Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Dignified care?

The experiences of older people in hospital in Wales

This Review was conducted under Section 3 of the Commissioner for Older People (Wales) Act 2006

RESPONSE FORM

Response required by 14 June 2011

Please send to:

ask@olderpeoplewales.com

or

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This is the response from Hywel Dda Health Board which welcomes the report and the opportunity to focus on this aspect of our care. In addition to the broad areas for action which have been agreed and are specified within this response, the Board is finalising detailed operational action plans which will form evolving plans for driving

forward the standards of care in the areas we know to be of concern; will acknowledge the good work already undertaken; and will guide the journey still to be made.

Commissioner's Recommendations and legal requirements

The Review has resulted in the Commissioner making recommendations. In accordance with The Commissioner for Older People in Wales Regulations 2007, r. 15(2), the Commissioner requests a written response to these recommendations by those bodies mentioned in them.

Body	**Recommendations to be responded to in writing**
Local Health Boards	Please respond to all the recommendations
Velindre NHS Trust	Please respond to all the recommendations
Local Authorities	Please respond to Recommendation 5 **jointly** with your Local Health Board
Welsh Assembly Government	Please respond to Recommendations 2, 7, 10, 11 and 12

The Regulations specify a response period of three months from the publication of the Review report. Therefore, these recommendations should be responded to by **14 June 2011**. If you have any questions regarding your response, please contact Rebecca Stafford on 08442 640 670.

Recommendations

Please refer to the Review report when responding.

Changing the culture of caring for older people in Welsh hospitals

1. **Stronger ward leadership is needed to foster a culture of dignity and respect**

Health Boards and the Trust should ensure that the ward managers on every ward in which older people are treated are empowered with the skills and authority to create a culture of dignity and respect. This must include the necessary clinical leadership skills; the support of specialist consultant nurses especially in dementia care and continence; knowledge of the correct staff numbers for their ward; the authority to select staff; authority to ensure that their training needs are met; and the responsibility for regular appraisal of the skills, knowledge and attitude of the ward staff.

Response

The Hywel Dda Health Board (HDHB) welcomes this recommendation and concurs with the view that the nature and quality of the leadership of clinical teams will have a most crucial influence upon the culture of the care environment and the ethos that exists. In recognition of this, the HDHB has put in place a structure which has clinical leader roles at every level of the organisation and in particular at the level of direct clinical care delivery. In addition to a corporate nursing leadership team, this includes a County Head of Nursing for each of the three county teams, an Acute Services Nurse Manager for each hospital site, Community and Primary Care Services Nurse Managers and Mental Health & LD in each county with responsibility for the Community hospitals, Senior Nurse Managers with responsibility for groups of wards/services within each hospital and a Sister/Charge Nurse in charge of every

ward or department. The roles and responsibilities of all these posts in relation to creating and maintaining a culture of dignity and respect is explicit within their Job Descriptions and the professional forums that have been established in each county and for leaders at each level are all putting dignity as a core agenda item / specific objective of their purpose, promoting a zero tolerance of poor practice and undignified care. These forums are also enabling a culture of visible and accountable leadership and are a place where shared learning takes place. Furthermore, the Director of Nursing and Midwifery has undertaken to meet with every nurse involved in a complaint in which undignified care/poor or uncaring attitude is a component part of the complaint/concern, in order to reinforce the expectations of this organisation and a Zero Tolerance to a lack of dignity and respect being afforded to our patients.

The County Heads of Nursing (CHoN) are accountable for the professional standards of care for all adult nursing services within their counties and are establishing an infrastructure to ensure that a ready interface and communication between mental health and general services is in place. This will enable the psychological support for patients with dementia and other mental health issues being cared for in general ward areas to be more readily facilitated and, likewise, the physical care needs of patients being cared for in mental health care settings to be more readily met. In addition the CH'soN lead the Quality and Safety (Q and S) Committees in each county and this Older People's Commissioner for Wales report, and its consequent, detailed action plans feature on/are monitored through the agenda of these county groups as well as through the corporate Q and S Committee.

The HDHB has a roll-out plan through which the Transforming Care model (part of the 1000 Lives plus programme) is being spread to all in-patient areas. We consider this model to be a vehicle through which to deliver significant improvements to, individualised patient care; the care environment; the dignity in-built within the operational procedures in hospital wards; and the leadership skills at all levels within the multi-disciplinary clinical teams. This work is supported by the Fundamentals of Care electronic audit tool which has been embraced in all hospital areas across the HDHB as a tool by which to monitor our performance in 'caring'; obtain patient feedback on their experience; and support the development of area-specific, as well as high level, action plans to address the identified care deficits: The principle of

'Knowing How We are Doing', inherent within the Transforming Care model is gradually gaining a foothold, with the patient experience perspective being fundamental to the culture being promoted and established amongst clinical staff within the HDHB.

Another approach to be used across the HDHB will be the requirement for all clinical teams to jointly undertake a '10 point Dignity Challenge' Assessment over the coming months. This assessment, based on ten simple statements that are used within the HDHB to summarise the basic expectations of the conduct of every member of staff, help teams to focus on the issue of dignity and to take an honest and open look at their behaviours, both individually and collectively, in relation to different elements of dignity and respect.

Ward leaders and aspiring leaders have access to a range of leadership development opportunities, through in-house programmes. With the overall title of 'Free to Lead; Free to Care Development Suite' this includes clinical leadership development for Existing, Aspiring and New Ward Leaders. Accreditation is available at ILM levels 3 and 5, and BSc / MSc at Swansea University. These programmes address the competencies for ward sisters described in the Welsh Government led 'Free to Lead Free to Care' programme work

A key component of all programmes is the application of learning in the workplace. Course participants progress real projects, in their workplace, and attend professional and practice development focussed Action Learning Sets as part of the programme.

The HDHB has made explicit its desired organisational culture, through which it aims to deliver high quality healthcare. The key components of this culture are seen as:

- **Effective Leadership** to create the environment where there are high levels of trust and empowerment throughout the organisation underpinned by effective communication, collaboration and partnership working
- **Continuous Improvement and Innovation**, underpinned by a culture of learning, where staff maximise their potential and feel they are part of the organisation's success

- **Accountability and Productivity** where individuals and teams have clarity about their roles and responsibilities, and are held to account for delivery of agreed objectives, team working and effective governance, ensuring the organisation provides the best possible health and well-being outcomes for the people the HDHB serves.

A culture change delivery programme is in place, led by the Chief Executive. The programmes such as Transforming Care and REACH that the nursing services are using as vehicles for practice and professional development across the HDHB are underpinned by these components, although we acknowledge that there is a significant distance to travel yet to achieve our goal.

The position in relation to specialist dementia and continence clinical staff is discussed in more detail in Section 2 and 3 of this response.

