Agenda – Health, Social Care and Sport Committee

Meeting Venue:	For further information contact:
Committee Room 3 – Senedd	**Claire Morris**
Meeting date: 19 October 2017	Committee Clerk
Members pre-meeting: 09.15	0300 200 6355
Meeting time: 09.30	SeneddHealth@assembly.wales

Public

1 Introductions, apologies, substitutions and declarations of interest

2 Use of anti-psychotic medication in care homes – evidence session 9 – Royal College of Occupational Therapists & Royal College of Speech and Language Therapists

(09.30 – 10.15) (Pages 1 – 26)

Karin Orman, Royal College of Occupational Therapists

Dr Alison Stroud, Royal College of Speech and Language Therapists

Beth Bowen, Royal College of Speech and Language Therapists

Break (10.15 – 10.20)

3 Use of anti-psychotic medication in care homes – evidence session 10 – Care Forum Wales

(10.20 – 10.50) (Pages 27 – 42)

Melanie Minty, Care Forum Wales

Steven Ford, Care Forum Wales

4 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following item of business

Private

5 Inquiry into the physical activity of children and young people - inquiry refresh

(10.50 - 11.20) (Pages 43 - 45)

Break (11.20 - 11.35)

Public

6 Use of anti-psychotic medication in care homes - evidence session 11 - Care and Social Services Inspectorate Wales

(11.35 - 12.05) (Pages 46 - 49)

David Francis, Assistant Chief Inspector, Care and Social Services Inspectorate Wales

Lunch break (12.05 - 12.45)

7 Use of anti-psychotic medication in care homes - evidence session 12 - Cwm Taf University Health Board and Cardiff and Vale University Health Board

(12.45 - 13.30) (Pages 50 - 54)

Mr John Palmer, Director of Primary, Community and Mental Health, Cwm Taf UHB

Mrs Kim Williams, Consultant Psychologist Older Persons Mental Health, Cwm Taf UHB

Victoria Gimson, Specialist Mental Health Pharmacist, Cardiff and Vale UHB

Candace Rowlands, Cardiff and Vale UHB

Break (13.30 - 13.35)

8 Use of anti-psychotic medication in care homes - evidence session 13 - Aneurin Bevan University Health Board and Hywel Dda University Health Board

(13.35 - 14.20)

Claire Aston, Divisional Nurse/Head of Complex Care, Aneurin Bevan UHB

Dr Chineze Ivenso, Old Age Consultant Psychiatrist (Newport Community Mental Health Team), Aneurin Bevan UHB

Sarah Isaac, Senior Pharmacist Manager – Primary Care, Hywel Dda UHB

Sue Stephens, Prescribing Advisor, Hywel Dda UHB

9 Paper(s) to note

9.1 Use of antipsychotic medication in care homes - additional information from Community Pharmacy Wales

(Pages 55 - 66)

9.2 Letter from the Cabinet Secretary for Health, Well-being and Sport regarding the upcoming Committee inquiry into suicide prevention

(Page 67)

9.3 Letter from the Chair of the Public Accounts Committee regarding the NHS Finance (Wales) Act 2014

(Pages 68 - 69)

10 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

Private

11 Use of anti-psychotic medication in care homes - consideration of evidence

(14.20 - 14.35))

Agenda Item 2

Document is Restricted

National Assembly for Wales Health, Social Care and Sport Committee's consultation on the use of anti-psychotic medication in care homes

This submission is made on behalf of the Royal College of Occupational Therapists (RCOT), the professional body for occupational therapists across the UK.

The submission is made in response to the Health, Social Care and Sports Committee's consultation on the use of anti-psychotic medication in care homes. Further information on any aspect of this response can be gained by contacting the RCOT.

Executive Summary

1. This response outlines the importance of specialist dementia services providing support to care homes and the role occupational therapists can play in supporting care homes to deliver on person centred care and non-pharmacological interventions to address behavioural and psychological symptoms associated with dementia.

2. The Royal College of Occupational Therapists is currently gathering further data on best practice examples as part of its *Occupational Therapy: Improving Lives, Saving Money* campaign.

Submission

Establishing a person centred ethos:

3. Older people living in care homes historically have not had equality of access to multidisciplinary services, although they arguably have the greatest health and social care needs. Within the UK multidisciplinary liaison services are providing in-reach support to care homes. In these teams, occupational therapists can promote person-centred care through training, on-site role modelling and working directly with care home staff. This would include:
   - using dementia-specific assessment tools to ensure person-centred activity planning and establishing accessible one-page profiles of residents with staff members. Supporting meaningful activity is dependent on having insight into the person's life experience, roles and interests. The Pool Activity Level (Pool, 2006) is often cited as an assessment tool as it provides a life history and it describes the different levels at which an individual may engage.
   - Reviewing needs of residents, suggesting ways of breaking activity down and delegating different roles/steps of activity.

4. A person centred approach would primarily focus on identifying and understanding who and what is important to the person so that they can be supported to maintain a relationship/involvement with these as their illness progresses. This focus on living life would allow an enablement rather than a management ethos. For example: in consideration of risk the value of the activity to the person and their previous approach/attitude to risk would be a key deciding factor within support plans. The focus on enablement would encourage a more positive approach – working with the person's strengths and skills and existing support. This will lead to a less risk adverse culture, minimising restrictions on people living their lives and engaging in the occupations that matter to them.

