Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

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

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Date	**28th March, 2017**
Signed	

Chief Executive Officer

Name: Rob Thomas

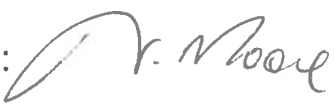
Date: 28.3.2017

Signed: 

Council Leader

Name: Cllr Neil Moore

Date: 28.3.2017

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)	***In partnership with the Cardiff and Vale University Health Board the Vale of Glamorgan Council has full compliance with this requirement.*** The Vale of Glamorgan Council and the Cardiff and Vale UHB jointly provide a reablement service. The integrated Vale Community Resource Service (VCRS). provides specialist rehabilitation and reablement services to people within the community, including care homes. The VCRS service operates over a 7 day week and works to reduce unnecessary hospital admission and facilitate timely discharge from hospital Targeted programmes of training and awareness have been delivered to care homes across the Vale focusing on nutrition, swallowing issues and falls prevention. Care homes are able to refer directly to the VCRS for assessment and intervention if required. In November 2016, six Intermediate care beds at Ty Dyfan Reablement Unit were commissioned by the Vale of Glamorgan Council and Cardiff and Vale University Health Board, utilising the Intermediate Care Fund. The Reablement Unit is suitable for individuals who for short periods of time are likely to need more intensive support with activities of daily living than it would be possible to provide at home. Our aim is to provide a bridge between hospital discharge and home for those people who require additional time in a supportive environment to maximise independence. The multidisciplinary team (MDT) aim to ensure a seamless transition back home within a maximum of six weeks. Following an assessment of need we will work with the person to develop a reablement programme to maximise functional independence. Early indicators show a high success rate with individuals who would have previously accessed permanent care home placements or long term packages of support, now able to

	successfully return to their own home with a low care package or independently. We will continue to evaluate this model and its outcomes. The residential homes access community based services that respond in times of crisis and contribute to rehabilitation following ill health. This includes referral to GP surgeries for medication review and to services such as the Falls clinic, nutritionist/dietician, manual handling advisors, district nurses, podiatry, the dementia care home liaison team and REACT.
On what evidence has this assessment been made? (850 words)	The evidence to corroborate this statement has been based on the long established VCRS team. There has been many acknowledgements of the value of this service, but it is recognised that the most celebrated aspect has been about outcomes for people being discharged from hospital and regaining and retaining their independence, even if this is partial. However, the impact within Care Homes is less well documented. This is because we have not found the demand for this service to be high and therefore we respond to the need but have not conducted an overall evaluation. However, we do know that through the support of specialist teams that we are able to maintain and treat residents within care homes for longer, preventing, or sometimes delaying admissions to hospital, or nursing homes. We also know that with access to this specialist care that residents are able to return to care homes rather than remain in hospital to be treated once the acute episode has been resolved. As stated previously, with the assistance of the Intermediate Care Fund, we have been able to pilot reablement unit within one of our own council run care homes – Ty Dyfan. We are evaluating this in order to respond to the efficacy of the Intermediate Care Fund and would be willing to share the outcomes of the evaluation in due course. Qualitative information we have ascertained to date from professionals and users of this service state that the reablement units are highly valued and people give positive feedback on their experiences. Although it is recognised that this response relates specifically to residents of care homes within the Vale of Glamorgan, we have been working hard to ensure that we extend our facilities to assist people in maintaining their independence and not needing to access care homes. Our strategy is currently being developed and will respond to the Population Needs Assessment and Market Position Statement, but we already have reablement units through our Accommodation Solutions project and through accessing a respite flat within Extra care both follow the same model as the Ty Dyfan reablement beds and have already been evaluated with positive outcomes.

	Specifically we are able to report the following: Individual Strength and Balance Programme (ISBP): The six month Individual Strength and Balance Programme replaced OTAGO (From 1/11/2015). The evaluation report will not be ready until the end of March. However, we are advised that the early indicators are as follows: • Reduction in number of falls per participant • Reduction in number of falls related 999 call outs • Reduction in falls related AE attendances • There is an improvement in outcome measure – TINNETI, Fear of Falling, 3 meter timed up and go. • Patient feedback has been very positive (When comparing 6 months during ISBP prior to 6 months starting ISBP) Care Home Falls prevention training: The 21 care homes in the Vale were approached and offered Falls prevention awareness training. 19 participated and 195 staff members attended the sessions. Feedback from the staff members was very positive. We are currently targeting Day Centre, Sheltered complexes and Community Social activity groups. Most of the Vale of Glamorgan Council's care staff members have attended falls prevention training and managers routinely undertake a falls risk assessment prior to admission. Poor nutrition, the impact of medication or a developing dementia and poor sight can contribute to falls and ill health, and we ensure resident's medication is regularly reviewed by their visiting GP and we ensure they have access to among other professionals nutritionists, opticians and that a nutritional plan is in situ. There is evidence that assessments are reviewed at least monthly, following incidents and accidents and when individual needs change. Information gathered is reflected in the service delivery plans that are created and reviewed with the input of