Ward establishments are currently under review in all hospitals as service models change and develop across the HDHB and ward sisters are intimately involved in this work. Section 7 provides further detail on the HDHB specific work, and our engagement in the All Wales work, in relation to this. Consideration is being given to the inclusion of a Dignity Champion role as a standard within ward/team establishments across the HDHB in order to ensure that there is a named individual who acts as a constant reminder to all regarding the importance of respect and dignity as a core value underpinning the way in which care is delivered.

Sisters are fully engaged in and responsible for the recruitment of staff to work in their teams and are supported and coached in the development of their skills in this by their Senior Nurse Managers as well as the Human Resource and the Learning and Development teams. In support of Sisters in this work, a personal objective of the Director of Workforce and Organisational Development is now to ensure that respecting the dignity of patients becomes a key behavioural requirement for all clinical roles and that attitudes towards patient dignity will be assessed at all interviews.

In an effort to address a poor historical performance in relation to undertaking annual appraisals with staff across the HDHB, a ‘Lean PDR’ system through which to

appraise staff and identify learning needs is being rolled out. For registered nursing staff this is being combined with an approach based on Practice Development principles i.e. REACH which encourages reflection and portfolio development and facilitated work-based learning, although priority is being given to compliance across the workforce with the use of the 'lean PDR' system in 2011/12. This year, in addition to other routes by which awareness of it is raised across the organisation, the new All Wales HCSW Code of Practice will be discussed on an individual basis with every HCSW as part of the 'lean PDR'. This will facilitate an individual discussion regarding the expectation of conduct and behaviour with every HCSW over the next twelve months. Clinical supervision is in place in some services in particular Mental Health & LD.

In addition to the lean PDR , more detailed Training Needs Analysis for Nursing and Therapy staff across the HDHB are currently being undertaken in a piece of collaborative work with Swansea University.

Supporting attendance at training events for all staff continues to be challenging and creative ways of providing training for staff are always considered. The potential use of e-learning is promoted; flexible provision times for programmes to meet those with family friendly/shift working etc needs; short, drop-in sessions to get across key messages are arranged; work-based learning facilitated in the care environment; and, increasingly, simulation exercises are all approaches adopted in addition to conventional classroom based training and teaching in an effort to ensure that the training needs of staff can be met. Ensuring that the HDHB takes every opportunity to embed a consistent message re the importance that we put on respecting the dignity of all people in our care into all learning programmes will be an objective in the coming months, working with all colleagues who deliver and facilitate any training development programme.

The HDHB feels strongly that the clinical leadership in this aspect of our care is provided not only by ward sisters but by all clinical colleagues and therapy services in particular play a major role in influencing the culture of the clinical environments in which they work, nurturing and working towards independence and autonomy amongst their patients. Therapists in HDHB are taking the opportunity to consider

how they can structure and lead their services in order to strengthen their contribution to this work e.g. through developing an 'in-reach' service that focuses on promoting continuity of care and speedier discharge; they are seeking to work integrally as part of a multi-disciplinary, integrated (across NHS and Social Services wherever possible), patient-focussed team; they are using their often unique skills for the benefit of the patients directly in their care and also to positively influence the ethos and approach of the team they are working within in order to provide care that promotes a sense of dignity for each individual patient.

2. Better knowledge of the needs of older people with dementia is needed, together with improved communication, training, support and standards of care

Regular dementia awareness training and skills development should be a requirement for all staff caring for older people. Specialist and skilled multi-disciplinary input needs to be available to support staff to deal more effectively with people with dementia. This should include a Consultant Nurse/Clinical Nurse Specialist available to give both case specific advice and to assist with staff learning and development in this area more generally.

The Welsh Assembly Government should commission further work exploring the treatment of and experience of, people with dementia in hospital, and ways to improve, building on the National Dementia Action Plan for Wales and the associated 1000 Lives plus work programme. This should bring about better care for older people with dementia in hospitals in Wales.

This recommendation is acknowledged as amongst the most important of the report as the care of patients with dementia across the HDHB is currently receiving focussed attention but it is acknowledged that the strategy for the care of this most

vulnerable group has not been as comprehensive and integrated as it might have been within the HDHB up to this point. The work being undertaken within the HDHB to prepare a comprehensive action plan in relation to dementia care is gaining momentum and two Executives along with three Consultants and other clinical staff will attend the action planning workshop being led by Welsh Government on June 29th 2011 and will continue to lead on the implementation of the plan thereafter. In addition, an internal 'Engagement' workshop led by our mental health services will follow this up on July 1st in order to specifically consider how the HDHB is to achieve care across all its service areas, that is in line with the requirements of the Intelligent targets for dementia within the AQF

Programmes and attendance at dementia care training is not yet fully coordinated and targeted across the HDHB and this will form an arm of the specific action plan under development but various initiatives are in place such as training responding to local needs identified through the Mental Health /General interface meeting; joint training programme initiatives between the NHS, Social Care and the Alzheimer's Society; collaborative work between the Alzheimer's Society and the NHS specifically relating to awareness raising for managers and specific training programmes for various groups of staff; the use of the Social Care Institute for Excellence "Open Dementia e- learning programme; inclusion of sessions on dementia care in the basic in-house HCSW and newly qualified Registered Nurses programmes; and the collaboratively-designed academic programme, focussing on the mental health care needs of physically ill people, run by Swansea University. The Health Board is also an active member of the The Wales Dementia Care Training Initiative and will utilise the links with, and resources emerging from, that work to inform its strategy in taking this aspect of the work forward.

At present the areas of good practice in relation to the care of patients with dementia, especially in general ward settings, are not consistent across the HDHB and the spreading of this good practice will form a core part of the developing action plan.

In relation to specialist support and advice for individual clients, Dementia Care Facilitators have recently been appointed in each of our three counties.In addition

appropriately skilled members of the CMHT's provide support for patients and staff in community hospitals and general wards as appropriate. Both the current CMHT members and the new facilitator roles will attend MDTs and provide case specific guidance and advice as well as structured teaching programmes. These roles support the implementation of a recently developed and implemented Memory Care Pathway and a Dementia Care Referral pathway and flowchart

In one county a Dementia Operational group has recently been established with support and membership from the Alzheimer's Society at the table. The group, which has wide representation from acute and community settings, will focus on improving the standards of dementia care, learning from events and improving the information sharing required to ensure personalised care using e.g. the 'This is me' leaflet scheme between hospitals and care homes and the use of memory boxes promoted by the Alzheimer's Society.

We are aware that a culture change on general ward areas is needed to meet the needs of this client population which is currently provided for through traditional ward routine and whilst we manage safety through the provision of additional staffing for clients with complex care needs we acknowledge that the provision of more structured and focussed training will improve the effectiveness of the use of that resource as well as the care afforded to our patients.

