Follow-up to 'A Place to Call Home' Review
Local Authority Self-evaluation Pro Forma

Organisation	**Isle of Anglesey County Council**
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Date	**31st March 2017**
Signed	

Chief Executive Officer	**Council Leader**
Name: Dr Gwynne Jones	Name: Mr Ieuan Williams
Date:	Date:
Signed:	Signed:

Deadline for responses: 31 March 2017

Please email responses to: review.adolygiad@olderpeoplewales.com

Outcome Older people receive full support, following a period of significant ill-health, for example, following a fall or stroke, to enable them to maximise their independence and quality of life.	
Action Required (Requirement for Action 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. (In partnership with Health Boards)	
To what extent do you comply with this Requirement for Action? (300 words)	The Local Authority in partnership with the local Health Board is becoming compliant with this Requirement for Action. There is now provision in place for residents following a period of significant ill-health that enable them to maximise their independence and quality of life and that supports their rehabilitation. The 'Complex Older People's Assessment' (COPA) has recently been developed and has been operational since January 2017. This is a specialist service made up of multidisciplinary staff from the social care and health sector that rehabilitates older people in hospital, and back to the care of a care or nursing home. There are also designated intermediate care beds available for the rehabilitation of older people with a multidisciplinary team of staff providing a specialist service for the older person. These beds are located at Plas Mona Care Home in Llanfairpwll, Anglesey. These resources within the care home is an integral element of the intermediate care journey from hospital to go back home.
On what evidence has this	**Complex Older People's Assessment (COPA) Programme** In partnership with our local Health Board, arrangements are in place to ensure that current existing multi-

assessment been made? (850 words)	disciplinary teams support residents following admission to hospital and return to care and nursing homes. Depending on the nature of admission, an assessment is made of the rehabilitation potential in each instance. The COPA programme is delivered from the Frailty Unit in Ysbyty Gwynedd. The COPA is a specialist team made up of Nurses; Social Workers, Physiotherapists and Occupational Therapists that work on the rehabilitation of the person and ensures that the rehabilitation continues once the person has returned to their care or nursing home. This supports the maximisation of their independence and quality of life following discharge. This is open to all residential and nursing care home residents. The COPA programme has a 100% discharge from hospital back to home rate since the service began in January 2017. As this is within its early stages the number of people that has received this service is currently low (7 older people), however we anticipate increasing numbers as the service develops. The next phase of the scheme has been agreed and an implementation plan is in place to support discharges out of the local community hospital with particular emphasis around patients who have had a stroke. **Intermediate Care Beds** Intermediate care beds provide a community resource for a time limited period with a clear focus on recovery and reablement to promote independence and self-reliance. The service involves the commissioning of 3 intermediate care beds within Local Authority residential care home settings with dedicated: • Therapy resource- community Occupational Therapy (Local Authority) and Physiotherapy (Health) • Medical / clinical support through local GP surgery • Nursing in-put via community nursing service. The beds are accessed via Health or Social Care in accordance with jointly agreed admission criteria. Both

	hospital discharges (Step-Down) and community referrals (Step-Up) have equal access to the resource. A multidisciplinary assessment will have been undertaken prior to the placement with clear outcomes agreed. Weekly reviews are undertaken and progress monitored. Following the period in the intermediate care bed, the specialist therapy plan followed through is discussed with the care home to ensure continuity of support. Ongoing monitoring strengthens the pathway from intermediate care and compliance of the specialist therapy plan. Between April 2016 and March 2017, 25 older people have accessed the intermediate care beds in Plas Mona. We also have independent spot purchase arrangements with other independent care homes. The main measures of success are the number of people discharged home who are self-managing; discharged home on reablement services; discharged home on decreased care package and admitted to long term residential home following comprehensive care and support assessment, indicating appropriate placement for the older person.
What impact has this had on residents' quality of life and care? (850 words)	**Complex Older People's Assessment (COPA) Programme** Residents are discharged back to their own environment and continue to receive the therapeutic care that they need following discharge. This supports their rehabilitation and maintains their quality of life. The rehabilitation process continues from hospital back to the care home. **Intermediate Care Beds** Residents receive continuity of support with their rehabilitation back to the care home from the intermediate care bed maintaining their quality of life and functioning. The intermediate care beds are an invaluable resource to support early discharge from hospital and provide a

