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Care Inspectorate Wales

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Healthcare Inspectorate Wales

Inspection of Older Adults Services Rhondda Cynon Taf County Borough Council

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Contents

Background

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

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

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

The principles of the Act are:

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

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

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

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

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

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

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

We (CIW and HIW) focused upon the experience of older adults as they come into contact with and move through social care services up until the time they may need to enter a care home. We also considered the times when they experienced, or would have benefited from, joint working between Local Authority services and Health Board services.

We evaluated the quality of the service within the parameters of the four underpinning principles of the Social Services and Well-being Act (as listed above) and considered their application in practice at three levels:

- Individual
- Organisational
- Strategic

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

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

Senior managers in Rhondda Cynon Taf County Borough Council (RCTCBC) told us their practice model had been developed to comply with the SSWBA, with emphasis on wellbeing, independence and prevention. We found RCTCBC, via its short term services, offered information, advice and assistance to people supported by a

proportionate assessment and a range of preventative services. Our inspection had particular focus on the effectiveness of the Single Point of Access (SPA) service and the StayWell@Home (SW@Home) initiative and how this promoted people's well-being. This comprised:

- A hospital based team (social workers, occupational therapists (OTs), physiotherapists-all undertaking a trusted assessor role)
- @Home Nursing, nurse led service enhancing community health service
- Support@Home local authority based service which provides a four hour response and includes a number of dedicated teams:

    - Reablement service, providing a duty function working closely with SPA and a therapy programme for up to six weeks
    - In house short term enabling and reablement domiciliary care
    - Memory reablement
    - Intermediate Care, providing an enabling programme of support for up to six weeks
    - Adaptations and Community Equipment, providing an emergency function, suggestions and practical support to help people cope better with daily living and specialist equipment.

Given our inspection theme we had particular but not exclusive focus on the Short Term Care Management Team. This team comprised social workers and care and support practitioners providing a care management function for new referrals, generally working with people for up to twelve weeks. RCTCBC's locality Care and Support Teams provided a social work service for people who have longer term and more complex needs across a range of conditions and circumstances which impacted on their well-being.

Strengths and Priorities for Improvement

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

Well-being	
Strengths	People can be reassured the local authority recognises adults are the best people to judge their own wellbeing. The local authority is able to demonstrate a good understanding of its own strengths and areas for improvement through a developing approach to quality assurance and learning across service areas. Professional disciplines work effectively together to support well-

	being. Prompt professional responses are evident at times when people experience acute ill health or crisis, this is integral to help secure independence for people.
Priorities for improvement	Consistently recognise carers' roles and to ensure the voice of the carer is heard; with improved support for carers tailored to enable them to achieve their own wellbeing outcomes. Ensure teams working with people with longer term needs satisfactorily manage the volume of work and ensure people's needs are appropriately reviewed.
People – voice and choice	
Strengths	People who lack mental capacity can be confident assessment and decision making is made in their best interests. RCTCBC has a clear understanding of the learning and development needs of its workforce and has a programme to address those needs. Workforce is well supported by the management group, with leaders who provide clear direction. RCTCBC and Cwm Taf University Health Board (CTUHB) work collaboratively and responsively to support people's independence at times of acute ill-health and during their recovery.
Priorities for improvement	To ensure consistent consideration is given to both informal and formal advocacy as outlined in Part 10 Code of Practice (Advocacy). To ensure a consistent approach to reviewing people's needs and if their outcomes are being achieved. To ensure a consistent approach to involving people's networks of significant family and friends' as appropriate so they actively participate and contribute to the assessment, planning and safeguarding process. To ensure a consistent approach to people having choice and control, and improving opportunity for take up of Direct Payments. Develop wider opportunities for people to access assistive technology.
Partnerships and integration - co-production drives service delivery	
Strengths	Safeguarding coordination and communication across the multi-disciplinary group ensures an effective process to safeguard people. There are examples of innovative and collaborative thinking by health and social care managers who are able to influence and demonstrate expertise and shared purpose. This results in efficient and collaborative services which meet people's outcomes

