Health Boards (12 Required Actions)	Current Position – Cwm Taf UHB
1.3 Specialist care home continence support should be available to all care homes to support best practice in continence care, underpinned by clear national guidelines for the use of continence aids and dignity.	Cwm Taf have a specialist Continence Team who in partnership with the District Nurse Teams support individuals in their own home, nursing home and residential home settings with their continence needs. The Continence Team provide monthly training as part of the Cwm Taf Training Matrix which is extended to community staff, local authority staff, care agencies and care home staff. This is provided in a number of ways either though formal sessions with NHS peers or delivered care home specific to encourage attendance. Cwm Taf Health Board undertakes continence assessments and prescribe appropriate provision to individuals in residential home and community settings. Currently Health Boards provide specific funding for continence products in care homes with nursing, but do not procure this. However, there is national work to consider procuring these products on behalf of the care home sector which would work within the national guidance and provide a framework for assessment, reassessment and product use. The specialist continence service provide individual assessment for all those individuals using urinary catheters in the care home sector and have regular contact with the homes where they prescribe continence products aids and appliances for this client group. They also provide training and advice for patients, staff and families in living with specialist continence issues Individuals are assessed on an annual basis through their annual review. Specialist Continence Service have open access and provide advice, care planning and support for patients, families and carers on an individual basis, this includes

	patients living in care homes. Through the Health Board's Pharmacy team, training has also been provided in a number of homes in relation to bowel continence and laxative medication. Changes in practice are being audited.. Patient specific – Individual 1:1 training is provided for patient specific issues Training is provided in a number of ways on an annual basis through formal sessions with NHS peers or delivered care home specific.
1.6 Older people are offered independent advocacy in the following circumstances: when a care home is closing when a POVA referral has been made when moving directly from hospital to a care home or from another care home as a result of safeguarding issues. For those with fluctuating capacity or communication difficulties, this should be non-instructed advocacy.	Cwm Taf HB provide advocacy by commissioning statutory IMHA and IMCA services on behalf of Welsh Government. Staff in older peoples mental health services and general hospital settings can also refer patients to the service provided by Age Connect Morgannwg which is currently funded by Big Lottery until March 2016. In instances such as the closure of a care home or hospital ward, we would (and have previously) commissioned independent advocacy as required.

When a care home is in escalating concerns, residents must have access to non-instructed advocacy.	
2.2 Older people in care homes have access to specialist services and, where appropriate, multidisciplinary care that is designed to support rehabilitation after a period of ill health.	All residents in care homes have access to all members of the multi disciplinary teams including GPs, Specialist Consultants, Psychiatrists, Dentists, Dietetics, Speech and Language, Occupational Therapy, specialist nurses including tissue viability, continence, Parkinsons, Community Psychiatric Nurses, Dementia care and Huntingdon Diseases nurses. Following a period of ill health individuals are reassessed and referred to local authority for consideration of reablement. If individuals have a potential of being medically unstable, then they are supported by our "At Home Service". This pilot has been supported via a small percentage of our homes to promote well being and prevent hospital admissions. This service consists of a Consultant, Four Nurse Prescribers, O.T., SALT and Mental Health / Dementia Specialist. This team works with the care home, families, patient and GP to maintain individuals in a safe and caring setting. This is a new service that will focus on recovery, enablement of individuals with a patient centred focus.
3.4 In-reach, multidisciplinary specialist mental health and wellbeing support for older people in care homes is developed and made	All individuals have a comprehensive assessment involving a number of health care professionals including Nurse, Mental Health (as required) Social Worker, Doctor, SALT, Physio, O.T, prior to admission to any care home. This identifies individual need and proposes a care plan. It is a requirement that anyone with a formal Mental Health diagnosis has a specialist Mental Health Assessment.