5. Supporting people with dementia to be active, engaged and to have outlets for communicating thoughts and emotions through activity reduces the build-up of frustration. It allows staff to be alongside the person and offers insight into who they are beyond the diagnosis and symptoms of dementia.

6. The Royal College has produced a toolkit to establish an enabling ethos within care homes and addresses dementia within the guides.
College of Occupational Therapists (2013). *Living well through activity in care homes - the toolkit.* London: COT. Available at:.*https://www.cot.co.uk/living-well-through-activity-care-homes-toolkit-0*

7. There are existing examples of high quality training delivered by occupational therapists. For example:
   - Abertawe Bro Morgannwg University Health Board Dementia Care Training Team picked up two awards for their specialist training. The jointly funded team, based at Glanrhyd Hospital, were awarded Stage 1 Practice Innovation Unit by the Welsh Centre for Practice Innovation (WCPI) acknowledging continuing work to improve standards in dementia care. Plus, they've been Highly Commended in the National Social Care Accolades which are awarded by the Care Council for Wales.
   - Helen Lambert and Alison Turner, both Occupational Therapists, and Mental Health Nurse Karyn Davies developed and delivered training to ABM and Bridgend County Borough Council staff to improve the support people with dementia received, and ensure everyone receives the same care across the area. Helen Lambert, went onto lead on the development and delivery of a Dementia Reablement Training Package for Cardiff City Council and the Social Service Improvement Agency. http://www.ssiacymru.org.uk/home.php?page_id=8644. This led to the development of a Dementia Reablement toolkit and service model: http://www.ssiacymru.org.uk/resource/english--lr.pdf. These can be translated to span care homes and the training of care home staff.

Training for Care Home Staff in non- pharmacological interventions:

8. The majority of care homes have not specifically been designed to provide care for people with the complex needs of those with severe/later stages of dementia. This means that residents with dementia often have multiple unmet needs such as: involvement in everyday activities, isolation and anxiety and depression. These unmet needs can lead to decreased quality of life and increased costs of care due to managing the resulting symptoms of behavioural and psychological symptoms of dementia. (Orrell et al. 2007.)

9. Occupational therapists can directly work with residents to address behavioural and psychological symptoms of dementia. Through:
   - Assessing patterns of distressed behaviour and identifying potential reasons, such as pain, anxiety, the approach of staff and the environment.
   - Providing help and training to staff to support the person with dementia to undertake daily living activities such as bathing, dressing, eating, and participating in social activities, thereby minimising frustration. This may involve adopting assessment tools, adapting communication, the environment and activities. (Gitlin et al 2001, Padilla, 2011).
   - Evaluating communal spaces in care homes and improve the environmental design to help compensate for impaired memory, learning and reasoning skills. This helps reduce the levels of stress experienced by people with dementia

and their carers and improves the quality of individuals' daily lives. (Barber-Miller 2010, Morgan-Brown et al 2011).

- Providing appropriate exercise or other activities that are graded to an individual's capabilities to increase their quality of life, preserve their identity and provide them with a positive emotional outlet.(NICE 2008)

10. Within the Royal College's next report *Living, not Existing: Putting prevention at the heart of care for older people in Wales* there is a call for equality of access to be the guiding principle for older people who, due to their age and health, are unable to care for themselves and keep themselves from harm. If equality of access to occupational therapy is to be achieved, the design of services must enable occupational therapists to widen their approach in order to meet the varying needs within their local communities; this includes providing in-reach support to care homes.

References:

Barber-Miller, C (2010) An evaluation of service provision. Occupational Therapy News, 18(5), 26.

Gitlin LN, Corcoran M, Winter L, Boyce A, Hauck WW (2001) A randomized, controlled trial of a home environmental intervention: effect on efficacy and upset in caregivers and on daily function of persons with dementia. The Gerontologist, 41(1), 4–14.

Morgan Brown M, Ormerod M, Newton R, Manley D (2011) An exploration of occupation in nursing home residents with dementia British Journal of Occupational Therapy 74(5) 217-225

National Institute for Health and Clinical Excellence (2008) Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care. London: NICE. Available from: http://www.nice.org.uk/nicemedia/pdf/PH16Guidance.pdf

Orrell M, Hancock G, Hoe J, Woods B,Livingston G and Challis D (2007) A cluster randomised controlled trial to reduce the unmet needs of people with dementia living in residential care. International Journal of Geriatric Psychiatry. 22(11)1127–1134

Padilla R (2011) Effectiveness of interventions designed to modify the activity demands of the occupations of self-care and leisure for people with Alzheimer's disease and related dementias. American Journal of Occupational Therapy, 65(5): 523-531.

Pool J, (2012) The Pool Activity Level (PAL) Instrument for occupational profiling (4th ed). London: Jessica Kingsley Publishers.