	and supports their independence. Strong relationships and communication between providers and local authority commissioning staff. Immediate and short term response to acute referrals involving prompt multi-disciplinary responses.
Priorities for Improvement	Take time for structured joint learning across health and social care. Monitor the timeliness of provision of adaptations and community equipment. Develop more effective links with GPs to improve utilisation of community services to reduce the potential deterioration of older people living independently in the community.
Prevention and early intervention	
Strengths	Staff from across health and social care services reflected a compassionate and shared vision to support people in the community. Health and social care strategic managers promoted a shared approach to prevention. Joint health and social care services, different disciplines and the third sector complement and work effectively together.
Priorities for improvement	Ensure there is clarity in health and social care collaborative planning of preventative services (for example in the development of primary care hubs and community hubs). Improve engagement with people and communities including third sector partners to help prevent escalation of need.

1. Well-being

Findings:

Senior officers demonstrated a consistent approach to changing the way RCTBC delivers services. Their planning featured improved ways of integrated working and a move away from a previous culture of dependence on services to identifying what works for the community in supporting the well-being agenda. The local authority has invested heavily in sport and leisure with a clear plan to incentivise people to look after themselves. This has significant relevance for the future well-being of all people living in Rhondda Cynon Taf County Borough (RCTCBC).
An approach to quality assurance was evident based on an organised auditing schedule which emphasised strengths and practice learning. Management oversight of operational performance was evident.

Underpinning practice was a clear priority to identify what matters to the person. People told us of their desire to remain living at home as long as possible and how they had been supported to achieve this outcome through the support of a range of services that addressed their needs.

We identified how practitioners across different disciplines were able to respond promptly to people's changing needs; support being developed to address escalating need in order to meet an individual's desired outcome, to remain living independently.

Evidence at the individual level:

1.1 People can be confident their wishes and feelings will be prioritised and the local authority has regard to the presumption that the adult is best placed to judge his or her well-being.

1.2 The recording of *What Matters* conversations captured people's perspective and individual histories, particularly important for people living with dementia.

1.3 People can expect to be supported to meet their outcomes, but sometimes more specific personal outcomes related to overall well-being and recognition of strengths would have improved the quality of an assessment.

1.4 We found people received prompt support from multidisciplinary teams to return home following a period in hospital. This meant people's well-being was quickly promoted and enabled people to meet this personal outcome. The integrated SW@Home service (see also section 3.6) was pivotal in this respect; we identified many examples of different disciplines working effectively together to support people's independence. For example, we reviewed a file where an individual who was unable to mobilise was supported to return home through coordinated planning involving the person, Support@Home, family members, a domiciliary care provider and district nurses.

1.5 We identified opportunities to support carers were sometimes overlooked, with the pressure of caring not fully acknowledged during assessments. A person discharged from hospital had received Support@Home and was being visited by her daughter twice every day. Records did not indicate the role of the family carer had been considered. Practice in consideration of the role of carers was inconsistent as we found some files had recorded the offer of a formal carer assessment and a carer assessment being undertaken.

Evidence at operational level:

1.6 RCTCBC has developed a responsive service partly because it has embedded a culture that is flexible and allows staff and managers to make decisions and allocate resources. SW@Home has a system of trusted assessors which allows professionals across different disciplines to assess and promptly arrange support to meet people's outcomes.

1.7 For short term social work case management a daily panel enabled packages of care for people to be promptly implemented whilst also providing a quality assurance function. Managers who support the locality teams (working with people who had longer term and more complex needs) also have autonomy to approve packages of care promptly.

1.8 The SPA team was able to directly and promptly arrange services such as the local authority's intermediate care service or its reablement team.

1.9 We found some teams, notably the locality, safeguarding and review teams were working beyond their capacity, although we did not see this adversely impacted on the quality of practice across files reviewed. Delay in allocation was identified in the locality teams and some staff described crisis management as a means of managing high caseloads. They described the challenge in balancing risk and prioritising casework. Responses to our staff survey corroborated this finding and the pressure some staff experienced as a consequence of the volume and increasing complexity of caseloads. The senior management group have to an extent recognised this pressure in utilising agency staff and employing additional staff, however we found pressures remained.

1.10 The purpose of the local authority's Community Review Team is to ensure people have a timely review of their care and support plan. It was evident the capacity of the team meant not all people were receiving a timely review. Managers and staff have recognised this and the remit of this team is under review. We found some key professionals commented they were not invited to review meetings, this means they were not involved in important amendments or

changes to care and support plans. Our findings indicated this did not appear to have an adverse impact on people's outcomes.

