidance for care workers about managing risks needs more detail. People's plans set out their care needs and contain guidance for care workers in how to meet them. Short-term care plans are used to help people work towards temporary goals (e.g. recovering from a short-term illness). Guidance for care workers about managing risks needs more detail. Evidence suggests that people and their relatives are more involved with their care planning needs, but reviews need more detail to make them meaningful.

People are treated as individuals. All residents we spoke with told us they felt safe and happy with the care they received. They gave us positive feedback about the care workers, variety and quality of meals and felt their preferences were respected. People exercise choice day to day, for example choice of food, where to spend their time and when to go to bed and awake. Appropriate arrangements are in place for residents with limited cognition to make important decisions about their care and well-being. Relatives told us people are treated with care and respect.

Measures for managing medicines and reducing risks of cross-infection are in place. Medicines are stored adequately, safe from unauthorised access, but some aspects relating to storage need addressing. Record keeping of medicines is satisfactory. The home uses an external auditor to help monitor and maintain good practices. A medication policy is in place. There are written procedures for infection control, but they could be clearer for care workers. The majority of care workers wore personal protective equipment (PPE) appropriately. We spoke with provider about monitoring care workers' use of facemasks to ensure they are at all times worn in line with relevant guidance.

Protocols for protecting people from the risk of harm and abuse are in place, but due to a lack of staff training, not all care workers may be familiar with them. Policies and procedures for whistleblowing and safeguarding vulnerable people are present. All residents and relatives spoken with knew who to contact if they had any concerns. There is

evidence the home raises concerns with relevant professionals in a timely way, to help protect people. As indicated in the 'Leadership and Management' section below, training for care workers, which includes safeguarding, needs improving. This means people cannot feel confident all care workers will have an up to date awareness of important policies and protocols.

Final unpublished report

Environment

The home is clean, tidy and welcoming for people who live there and visit. Ty Bargoed Newydd is a purpose-built care home which is spacious and modern inside. Its layout and décor is suitable for the people living there and consistent with what is described in the home's written information. People personalise their bedrooms as they choose and there is a good amount of space for them to enjoy, inside and out. At the time the inspection took place, relatives had started revisiting, following the COVID-19 lockdown. The provider has arrangements for enabling these visits to take place in a safe way. This is supported by a new policy. Areas in the home where only staff are allowed to access (e.g. due to confidentiality or potential risk to residents) are secure. There is a secure front access system and a record of visitors is kept.

The home's management ensure it is a safe place for people to live, work and visit. We looked at a range of documentation relating to health, safety and maintenance. They show appropriate checks and servicing is carried out to ensure facilities and equipment are safe. Fire safety records are kept which evidence regular fire drills and servicing. Residents have individual emergency evacuations plans. There is a fire safety risk assessment and the service provider told us they are working towards making some improvements.

Final unpublished report

Leadership and Management

Written information about the home is present, but it needs updating. The home's aims and objectives are clear and relatives told us they received written information about the home. Policies and procedures support the running of the home, but some needed reviewing. We were unable to access the incident and accident records at our visit as the manager was not present. We will look at these at the next inspection. We saw, from information we already held, that the provider had been notifying us appropriately of events.

Training and supervision for care workers needs improving. Care workers spoke highly of the home's manager and considered they worked well together. They told us they felt well-supported, but records we viewed showed many care workers did not receive supervision regularly enough. Since the last inspection, the provider has introduced a training and development policy. We informed the service provider at our last inspection that training needed improving. Discussions with staff and examination of records at this inspection showed this remained the case. There is a lack of evidence that management monitor staff training effectively and have a clear training programme in place. We were made aware of a recent incident that had occurred in which care workers failed to follow correct protocols to safeguard people, resulting in a significant infringement to a resident's privacy and dignity. People are unable to have confidence that all care workers will have an up to date understanding of important policies and protocols. Because of the impact of this, we have issued a priority action (non-compliance) notice. The provider must address this and we will carry out another inspection to follow it up.

There is satisfactory information in place regarding people working at the home. Documentation had improved since our last inspection. Overall, we are satisfied there is sufficient information and/or documentation in place relating to people working at the home. The service provider needs to ensure though that employment histories are always documented fully.