available, including: □ An assessment of the mental health and wellbeing of older people as part of their initial care and support plan development and their on-going care planning. □ Advice and support to care staff about how to care effectively for older people with mental wellbeing and mental health needs, including dementia, and when to make referrals. □ Explicit referral pathways and criteria for referral. □ All residents on anti-psychotics are monitored and assessed for potential withdrawal and reviews are conducted in line with NICE guidelines.	Following admission, the care homes are supported by the Mental Health Support Team established in 2014 who provide, prompt support, advice and training to the care home sector. The aim is to build knowledge and skills of staff in order to improve the quality of life for people residing and working there. They aim to provide a staff centred focused approach help understand and intervene to reduce behaviours that are difficult to manage. This work is based on a model derived from work by Dr. Ian James at Newcastle. The team includes a Specialist Dementia Nurse, Support Workers and a Clinical Psychologist. The team will provide annual report using individual case studies which will demonstrate quality for individuals living with dementia in care homes. The team provides holistic assessment, formulation and care planning working closely with residents, staff, relatives, GPs and secondary care colleagues. A successful conference was held in February 2015 involving staff from community and secondary care together with care home staff. Different aspects of care were discussed in workshops including the importance of environment, life story work and the power of music. A video of a service user talking about her experiences of and fears about being in residential care was shown and well received. This team support referrals to the single point of access, expediting these if necessary. Additional to this work the local authority dedicated a large training resource to

	Dementia Care that is well received by the Independent Care Sector, at no cost to the home.
3.5 Information is published annually about the use of anti-psychotics in care homes, benchmarked against NICE guidelines and Welsh Government Intelligent Targets For Dementia.	We do not currently publish this information but there has been a study undertaken by one of the Consultant Psychiatrists and the Pharmacy team into antipsychotics and dementia in care homes. The purpose of the study was to help us understand the prescription pattern of antipsychotic medication locally, its appropriateness and reduce any undesirable side effects. The learning from this study will inform our plans to put in place arrangements to meet this requirement.
4.2 A formal agreement is developed and implemented between the care home and local primary care and specialist services based on the Statement of Entitlement. This should include: Referral pathways, including open access Waiting times Referral and discharge information Advice and information to	In relation to primary care, we have 46 GP practices. In addition to the services required as part of GMS, 32 Practices are signed up to a Locally Enhanced Service. 14 have a Care Home LES which specifies what services must be provided eg full assessment on moving into a care home, an annual health review, monthly surgeries/ward rounds at the home etc. In relation to the Nursing Home LES, there is I practice signed up to Level 1 and 17 at level 2. We will monitor the use of these as part of the annual Practice Development Visits to check all care home patients being treated under a LES have received relevant services and for all Practices under the main contract, that patients in care homes have had the same level of service eg new patient examination and regular medication reviews. We have a number of care homes who are currently on an allocation rotation. This is because we have specific practices who report that they have reached saturation

support the on-going care of the older person in the home Access to specialist services for older people in nursing homes, in line with the Fundamentals of Care Guidance.	point with the number of house calls being requested by particular care homes, and it means that as each new patient enters the home, they will be allocated a different (local) GP practice (in order to try to make sure that there is a fair distribution of care home patients among the practices). As a result, there have been discussions about whether we should have a dedicated GP service for care home patients, whether we should have a one home-one GP type of arrangement, or whether we should have some other form of dedicated service or additional support. One of the GP Locality Clinical Directors is taking forward work on this issue and it will be linked to the work required by the OPC. Cwm Taf Health Board are committed to work with Welsh Government to develop a formal agreement with Care Homes, Specialist Care Services and Primary Care, that will be localised to enhance the lives of the older person living in care homes within the Cwm Taf foot print.
4.3 Care staff are provided with information, advice and, where appropriate, training to ensure they understand and identify the health needs of older people as well as when and how to make a referral.	Through our Care Home Forum we provide awareness sessions of all Specialist Care Services and Primary Care and wider professional issues. Currently the subject/ topics are chosen adhoc to reflect any recent events or service development and we recognise that there needs to be a 2 year cycle to incorporate adequate coverage of all specialist provision.
4.4 Upon arrival at a care home, older people receive medication reviews by a	GP’s are responsible for undertaking medication reviews in line with the GMS contract and Local Enhanced Service agreements. A template has been developed by the Pharmacy team to assist GPs with medication reviews. This part of the