We see opportunities to link with planning colleagues to ensure that new capital and refurbishment schemes take account of the emerging evidence in terms of how the environment can be adapted to support the care and safety of patients with dementia and ensuring that we take full advantage of these opportunities will again be written into the specific HDHB dementia care action plan

The roles of expert therapists in supporting the care of patients with dementia are crucial and the development of a common approach to assessment, problem solving and intervention, harnessing the skills and experience of occupational therapists in supporting e.g. memory clinics will be further explored as part of the imminent action planning work, although it is acknowledged that specialist therapists in this field are currently limited in numbers within the HDHB. The potential development of Advanced Practice roles in this field, whether nursing or therapy, as meets the needs

of the patient, will be further considered as part of the detailed action plan under development

Therapists may be in a position to provide the specialist expertise and support to general ward staff that these patients require and this opportunity will also be fully explored. Psychologists in particular have a crucial role to play in ensuring that the behaviours of people with dementia can be understood and effectively managed. They can also play a key role in supporting services to learn from work such as that coming from the Bradford Dementia group that suggests that supportive interventions for staff to help them manage their own reactions and emotions when working with this client group can have a positive impact on the care of the patients. Evidence relating to other aspects of care e.g. that published in the RCP 'Oral Feeding Dilemmas' (2010) will need to form part of our training programmes for staff to inform best practice in relation to nutritional care and decision making in this context.

3. Lack of timely response to continence needs was widely reported and is unacceptable.

Health Boards and the Trust should prioritise the promotion of continence and management of incontinence. They should ensure that staffs at all levels are empowered, trained and aware of the impact of both the ageing process and acute health conditions on continence. They should also devise an appropriate method for identifying older people's experience of continence care.

Response

The HDHB fully endorses this recommendation and has recently recognised the need to focus on this aspect of care itself by merging the specialist continence services across the HDHB and appointing a single manager to lead and develop the

service in line with the ethos within this recommendation. The service review currently underway in relation to the specialist continence service in the HDHB is also driven by the findings of the recent RCP audit. The service has identified key areas that need to be addressed. These are:

- Establish an integrated multidisciplinary forum.
- Develop Nurse led clinical triage in Primary Care with the aim of instigating first line treatment.
- Monitor quality and patient outcomes with further development to engage public and patient involvement.
- Identify and engage with key stakeholders across health, primary care, social care, the voluntary sector & patient and public involvement to form the Hywel Dda Continence Forum.
- Implement reporting mechanisms to ensure that there is good communication within the groups and to all levels
- Embed continence services in the ongoing work being undertaken in relation to “integrated communication hubs”.
- Critically examine existing care pathways, generic workers, shared training and development and in particular how we can deliver and develop the service within existing budgets to address the needs of all.
- Review existing service provider groups looking at how continence service provision is incorporated and to raise the profile of continence issues.

A key tool in the approach to promotion of continence within the HDHB comes as a by-product of the approach to the prevention of pressure damage to skin. The implementation of the SKIN Bundle, promoted through the 1000 Lives plus work, requires staff to give attention to whether the patient’s skin is wet and if so has it been washed and dried. Patients are asked routinely if they require toilet assistance as part of this ‘care bundle’ approach. This process is proving beneficial in helping to ensure the person’s continence needs are met.

Concerns regarding the passive management of continence problems through advising/encouraging patients to simply urinate into their incontinence pads that are raised in this report is of such a concern to the HDHB that a letter to all nursing staff is being prepared by the Director of Nursing and Midwifery, reminding them of their Codes of (Professional) Conduct and the fundamental right patients have to dignified care. This is an issue that will not be tolerated within the HDHB if/when it becomes known about.

As part of the recent drive to ensure fully segregated facilities for males and females, Ward toilets have been reviewed to identify single sex facilities. In some areas toilets have been signposted with pictorial identification. This helps those patients who have difficulties in unfamiliar surroundings to clearly identify appropriate toilet areas.

This recommendation creates the opportunity for clinical teams to think much more creatively about the skills that each team member has to contribute to addressing the fundamental issue of meeting the patient's care need: For example, Occupational therapists may have a significant untapped contribution to offer this aspect of care in a ward setting whilst Art Therapists may be able to assist patients to explore and express feelings and concerns about such a sensitive issue and these will be further explored as part of the work of the Continence Forum

Good nutrition and hydration plays a crucial role in well being and continence. It is well recognised that some elderly people reduce their fluid intake in the belief that this will reduce the need to access the toilet and this is likely to be exacerbated when they are in hospital: It is also known that dehydration increases confusion.

Improving response and communication in relation to patient's continence needs is not only the dignified thing to do it is also likely to improve hydration which reduces confusion and improves general well-being. Thus, development of a method for identifying continence needs must also recognise the role of, and impact on, identifying and meeting nutrition and hydration.

The current hospital menu provides adequate opportunity to achieve the recommended fruit and vegetable intake and contains foods with a higher fibre content to support avoidance of constipation. Drinks are provided regularly

throughout the day and fresh drinking water is always available. As part of the combines approach to Nutritional and Continence Care, we need to be totally confident that patients are always given support to make appropriate meal choices and encouraged to ensure an adequate fluid intake from the time of admission as this will support continence care.

In the future, the HDHB aims to work much more integrally with our Care Home Partners using the approach of Nursing Care Assessors who are linked with specific homes to improve the relationships between commissioners and providers and thus to work more collaboratively to drive up standards especially within this fundamental area of care.

Awareness training in relation to the impact of the aging process and acute health condition on continence is vital if the service is going to change. All health staff needs to be empowered to ensure that patients are being offered alternatives to pads and this includes promotion of continence.

Regular training programmes are already provided by Hywel Dda and are open to all health & social care providers including private sector across primary and secondary care. However the Continence Nurse Group acknowledges that further work needs to be undertaken with staff to ensure that first level assessment is undertaken before referral to specialist continence services.

The HDHB has planned the developed of county based Health Care Support Worker work-based trainers who will be prioritising this aspect of care amongst others as an area of focus for work-based learning over the coming year.

The introduction of link nurses in all clinical areas is to be explored as a potential vehicle to improve patient experience and ensure that any intervention, if required is timely and responsive.

Obtaining and acting upon Patients Stories already forms a key part of the HDHB Quality Improvement Strategy and this recommendation endorses the actions already in train to expand this work: One of the counties has recently established a programme for the structured approach to effectively and sensitively capturing and

ensuring action upon patients' stories: A group of 22 multi-disciplinary staff have been trained and a public and patient recruitment campaign launched to support the work.

Specifically, the Continence Forum plans to obtain and use patient stories and also meetings with public and patient involvement groups to inform and monitor its work

4. The sharing of patients' personal information in the hearing of others should cease wherever possible.

Clinical staff should regard their routine review of patients as a series of individual consultations, and whenever possible these should take place in a ward facility which is accessible, appropriate, and offers privacy.