About the Royal College

The Royal College of Occupational Therapists is the UK Professional Body and Trade Union for over 31,000 occupational therapists, support workers, managers and students. Occupational therapy enables people of all ages to participate in daily life to improve health and wellbeing. They are the only Allied Health Profession trained at a pre-registration level to work within both physical and mental health.

Contact

For further information on this submission, please contact:
Karin Orman
Professional Practice Manager
Royal College of Occupational Therapists

National Assembly for Wales Health, Social Care and Sport Committee consultation on the use of anti-psychotic medication in care homes

Executive Summary

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to respond to the Health, Social Care and Sport Committee's consultation on the use of anti-psychotic medication in care homes. We believe this consultation is very timely given the concerns raised by the Alzheimer's Society, Older People's Commissioner for Wales, Royal Pharmaceutical Society and the Royal College of Psychiatrists about the inappropriate and overuse of anti-psychotic medication in care homes. Our response below focusses on two key elements within the terms of reference namely;

- the provision of alternative (non-pharmacological) treatment options
- training for health and care staff to support the provision of person-centred care for care home residents living with dementia.

Key recommendations to the Health, Social Care and Sport Committee

- There is a clear link between communication difficulties and behaviour that challenges. Non-pharmacological treatment options should include access to communication support provided by Speech and Language Therapists.
- Staff in care homes should receive training on identifying communication difficulties in dementia and strategies to support and enhance communication.
- We recommend the Welsh Government institute a cycle of national and local audits into anti-psychotic prescribing practices in Wales. The audit should also gather evidence on whether the patient received the anti-psychotic medication as the first option treatment and/ or whether there were alternative therapies available within their locality.

1. RCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK. The RCSLT has 17,500 members in the UK (450 in Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council). We promote excellence in practice and influence health, education, care and justice policies.

2. Speech and Language Therapy manages the risk of harm and reduces functional impact for people with speech, language and communication support needs and/ or swallowing difficulties.

3. Speech and Language Therapists (SLTs) provide life improving treatment, support and care for adults who have difficulties with communication, eating, drinking or swallowing. Using specialist skills, SLTs work directly with clients, carers and other professionals to develop personalised strategies. They also provide training and strategies to the wider workforce; such as care assistants so that they can identify the signs of speech, language and communication needs (SLCN) and eating, drinking and swallowing difficulties, improve communication environments and provide effective support.

The provision of alternative (non-pharmacological) treatment options

4. Communication helps us to cope with specific life events including transitions, illness, bereavements and stress. When communication is impaired it is much harder to adapt to challenging circumstances. Communication problems occur in all forms of dementia & in the later stages these problems become increasingly challenging (Bourgeois 2010). Communication difficulty can be exhausting for the person with dementia and affects their identity and relationships (Bryden, 2005). Limited communication has significant social and psychological impact. Frustration can lead to distressed behaviour and James (2011) argues that behaviour that challenges is an attempt to make sense of the environment or communicate an unmet need.

5. Loss of meaningful interaction and conversation also places increased pressure on caring relationships (O'Connor et al, 1990 Nolan et al, 2002). Communication difficulty has been described as one of the most frequent and hardest to cope with experiences for family carers (Egan 2010 Braun 2010). Orange (1991) found that a survey of family members of dementia patients around half of the respondents noted a change in their relationships as a result of communication difficulties. In considering alternative options to pharmacological interventions, there is a clear need to ensure that the communication difficulties underlying distressed behaviour are identified and appropriate strategies put in place. Staff and family carers who are trained to recognise how people in their care communicate distress, anxiety or pain through their behaviour (verbal and non-verbal) are better equipped to identify the triggers of behaviour that challenges in an individual, and address the potential for a person with dementia to harm themselves or others.

6. SLTs have the specialist knowledge and skills to directly assess the contribution that unmet speech, language and communication support needs make to behaviour that challenges and provide advice on maintaining and maximising communication function to the person with dementia, their family and carers. SLTs also have a clear role in training health, social care and voluntary sector staff, including care home workers in identifying communication difficulties in dementia and strategies to support and enhance communication. Communication training for carers within the residential setting has been evaluated positively (Jordan et al, 2000) as effective and the role of SLTs as trainers outlined (Maxim et al, 2001). This short case study provides an example of the difference SLTs are able to make within this environment.

David's story

David lived in a care home where he often argued with staff and residents making it difficult for everyone to live and work with him. Although, David's speech was limited to a few words, staff thought David knew what he was doing and saying.

- An SLT assessment showed David had significant difficulties understanding what was said to him so he became confused, he didn't always know why people wanted him to do things and he made unintentional mistakes which of course frustrated him and others.
- The SLT gave staff guidance on how best to interact with David to help his understanding. This greatly reduced his confusion and the arguments and stress which had been caused by it.