	residents and ensure that care is tailored to the individual and reflective of individual preference as well as need. If a fall occurs, staff members follow manual handling techniques and manual handling risk assessments. They refer to a 'falls flow chart' and if necessary request a GP referral to the falls clinic where people have taken part in Individual Strength and Balance Programmes. Advice from the falls clinic is reflected in the individual service delivery plans and in falls risk assessments. <u>Supplementary training/awareness</u> Cardiff and Vale University Health Board, in partnership with Age Concern and the Society of Chiropodists and Podiatrists, developed a training course for people to deliver foot care for patients at low risk of developing complications. Many to the Vale of Glamorgan's residential care staff attended. Neglected toe-nails are a common problem that can lead to a host of problems including mobility problems and infections. Most residents struggle to care for their feet due to physical challenges. There is no nail trimming service available as part of NHS podiatry services and residents were previously reliant on private podiatry / chiropody services. Toe nail cutting for 'low risk' residents, is now routinely undertaken by trained care staff. Care staff are also trained in caring for people living with chronic conditions such as diabetes and Parkinson's. <u>Involvement of the Vale 50+ members</u> One Vale 50+ Strategy Forum members is LIFT trained and facilitates two low impact strength and balance exercise programmes weekly, in our day care provision. Many of those benefiting from these sessions are experiencing dementia. The Action for Elders Balanced Lives exercise and health check programme has just received a small ICF grant to facilitate a programme in the day centre. Both these programmes are designed to build core strength and improve cognitive reasoning. Day centre customers have also benefited from art and craft sessions provided by the mental health charity NEXUS.

What impact has this had on residents' quality of life and care? (850 words)	Ty Dyfan Reablement unit: Research states that a person in hospital will spend only 1% of their day mobilising and every day spent like this can subsequently impact on balance and strength. This not only places the individual at greater risk of falling, but once a loss of 14% has been reached it also means the difference from independence to dependence and a greater reliance on care. The Ty Dyfan reablement unit is in its infancy but those residents that have completed the rehabilitation programme have been able to return home with a minimal package of care. A study undertaken in the first three months show an increase in confidence from when the resident initially attended the Unit to the day of discharge home. All residents' confidence levels improved and all care input reduced over the period of their time on the Unit, with 5 out of the 6 patients becoming independent by discharge. From the resident's perspective the stay at the Unit has had a successful outcome. They have progressed from dependence to independence regarding care needs and have improved physically and psychologically and in their quality of life perception. The multi-disciplinary approach that is applied in the Vale care homes has had positive outcomes for residents. The homes work with a variety of social services and health colleagues to enhance the quality of life experience of residents. Nutritional and SALT assessments implemented with the assistance of Health Colleagues has prevented risks associated with swallowing and malnutrition. The prevention of malnutrition by means of nutritional plans has addressed weight loss and has prevented the development of pressure ulcers. The implementation of the falls risk assessments and a 'falls flow chart' has had a significant impact on how care staff have responded to falls and the overall outcome for people who are prone to fall. Falls risk assessments are competed prior to admission,

	reviewed monthly, after a fall and when needs change. The completion of the document prompts exploration of necessary action, such as foot care, requests to GP for medication review and/or referral to the falls clinic. Early intervention has proven to be effective in fall prevention and outcome. Multi-disciplinary and partnership work with professionals such as specialist nurses and dietician, have prevented the exacerbation of health problems and the admission/readmission to hospital, transfer from residential to nursing care and for people who use our services for respite, the admission to long term residential care. The referral to GP surgeries for medication reviews and partnership work with the REACT team and the dementia care home liaison team have enabled the homes to positively manage behaviour which can challenge our services and reduced the use of antipsychotic medication in the care for people who live with a dementia. The routine foot care and toe nail cutting by care staff has had positive outcomes for the wellbeing of residents and has contributed to falls prevention. Partnership working has proven effective when caring for residents with chronic conditions such as diabetes. Research shows that people with diabetes living in residential care are generally more frail and have a higher prevalence of co-morbidities. Residents with diabetes living in our homes are cared for by a variety of people such as diabetic nurses, district nurses, GPs, podiatrists and practice nurses. Good communication between the homes and the health professionals and the older person with diabetes has led to better insight and better individualised care.
If further actions are needed to be compliant, please	We have good evidence around the impact our services have within our own residential homes, for both LA funded and self-funders. However, although we know this is happening within the independent sector, we