Standards of governance and quality monitoring need to be improved. There is evidence the RI oversees how the service is running to an extent, but they need to visit and speak with people more frequently. There is a lack of consideration in the RI's monitoring of training and how deficits will be addressed. In addition, the quality of the service provided to people is not reviewed as often as it needs to be. This means feedback from people connected with the service (e.g. residents, relatives, care workers and commissioners) is not sought and evaluated regularly. This is important to enable the RI to give assurances about the home's safety and performance, and to allow it to continually learn and improve.

Areas for improvement and action at the previous inspection

Ensure full and satisfactory information and/or documentation is available for people working at the home.	Regulation 35(2)(d)	Achieved
Ensure care workers receive ongoing training appropriate to the work they perform.	Regulation 36(2)(d)	Not achieved

We found an individual had experienced a poor outcome and there were potential risks to the well-being of other residents. Therefore, we have issued a priority action (non-compliance) notice. We expect the provider to take immediate steps to address this and make improvements.

Areas where immediate action is required

Ensure care workers receive appropriate ongoing training	Regulation 36(2)(d)
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Areas where improvement is required

Ensure personal plans take sufficient account of risks to the individual's well-being and measures for managing them	Regulation 15(7)(e)
Ensure personal plans are reviewed with residents and relatives at least every three months and consider the extent to which people achieve their personal outcomes	Regulation 16(1)-(4)
Ensure all persons working at the service receive appropriate supervision	Regulation 36(2)(c)
Ensure the RI visits the service at least every three months to speak with residents and care workers	Regulation 73(1)
Ensure the RI maintains a system for monitoring, reviewing and improving the quality of care and support at least every six months	Regulation 80(2)

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Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Care Home Service

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on our website
www.careinspectorate.wales

Tŷ Bargoed Newydd Residential Home

Tŷ Bargoed Newydd
Williams Terrace
Treharris
CF46 5HH

Date of publication: **(manually entered)**

Final unpublished report

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Leadership and Management	Our Ref: NONCO-00009547-NRCS
Non-compliance identified at this inspection	
Timescale for completion	21 September 2020
Evidence	
<p>The service provider is not compliant Regulation 36(2)(d) of The Regulated Services (Service Providers and Responsible Individual) (Wales) Regulations 2017.</p> <p>This is because it has failed to ensure all care workers maintain appropriate training.</p> <p>Evidence:</p> <ul style="list-style-type: none"> • Staff training records indicated high numbers of staff who had either outdated key training (e.g. where they last received it 3 -8 years ago) or where there was no evidence key training had been provided. This included training in safeguarding (approximately 60% of staff); infection control (approximately 73% of staff); health and safety (approximately 71% of staff); and medication (approximately 36% of staff). • Three staff spoken with were uncertain when they last received safeguarding training. Their training records showed no up to date safeguarding training had been received. Records for one person reflected safeguarding training over 6 years ago. • At the last inspection on 15 August 2019 the service provider was informed it was non-compliant with Regulation 36(2)(d) (staff training). Evidence at this inspection indicates this remains the case. • We were made aware of an incident which had occurred in the home whereby two care workers failed to correctly follow adult safeguarding protocols, which would have been outlined in safeguarding training, resulting in a significant infringement on a resident's privacy and dignity. • We looked at supervision records for three staff who had notable gaps in their training. There was insufficient consideration of these training deficits during their supervisions and how they were to be addressed. • We examined RI visit reports dated October 2019 and February 2020. We found six monthly quality of care reviews had not been maintained in line with Regulation 80 since the service registered under the Regulation and Inspection of Social Care (Wales) Act 2016. These demonstrated a lack of RI oversight of the training deficiencies within the 	

service and there was no robust action plan for addressing them.

Impact on people using the service:

There is evidence the privacy and dignity of a resident has been significantly implicated as a result of a lack of robust governance in the service. Where staff fail to receive regular training, it places other residents at potential risk as staff may not know how to respond correctly to concerns, in line with the service's policies and procedures.

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