Source: RCSLT/Alzheimer Scotland- Speech and Language Therapy Works for People with Dementia

7. Despite a growing body of evidence to justify the impact of speech and language therapists within dementia care, provision of services in Wales is extremely patchy. This is in sharp contrast to other nations, such as Scotland, where there have been significant developments with regard to speech and language therapy provision for people with dementia. The recent audit of memory loss services by 1000 Lives (Public Health Wales, 2016) highlighted only 0.6 full time equivalent provision of speech and language therapy in specialist teams across Wales. Similarly at a community level, despite evidence of the value of the inclusion of SLTs within multi-disciplinary community teams and the potential opportunities which exist, we are aware that too few

teams across Wales stipulate inclusion of the role as part of a dedicated primary care integrated workforce. In the current model, our services are often provided by small, flexible teams who must meet the competing demands of primary and secondary care. Our members tell us that dementia services are not consistently delivered across Wales and resource pressures mean that dysphagia training often takes precedence over training to support management of communication difficulties.

Training for health and care staff to support the provision of person-centred care for care home residents living with dementia

8. RCSLT believes that central to the provision of person-centred care is the concept of preserved ability and wellbeing and the belief that all people with dementia, at all stages, have something to communicate. As we have highlighted above, Speech and Language Therapists have a clear role to play in training health and care staff about communication difficulties and strategies to support and enhance communication.

9. In addition, we wish to highlight the importance of training for staff to identify difficulties eating, drinking and swallowing as a key element within the delivery of person-centred care. Difficulties eating, drinking and swallowing can lead to a poorer quality of life for individuals with dementia leading to embarrassment and lack of enjoyment of food. They can also have potentially life threatening consequences, resulting in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. Dysphagia is a recognised challenge for people with dementia, particularly in the later stages of the disease. 68% of people in care homes with dementia have difficulties eating, drinking and swallowing (Steele et al, 1997). Managing swallowing problems (dysphagia) in residential care reduces the risks of choking, chest infections, aspiration pneumonia, dehydration and malnutrition and decreases the need for crisis management that often results in unnecessary hospital admissions. We believe that training is required to ensure staff, in addition to understanding the communication difficulties experienced by people with dementia, are able to identify the early signs of eating, drinking and swallowing difficulties to ensure people's nutritional needs are met.

10. In a number of local health boards, SLTs provide telephone triage to care homes managing the communication and swallowing problems of those in their care, removing the need for a GP visit. They also provide training to care home staff and others in the community to manage decline in swallowing performance from age and disease and communication difficulties. For example, an SLT is employed on a part-time basis as part of the Care Home Liaison Team in Cardiff and

Vale University Health Board and is an important part of the alternative support available to manage the behavioural and psychological symptoms of dementia. However, as highlighted above, we are aware that these services are not consistently delivered across Wales and dysphagia training often takes precedence over training to support the management of communication difficulties.

Further Information

11. We would be happy to provide any additional information required to support the Committee's decision making and scrutiny. For further information, please contact:

Dr Alison Stroud
Head of Wales Office
[redacted] / [redacted]

References

Bourgeois MS, Hickey EM (2009). *Dementia: from diagnosis to management. A functional approach*. Taylor and Francis: New York
Braun M et al (2010). Toward a better understanding of psychological well-being in dementia caregivers: the link between marital communication and depression. *Family Process*;49:2,185-203
Bryden C (2005). *Dancing with Dementia*. Jessica Kingsley Publishers: London
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James I A (2011*). Understanding behaviour in dementia that challenges: a guide to assessment and treatment*. Bradford Dementia Group Good Practice Guides:Bradford
Jordan et al (2000). *Communicate: Evaluation of a Training Package for carers of older people with communication impairments*. Middlesex University/UCL Publication: London:
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Public Health Wales (2016). *1000 Lives Second Welsh National Audit Report. Memory Clinic and Memory Assessment Services*. Public Health Wales: Cardiff
Steele CM, et al. Mealtime difficulties in a home for aged. Dysphagia 1997;12:1,43-50

Consultation response –

Use of Anti-psychotic Medicines in Care Homes

1. Care Forum Wales welcomes the opportunity to respond to this call for information. We are a membership organisation for Health and Social Care Providers in Wales representing over 450 independent providers (both private and third sector), the majority of whom own care homes.

2. We promote excellence in practice in health and social care and have a number of expert leads in key areas, including dementia care. Steve Ford, our dementia lead, recently appeared on BBC's television programme, Eye on Wales, endorsing calls for the use of anti-psychotic medicines to be carefully monitored and reduced wherever possible, to enhance the quality of life of people living with dementia and to avoid unnecessary and harmful side effects, such as increased likelihood of falls.

3. Some of the first generation medicines have potentially serious side effects and have been largely discredited for use for people living with dementia. Some studies have shown increased mortality rates, incidence of stroke and cardio-toxicity. We believe that anti-psychotic medication should only be given as a last resort and, if it is appropriate, there should be a robust system of review every 3 months.

4. We are in the process of writing to our members to remind them of our campaign to be "A Champions" (Assessment of Challenging and Management Problems Initiating Options for New Solutions) and to re-issue guidance that we first issued in 2011.

5. We recognise that the responsibility for prescribing antipsychotic medicines rests with the GP and hospital psychiatrists or clinicians. However, it is often prescribed in response to the care team seeking to manage behaviours that challenge. We would rather urge care practitioners to seek individualised, creative and innovative interventions. The first step is to recognise and understand the triggers that cause this behaviour. The A Champions document includes a concise and practical checklist to help care practitioners to identify behaviours and likely triggers; to rate the level of incident and to find interventions that work for the individual. A copy of the document is attached at the bottom of this response.