Response

Again, this recommendation is to be welcomed and is endorsed by this HB

Ward teams are constantly reviewing their systems and practices to ensure that patient's dignity and respect is maintained at all times. The introduction of red pegs and other curtain 'No admission' identifiers are also helping in this area. As part of the Transforming Care initiative, a paper is currently being developed to get organisational agreement on principles that ensure that Information Governance requirements are complied with at the same time as patient safety issues being met through the use of Patient Status Boards which capture key information about each patient – we recognise the need to get the balance right between what is needed for safe patient care and when does enough information become too much?

In many wards documentation is now undertaken at the patient's bedside. This has increased nurse time spent in direct patient care, a key objective of the Transforming Care work. This change in practice supports the patient is involved in the review of their plan of care and goal planning with members of the Multidisciplinary Team,

which is recognised as a vital aspect of providing dignified care in itself.

A cohort on a recent Clinical leadership programme developed a campaign in one hospital based on 'EARWIG' – Everyone Always Remember Where Information Goes! This campaign has proved successful and will now be shared with other areas of the HDHB as a possible aid to promote the messages in relation to confidentiality of patient information.

As environment and service changes are introduced, it is essential that provision is made for quiet rooms which offer an area for patient / relatives consultation. Therapists refer to the difficulties of finding an accessible and appropriate environment at ward level and that this can be a barrier to taking the patient into a private area for the consultation as well as timely access to the necessary ward staff support to safely transfer the patient when the consultation is to take place. It is recognised that these issue can impact significantly on a patient's experience of their care. However, we recognise that ward Sisters are pivotal in advocating for the patients needs ensuring that this requirement is a priority during the planning process, as there are often conflicting requirements and constraints.

We continue to participate collaboratively in Community Health Council (CHC) Hospital Patient Environment Team (HPET) inspections which consider this issue amongst many aspects of the patient environment and we continue to work in partnership with the CHC as our supportive partners on the common theme of hospital patient experience.

A review of how/where patients records are stored at ward level is timely in the light of this recommendation and will be undertaken and acted upon within the HDHB.

The importance of asking the patient wherever possible what information they would like shared with their family cannot be overstated. Negotiating this can prove difficult with individuals with dementia but it is important to recognise individual needs and preference.

The HDHB is working across its many client groups to develop systems which have relevance to the patients/ and recognises particular consideration could be given to

the sharing of interpretations of information and feelings communicated through art.

We fully recognise the requirements to act in accord with the Data Protection Act 1998, the duty of confidence at common law and, as such, the sixth Caldicott principle. It also enhances the privacy of the individual as contained in article 8 of the Human Rights Act 1998. In relation to this, any staff that use person identifiable information (PII) will have those Acts and their requirements incorporated into the training and those staff who are involved in the transfer or other dissemination of PII will be offered an enhanced course. Staff on these courses will be identified by their manager. For doctors, we are considering incorporating Information Governance training into Junior Doctor induction although it should have been covered in their university training.

The HDHB is also developing general guidance, in a variety of mediums, to all staff on how to meet the rights and duties required by Data Protection, confidentiality and Caldicott.

5. Too many older people are still not being discharged in an effective and timely manner and this needs urgent attention

Health Boards, the Trust and Local Authorities should jointly develop more focused and effective commissioning of services and care for older people, including those with dementia, in order to reduce further the level of delayed discharges; and support this work through more robust embedding of Social Services staff in this process through ward level multi disciplinary teams.

The HDHB recognises that this is an area of considerable importance and has focussed much work on it for some time. It still has complaints where discharge has not gone well and wants to improve this aspect as a matter of urgency. The Board is developing service models which will support more patients in the community and in

future only admit patients who really need acute hospital care.

All of our county based operational teams are integrated with social care with joint posts at a senior level to drive the required changes. Whilst we have joint MDTs and work hard to ensure effective and timely discharge we recognise that further work is required and hence this is a specific focus across all counties. All of our county operational teams have working groups that focus on discharge planning with systems in place to monitor effective discharge process and clear protocols to ensure proactive joint action to remove any barriers to the discharge process. We have recently developed a new discharge policy for localisation and implementation across the Health Board. All wards are encouraged to introduce estimated date of discharge and 58% have implemented this initiative.

A number of service models are being developed in our occupational therapy services, as recognition of the crucial role they play in the safe discharge of older people. Specific examples include

a. Integration of the occupational therapy service (across NHS and Social Care) to improve continuity of care

b. Development of occupational therapy in reach in order to:-

    i. Follow the patient from community to inpatient and back again

    ii. Speed up and simplify the process of achieving discharge

    iii. Deliver a common model to convalescence and transitional (social care) community beds

c. Improve utilisation of Social Care resources (residential and home care) through:-

    i. Provision of community rehabilitation/reablement

Timely modification of the environment through provision of community equipment and modification of the home layout e.g. supporting disability facilities grants.

Similarly in physiotherapy with the concept of an in reach model being developed to provide the necessary “pull” to improve discharge.

Work is on-going across the Health Board to improve our knowledge and understanding of the needs of carers, particularly those caring for a person with dementia and we have some positive examples of working with the third sector. As an example; Over the past few months we have successfully worked in partnership with the Carmarthenshire Stroke Association. The Stroke Co-ordinator for Carmarthenshire has worked with clinical leads to develop signposting and support services for patients /carers. This initiative has involved engaging with carers/ relatives during visiting times. This development has the following key aims

- Provide emotional support to family members
- Provide information
- Improve carer’s self efficacy with regard to transfer of care
- Reduce clinical time signposting

Much has been learnt about relatives and carers concerns. For example clarification on hospital processes and policies in relation to discharge planning.

In addition. Closer links have been established with Carers Support services with one partner County Council. In - Reach services are about to be piloted primarily in two elderly care areas in one District General Hospital thus providing an ideal opportunity to develop information provision and signposting support for elderly patients and their carers. It is anticipated that voluntary groups e.g. Dementia support will be part of this pilot programme. This initiative is in its early stages of development.

Our work on “Transforming Care” has provided teams with opportunities to look at their discharge planning processes and to ensure involvement of MDT e.g. introduction of include “Ticket Home”, Patient Status at a Glance boards, use of “pyjamas not prescribed” posters to promote the principle of wellness and early

discharge.

We have some good examples where Arts Psychotherapists input into MDT Care Planning process and this has been seen locally to be of benefit. Our challenge is to ensure that these examples are universal across the health Board. We have a developing psychology strategy recognising that care planning and identification of appropriate placement would ideally include an integrated assessment of behaviour and psychological intervention or occupational therapy work to improve/reduce behaviour.