1.11 Practitioners captured information to develop a person's assessment. Across teams we found recognition of the importance of *What Matters* conversations in developing preventative responses to people; for example a person who was lonely due to immobility was quickly linked to a befriending service. A distressed person was listened to by a SPA team member and through prompt inter agency communication it was arranged for a support officer to visit the person that day.

1.12 As referenced above, sometimes the role of the carer was underestimated and this contributed to a breakdown in support arrangements. Greater reflection during assessment on the role of the person's carer, the support they may need and contingency planning would have improved circumstances for some families.

1.13 There was a multi-agency approach to responding to safeguarding concerns. Whereas actions were generally recorded and cooperation was evident in working towards the person's safety and well-being, improved clarity in recording the rationale for safeguarding decisions was required in some of the files we reviewed. For example, a file we reviewed centred on three referrals to the Multi-Agency Safeguarding Hub (MASH) in relation to alleged financial abuse. Although no harm was evident to the individual, there was no narrative or rationale for the decision not to proceed to a Section 126 investigation.

Evidence at strategic level:

1.14 We heard a consistent message from senior officers in promoting integrated working and a clear understanding of the principles underpinning the SSWBA and the well-being agenda. Senior officers demonstrated an awareness of strengths and areas for improvement; this was corroborated by the openness of responses during interviews and the local authority's own self-evaluation.

1.15 Managers modelled the principles of the SSWBA by working co-productively with their workforce. This has, for example, resulted in managers actively working with staff to develop a shared view of their learning needs. Bespoke training had been organised since a service re-structure two years ago. Most recently a number of staff had requested specific learning disability training and this had been arranged.

1.16 RCTCBC is developing its approach to quality assurance; a methodology for auditing files was seen but this was not fully embedded across service areas. An overarching quality assurance document had been developed with staff which requires time and focus to ensure it is fully implemented. A quality assurance

board is being established with the intention of drawing together learning from practice.

1.17 Although staff reported receiving good supervision and support from management at all levels, we did not see evidence of critical evaluation in supervision recording we reviewed which is one of the goals outlined in the quality assurance document.

2. People – voice and choice.

Findings:

Through review of care and support records and talking to people receiving services we were satisfied people's views were ascertained and their wishes and feelings given high regard. When people's capacity to understand was compromised, significant family members and advocates participated in best interest meetings when critical decisions were being made about key aspects of the person's life.

We identified the profile of family carers was not fully recognised by practitioners, with consideration to a carer assessment not always evident. Work is required to improve consistency in relation to considering carer's needs.

Where people and carers wished to take risks in order to remain independent, records showed a balanced approach with options explored to minimise risk. We identified situations were older people as carers were supported to maintain their caring role. This enabled them to meet their desired outcome, to remain living at home as independently as possible. As indicated, however, sometimes the circumstances for the carer and the pressure they experienced was not fully understood.

Evidence at individual level:

2.1 We found records of conversations with people talking about what was important to them. We spoke to one person who described how as she became increasingly mobile she and her family were consulted about reducing the level of support. She felt practitioners had accommodated her wishes and feelings.

2.2 The voice of informal advocates was recognised in the records we reviewed, but this was not always given sufficient prominence. This means assessments were not always holistic and were at risk of omitting important information and not fully understanding the role of key family and friends in supporting an individual's independence.

2.3 People who lack mental capacity can be confident formal advocacy is offered and their contribution is evidenced in best interest decisions.

2.4 Mental capacity assessments we audited were undertaken to a good standard. Recording of mental capacity assessments demonstrated verbatim recording of the questions asked and the responses people provided. Questions were articulated in an appropriate manner, practitioners were recognised to give depth of thought and time in communicating with people. They considered the individual's understanding, retention, use, and weighing up of salient information.

2.5 Assessment practice demonstrated an intense focus on the outcome for the person to maintain independence; sometimes the carer's needs were not always fully recognised. This has potential for packages of care to be unsustainable as strain on family carers may not be fully acknowledged.