6. We have worked previously with the University of South Wales in devising a dementia certificate for nurses to create better understanding of these issues. We are currently in discussion about adapting the training materials to a format that can be shared and used by all care practitioners.

7. We would encourage providers and GPs to work together to review medication with a view to reduction and eventual elimination over a suitable time period, not forgetting the contribution that community pharmacists can make.

Melanie Minty

Policy Advisor

DEMENTIA CARE: 'A CHAMPIONS' DOCUMENT

Assessment of Challenging and Management Problems Initiating Options for New Solutions

Responsible care providers are committed to finding sensitive creative and individualized appropriate care interventions to safely manage behaviour that challenges, exhibited by service users with dementia, and thereby avoiding administration of antipsychotic medications as far as is practicable and safe to do so.
The elimination of or successful management of catalysts and identification of common denominators will inform care intervention strategies and promote problem resolution.
Please tick the appropriate boxes, as relevant and complete the document which is designed to take no more than 5 minutes.

This document is suitable for use in all care delivery settings and can be completed by careworkers, carers, nurses or others providing care in hospitals, clinics, day centres, care homes, domiciliary care or care at home by family members or others.

Name of Service User…….
Date of birth…….
Type of care setting …….
Address ……
Date of Admission/Residency……
Diagnosis……..
G.P…….
Other relevant agencies……..
……

TYPES OF BEHAVIOUR THAT CHALLENGES

PHYSICAL AGGRESSION Please tick as appropriate.

Punch ( ) Slap ( ) Kick ( ) Bite ( ) Head butt ( ) Squeeze ( ) Pinch ( ) Push ( ) Spitting ( ) Throwing objects ( ) Describe object thrown…….. Blocking others movements ( ) Throwing liquids ( ) Stamping ( ) Using items as weapons e.g. walking stick ( ) Describe……..
Other ……
Comments …….

PSYCHOLOGICAL BEHAVIOUR

Screaming ( ) Shouting ( ) Repetitive statements ( ) Demanding ( ) Loud behaviour ( ) Unreasonable requests ( ) Threatening ( ) Intimidating ( ) Swearing ( ) Clapping ( )
Other…….
Comments ……

SELF HARMING BEHAVIOUR

Hitting oneself ( ) Scratching oneself ( ) Pinching oneself ( ) Using an object to hurt or injure oneself ( ) Describe…… Threatening to hurt oneself ( ) Verbalizing suicidal thoughts ( )
Placing oneself on floor ( ) Deliberately rolling oneself out of bed ( ) Attempting to eat/drink non food objects ( ) Describe…….
Other……..
Comments…….

SEXUAL BEHAVIOUR

Unwelcome sexual comments ( ) Inappropriate kissing ( ) Inappropriate touching ( ) Fondling ( ) Penetrating actions ( ) Describe ……..
…… Exposing oneself ( ) Use of sexual swear words ( )
Masturbation in room other than bedroom ( ) Identify ……..
…… Inappropriate flirting ( ) Describe ……..
Other……..
Comments …….

DESTRUCTIVE BEHAVIOUR

Damage to electrical appliances ( ) Homes fixtures and fittings ( ) Walls/wallpaper ( ) Throwing objects ( ) Please describe …….. Throwing food ( ) Trashing rooms ( ) Identify which …… …….. Shredding/Ripping items……..
Other ……
Comments …….

INAPPROPRIATE BODILY ELIMINATIONS

Urinating in inappropriate places ( ) Describe location ……..
Defecating in inappropriate places ( ) Describe location ……..
Manually handling/smearing/throwing faeces ( ) Other ( ) Describe……..
……
Comments…….
……

Any further relevant information.

……
……
……
……
……
……
……
……

REASONS/CATALYSTS/TRIGGERS FOR UNDESIRABLE UNWANTED BEHAVIOUR

(Please record as appropriate in the following sections)
P = Possible I = Identified/Confirmed …….

MEDICAL ISSUES

Dehydration ( ) Constipation ( ) Diarrhoea ( )
Infection (e.g. U.T.I) ( )Describe ……..
Pressure ulcers/wounds/tissue viability problems ( ) (describe)……..
……
Medication side effects () describe …….
Sight/Hearing/Sensory problems ( ) describe ……..
Dental pain/oral problems ( ) describe …….
Sleep disturbance ( ) describe ……..
Seizure activity ( ) describe ……..
Specific Medical Condition ( ) describe …….
Polypharmacy ( ) describe ……..
Immobility ( ) describe …….. ……..
Other Medical Issues ( )
describe……..
.....

PERSONAL COMFORT ISSUES

Pain ( ) Discomfort ( ) Sore bottom (sitting/lying for long periods of time ( )
Hunger ( ) Thirst ( ) Too hot ( ) Too cold ( ) Wanting to go to the toilet ( )
Incontinence ( ) Feeling of being interfered with ( )
Other ……
Comments …….