County teams have identified the need for training around effective discharge management. A dedicated effective discharge module is available through Swansea University and arrangements are in place for this to be commissioned for delivery in September 2011. (Module details). Additionally a new module entitled mental health issues with physically ill patient has been developed with Swansea University. This module has seven specific study days for example dementia care, eating disorders, depression. The aim of this program is to address practitioner's skills and knowledge and care delivery. The training needs analysis is being planned to identify staff's current clinical skills and knowledge and identify ongoing training requirements.

Problems related to discharge are not uncommon themes in complaints. We will constantly analyse our complaints to establish whether there is a theme amongst older patients and whether there appear to be common underlying issues with an ensuing action plan to address.

Resourcing the care of older people in Wales

6. The appropriate use of volunteers in hospitals needs further development, learning from successful initiatives.

Health Boards and the Trust should ensure that their hospitals further develop imaginative volunteer programmes to enhance patient experience, building on existing successful initiatives.

The HDHB has been privileged to obtain a Big Lottery Grant to develop a volunteer scheme. The work to prepare for this in governance terms has been going on for 18 months or so and now the developments of volunteer roles providing activities to support patients and enhance their experience and starting to emerge.

Volunteer Befriended

Volunteer befrienders are established on many wards throughout the HDHB. This is an important role providing social interaction and activities. In addition our volunteers can act as a listening ear for any worries the patient may have and who may not feel confident talking to a nurse.

The roles which our volunteer befrienders carry are varied but include sitting with patients requesting company providing an opportunity for the patient/relative to chat. Help patients to read letters/books, reading to the patient, do crossword puzzles.

Support staff in enabling patient needs to be met i.e. ensure that patients have sufficient water in jugs, informing staff of patients' needs etc. Provide companionship as directed by the registered nurse for patients' needing to attend other departments during their hospital stay e.g. X-Ray.

Meet & Greet Volunteer

HDHB is currently developing meet & greet volunteer roles to be stationed in hospital reception areas. These volunteers will (in some instances) be the first contact a patient or visitor has on arrival at hospital. A friendly face can make all the difference for many older patients on arrival at hospital and if they are not sure where to go the volunteer will accompany them to the appropriate ward or department.

Volunteer Ward Feeder - planning

These roles are mostly in the planning stage but will develop a volunteer ward feeder to help patients wash their hands before eating their meal, make sure the patient is in the correct position to be able to eat and drink safely, prepare the eating area, physically assist with feeding of patients identified by the nurse in charge, encourage patients to eat and drink and ensure food and fluids charts are up to date following the assistance.

In addition we are keen to hear from patients, ward staff and visitors for suggestions for further volunteer engagement.

In Carmarthenshire we have 45 active volunteers doing a range of volunteering activity from ward befriending volunteers, department support volunteers through to patients' refreshments volunteers and a volunteer driver. All opportunities are developed in accordance with the Hywel Dda Policy on Volunteering.

Current Volunteering Opportunities

- There are a team of 6 volunteers in the Pharmacy Department in Glangwili which deliver medication from Pharmacy to the wards which in turn allows patients to be discharged and beds to become free for patients, to fill them from departments such as A&E. This volunteering role reduces stress and anxiety for both patients and relatives. It also helps the hospital staff as this volunteering opportunity increases patient flow generally. With this opportunity we had to take it through staff partnership forum and get approval from Unions as it was commonly seen as a porter's role. However the porters would only visit pharmacy first thing in the morning and afternoon and no take home medication would be delivered to the wards in between, unless staff were released from either pharmacy or the wards or patients relatives could collect , hence the need identified for volunteers.
- We also have a team of volunteers in the Chemotherapy day units in both Glangwili and Prince Phillip Hospital. The team comprises of 6 volunteers in Glangwili and team of 2 volunteers in Prince Phillip Hospital. They help out with taking bloods to pathology, making tea's etc and running general department errands.

- In Ty Bryngwyn we also have a team of 2 volunteers comprising of 1 patient refreshment volunteer and a volunteer driver. In Ty Cymorth we also have a team of 2 volunteers helping with patients refreshments.
- Within the Bereavement Support Service in Carmarthenshire we have a team of 11 active volunteers and 4 processing volunteers. These are all 2nd year counselling students on a counselling course in Ammanford College and are completing their clinical hours with our scheme as vocational volunteers, to complete their course requirements.
- A number of ward areas have some volunteers with many more going through the recruitment processes.
- We have 5 active volunteers with the Mental Health and Learning Disability service in Carmarthenshire and potentially 80 more volunteers within this service coming under our auspices.
- We have an Inpatients Library Support Service in Prince Phillip Hospital which is run by a volunteer every Tuesday and Thursday between 2-5 and visits every ward within the Hospital. This ensures that patients have access to books during their hospital stay and it also ensures that patients have a level of interaction apart from staff and family members.

Developing Volunteering Opportunities

We are now working on several community initiatives.

- Audiology department - volunteers will be out in community venues to deal with minor problems with hearing aids.
- We are working in collaboration with the Stroke Association, to develop a Generic Stoke Club in Carmarthenshire to deal with the physical and emotional effects of stroke. This will commence first week in September and will be supported with four volunteers per session and an assigned Stoke Specialist from the Stroke Association, which is going to volunteer her time with this initiative outside her role with the stroke Association. The Capacity for this group will be 16 service users/clients and will run 1 Friday per Fortnight 9-1.

- We are also working with the Fire and Mental Health Project on home safety checking initiatives.
- Many wards have expressed a great interest in the assisted feeding volunteers working with Nutritional Strategic Group and County Nutrition Groups for volunteer assisted feeding opportunities. This will be piloted on ward 3 and Teifi ward in Carmarthenshire
- The first dietetic volunteer is starting in June 2011 and this role will be utilised to enhance the nutrition focus, support information gathering, patient views and promotional material re nutritional care.
- trained volunteers are used to help capture patient experience as part of the Fundamentals Of Care audit programme

HDHB has been innovative and fortunate in obtaining the services of two experienced and dedicated Art therapists who provide a service to patients and staff at Enlli Ward (Old Age Psychiatry). These posts work closely to improve other volunteer links in particular in Ceredigion. They have successfully extended their work into the community, and with the support of other charitable funding provide other training & group art therapy interventions (e.g. “Crossroads” Project for social services; projected work with the ‘Memory Café’).

7. Staffing levels have to reflect the needs of older people both now and in the future

The Welsh Assembly Government, building on existing tools as a guide for determining staffing levels, should develop and implement a tool for Wales to determine both appropriate staffing levels and how staff should be deployed. This work should encompass current and forecast levels of need in relation to the care of older people.