Evidence at operational level:

2.6 We found staff were aware of direct payments but did not give this a high priority. This seemed to be due to a perception direct payments were not appropriate for older people to manage, and there was a shortage of identified personal assistants to provide care and support. This meant the full range of options for people and their carers to meet their outcomes may not be fully presented to them.

2.7 Assessments would be improved if there was greater clarity and fuller conversations about outcomes. We saw routine recording of outcomes (this was often about the person wishing to remain or resume independence) but more detailing of desired personal outcomes, and ascertaining the views of significant family members would have enhanced both understanding of what were important considerations and the quality of the response to meet outcomes.

2.8 Some file records we reviewed which followed a safeguarding pathway did not include the views of key family members. Through their own audit process, the local authority recognised the need to ensure all key professionals are involved in strategy discussions and enquiry. This should be broadened to include key family and friends as appropriate, taking in to account the informed consent of the individual. This is important to ascertain a fuller account and understanding of people's circumstance, the strengths and barriers to achieving positive outcomes and has potential to miss opportunities to co-produce solutions. It is equally important people and their carers are made fully aware of the outcomes of the safeguarding process.

2.9 We were told there was a shortage of independent sector domiciliary care support in some areas of RCTCBC. This has potential to limit the care and support available to people depending on where they live. The RCTCBC Support@Home service offered a flexible service and was able to respond when other providers had a capacity shortfall.

2.10 We also heard the availability of other support services, such as befriending, could be locality dependent.

2.11 We recognised local authority managers were responsive to identified need. For example, a new carers post is to be appointed to improve support for carers across the service, improve carer assessment and to develop policy.

Evidence at strategic level:

2.12 We noted senior managers had introduced a quality assurance system to address practice concerns that may impact on individual well-being. We saw an issue log which recorded practice concerns in relation to hospital discharges (including delayed discharge), community services and inter-professional liaison with the SPA. A group of local authority managers analysed any patterns and raised these with CTUHB colleagues as appropriate.

2.13 Senior managers worked closely with the Older People's 50 Plus Forum (known as OPAG) as a group representative of people living in the community. The local authority considers this group provides an important role in consultation processes, for example participating in RCTCBC's review of Day Care Services and Residential Care for Older People.

2.14 RCTCBC has contracts in place to provide advocacy through Age Connects Morgannwg for people aged fifty and over. One paid advocate is provided with scope to draw on others if necessary. Quality monitoring meetings are held with the provider; the local authority has identified a capacity issue and is currently reviewing plans for formal advocacy support.

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

Findings:

Professionals we interviewed at operational and management level were consistent in how they described the way they wanted to support older people's independence. This was evident across the multi-disciplinary groups working with older people. There was consensus and cooperation about the way they provided services to help people meet outcomes and take on board people's wishes and feelings. The ethos of the SSWBA was understood and operationally we recognised professionals working towards reduction of risks to enable people to maintain their independence.

The multi-disciplinary model was not predicated on co-location but was effective as agencies were working closely together to support independence.
The provision of support to individuals with acute ill-health is heavily reliant on a group of senior managers working closely together across health and social care. We found these managers worked well together as they recognised common ground, respected professional difference and could challenge one another through healthy communication. This was a prominent theme emerging across our fieldwork methodology.

RCTCBC's Adult Safeguarding Team is based at the MASH at Pontypridd Police Station. Staff consistently reported good working relationships with the Safeguarding team, with a consistent understanding of thresholds. Through review of files we identified a satisfactory standard of multi-agency safeguarding practice.

Evidence at individual level:

3.1 We identified examples of partnership working having a positive impact on people's well-being. One person told us how the SW@Home service worked with him for four hours at the hospital emergency department after a fall to avoid admission. What mattered to this person was to remain living at home independently. Staff in the hospital recreated a domestic environment and tested the person's mobility. This resulted in the person returning straight home with support. The person's family member described this as a 'seamless and immediate' response. At home, therapists arranged aids and equipment and helped reorganise the environment to ensure that the person was able to get around the home safely. The package of domiciliary care was also increased.

3.2 Files we reviewed illustrated good communication across disciplines during a range of different assessments about for example; nursing assessment, potential end of life care arrangements, urgent occupation therapist (OT) and adaptation assessment. Commonly these conversations centred on preventing people

reaching crisis. This means the needs of people are being addressed by a range of disciplines, helping people to maintain their independence.