evidence what these will be and provide a timeline for compliance? (500 words)	cannot state how consistent this is, and our challenge will be to engage with care home providers about how we ascertain this information, and also how we support any gaps.

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 LA has achieved partial compliance with the Requirement within LA care homes.** However, given the fragility of the care home work force in terms of the availability and movement of care home managers, nurses and paid care staff, **compliance is difficult to achieve within commissioned care homes** at this time. Notwithstanding this, we have made significant inroads through our Dementia Training Plan. The Vale of Glamorgan Council Training Manager chairs the Cardiff and Vale NHS Dementia Training subgroup, which reports progress to the Dementia Task Force, in meeting the requirements of the 3 Year Dementia Strategy Action Plan. In reviewing the Dementia training requirements, the Dementia training delivered across the Vale and Cardiff was assessed against the Good Work - National Dementia Learning and Development Framework for Wales. **Attached as Appendix 1.** It has been noted by the group that a couple of the 'gaps' identified for the dementia courses delivered to social

	care staff are met in other ways, e.g. the section on medication is met through delivery of courses such as Basic Care of Medication and Advanced Care of Medication. It is not yet evident that the 'Influencers' are receiving sufficient appropriate training, although the 2 day Dementia Care training offered out to managers would meet this category. This information has been taken to the NHS and Social Care Dementia Taskforce meeting for further discussion to ensure on-going effective leadership in Dementia Care. All Dementia courses attended by Vale of Glamorgan Council staff is **attached as Appendix 2**
On what evidence has this assessment been made? (850 words)	Appendix 1 (as above) Appendix 2 (as above) Figures ascertained through training department and care homes to identify the number of internal care home staff who attended dementia training. During the period 01/04/15 – 20/03/17 we delivered 32 courses and trained a total of 344 people, of which 215 were internal and 129 were external. 134 of those were invited to become Dementia Friends, of which 100 were internal and 34 were external. Recognition of the value of Dementia Champions within Care homes and how they contribute to the cultural change and personal outcomes for residents Outcomes from Team Meetings, Supervision and Annual Personal Development and Performance Reviews for all care home staff within our own care homes.
What impact has this had on	In the residential homes, many areas of interest have been created to encourage residents to reminisce. Life

residents' quality of life and care? (850 words)	story boards have been created with input of the residents, their family and friends and identify the resident's room. Bedroom doors in two residential homes have been painted and numbered to reflect the front door colour and house number of the resident's last home which has aided orientation and belonging. Plans are in situ to roll this initiative out to the other two homes. <u>Cultural change examples</u>: Managers and staff attended range of training incl. Experiencing dementia, David Sheard 'culture change in dementia care', creative leadership. All homes have appointed dementia champions who meet frequently to share ideas, influence practise and plan activities. Introduced a creative and reflective aspect to team meetings Changed induction and recruitment process with focus on 'feelings matter most' and dementia care. Changed environment to support individuals more appropriately including décor, and general environment. <u>Leadership examples</u>: The team manager and two managers in the residential homes have completed the David Shears Culture Change in Dementia care program and one manager takes part in Re-live life story performances. The residential management group have completed dementia friends briefing sessions. One of the Vale homes achieved 'runner up' in the Care Council for Wales, excellence in care for older people accolades. The Older Person's Strategy Co-ordinator (OPSC) chairs the Vale Dementia friendly communities steering group and a number of Social Service managers contribute to the initiatives development. <u>Service user and carer consultation outcomes</u>:

	Resident meetings take place bi-monthly, frequently they are chaired by an Age UK advocate. As outlined in Requirement for Action 6.2 and 6.7 we have a quality assurance and policy officer who supports stakeholder consultation and the outcomes of this consultation are outlined in that section. <u>Evaluation:</u> The Policy and Quality Assurance officer completes an annual evaluation Introduced the use of one page profiles as a talking point - for residents and staff to promote conversation and learn about the individual to provide person centred care. <u>Specific Leadership Projects:</u> There is a current project jointly working with the Community Mental Health Older Persons integrated health and social care team support the reduction of antipsychotic medication.
If further actions are needed to be compliant, please evidence what these will be and provide a timeline for compliance? (500 words)	1. Ongoing evaluation of the Dementia training programme to ensure that the training delivered adheres to the National Dementia Learning and Development Framework and that the learning is implemented in practice. 2. Ensure that further actions are included in the development of the Cardiff and Vale of Glamorgan Dementia 10 year Strategy and Action Plan for the next 3 years. Recommendations for action to be signed off by the Director of Social Services and the Dementia Task Force. 3. All commissioned and LA Care Homes to deliver against the Good Work, National Dementia Learning and Development Framework for Wales should they wish to be considered for dementia care placements. 4. Ongoing contract monitoring to monitor progress and achievements for older people. Contracts are currently being re-written and should provide the opportunity nationally to include outcomes based commissioning. 5. To ensure 'influencers' are encouraged to attend

	appropriate Dementia courses and that they are reflective of the roles of strategic leaders, as opposed to being considered operational. 6. The Older Peoples Strategy Coordinator (OPSC) facilitated a dementia friend's session for the residential management group and it expected that a staff member will undertake dementia champions training, to ensure sustainable ongoing dementia friends briefings for all future staff. 7. The OPSC in partnership with Vale Housings Community Investment & Involvement Officer will be facilitating a programme of dementia friend's sessions and dementia friendly community's briefings to sheltered housing staff and residents throughout the Vale.

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 Vale of Glamorgan Council work with the sector to deliver this requirement.** There are homes within the Vale which have adopted very innovative approaches to ensure that residents have a wide range of social opportunities. The Council continues to work with the sector to ensure that this good practice operates throughout all sectors. The Vale 50+ Strategy Forum (V50+SF) invite care home residents to all their events throughout the year. Residents have enjoyed dance, sing-a-longs, fashion shows, art and craft workshops and other activities. However, we need to further promote this and include in our commissioning mechanisms as currently we recognise that this is not consistent across the sector, and therefore our compliance with this requirement for action is dependent on the individual care homes. We recognise that we need to remedy this situation and will look to promote, both internally and through the Care

	Home Provider Forum, befriending schemes within care homes. The division has experienced difficulties in engaging with the care home sector over the past year, partially due to interim management arrangements within the Council and the care homes wish to focus primarily on fee setting, which has hindered the ability to have conversations about how to introduce new service or extend services within the sector. This is a real problem within the care sector currently. However, to provide reassurance through ongoing case management and review processes, the Council continues to ensure that individuals have their needs properly met in the care home environment through individual plans that include access to faith based support and the retention of friendships prior to admission. In a recent home closure we actively sought to maintain people who had connected to move to alternative provision collectively, recognising the importance of relationships and friendships. We also ensure that an advocacy scheme operates within the care home sector within the Vale of Glamorgan to ensure that this happens.
On what evidence has this assessment been made? (850 words)	The evidence that this is based upon is sporadic. It is recognised that the Council as a commissioner needs to further develop this area of action. Commissioners agree that this is an ongoing requirement for action and one that we must improve with placements commissioned from the independent sector. There are some examples of good practice within the care homes of the Vale of Glamorgan which we have become aware of during contract management visits, but we have not gathered the evidence from the homes in the format of case studies. Our own council run homes have evidence of maintaining relationships outside of the residential home and ensuring the environment is welcoming so that residents can have guests. We also ensure that we support advocacy within all homes across the Vale of Glamorgan to support