Response

We welcome this recommendation and look forward to working with the Welsh Government to find suitable solutions. We believe that it is the establishments and

the skills of multi-disciplinary teams that should be considered here and not solely nursing teams. Currently there is an All Wales Professional Nurse Staffing Group which has been established by the LHB Nurse Directors group. This group consists of Assistant Directors of Nursing with responsibility for workforce planning from each Health Board. This group is reviewing workforce and staffing issues with the aim of developing a set of key principles in relation to staffing levels and developing a work programme. The work programme will be considering the use of acuity models along with benchmarking data on staffing levels. HDHB has participated in reviews undertaken by the Welsh Audit Office (2008-09) developing action plans to address the issues identified.

Internally, the HDHB has established an integrated workforce planning process which works with county teams (including primary care) to identify new commissioning numbers required. The integrated workforce plan utilises the NLIAH planning tool and references key policy drivers from the Welsh Government regarding staffing and modernisation, for example the Annual Quality Framework.

Additionally the HDHB has developed a governance framework known as Eagle. (Excellence, Assurance and Governance in a Learning Environment).This framework helps address the modernisation agenda particularly with the new assistant practitioner role and the development of advanced practice to support patient care. The HDHB has senior nursing representation within the development of the new pre-registration curriculum planned for 2012. Strong emphasis is made upon the need to include dignity in care, nutrition, hydration and focus upon the fundamentals of care. The HDHB has a preceptorship program to support newly qualified staff which again emphasises patient dignity, POVA, and the fundamentals of care. The HDHB utilises as appropriate temporary staffing (bank and agency), to address shortfalls in staffing levels incurred due to short-term sickness, increased workload, patient acuity or vacancies. The HDHB has introduced electronic rostering to ensure effective deployment of staff. Using the ‘Lean PDR’ system, teams are now undertaking personal development reviews to ensure appropriate training needs are identified and addressed. Staffing considerations are also taken into consideration by the county teams with the planning of new services or service models, for example the community ‘Virtual Ward’ concept, DGH ‘Front of House’ scheme, Acute

(Community) Response team

Within this HDHB, nurse staffing levels have recently been reviewed/are in process of being reviewed across all clinical areas in the past twelve months. The calculations used have aimed to utilise some form of dependency calculation that takes account of the caseload of older people with general health needs and dementia. We are aware that this care takes time, benefits from continuity and highly skilled carers supervised by highly skilled registered staff

It is important to recognise that the Transforming Care programme provides teams with the opportunities to look at their way of working and to recognise waste within their practices and opportunities to reinvest their time in direct patient care.

One specific area of significant dependency is in relation to nutritional care needs. There does not appear to be evidence or data in relation to the time required to ensure adequate nutrition and hydration for dependant and semi- dependant patients at ward level, which makes staffing level planning challenging in relation to this area of care. 'Protected Mealtimes' at ward level are implemented across the HDHB. This enables/requires staff time to focus their time on the support of patients with feeding and nutritional care but better engagement with relatives and carers from home, who may be keen to be more involved with this aspect of care, would likely enhance nutritional care further and provide a continuum for the individual patient who may also eat better when someone familiar is supporting that process. Also the role of volunteers in this aspect of care needs further exploration (see Section 6): If nothing else, this example reflects that the approach to ensuring that adequate human resources are available to meet patients' care needs are met requires creative and out of the box thinking.

8. Simple and responsive changes to the ward environment can make a big difference

The Health Boards and the Trust should, in collaboration with older people and their families and carers, make changes to ward layout which are most beneficial. This is to ensure all patients have

satisfactory access to ward facilities.

The Health Boards and the Trust should work together to devise and adopt an inclusive consultation process with patients, their families and carers and a representative mix of staff of all grades and across all roles to takes account of the principles of good design when refurbishing or building hospital facilities. The needs of those with sensory loss or dementia should be central to this process.

Response

The Transforming Care programme facilitates all staff to be involved in taking a step back from their work/care environment to consider it afresh with the aim of creating a 'Well Organised Ward'. This work to date has tended not to engage with patients and their carers as a general rule and this approach will now be built into work with the facilitators. This will enable all in-patient care environments across the HDHB over the coming two years to undergo a scrutiny that will take account of this recommendation

Specific refurbishment schemes underway in each county have staff and patient/community representation on the working groups

Occupational Therapists have many ideas in relation to achieving a positive influence on the patient environments and further attention will be given to these views: There may well be opportunities for review of the environment in the context of affording opportunities for occupation that can be considered, such as the example in this report i.e. a dining table positioned within a patient bay being more likely to encourage people to move to the table and speak to others than positioning out of sight in a day room. It is important however to ensure some consistency of approach and to share good ideas across similar areas so that the maximum number of patients can benefit

The HDHB is supportive of the Welsh Government Arts in Health and Well Being

Strategy and aims to take account of it wherever possible in capital new builds and refurbishments.

There is a commitment from the HDHB Public and Patient Engagement team to support wherever possible, focused work with patient groups, families and carers to explore specific issues which could help to improve the environment for the older person.

The soon to be established Involvement and Engagement scheme will support the Health Board in consulting with a wide range of people in our community. The aim is to recruit members from a wide range of backgrounds and to establish their specific interest – this would include an interest in 'older people's health', 'carer's health' and 'physical and sensory disabilities'. Members will be able to sign up to be active participants and we could work with these individuals to gain their views on improving the care environments specifically.

Creating the conditions for greater dignity and respect in hospital care

9. Effective communication can raise patient expectation and involvement and can improve their hospital experience

The Health Boards and the Trust should provide older people, their families and carers, with a clear explanation of their right to receive good quality, dignified care. This must take careful account of sensory loss or other barriers to effective communication. Staff should maintain standards of communication and involvement which reinforce dignified care.

The Health Board subscribes to Language Line which is an industry leader translation service providing written and verbal translation and interpretation services in more than 170 languages, 24 hours a day, 7 days a week. Both our public

internet and staff intranet websites adhere to guidance by Government standards WCAG which is the international standard for accessibility on the web. Our websites are speech-enabled for use with Browse Aloud software and the font sizes of WebPages can be increased to suit the users needs (screenshots available).

The Health Board has a policy for the production of patient and carer information which ensures that all written communications are suitable for readers of different abilities, including children and young people, people with learning disabilities and bilingual people.

Health professionals provide patients with information on their condition, care, medication, treatment and support arrangements wherever and whenever appropriate throughout the patients journey of care, whether this be in primary, community or hospital settings. Patients are given up-to-date information during individual discussions and via in house and externally provided patient information leaflets, validated internet sites, NICE and other national guidance. For example GP's, hospital doctors, nurses and community and ward based pharmacists all provide patients with information regarding medication as part of standard practice. It is inevitable that there will be variations in the timeliness and quality of the information provided, but all health professionals are aware of their responsibilities in this area.