	comprehensive assessment of care needs resulting in improved personal outcomes for the older person. *(Further specific evidence of outcomes for people supported by the COPA programme and Intermediate Care Beds will be collated from individuals supported through these schemes and forwarded as supporting evidence)*
If further actions are needed to be compliant, please evidence what these will be and provide a timeline for compliance? (500rds)	**Complex Older People's Assessment (COPA) Programme** To further enhance the monitoring of outcomes within the care homes. Will be seeking to increase Physiotherapy capacity in partnership with our Health partners to deliver on this agreed action within the next 6 months. Also want to gain further understanding from service users and staff of the impact of this supportive initiative. The next phase needs to be agreed and implemented around extending to a wider ADT service. An operational group has been set up and will be developing this work further over the next 12 months. Need to ensure that the current intermediate care beds and specialist support continues to support this initiative with a view to increasing the number of beds available and the resource that comes with this in the near future.

N.B. The Commissioner's expectation is that specialist services are made available to all residents, where appropriate, including self-funders evidence submitted in this section should therefore reflect this.

Outcome
All staff working in care homes understand the physical and emotional needs of older people living with dementia and assumptions about capacity are no longer made.

Action Required (Requirement for Action 3.2): All care home employees undertake basic dementia training as part of their induction and all care staff and Care Home Managers undertake further dementia training on an on-going basis as part of their skills and competency development, with this a specific element of supervision and performance assessment. The Commissioner's expectation is that this will include reference to actions that the Local Authority has taken as commissioners of care to ensure that all staff working in care homes understand the physical and emotional needs of people living with dementia.	
To what extent do you comply with this Requirement for Action? (300 words)	The Local Authority is compliant with the Requirement for Action in terms of Local Authority and independent care homes. Training around dementia is offered via the Local Authority Care Workforce department and is taken up by care home staff. Contracts team monitor the uptake of the training within the care homes to ensure staff are trained within dementia care.
On what evidence has this assessment been made? (850 words)	The Local Authority's Care Workforce department offers a dementia awareness training session which is accessed by all relevant Local Authority staff, and is also available to all staff in local independent care homes. We are similarly aware that training is offered by Bangor University which supports local providers. We also offer specific awards at QCF level 2 and 3 which are available to all internal and externally employed staff. The following training courses are provided via the Local Authority Care Workforce department - 'Communication/Dementia'; 'Home Alone - Dementia Training'; 'Dementia Awareness'; 'Level 2 and Level 3 Award in Awareness of Dementia'; 'Dementia Leadership'; 'OCN Dementia Level 1, Level 2 and Level 3 Award'; 'Dementia Support Training'; 'Understanding Dementia'; 'Introduction to and Dementia Awareness'; 'Adapting Change in Dementia Care'; 'Recognising the

	Early Signs of Dementia'; 'Activities with Older People – Dementia'; 'Loss, Stress & Change – Dementia'; 'Dementia Friends Champions Induction'; 'Communicating with People with Dementia'; 'The Ageing Process & Dementia'; 'Therapeutic Activities in Dementia Care'. When staff complete the 'Dementia Awareness Course', the Local Authority Quality & Assurance Development Officer will follow up with Local Authority and independent care home staff what they have learned and how this has changed their ways of working. Care Council for Wales have a 12 week induction programme for all care home employees, to ensure that they include basic dementia training as part of this programme. Local Authority contract monitoring is in place to ensure compliance with this standard, and this now has a higher focus than it has historically. As part of our yearly monitoring of care homes we review the uptake of this specialist training and make recommendations where necessary if performance of private care homes is insufficient. Reflective practice is included in individualised staff supervision. This is a way of monitoring if what has been learnt in training is put in to practice. Also, as part of outcome based care planning that staff undertake, they now complete the documents in the 'first person' which is very much focussed on the person and their point of view. Local Authority care home managers are trained as 'Dementia Friends'. Currently in the process of identifying key members of staff to become 'Dementia Champions' and 'Dignity in Care Champions' within the care homes. A Local Authority care home uses the 'Getting to Know Me' document. Staff are trained to understand the need to know a person so that they can tailor care to individuals based on personality and what stimulates them. Going to roll out to the other Local Authority care homes.