3.3 We identified RCTCBC fully utilises OTs who had an essential role in reablement. These health and social care funded posts were based in the local authority Reablement Team as part of the Support@Home service. They were integral to multi-agency working and were key in working with hospital based OTs in the SW@Home team to allow optimum patient flow with prompt assessments recognised in both admission to and discharge from hospital teams.

3.4 Robust functional assessments were recognised to secure independence; for example a prompt social worker and OT assessment enabled a person who was unable to mobilise to utilise equipment to aid standing and safe transfers without any delay to support the person's identified outcome to be independent. Another person told us how an OT delivered equipment needed the same day it was required, therapists then provided support and quickly returned with a wheeled commode and hoist.

3.5 We found assessments undertaken by physiotherapists and OTs complemented social care assessment. We regularly identified the assessment output as an adaptation to a home, supported by moving and handling advice and complemented by district nurse involvement, this enabled people to meet their outcomes. There was a smooth transition of referrals between the hospital based OTs and those OTs based in the Support@Home local authority team. We were told there had been a long waiting list in the *Adaptation and Community Equipment Team* (ACE) team but some diverted work to *Care and Repair* and improved system management had increased efficiency and reduced the waiting list. A system was now used to prioritise urgent need and lower priority referrals were mostly being managed in the set six week RCTCBC target. This is an area that RCTCBC senior managers have already identified and continue to monitor demand.

Evidence at operational level:

3.6 The regional integrated health and social care team, SW@Home, provides a pathway from hospital discharges through to the community, with the aim of preventing admission and reducing the length of stay in hospital. We identified this service as efficient and responsive enabling people's outcomes to be met and independence promoted. This is a good example of how health and social care can work effectively together. The Support@Home service provides a four hour response to SW@Home and is able to support hospital discharge seven days a week, including bank holidays. Some difficulties were identified when

there was poor communication from hospital ward staff in respect of planning, with people not being kept updated of developments.

3.7 All staff for this service can undertake proportionate assessments as trusted assessors and support from either of the local authorities (RCTCBC or Merthyr Tydfil County Borough Council), including where necessary, community health or pharmacy support, via specialist services, can be brokered.

3.8 SW@Home team continue to be involved with people for up to 14 days, during which period a review is undertaken, with referrals and handover outside the service for continuing input and support where this is required. Our findings corroborated people experienced timely responses from this service.

3.9 We found evidence of strengthening community health responses through the Health @Home nursing service, the Your Medicines @Home and third sector partnership through Age Connects Morgannwg providing additional community health and pharmacy support. These services were supplemental to district nursing service and also provided a four hour response. We noted referrals to this team were in the main made by professionals in secondary health care. We did not find strong evidence of GP uptake, although we recognised the team fed back into the responsible GP regarding interventions they made for the individual concerned.

3.10 Age Connects Morgannwg also has hospital based staff supporting discharges and works closely with SW@Home. They facilitate hospital transport arrangements and can assist with medicine collection.

3.11 We saw examples of GPs working directly in primary care hubs and with ‘virtual’ wards and plans for OTs to be placed in health centres. This provides a full multi-disciplinary team approach to assist in maintaining an individual at home but is not yet widespread across the county.

3.12 Although we heard of examples of joint learning between health and social care staff, this was mainly at times when teams were newly set up and some opportunistic events such as working lunches.

3.13 We heard from domiciliary care providers about their good working relationship with the local authority. They told us about mutual support to ensure people received continuity of service. Brokerage staff and providers referred to a revision of the commissioning strategy and a commitment to move towards an outcome based commissioning process. We noted part of the current contract for domiciliary care and extra care is that providers will signpost people for advice as part of a more holistic community response.

3.14 We identified good joint working where the district nurse had played an integral role in supporting people's independence, however communication with district nurses was identified as problematic by some social care staff. They described persistent problems contacting the district nurse which was a source of delay in taking forward assessment and care planning with people.

3.15 We saw strong inter-disciplinary working at the MASH. RCTCBC's adult safeguarding staff in the MASH used the MASH Information Sharing Platform, a system used to share case work information across professional groups. The 'MHub' system is accepted as having operating difficulties and the MASH partnership is in the process of replacing or upgrading it via South Wales Police, who manage the system.