Where written consent is required, the Consent Policy and Forms facilitate timely information giving and discussions about the proposed procedure. In line Policy for the Production of Patient and Carer Information patient information leaflets must be produced in an accessible format. Clear guidance is provided regarding formatting and content of these leaflets. A comprehensive Patient Information section has been developed on the Health Board intranet site. This offers a useful resource to staff containing links to the Policy for the Production of Patient and Carer Information, the EIDO healthcare system (which now contains information leaflets in six different languages) and a link to NHS Direct Wales. A document library is also being developed so that staff can download copies as required and the site contains useful tips for developing patient information.

Participation in Expert Patient Programmes also enables patients to take a more

active role in decision making about their care.

The HDHB participates in the Fundamentals of Care audit which allows monitoring of communication with patients. As well as the annual audit into compliance with the national and local policy on consent, clinical audit on the quality of consent is carried out as part of the Global Trigger Tool work on all sites.

Health professionals provide patients with opportunities to discuss and agree treatment options wherever and whenever appropriate throughout the patients journey of care, whether this be in primary, community or hospital settings.

As well as the Annual Clinical Audits that are carried out in relation to National and Local guidance on taking consent, the Health Board reviews consent for treatment as part of the audit process supporting the Global Trigger Tool. This takes place on a weekly/fortnightly basis depending on the site concerned.

Since the Mental Capacity Act came into force various measures have been introduced to support staff with implementation. These include:

- placing copies of the MCA Code of Practice in all clinical areas

- providing a considerable amount of training, with large groups and small, for all professional groups and service areas. As well as providing specific MCA/DoLS training courses, the Act is also embedded into the consent training provided to all new junior doctors and staff nurses.

- developing an in-house e-learning tool which is mandatory for clinical staff to complete

- establishing an intranet website with access to a wide range of resources

- producing paper based flowcharts both for Assessing Capacity and Best Interests and for the Deprivation of Liberty Safeguards. These documents evolved into unique electronic pathways on the Map of Medicine which staff found really helpful for working through the processes of the Act

- and providing a checklist for documenting decision making

- An additional statement of belief has been added to Consent Form 1 to the effect that the clinician believes that the patient has capacity to consent to the procedure.

Various policies are in place to support staff including:

• Guidance on the Mental Capacity Act 2005

• Policy on Advance Decisions

• Deprivation of Liberty Safeguards Guidance and Procedure

as well as a section on the MCA within the Policy for Consent to Examination or Treatment.

Various members of staff within the Quality Improvement Support Unit currently provide support, advice and training to staff across the organisation in relation to the Act. However, this responsibility is only currently recognised within the job description of the Head of Clinical Effectiveness in relation to consent (this post holder is the HDHB Lead for consent).

Training and support in relation to the Deprivation of Liberty Safeguards is provided, in part, by the same group of QISU staff, but also through the Primary Care Directorate, who, for example, employ the Best Interests Assessor in their capacity as the Supervisory Body. Managing Authority responsibility sits with the Director of Planning, Performance and Delivery.

There are areas of best practice in communications being taken forward to support improved care of older people for example the role of the healthcare support worker in liaising with the family on patients belongings such as toiletry requirements, changes of clothing etc to further involve families in the care of their loved ones. In addition this specific recommendation has initiated a review of the comprehensiveness of our approach to ensuring that the diverse communication needs of all patients can be met in a consistent and equitable manner.

10. The experience of older patients, their families and carers should be captured more effectively and used to drive improvements in care.

The Welsh Assembly Government should lead on, develop and implement a clear, consistent mechanism through which Health Boards and the Trust will capture and act on the experiences of older patients, including those unable to speak for themselves. This mechanism would allow qualitative data about older people's experience to be captured, understood and used to drive organisational learning and positive change. Results should be made publicly available in a form allowing ease of understanding and comparisons over time, on a Wales wide and on a Health Board and Trust basis.

Health Boards and the Trust must demonstrate, for example, through Board meeting records, how they have taken account of and acted on, their patient experience results; Board members should also play a direct role in assessing the patient experience through means that include regular ward visits to both speak to patients and their families and observe care delivery.

The Fundamentals of Care audit results are being driven through the Board and our Quality & Safety committee.

We have a number of examples of the use of patient stories to highlight patient experiences and learn from them and a specific project on the use of patient stories has been established in Ceredigion. The results from this pilot project will be used to roll out this initiative across the Health Board.

All executive directors and many Independent Members undertake clinical visits as part of a number of programmes e.g., 1000 lives plus, Transforming Care and general walkabouts. Each Executive has an Independent Member "attached to them"

who also engages in the work of that Executive for example the Director of Nursing & Midwifery Independent member meets directly with clinical staff and teams such as Infection Prevention and Control. In each walkabout the execs will take the opportunity to speak to patients and relatives. The Director of Nursing & Midwifery specifically takes the opportunity to walk around the clinical environment and challenge care, attitudes or issues such as the environment. This really sets the tone of tolerance. The County Management Teams also carry out walk arounds and speak to staff, patients and their carers across inpatient settings. They have attended a number of community groups to discuss issues and concerns and provide updates re service development

The Director of Corporate Services is working to improve our engagement approach and ensure that the experiences of our patients are considered in all aspects of direct care and service planning.

The HDHB embraces the CHCs & HIW coming in unannounced to monitor the service delivery for example protected meal times and the support offered to patients in feeding.

The Executive Team have all agreed to a personal objective to ensure that Dignity and Respect are driven at the highest level within the organisation.

One of the aims of the Transforming Care is to increase patient satisfaction to at least 95% and all the wards involved are using the Fundamentals of Care All Wales audit as the evidence for this objective.

The Fundamentals of Care users perspective comments have been used for “You Said, We Did” notice boards

The All Wales Nutritional Pathway has been embedded in practice which includes good practice initiative e.g. protected meal times, red tray, volunteers at ward level during mealtimes.

Work being undertaken to evaluating the changes in quality of life of people who attend a Social Care Day Unit

Building on our experience of capturing patient stories to incorporate an MDT

approach. Outcomes of the patients stories were used to inform the Dignity E-learning programme

11. Good practice should be better identified, evaluated and learnt from to bring about improvements in care.

The Welsh Assembly Government should drive forward the evaluation and adoption of good practice across Wales, with an emphasis on securing positive, demonstrable changes in practice in the care of older people. The Welsh Assembly Government should hold the Health Boards and the Trust to account for their success in adopting good practice which enhances dignified care, or justifying why they have not done so.

The HDHB will embrace any performance system the Welsh Government wishes to adopt and would welcome the attention. We have an action plan which will be internally monitored and individual Executives held to account for their personal objective. Inclusion in the future AQF should be considered as a way of recognising its importance.

Some way of sharing good practice across health and social care would be very valuable.

This HDHB also has started to discuss Dignity and Respect with it education to ensure that our providers are also addressing this at the root of training and recruitment.

