Caring Together
Western Bay
Health and Social Care Programme
Gofalu Gyda'n Gilydd
Bae'r Gorllewin
Rhaglen Iechyd a Gofal Cymdeithasol

WESTERN BAY – RESPONSE TO THE OLDER PERSON'S COMMISSIONER'S REPORT 'A PLACE TO CALL HOME'

A Collaborative response between City & County Of Swansea, Neath Port Talbot County Borough Council, Bridgend County Borough Council and Abertawe Bro Morgannwg Health Board

No	Action Required	Initial appraisal of Health Boards response by Older persons commissioner received 17th April 2015	Resubmitted response in light of Older person's commissioner's request.	Lead
2.2	Older people in care homes have access to specialist services and, where appropriate, multi disciplinary care that is designed to support rehabilitation after a period of ill health.	The Health Board's response to this Requirement for Action includes a lot of detail and actions in relation to multi-disciplinary teams and the provision of mental health care. However, it appears that this Requirement has been misunderstood. This Requirement is asking for specialist services and multi-disciplinary care in the realm of rehabilitation following a period of ill health and not in relation to mental health care.	In Abertawe Bro Morgannwg University Health Board (ABMU HB) we do not discriminate on the basis of postcode but deliver services based on the presenting need. Across Western Bay via the relevant locality teams, care home residents can access specialist community services including rehabilitation services when appropriate. The Function of the three Community Resource Teams (CRT) is to maximise the independence of people, who require rehabilitation, to avoid unnecessary admissions to hospital and ensure fewer people make decisions regarding their long term care at a point of crisis. Across the Western Bay Region the three CRT's provide Rapid Access Clinics for people who appear to be deteriorating physically within the Long Term Care settings, offering a Comprehensive Geriatric Assessment with the aim of identifying the root cause of the person's decline. Work is then undertaken with the individual, their family, GP and Care Home staff to provide intervention, advice and support to stop the decline. In the three locality areas there are Specialist Nursing Services which works closely with our Care Home partners to provide subcutaneous and intravenous fluid replacement, Intravenous medication administration and End of Life Care. Across ABMU the District Nursing (DN) service provides input for both residential	Andy Griffiths & Jane O'Kane (NPT) Karen Gronert & Alison Ransome (Swansea) Michelle Chilcott & Elizabeth Collier (Bridgend)

			clients and more expert advice for those patients in receipt of NHS Funded Nursing Care and Continuing NHS Health Care. This includes the District Nurse acting as a specialist nursing support for patients where the nursing home staff may require further support to deliver care requiring more specialist knowledge and skills. To address any deficits identified in care provision all three areas provide support and training to Care Home staff via our specialist practitioners The District Nursing Service across ABMU HB is available 24 hours a day 7 days a week to provide advice and support to care homes to address the health needs of older people within the homes. **<u>In Swansea</u>** all older people regardless of place of residence have access to all services within the CRT this includes rehabilitation, full Multidisciplinary Team (MDT) assessment and treatment where required. The Speech and Language Service supports care providers to assess and manage swallowing issues and the recent appointment of a dietician has enabled the locality to better manage increased numbers of referrals from care homes where the most frail and often under nourished (because of advancing dementia) reside. Other therapists such as Occupational Therapist and Physiotherapists are also regular attendees at Care Homes, assessing and treating deficits in function and mobility. There has been a greater demand in the last few years for postural management and the provision of specialist seating services.	

			<u>In Bridgend</u> all older people who live within the boundaries of the county are able to access CRT services; these services will be delivered wherever they call home. This will entail assessment by the professional deemed most appropriate, the assessment may be uni or multi-disciplinary, depending on need. The CRT in Bridgend supports Reablement Programmes within these settings to either assist a person in leaving Long Term Care to live in other types of accommodation with support or maintain mobility levels within the residential setting. Bridgend has a Residential Reablement service aimed at maximising a person's independent living skills by either supporting them to learn different ways of undertaking tasks or attempting to maintain their skills, in order to avoid the need for nursing care. Bridgend also has a Residential Reablement unit which offers step down rehabilitation in preparation for reablement at home, and has supported people to be assessed at a more settled time and return to their home in the community. The staff are also able to educate, advise and observe Care Home staff to improve care interventions and prevent any delay or further deterioration. The CRT in Bridgend has also established Walking Aid Clinics to prevent falls. Trained staff will check the condition of walking aids and replace broken and worn out equipment, again with the aim of minimising the risk of falls. "Walking Aid Champions" have been identified to sustain this focus after the CRT team has left to maintain this focus within the home. There is also a pilot Falls Pathway model	

			being introduced across the Care Home sector in Bridgend to help prevent falls and admissions to hospital. This includes a training programme for carers on falls prevention. Bridgend offers a Mental Health Liaison Service, which provides in-reach specialist support to manage complex care and provide support for the staff. Furthermore, a dementia support service is funded jointly by Health and Social Care to offer training and support on the management of dementia care. **In Neath Port Talbot** the Acute Clinical Team which is a component of the CRT model will in-reach into Care Homes to provide a full range of services to support the individual in the acute phase of their illness, e.g. Intravenous drug administration and rehydration via Intravenous and subcutaneous fluid replacement. The therapy element of rehabilitation can form part of the ongoing rehabilitation if deemed necessary. A pilot undertaken during September 2014 allowed the Acute Clinical Team to receive direct referrals for patients from five care homes (all of which are dual registered). There is a clear process in place including communication with Primary Care, and consideration is now being given to rolling this out across the locality area. Within NPT we are aware that the CRT does not currently have a specific model for the Care Home Sector as we see the focus as one of prevention, providing input earlier in the pathway, whilst the individual is still able to consider their future care needs and setting. In NPT there is also a Residential Reablement Unit in Llys Y Seren which opened in	

			July 2014. This facilitates discharge from hospital and prevents readmission by providing a programme of rehabilitation to enable the individual to return home or reach their potential prior to the decision regarding a long term residential placement. From August 2014 to the end of March 2015, 60 patients have been discharged from Llys Y Seren, 58 to home and 2 to Residential Care. While this service is not currently designed for all existing Care Home patients, it has provided scope to reconsider a step down model in the future.	