PSYCHOLOGICAL ISSUES

Agitation ( ) Irritability ( ) Anxiety ( ) Anger ( ) Depression ( ) Tearful ( ) Accusatory ( )
Hallucinations ( ) Delusions ( ) Hyperactive ( ) Intolerant of others ( ) Boredom/isolation (

) Sleepy ( ) Not wishing to be disturbed ( ) Pacing ( )
Sundowning ( ) Disinhibition ( ) Suspicious/paranoid feelings ( ) Communication difficulties ( )
Other …….
Comments …….

ENVIRONMENTAL ISSUES

Crowded room ( ) Too noisy ( ) TV/Radio blaring away ( ) Wanting to leave ( )
Incompatibility of adjacent people ( ) Unpleasant odours ( )
Lack of therapeutic environment ( ) Deprivation of liberty ( )
Describe ……
Other ……
Comments ……..

STAFF ISSUES

Inappropriate approach by staff ( ) Medical/nursing procedures by staff ( )
Administration of medication by staff ( )
No/insufficient explanation of care intervention procedures by staff ( )
Inadequate numbers of staff to provide the necessary care ( ) Poor staff skills (
) Staff ignoring requests/questions ( ) Change of carer ( )
Other …….
Comments ……..

SERVICE USER ISSUES

Disturbed by behavior of other service users ( )
Describe …….
Aggression from another service user ( )
Repetitive behavior from another service user ( )
Unwanted personal contact/intrusive behavior from another service user ( )
Other ……
Comments ……

VISITOR ISSUES

Unwanted visitor ( ) Inappropriate behaviour from visitor ( )
Challenging behaviour to a visitor ( ) Challenging behaviour after a visitor leaves ( )
Challenging behaviour following an outing with a visitor ( )
(Please specify). …….
Other……..
Comments ……

Other catalysts/triggers/reasons

Comment upon domain/specifics:-

……
……
……
……
……

OTHER DETAILS

No identifiable catalysts/triggers/common denominators ( )
Issues/actions that are indefinable/unassessable/difficult to categorize ( )
Comments ……

Time of challenging behaviour ……..

Date of challenging behaviour ……..

Day of challenging behaviour (e.g. Monday) ……..

Location of challenging behaviour ……

INCIDENT RATING 0 = NO HARM; 5 = MODERATE HARM/RISK OF HARM 10 = VERY HIGH RISK OF HARM OR ACTUAL HARM/POTENTIALLY LIFE THREATENING

PLEASE RATE INCIDENT 0 – 10……
Other……..

Comments **……**

INTERVENTIONS THAT APPEAR TO HELP

Escort service user away from location ( )
Please identify to which area of the home…….
One to one care/reassurance ( ) Comment……..
Activity sessions ( ) Comment …….
Reality orientation ( ) Comment ……..
Validation therapy ( ) Comment ……..
Snoezelen room ( ) Comment ……..
Escorted outing ( ) Comment ……..
Contact/interaction with specific staff member ( ) Identify …….
Contact/interaction with family member/visitor/advocate ( ) Identify ……
Contact/interaction with service user ( ) Identify ……
Contact/interaction with visiting professional ( ) Identify ……..
Contact/interaction with visiting chaplain/clergy ( ) Identify ……..
Contact/Interaction with Other ( ) Identify ……..
Distraction ( ) Comments ……..

Use of comfort object ( ) Comments ……
Use of isolation with discreet observations ( ) Comments ……..
Use of drink substances ( ) e.g. glass of wine/cup of tea, Comments
……
Assess fluid intake ( ) describe tool used …….
Use of food Substances ( ) Comments ……..
Ventilation of feelings ( ) Expressions of anger ( ) Active listening ( )
Personal contact, e.g. holding hands ( )
Firm verbal directives ( ) *Identify in care plan
Address Medical Issues ( ) Describe ……

Medication ( ) Type …… Antipsychotic Yes/No PRN Yes/No
Name and dose…….
Method of administration…….
Comments ……

Restraint ( ) Was this the only feasible option? ( )
Type of Restraint ……. For How Long…… Comments ……. Recorded in Restraint register ( )

Who is the person(s) that was harmed/placed at risk of harm ……..
……
Designation of individual ……
Was the harm avoidable? Comments ……..
……

OUTCOME

Relevant/Likely Themes/common denominations relating to undesirable behaviour/incidents…….
……
……
What have we learned to become better equipped to deal with future incidents or avoid them……
……
……
……
……

MEDICATION ISSUES

Please describe any changes in service users presentation relating to behaviour without/since non administration of anti psychotic medication given for incident resolution……..

……
……
Time period involved……

Discussed with/ please identify ……
……

Has the Care home received recognition of good practice in dealing with behaviour that challenges. Yes ( ) No ( )
By whom……..…Designation……

Copy Sent To: Service user ( )
Service users family/advocate ( )
G.P ( )
Social services ( )
BCUHB ( )
CSSIW ( )
Police ( ) File ( )
Other ( ) Please specify ...…….

Name of Person completing document ……..

Designation ……...

Signed ……..