	residents. Our case managers have through the new 'what matters' conversation focused more heavily on this aspect and we expect to see changes in the future as a direct result of people having increased control over their desired outcomes and with whom and how they wish to interact. Two residential homes recently closed within the Vale of Glamorgan, we supported the transition of residents for both, including out of area and self-funders. We ensured that the residents had access to advocates, and that if friendship groups existed that wherever possible these were maintained and people were placed together.
What impact has this had on residents' quality of life and care? (850 words)	In the homes managed by the Council, we have invested in WiFi connections and tablets, to enable older people within those homes managed by the Council to maintain contact with family and friends. We currently use tablets in all of our own Council run homes. We find that there are a multitude of apps available that provide effective and beneficial tools to help support people who are living with Dementia. Many apps prove popular, such as Mindmate which uses interactive games to stimulate a user's cognitive abilities. Also much used are drawing and colouring apps and "My house of memories" which is a free app that allows service users to explore objects from the past and share memories/reminisce. As many residents are not able to access shops the tablets are proving a useful tool to assist residents to choose clothes and other items on line. The tablets are also used to skype relatives and friends. The daughter of one gentleman who died recently lives abroad and she was able to see and speak to her dad regularly during his illness which was a great comfort to her and to him. We have found that the tablets versatile and as they are tactile, easy to use.

	During our consultation exercises this has not been identified as an issue, however, we will continue to ask questions both at the entry point of a person becoming a resident and routinely during reviews and consultation.
If further actions are needed to be compliant, please evidence what these will be and provide a timeline for compliance? (500 words)	1. Ensure we collate evidence of good practice when completing visits to homes, and encourage care homes to document good practice and share with us via care home provider forum meetings. 2. Advocates, Case managers and care home staff will all be made aware of the need to ensure that this requirement for action improves. Commissioners will raise this item at a future provider forum. 3. As commissioners we will ensure that we maintain our current advocacy projects within care homes. 4. As we consider co-production more widely via the implementation of the Social Services and Wellbeing (Wales) Act 2014, further consideration must be given as to how the community can engage more consistently with care homes and maintain relationships with residents through befriending. 5. Not all carers are comfortable using technology and we have made contact with the Vale 50+ strategy forum and will in the near future receive assistance of their digital champions to support extending the use of technology in the Council run homes.

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)	Compliance is achieved by a number of measures; - Review and nurse assessor teams undertake regular reviews of individuals in nursing and residential homes. - The Age Connect team feed into the regular provider performance quality assurance meetings (monthly) and provide regular monitoring reports. We have positive relationships with the advocates and they are quick to refer to us anything that is not meeting the needs of residents. - Annual service user satisfaction consultation takes place annually with a planned timetable agreed at senior management level. This consultation is carried out by the Policy and Quality Assurance Officer for Social Services, as well as monitoring work carried out by officers within the Commissioning Team. <u>Service User Consultation - process</u> The Policy and QA Officer and the Care Home Manager meet to explore methodologies to ascertain the most appropriate way to obtain views for their particular home's needs. Methods include questionnaires,

	structured interviews and a questionnaire being distributed to relatives depending on what is appropriate. For example, for service users with poor vision, interviews or larger print questionnaires would be arranged. The questionnaires act as a self-assessment tool, the resulting reports contribute to inspections carried out by the Care and Social Services Inspectorate Wales. Questionnaires are designed and reviewed annually to ensure that they are capturing relevant and appropriate information. Moreover, with the implementation of the Social Services and Wellbeing (Wales) Act 2014, questions have been designed to capture information to ensure we are complying with relevant areas. For example personal choice, quality of life and involvement in decision making. The carers and relatives of residents are also sent questionnaires regarding the residential home and the residents' experiences. Interviews take place with residents who are happy to participate, and a minimum of 5 interviews at each residential home are arranged. Interviews are all carried out in a confidential manner and no names are used in this work. Once responses have been received and analysed, a report with recommendations is produced and shared with managers and staff. These are acknowledged and a plan is developed to ensure that these areas can be used as a benchmark on an annual basis. The report is separated by individual question area, and the outcomes from the residential homes are considered overall (considering views separately from both service users and carers). An overview of the service is also provided so that good practice across the service can be shared. This programme has been successfully completed on an annual basis and the current report for 2016/7 is in progress. These arrangements ensure that a culture of continuous learning within the Care Homes is embedded within the care home to ensure sustainability of successful improvement.