	Local Authority care home staff are trained to complete the 'Book of You' that helps people with dementia through life stories. This approach will be delivered in other Local Authority care homes. Currently in the process of preparing for the roll-out of this. Community Psychiatric Nurses provide specific individualised training based on individual cases as they support the management of complex dementia cases within the care homes. This model enhances training for staff within the care homes. One of the local independent care homes received an award via the North Wales Social Services Improvement Collaborative (NWSSIC) under the 'Care Home Competition' for the use of portable tablet computers and an interactive SMARTboard to aid communication between service users and staff. This 52 inch interactive whiteboard provides meaningful and therapeutic activities tailored for people living with dementia. Films are also projected on to the whiteboard, including black and white films that provides reminiscence activity. These are examples of good practice of specialist activities that staff carry out with residents.
What impact has this had on residents' quality of life and care? (850 words)	Staff working within residential care homes that have completed the different types of dementia training have an awareness and understanding of the physical and emotional needs of people living with dementia. It also supports with dealing and managing de-escalation and supports staff to provide specific personal outcome focused activity which enhances people's quality of life. Training is offered on an on-going basis as part of staff's skills and competency development. *(Additional evidence from the experience of residents, families and staff is being collated and will follow)*

If further actions are needed to be compliant, please evidence what these will be and provide a timeline for compliance? (500 words)	We will be looking to strengthen care and support planning in line with the Social Services and Well-being (Wales) Act 2014. We will ensure that all contractual monitoring and multi-disciplinary team reviews are focused on personalised outcomes and that the care home provision is meeting those identified needs. This is an on-going health and social care sector training initiative. We will be focussing on this work for the next 12 months. We will continue to ensure that all staff training is having a positive impact on individual's quality of life and that they are offered opportunities to engage in the local community. This is a rolling programme and we anticipate that progress will be made in the next 6 months. We are working to get the community more involved with dementia training and we look to develop on the 'Dementia Friendly Communities' work so that the care homes become more involved within the process. We anticipate that we will see progress with this within the next 6 months. We are looking to enhance the dementia training that we provide so that it includes co-existing health conditions as well as dementia (e.g. Parkinson's Disease and Diabetes). This has been planned and developed and will be implemented during the next 12 months. Locally we have been developing a bespoke additional unit to go with the current Social Care Induction Framework training that provides an awareness to dementia. This will be provided to all new staff within the care sector as part of their induction and this includes care home staff. This will be implemented over the next 12 months.

Outcome

Older people are supported to retain their existing friendships and have meaningful social contact, both within and outside the care home. Care homes are more open to interactions with the wider community.

Older people are able to continue to practice their faith and maintain important cultural links and practices.

Action Required (Requirement for Action 3.3):

Active steps should be taken to encourage the use of befriending schemes within care homes, including intergenerational projects, and support residents to retain existing friendships. This must include ensuring continued access to faith based support and to specific cultural communities.

The Commissioner's expectation is that this will include reference to actions that the Local Authority has taken as commissioners of care to ensure that older people are supported to retain their existing friendships and have meaningful social contact, both within and outside the care home.

To what extent do you comply with this Requirement for Action? (300 words)	The Local Authority is not fully compliant with this Requirement for Action at present both within the Local Authority care homes and independent care homes. This is something we are aware of and are working to support the sector to improve to be fully compliant. An initial Befriending Workshop was held by the Local Authority Care Workforce department in September 2015. Attendance from the care homes was at a modest level. There is however some areas of existing good practice and developing practice within care homes.
On what evidence has this	Our overall assessment is based on our contract monitoring findings and recent feedback from care homes. There is evidence of examples of good practice across the care sector that includes:

assessment been made? (850 words)	• Befriending groups within care homes • Local primary and secondary school children are invited to the homes that provides intergenerational befriending opportunities • Local vicars visit some care homes on a regular basis • Residents are taken to the local church / chapel services on a weekly basis which ensures continued access to faith based support and to specific cultural communities • A residential home has a bar on the premises which encourages socialising and social events are held there. An example of this is a New Year’s Eve party where residents and their families celebrated together • There are purpose built hairdressing suites on site in several care homes that encourages residents to socialise • A residential care home takes residents to the local Age Well Centre. This supports residents to retain existing friendships and to make new friendships within the local community and that is outside of the care home • Residents are taken to local community centres to play bingo and other community based activities • A Local Authority care home works particularly closely with the local community hub in the village. Residents regularly attend the ‘Afternoon Tea’ and the ‘Pint and Snacks’ sessions held in the local public house • Trips out in to the community are arranged by several care homes. Some have been on coach trips to places such as Blackpool and Dublin. • Some residents will also attend local leisure centres • Activity co-coordinators also come in to care homes to carry out specific activities with residents such as arts and crafts activities • Entertainers also visit care homes. Examples includes singing songs from different eras • ‘Pat Dog’ also visits Local Authority care homes on a regular basis. Some homes have pets such as cats and chickens