Dated ……

DATE		ANTECEDENCE	BEHAVIOUR	CONSEQUENCE

A CHAMPIONS DOCUMENT ABC ANALYSIS CHART

'A CHAMPIONS' document conceived by Stephen Ford MA, RGN, RMN.Dip.Ger. Dementia Care Policy Coordinator

Care Forum Wales **December 2011.**

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Agenda Item 5

Document is Restricted

Agenda Item 6

Care and Social Services Inspectorate Wales (CSSIW)

Evidence for Health, Social Care and Sport Committee: Use of anti-psychotic medication in care homes

CSSIW's response:

- **the availability of data on the prescribing of anti-psychotics in care homes, to understand prevalence and patterns of use;**

CSSIW does not currently collect information on the use of anti-psychotics in care homes.

We have recently introduced on-line annual self assessments which will be completed by care services and will consider whether it is feasible to capture annual census data on both prescription levels of antipsychotics and medication reviews in the future. This would enable us to capture prevalence and trends and importantly identify those homes where antipsychotic usage is particularly high. However the value of collecting this information would depend on staff completing the returns being aware that a particular medication is an antipsychotic.

In 2018/19 we will be undertaking a thematic study of the quality of dementia care provision in care homes in Wales. The use and impact of antipsychotics will be one of our lines of enquiry.

- **prescribing practices, including implementation of clinical guidance and medication reviews;**

This is not something CSSIW has information on. However we have noted concerns broader than the prescribing of antipsychotics, for instance the use of anticonvulsants like Epilim to manage behaviour of people with dementia. This is not recommended by NICE.

Clearly when people are prescribed antipsychotics it is important that care staff are alert to and carefully monitor potential side effects, keep the GP and any specialists involved informed of concerns and ensure that the prescription is regularly reviewed.

We believe that proper, person centred assessments are critical in reducing inappropriate prescriptions and that the following questions must be considered before contemplating the use of antipsychotics;

- What is causing a person to be distressed, behave or respond in the way they do? What is the pattern, when did it originate and what are the triggers? Importantly how is this understood from the person's perspective? What bearing does cognitive impairment, the person's biography, personality and physical health have on the way they are presenting and behaving? Are there clues here about solutions which should be considered?
- What is the quality of the social environment in which they live? What is the quality of the relationships around them; importantly what is the level of understanding, skill and empathy of the staff providing care? In what way does the physical environment support the person to feel at ease or perhaps cause them to feel distressed?
- Have there been concerted efforts to find ways of supporting the person and resolving the difficulties which are occurring; "psycho – social" solutions should always be explored before medication is prescribed.

- **provision of alternative (non-pharmacological) treatment options;**

Our inspections focus on people's well-being. We do this through careful observation and use a tool called Short Observational Framework for Inspection (SOFI) which is based on dementia care mapping. This assesses and tracks people's mood states, their level of engagement and the quality of and responsiveness of staff interactions. We are particularly concerned if we find people who are lethargic or withdrawn and will follow this up with staff and by looking at records and the medication profile.

We have noted during our inspections the importance of "social environment" and that the ambience, opportunities for engagement and activity as well as the physical environment all have a significant impact on people's experience. "Butterfly projects"* are often reported positively by our inspectors. People who are positively occupied are less likely to become bored or frustrated.

*see for example:
http://www.dementiacarematters.com/pdf/BUTMODELOAHNNS.pdf

Clearly it is not acceptable for antipsychotics to be used to compensate for poor training or insufficiency of staff, to make up for the lack of access to meaningful activities or because the physical environment is restrictive or unsafe.

- **training for health and care staff to support the provision of person-centred care for care home residents living with dementia;**

Training and awareness are fundamental to supporting people with dementia, as is the culture of care they work within and front-line leadership. Training alone is not enough; there has to be ongoing support for staff. It is paramount that care workers learn to see the world from the perspective of the person with dementia in order to know how best to respond.

Training in dementia care is variable and a confusing landscape. The new pathway published by Social Care Wales is helpful but in our experience awareness of it is low and it has yet to be applied by many care homes. It is hard to assess competency as there are no commonly adopted standards. There are many packages and routes available from on-line training to one year day release courses, internal courses run by providers and those supplied by external training agencies.

A significant proportion of care homes in Wales carry historical “EMI” “Dementia” or similar registration classifications. They also state in their Statement of Purpose / brochures that they care for people with dementia but in a number of instances we find that neither the staff or manager have had any specialised training in dementia.

We believe the staff in all care homes for older people should be trained and competent in the care of people with dementia.

We recognise the enormous challenge facing care workers when people requiring care and support are distressed, disorientated or experiencing hallucinations. Problems are accentuated when providing care to people with dementia; in their own mind they may perceive a situation from a previous time in their lives, not recognise they need to be helped, may feel that the care being provided is intrusive or a violation of their personal space or feel resentful due to a loss of personal choice or control.

People can be at significant risk unless care workers are able to take action either to prevent them from going missing, or enable them to have food and drink. We are aware for example that people who do not recognise they have been incontinent will need to be cleaned and changed and can be very assertive in resisting any attempt to remove their clothing and attempts to clean them.

Supporting people with dementia takes skill, compassion and patience. We know that these situations can become breaking points for the people and the care workers, putting people, workers and placements as risk. However the first approach must be to find individual solutions. Knowing the people you are caring for and having continuity of carers are critical to providing successful care and preventing difficult situations from being triggered or escalating.