3.16 We considered the overall standard of multi-agency safeguarding practice, mainly evidenced through audit of a sample of safeguarding files, to be of satisfactory standard. We identified safeguarding logs being used, but the rationale for key decisions was not always evident. We also found a thorough approach to thinking through future risks to vulnerable adults was not always evident.

3.17 Although not directly within the scope of this inspection, a theme emerging from interviews of professionals and people, relatives and carers was the essential role of hospital ward staff in promoting independence. Concern was expressed that this group of staff could have limited information about community services and misunderstood the role of social care staff. This was a catalyst to communication difficulties and restricted forward planning. Relatives were concerned that during the hospital stay people were clinically treated, but some aspects of their key independence skills, for example maintaining mobility, were overlooked.

Evidence at strategic level:

3.18 RCTCBC and CTUHB have invested heavily in working together to be responsive to people who have episodes of acute ill health, avoid unnecessary hospital admissions, reduce the time people spend in hospital, and support reablement and independence. Inter-disciplinary services have been aligned to respond in a coordinated manner to address individual outcomes. Through review of records, interviews with staff and people who had received support to maintain independence and their families we were able to corroborate the effectiveness of partnership working and how this impacted on individual well-being.

3.19 We recognised a clear strategic overarching framework that enabled multi-agency planning and delivery of services. The Area Plan Delivery and Implementation Group (APDIG) advises the Cwm Taf Social Services & Well-

Being Transformation Leadership Group (TLG) and Social Services and Well-being Partnership Board (SSWPB). The third sector (Interlink) are represented on the TLG and Regional Planning Board. A series of 'Statements of Intents' have been developed to help lead significant service development. Through this route RCTCBC and CTUHB hope to secure transformation funding to develop the next phase of the SW@Home initiative, SW@Home2.

3.20 We found the SW@Home approach was a good example of a joint approach to meeting people's outcomes. This has been based on mutual understanding across organisations, recognising common ground and working through professional differences. We identified other examples of joint working initiatives that have proven beneficial in both improving outcomes for people and demonstrating cost efficiency. This has been illustrated through the single carer project and the joint funding bid for the specialist dementia team currently working in care homes to extend its scope to also work with people in their own homes.

3.21 The co-location of the Community Psychiatric Nurse (CPN) team covering the Taf area, alongside social care staff has provided opportunity for sharing of knowledge across disciplines and effective communication. CPNs provided support for people across a range of mental health needs from complex dementia to acute depression with medication monitoring and stabilisation a key role. They offered mindfulness as therapeutic practice for people. Some concern was expressed by social care staff that CPNs had moved out of the Rhondda office and this had adversely impacted on the working relationship across health and social care staff.

4 Prevention and early intervention

Findings:

Our review of files identified examples of practitioners working together with emphasis on prevention and supporting people's independence. We found recorded evidence of collaborative conversations across all parties and the implementation of co-produced plans to minimise repeat of an incident.

RCTCBC has invested in services that are responsive to acute crises facing older people. The professional response to supporting people following a crisis was characterised by a thorough assessment and intervention of services that helped to meet individual outcomes. We found timely and proportionate responses that prevented the potential for circumstances to deteriorate or breakdown.

We found RCTCBC is working with the third sector to develop a preventative approach across communities. Working relationships between SPA and community professionals, including community connectors and Age Connects Morgannwg were recognised.

Evidence at individual level:

4.1 People can be confident RCTCBC will fully support a person's outcome to remain or return home and live independently. We found evidence of a range of services enabling people to meet their personal outcomes. For example, one person's care and support needs were met through a physiotherapist working on mobility, an OT looking at cooking facilities and care workers ensuring medication was administered.

4.2 We found changing circumstances and changes to personal outcomes were addressed ensuring people could remain appropriately supported living at home. People told us they felt listened to and were supported if they were unhappy with care being provided.