	• The 'Cadwyn Môn' befriending project via Gwynedd a Môn Age Cymru has been working closely with some local care homes. This brought the community in to the care homes as the project had befriending volunteers. • The 'Embrace Life Wales Project' is a befriending service to support residents in care homes to go out in to the community and access community facilities. 3 independent care homes on the Island are involved with this project. Most independent residential care homes have Wi-Fi and Local Authority homes are in the process of introducing Wi-Fi to all care home. Some residents already use social media such as Skype to talk face-to-face with family and friends. Many residents also have their own personal mobile phones that allows them to make contact with family and friends on a regular basis. This supports residents to retain existing friendships and to maintain contact with family.
What impact has this had on residents' quality of life and care? (850 words)	Residents are able to participate within the community outside of the care home which means that they make friendships outside and can also maintain existing friendships. Residents can maintain current relationships and strengthen ones within the care homes by participating in befriending activities with other residents within the care home. Seeing children and pets can have a calming and soothing effect on older people when in contact with children and animals. This promotes intergenerational relationships with the children and provides tactile contact with animals. Having on-site amenities such as the resident bar and hairdressing facilities, provides an experience that can be seen as something outside of the care home. Residents report that dressing up and going to the bar makes them feel that they are going somewhere outside of the care home environment.

	(Additional evidence and evidence from residents is being collated and gathered from care homes and residents within care homes and will follow)
If further actions are needed to be compliant, please evidence what these will be and provide a timeline for compliance? (500 words)	Developments are encouraged and we are publicising current, and developing new befriending schemes and these will be championed in provider forums in order to improve access. Further discussions to be held with third sector providers regarding current befriending provision within the community and see if these can be brought in to the care home setting. To roll out good practice from these schemes within the Local Authority and independent care homes. The development and prevalence of befriending is now included as part of contract monitoring visits to ensure that this is delivered and becomes good practice across all care homes. As commissioners we intend to use current residents meetings within homes over the next 6 months to see what they would like to have in place in terms of befriending and to support implementation within care homes. We have further Befriending Workshops planned and will encourage wider attendance so that care home managers will be equipped with the knowledge and skills to develop more befriending schemes within their care homes. This will also encourage a more consistent approach. We expect to maintain progress towards full compliance within the next 6 months.

Outcome Commissioners, providers and inspectors have a thorough understanding of the day to day quality of life of older people living in care homes. Older people's views about their care and quality of life are captured and shared on a regular basis and used to drive continuous improvement.	
Action Required (Requirement for Action 6.2 & 6.7): 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 the issue 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.	
To what extent do you comply with this Requirement for Action? (300 words)	The Local Authority expects to become compliant with this Requirement for Action within the next 6 months Peer Service Monitors are now in place. Initial training has been carried out with these individuals. There remains further work to be done to support these individuals to gain thorough understanding of the day to day quality of life of older people living in care homes however we expect the lay assessors to be visiting care homes in late spring/ early summer to support collation of feedback from residents.
On what evidence has this assessment been made? (850 words)	Working with Age Concern, the Local Authority has trained two lay individuals to act as Peer Service Monitors in all homes on the Island, and now plans are in place to roll out the Peer Service Monitor Scheme to more individuals. The Peer Service Monitors are people over the age of 50 who have been recruited independently and have an interest in older people's issues. The scheme provides the Local Authority with an independent view to inform the quality assurance system for the services provided in the residential care sector.