clinically qualified professional, with regular medicine reviews undertaken in line with published best practice.	contract and the LES will be monitored as part of the Practice Development Visits for 2015/16. Community pharmacists also work with GPs in reviewing medication, in line with national guidance and NICE recommendations to promote well being and prevent complication of poly pharmacy. The UHB Pharmacy team has undertaken a number of reviews with care homes to promote appropriate prescribing and structured medication reviews to benefit patients. For example, a team consisting of Pharmacist Prescribing Advisers, Specialist Registrars in care of the elderly and a care of the elderly Consultant from Cwm Taf Health Board carried out polypharmacy medication reviews in two care homes (mixture of residential, nursing and EMI beds) during 2013-14. Recommendations for changes/best practice were discussed and agreed with GPs and follow up audits undertaken in 2014 and 2015 to monitor change in practice. A local Toolkit was developed and additional care homes being included in future work. The Care Home Medication Review Resource Pack was updated in January 2014 and is due for review again in January 2016. Every care home has also received a copy of the NICE guidelines on Medication in Care Homes. As part of an A and E frequent flier project, any patient who is a care home resident will have a medication review. All patients admitted to a care home from hospital would have been subject to a medication review prior to admission. Details of this would be forwarded to the GP as part of the discharge letter. Additional information should be communicated in the discharge letter direct to the home. As part of the work to develop formal agreements we will need to consider how effective these arrangements are and how they can be

	improved .
5.6 A National Improvement Service is established to improve care homes where Local Authorities, Health Boards and CSSIW have identified significant and/or on-going risk factors concerning the quality of life or care provided to residents and/or potential breeches of their human rights. The national improvement team should utilise the skills of experienced care home managers, as well as other practitioners, to provide intensive and transformational support to drive up the standards of quality of life and care for residents as well as to prevent and mitigate future safeguarding risks. This service should also	The Health Board are committed to the development of a national improvement service to support and drive standards for the sector rather than focus on failing homes. With Local Authority partners we highlight good practice and share lessons learnt through SCWDP and the Provider Forum. The development of Annual conferences jointly with Health & Social Care will also assist and we will explore opportunities to extend the UHB's recognition event to include the independent sector and/or develop a care home specific event to showcase other areas of good practice.

develop a range of resources and training materials to assist care homes that wish to improve in self-development and on-going improvement.	
6.2 Care home providers, commissioners and CSSIW should develop informal and systematic ways in which to ensure they better understand the quality of life of older people, through listening to them directly (outside of formal complaints) and ensuring issues they raise are acted upon. Annual reporting should be undertaken of how on-going feedback from older people has been used to drive continuous improvement.	We currently only have formal methods, such as engagement with families and patients through the review process, complaints or Pova's around levels of satisfaction. However we recognise the value of listening to and acting upon the voices and experiences of older people wherever they live, including those in care homes. We therefore need to do more to capture these through a variety of means, working collaboratively with partners including Local Authorities, CSSIW and providers to maximise the opportunities for collecting, sharing and learning from this rich source of information.
6.8 Health Boards include the following information relating to the quality of life and care of	The Health Board Quality Strategy embraces the UHB philosophy of Cwm Taf Cares and is supported by an Annual Quality Delivery Plan. The Health Board is committed to putting patients, service users and carers at the centre of everything we do,

older people in residential and nursing care homes in their existing Annual Quality Statements: the inappropriate use of anti-psychotics access to mental health and wellbeing support access to falls prevention access to reablement services support to maintain sight and hearing Further areas for inclusion to be developed as part of the AQS guidance published annually.	engaging and listening to those who use our services to inform quality improvement. We need to ensure this approach is also reflected in our work with care homes and their residents. We will therefore use the production of an Annual Quality Statement as required by the OPC to help drive this agenda.
7.3 The NHS works with the care home sector to develop it as a key part of the nursing career pathway, including providing full peer and professional development	Through our annual contract monitoring process and frequent visits to the care homes, we are fully aware of the difficulties in recruiting both Registered General & Mental Health Nurses to Care Home sector The barriers include access to some of the more remote care settings, and poor terms and conditions.

support to nurses working in care homes.	We work with the Care Homes to assist in promoting and developing Job Descriptions and Job Specifications, and offer support with interviewing and the access of bank shift. We facilitate peer support and buddying with other care homes as required. National Workforce Planning has considered the need for succession planning in promoting community pathways for student nurses, newly qualified nurses and we will work with our colleagues to support these initiatives.