Evidence at operational level:

4.3 We identified a preventative approach being taken by practitioners. We saw assessment of people with multiple debilitating health conditions being provided with intermediate care with the goal of helping the person to regain their previous level of independence. We found examples of how care and support plans and assessments had been updated routinely with partner agencies to enable a person to live independently. A plan to address a risk of falls was implemented by an OT which minimised risk for a person. This was complemented by third sector services that helped with shopping and meals on wheels. Together with support from a speech and language therapist, this amounted to a

comprehensive package enabling the individual to be sustained living in their own home.

4.4 Assessments were sometimes so focused on supporting people to self-care that wider needs were overlooked. For example, a person was receiving a full package of support to maintain independence, but wider social needs were not considered. For this situation, the person was socially isolated and lonely. Similarly, the needs of carers were sometimes overlooked as the professional response focused on developing a package of care.

4.5 We identified the Adult Protection Prevention Officer post based with the Adult Safeguarding Team, as providing an important educative and liaison role with professional groups with an emphasis on prevention. For example, recent work had been undertaken with people living with a learning disability focusing on internet safety.

4.6 We found assistive technologies and telecare was promoted and often utilised as part of a package of support to address outcomes identified by people. From a sample of files we reviewed we found in all instances, the application for a lifeline was administered the day or day after the assessment where the need was identified. We saw examples where care and support plans agreed at the daily panel resulted in prompt approval of a range of assistive technology services. A file we reviewed involved a person living with vascular dementia who was determined to be as independent as possible. He had been referred to the memory clinic and a care and support plan agreed by panel included telecare; a falls detector and heat and smoke alarms linked to a Lifeline unit. A referral to Care and Repair was completed to undertake adaptations to a shower access area.

4.7 *Care and Repair* is supported through Welsh Government funding to complete minor practical work at home without going through the SPA service. *Care and Repair* have a rapid response project for people with dementia in addition to their mainstream delivery of minor works. There was no waiting list for the service and we identified integrated working alongside other services, and efficient and prompt responses.

Evidence at strategic level:

4.8 We found the local authority had a good understanding of need across the community underpinned by the population needs assessment. An effective front door service ensured people's needs were identified early and those who required help to meet their eligible needs and outcomes were identified.

4.9 RCTCBC is developing community hubs with the Ferndale area being used as a pilot area. Supported by good relationships with the third sector through Interlink, we found a developing ethos about facilitating communities to develop themselves. Third sector engagement in planning and partnership arrangements was evident.

4.10 Interlink is the voluntary umbrella body for RCTCBC, representing five hundred organisations across the borough. Community Coordinators (CCs) have been funded through the Integrated Care Fund and line managed by Interlink to promote independence through third sector provision, with a focus on loneliness and isolation. We found CCs had good communication with SPA and RCTCBC's First Response Team. This has benefits in that 'signposting' services can be promptly provided to people contacting RCTCBC. The local authority has good systems in place in relation to contract management arrangements, including regular monitoring visits.

4.11 We saw primary care clusters playing a role in promoting public health and are funding third sector projects around new approaches to managing loneliness and social prescribing. Primary care clusters also receive funding for CC posts and it will be important for RCTCBC and CTUHB to ensure good communication between the respective posts which are an essential element of a prevention approach and a bridge to services available in the local communities.

4.12 RCTCBC and CTUHB have identified funding for these and other preventative posts is time limited and sustainable funding is a challenge for both organisations, a persistent issue identified by health and social care managers of services established though short term funding.

Method

We selected case files for tracking and review from a sample of cases. In total we reviewed 69 case files and followed up on 16 of these with interviews with social workers and family members.

We spoke with some people and carers who used the services and administered a public survey via our website.

We reviewed 10 mental capacity assessments.

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

We administered a survey of frontline social care staff.

We reviewed nine staff supervision files and records of supervision. We looked at a sample of three complaints and related information.

We reviewed performance information and a range of relevant local authority documentation.

We interviewed a range of senior officers from the local health board and spoke with operational staff from the local health board.

We interviewed a range of senior officers from statutory organisations and partner agencies from the third sector.

We read relevant policies and procedures.

We observed strategy meetings and allocation meetings.

Welsh Language

English is the main language of the local authority and the inspection was conducted accordingly. We offered translation in co-operation with the local authority. Welsh is spoken in RCTCBC as are a small range of other languages. RCTCBC is developing the active offer of contact through Welsh, and promotes and raises awareness of the language amongst staff and provides workforce development training through the language.

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