	Lay assessors will be supported to hold informal conversations with care home residents and feedback to all partners in a simple way which does not replicate formal inspections. A partnership approach, including registered providers will be taken. Feedback provided to care homes and commissioners will be used to inform future developments. Where positive trends are highlighted, they will be used to roll out good practice. Where improvements are indicated, the Anglesey Provider Forum will be utilised to agree how these will be addressed. Local Authority care homes use a 'Magic Moments Tree' and a 'Wish Tree'. When the wish from the 'Wish Tree' is granted, the picture is then transferred to the 'Magic Moments Tree'. This is a way fo communicating wishes and feelings. Local Authority care homes use the 'Kitword Flower' which helps older people to communicate how they are feeling by using different 'petals' that covers different aspects. Principles of the 'The Butterfly Scheme' is used within the Local Authority care homes. This is a method of working tailored for people with dementia and memory loss. This way of working supports older people to be able to communicate with care home staff.
What impact has this had on residents' quality of life and care? (850 words)	The Peer Service Monitor volunteers are able to support residents and listen to them directly if they wish to share their feelings, wishes, concerns and complaints. There is a contact point for them to speak to. Using physical objects such as the 'Magic Moments Tree' and 'Wish Tree' provides a different way of communicating. *(As the Lay Assessors become operational feedback from Care Home Residents will be collated to inform*

	our assessment of the quality of residents' lives within homes).
If further actions are needed to be compliant, please evidence what these will be and provide a timeline for compliance? (500 words)	To further develop a more robust Peer Service Monitor training agenda so that more volunteers receive the training. This will provide more volunteers within residential homes that residents can talk, communicate and share their thoughts and feelings with. To develop a 'mystery shopper' process and asking people's views of being in care homes (Local Authority and independent care homes). To further develop and support lay assessors to hold more informal conversations with residents. To have a more robust training plan in place. To strengthen the monitoring process around the systems and processes in place to ensure that older people's views about their care and quality of life are captured and shared on a regular basis and to monitor if this information is used to drive continuous improvement.

Sharing good practice and organisational achievements that have made an impactful difference to the quality of life and care of older people in care homes in Wales.

Please use this space to describe any new, different and innovative approaches that the Local Authority has invested in to improve the quality of life and care of older people in care homes in Wales, and the impact that this has achieved for older people. References to good practice may reflect any area relevant to the Commissioner's original Care Home Review.
Free text statement: 1,000 word limit.

The Local Authority and BCUHB are working in partnership to develop a service model to support people living with dementia who are presenting as experiencing distress and with complex care needs. This will be a

model of residential care within a Local Authority care home Garreglwyd which will provide enhanced facilities and staff with knowledge and skills specifically developed to support people who present with complex need and who are experiencing distress. Increased specialist health capacity will be provided by community mental health nurses who will support this approach together with district nursing who will be available on a 24/7 basis.

Aims:

- To work in partnership with BCUHB to develop appropriate care models for people living with dementia and develop viable alternative options of housing and care available within reasonable travelling distance to the individual's home to allow that individual to maintain contact with family, friends and his/her community.
- To provide a quality of life that enables residents to retain their independence, identity and a sense of value.
- To increase the specialist dementia care bed capacity on Anglesey to meet the expected increase in demand.
- To support people living with dementia in the same care home for as long as possible by delaying the need to go into nursing care.
- To reduce Delayed Transfer of Care out of hospital.
- Pilot the service model for 18 months starting from the date of the signing of this MoU and agree to conduct a joint evaluation of the model.
- The new service model will be established at Garreglwyd Care Home in Holyhead owned by the Local Authority.
- All aspects of physical health and nursing care at Garreglwyd will fall within BCUHB governance framework; this includes support planning, clinical supervision and delegation of tasks. BCUHB will facilitate access to the Older People`s Mental Health Team as part of the individuals` care management plan and access to BCUHB OPMH inpatient beds will be provided equitably with other residents of Anglesey.
- BCUHB will recruit 3 Community Mental Health Nurses and 1 District Nurse (DN) initially for the 18 month period.
- Social Services Department will be responsible for staffing arrangements at the care home and will ensure all staff have the necessary skills/training to provide the service.
- Social Services Department will undertake the required environmental adaptations of the care home in keeping with best practice.

- CPN and DN will prioritise support to Garreglwyd within their caseloads.
- CPN`s and DN`s will commit to a minimum of daily visits to Garreglwyd by adopting Multi- Disciplinary Team approach to reviews of service plans. More than one visit in a day may be required as needs arise.

Out of hours service for District Nursing will include a response service either by phone or visit to the Care home by Registered Nurse or Health Care Assistant based at Ysbyty Gwynedd. Community Mental Health Nurses out of hours service will include the OPMH Liaison Nurses based at Hergest Unit, Ysbyty Gwynedd who will be available to provide telephone advice.