	The Residential Service Manager speaks with managers and staff and evaluates satisfaction levels with people who use the service (and others) to ensure that identified outcomes meet expectations.
On what evidence has this assessment been made? (850 words)	The Quality Assurance consultation timetable is agreed with senior management at the start of each year. Residential Services has an allocated time each year for the consultation to take place. Residents are advised of the role of the Policy and Quality Assurance Officer, and are included in discussions about how the consultation takes place and their own preferences about methods. Those residents interested in participating in a structured interview are also identified. A residential forum is to be brought together so that specific themes are brought to the attention of staff and managers through a formal process. This is due to commence within the next six weeks. Monitoring visits are carried out at all residential homes by officers from the Contracts and Commissioning Team. Monitoring questionnaires are also distributed by the team. Provider Performance Concerns/Compliment Reports are also produced which demonstrate a range of monitoring information pertinent to quality of the service delivered, and identifying any themes. The Policy and Quality Assurance Officer has also developed a set of service criteria in relation to the quality of life and wellbeing of residents. Question areas for questionnaires and interviews focus on: • Social interaction with other residents and with staff; • Level of choice and control over what activities the residents participate in and when they participate; • Staff manner and attitudes; • Respect and dignity; • Respecting faith and dietary requirements; • Accessing primary care; • Feeling that they belong, and feeling 'at home';

	• Belief Systems and Family, Personal and Social Life • Safety support and security • Advocacy Evidence is available from the 2015 and 2016 consultation outcomes, a brief summary is outlined below; <u>The Care Experience</u> In the consultation from 2015, nearly all respondents said the staff made them feel welcome when they first moved into the residential home. Residents reported that they have been able to visit the home and feel they have more of an informed choice about living there. Residents have been able to bring their personal belongings with them to the home when moving in. This helps to make residents feel more at home. Many felt able to make decisions about how their care is provided. Many are satisfied with the food provided, and are pleased with the choice available and times of meals. Respondents felt that they are able to choose whether or not they spend time with others or on their own. They are also encouraged to do things for themselves if they are able. Some improvements were suggested regarding the environment of the home (décor, furniture). Residents have been able to access primary care services with the help of staff. Residents confirmed that the home provided them with the opportunities to express their faith needs (e.g. church transport, prayer, dietary requirements). Most residents felt that they know who to speak to if they have a concern about anything in the residential home. They were aware that staff would help them find an advocate if they needed one. Many residents in the 2016 questionnaires felt they could do the things they wanted to do, and feel part of their community in most cases. Nearly all live in a home that best supports their well-being and most could do the things that are important to them. Three quarters felt part of the community they lived in and all felt safe.

	Just over half knew who to contact about their care and support and nearly all had had the right information or advice when they needed it. Many felt they had been actively involved in decisions about how their care and support was provided. All have been treated with dignity and respect during their care and happy with the care and support they have received.
What impact has this had on residents' quality of life and care? (850 words)	The quality assurance activity has promoted a formal process to raise concerns and compliments. Care home managers are able to organise residents' meetings and confidentially discuss themes that have arisen from the consultation process if appropriate. The Policy and QA Officer and Officers from the Commissioning Team are able to provide an objective role and build trust with the residents to encourage and facilitate engagement. The residents are aware that this takes place and that this mechanism is separate from the residential service. Consultation has shown that service users and their families appeared to be satisfied with many aspects of the care they receive from the Residential Service. People feel safe, and relatives feel reassured that the residential service is providing a high quality standard of care. Information provision is good, particularly where people have visited the homes. An advocate is now available for all residential care homes. This enables the residents to access a confidential service in which concerns can be raised. The quality assurance processes ensure that standards are maintained, and that personal concerns are addressed. Moreover, the service is outcome focused. Residents are also aware that if they are dissatisfied with any of the aspects of daily living, they are able to suggest improvements. The anonymity of the feedback process ensures residents' trust is built and they are familiar with the quality assurance processes. The quality assurance process also facilitates

	benchmarking for the residential homes, and ensures they are kept aware of areas for continuous improvement and sustained performance levels.
If further actions are needed to be compliant, please evidence what these will be and provide a timeline for compliance? (500 words)	1. The consultation for 2016 has been carried out in conjunction with interviews in 2017 to incorporate requirements for qualitative measures for the Act. Questionnaires were sent to all Adult Services citizens with a care plan as at September 2016 (which included residents of care homes). These responses have been identified and incorporated into a report. To ensure that the residents are given further opportunity, interviews have been arranged for April 2017 to be incorporated into a report for 2016/7. It is anticipated that this report will be completed by June 2017. 2. A residential forum is to be developed across the Council's four residential homes in the Spring of 2017. 3. The Provider Forum for Care Home managers will be reinstated on a regular basis in 2017, following a hiatus for the past 12 months. Also, Vale of Glamorgan Council are working with Cardiff Council to ensure that we maximise the providers input by planning to propose to the sector some regional meetings/forums in preparation for joint commissioning in April, 2018.

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.