The HDHB Quality Improvement & Patient Safety Strategy to Reduce Waste, Harm and Variation 2010 – 2015 (Quality Improvement Strategy) was approved in May 2010. The Strategy defined the challenging actions and targets that were used to improve the safety and experience of patients using the services of HDHB. These actions are framed within the broad headings of:

1. Patient safety

2. Effective treatment with good outcomes

3. A good experience for patients, staff and visitors

Dignity and Respect are key components of the Health Board Quality Improvement Strategy going forward.

The Strategy helped provide positive assurances around the quality and safety of care given to patients. This is important as it ensures that service users including the wider public, external inspectors and regulators that Hywel Dda Health Board is committed to improving the quality and safety of the services it provides.

The improvement work generated by the Quality Improvement Strategy is influenced by Government targets and the Standards for Health Services in Wales (SHSW), and national programmes such as the 1000 Lives Plus work plan. The work falling out of these programmes is key to ensuring compliance with all aspects of the clinical governance agenda. This work is pivotal to fundamental care issues such as preventing falls, stopping pressure sores developing and effective communication, to technical issues such as responding to seriously ill patients and enhanced recovery following major surgery.

To help the HDHB deliver on this work, a central Quality Improvement Support Unit (QISU) was established to help the Counties and Services in areas relating to Clinical Risk Management, Clinical Audit and Effectiveness, the Patient Experience and Research and Development.

An example of how pre-existing pathway developments have been absorbed into the new Clinical Programme Group approach can be seen in mental health services. Work was ongoing to develop a process pathway for the mental health acute service. This will now be reconfigured as a core element of the Mental Health CPG's identified priority for a pathway detailing access to services.

Each CPG is required to ensure appropriate patient / user input into the developing pathways. Planned pathway developments within each of the Clinical Programme Groups will be reviewed via the Stakeholder Reference Group (1). The Clinical

Programme Groups will then feed into the Clinical Advisory Group which will approve the pathways from a clinical perspective before they are assessed for financial implications prior to final agreement for implementation by Senior Management Team. Where appropriate the clinical content of the newly developed pathways will be audited to assess whether they have had the desired impact on patient care.

Representatives from HDHB also participated in the 'Focus On' Programme with the DSU to develop nine national pathways within the specialities of Orthopaedic, Ophthalmology and ENT. These pathways are now being implemented across the HDHB, through the relevant Clinical Programme Groups. The DSU were impressed with the baseline audit completed for the fractured neck of femur pathway and asked if they could share it with the other Health Boards in Wales.

The All Wales Last Days of Life care pathway is used within Hywel Dda. Variance reporting is submitted into a national report for Wales. Figures collected at a local level inform the content of the training provided to staff.

Any pathways being developed outside the auspices of the Clinical Programme Groups (e.g. Falls Strategy Group are developing a Falls pathway) are required to go through Clinical Advisory Assurance Group for approval, in the same way as the Clinical Programme Group pathways.

The Clinical Effectiveness Coordinator (Pathways) undertook a review of all existing care pathways during 2010. This demonstrated that completion of integrated care pathway documentation is not always adequate and the Director of Nursing & Midwifery is currently considering the results with a view to deciding the future direction of ICP documentation across the HDHB.
The Annual Operating Framework and Annual Quality Framework provide the framework and guidance to drive and monitor the areas outline in the criteria statement. Performance against these areas is managed locally and by Welsh Government by measurement against targets. This occurs via the quarterly reviews by Welsh Government and through the HDHB performance monitoring arrangements.

The Chronic Condition Management Demonstrator in Carmarthenshire has collected

a number of digital patient stories particularly in relation to respiratory disease, exercise and lifestyle change service improvements. We have used these to inform the continued development of our self care and support services and they are available on a DVD if required. The diabetes X-pert educational programme in Carmarthenshire has been extended in the last 12 months to provide an evening course as a result of feedback from our patients living with diabetes and this has proven to be very successful.

Our telehealth work has also involved citizens and patients living with chronic conditions to participate in the design and development of the next generation of telehealth home monitoring device as part of our Assisted Living Innovation Platform project.

The HDHB is responsible for implementing, evaluating and auditing the 12 standards identified in the Fundamentals of Care Document (2003) and this has been undertaken via the electronic audit tool that was developed on an All Wales basis. 67 wards across Hywel Dda completed the Audit in 2009. 68 wards completed the audit by the end of August 2010. 27 Non-Inpatient areas completed the FoC Audit by the end of December 2010 with a further 6 Departments expected to complete by the end of February 2011. A preliminary report has been presented to Hywel Dda Health Board (Oct 10) and the report was submitted by the Director of Nursing & Midwifery to Welsh Government in Jan 2011.

12. All those working with older people in hospitals in Wales should have appropriate levels of knowledge and skill.

The Welsh Assembly Government, Health Boards and the Trust should ensure that all staff caring for older patients acquire appropriate levels of knowledge and skill through continuing education and training.

The Welsh Assembly Government should ensure opportunities for those with high levels of training to specialise through a career framework appropriate for current and future need.

There are wide ranging opportunities for staff to acquire appropriate levels of knowledge and skills through continuing education and training. A contract for post-registration education is in place for nurses with Swansea University, and other Health Care Professionals are also able to access this education where appropriate.

Education activity is centrally co-ordinated through the learning and development department, and the Health Board operates a centralised education budget, which allows increase equity and flexibility of access.

There are a range of dedicated clinical skills training teams, practice development nurses and specialist nurses, all of whom develop expert education interventions – in both classroom and work-place settings.

For Health Care Support workers, a formal 'Skills to Care' education programme is delivered.

All new HCSW undertake training through Skills2Care which is a two week programme covering all there training needs to undertake the role as new HCSW. This covers: dignity, dementia, accountability, communication, team working, privacy, equality and diversity, nutrition and SaLT awareness and all care that a patient needs during their stay that a HCSW can undertake.

This prepares all new workers within the organisation to be trained to a level of good standards and to fulfil their job roles. Following this, they are enrolled onto the NVQ/Diploma which again has a section on equality diversity and dignity in the workplace, nutrition, communication, POVA and Health and Safety and many more.

POVA training is to be undertaken on a mandatory level every three years within the organisation by the lead nurse on this topic.

E-learning courses are available including: Valuing Diversity, Developing Cultural

Competence and Protection of Vulnerable Adults.

A Dignity conference has recently been held in Ceredigion locality with cross boundary working.

A training strategy for Equality and Diversity' is being developed for all staff within the organisation (including Board members). This will contribute to achieving this recommendation and will now be tailored to specifically build in issues related to older people In particular it will include recognition of the fact that Senior staff need training to support robust Equality Impact Assessment

Under the new Equality legislation, the HDHB is required to publish equality Objectives and to publish a Strategic Equality Plan by April 2012.