- **identifying best practice, and the effectiveness of initiatives introduced so far to reduce inappropriate prescribing of anti-psychotics;**

We are particularly aware of initiatives undertaken by

Alzheimer's Society, FITS programme.

https://www.alzheimers.org.uk/download/downloads/id/2262/fits_into_practice_summary_report.pdf

Swansea University:

https://cronfa.swan.ac.uk/Record/cronfa1810

Order of St John's care homes in England and their use of Admiral Nurses

https://www.osjct.co.uk/assets/downloads/Burdett_Trust-Admiral_Nurse_Evaluation-Final.pdf

Common to these programmes are:

1) The importance of ongoing medication review of people prescribed antipsychotics;
2) Monitoring Behavioural Psychological Symptoms of Dementia or similar pre and post changes in medication and
3) Support and training to care homes.

- **use of anti-psychotic medication for people with dementia in other types of care settings.**

This is not something CSSIW has information on.

Introduction

1. The Welsh NHS Confederation welcomes this opportunity to respond to the Health, Social Care and Sport inquiry into the use of anti-psychotic medication in care homes.

	The Welsh NHS Confederation response to the inquiry into the use of anti-psychotic medication in care homes.
Contact:	Callum Hughes, Policy and Research Officer, Welsh NHS Confederation. [redacted] Tel: [redacted]
Date created:	April 2017

2. The Welsh NHS Confederation represents the seven Local Health Boards and three NHS Trusts in Wales. We support our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

3. Anti-psychotics are a group of medications usually used in the treatment of mental health conditions such as schizophrenia. They are sometimes inappropriately prescribed to control the behavioural and psychological symptoms of dementia, where their use is commonly associated with a significantly increased risk of harm. Reducing the number of people with a dementia diagnosis inappropriately receiving such medication in care homes has been identified as a key action in the Welsh Government's Draft Dementia strategy.

4. To deliver on such a commitment, work must be done to ensure the effective provision of multi-disciplinary teams within care homes. This means ensuring the provision of effective integration frameworks between neighbouring Local Health Boards and Local Authorities, and also between Local Health Boards and individual care homes. There is also a need to reshape our relationship with dementia patients so that we treat them as partners in these changes and utilise the insights gained through direct experience of living with dementia to further our understanding of the condition and the role played by anti-psychotics within this process.

5. An ageing population and an increasing number of people with multiple long term conditions has meant that utilising medication has become a way of managing often complex behavioural and psychological issues. Where dementia is concerned, it is estimated that between 40,000 - 50,000 people in Wales are currently living with the condition[i]. Against this background, we welcome the Health, Social Care and Sport Committee's interest in this area.

6. Our response will address the terms of reference to the inquiry in turn.

The availability of data on the prescribing of anti-psychotics in care homes, to understand prevalence and patterns of use;

7. The lack of a central point of data makes it difficult to benchmark the level of anti-psychotic prescribing at a care home level as such data is linked back to the prescribing GP, of which there may be many covering one care home. This makes it difficult to identify patterns of use.

8. As such, the only data available to our members in relation to the use of anti-psychotic medication across the relevant Local Health Board would be available only as a result of a manual audit of GP records or an analysis of individual care home prescribing records. However, this can be more difficult for Health Boards with large population bases.

9. Numerous audits have been carried out by Local Health Boards and are ongoing. One of the key findings has been that the use of anti-psychotics is best undertaken during a holistic patient review, including the patient's need for an anti-psychotic by the GP or pharmacist during the regular polypharmacy medication review, rather than being reviewed in isolation.

Prescribing practices, including implementation of clinical guidance and medication reviews;

10. The use of pharmacological interventions to treat the behavioural and psychological symptoms of dementia should only be used when patients are severely distressed, or there is an immediate risk of harm to self or others. The cerebrovascular risk of anti-psychotics needs to be discussed, and target symptoms should be identified quickly so that changes to a patient's medication can be made. Furthermore, the decision to use anti-psychotics should be made only after an individual risk-benefit analysis and monitored closely, with reviews every three months at least.

11. However, it must also be remembered that, while in some cases the clinical view is that medication to relieve severe anxiety may be in a person's best interest, this must be part of a regularly reviewed care plan and not simply considered a convenient and accessible method of subsiding challenging behaviour as and when it arises. These prescribing practices are in accordance with the NICE-SCIE guideline on supporting people with dementia and their carers in health and social care settings.

12. Clinicians within Local Health Boards are broadly aware of such guidelines, but there can be resistance from care homes to reducing or stopping the use of anti-psychotics for fear of relapse. It is encouraging however that our members have reported a number of cases where patients who previously resisted reducing or stopping their anti-psychotic medication have done so in a safe and controlled manner following a discussion with a Nurse Prescriber. Referrals and admissions have reduced significantly the use of anti-psychotic medication in these cases. However, it could be argued that routine prescribing reviews are not the most effective use of a Consultant Psychiatrist's time. An alternative would be for a non-medical prescriber, or an in-reach nurse, to undertake these reviews with an emphasis on educating staff members around medication reduction and support for care homes, thus allowing more time to be freed up for more urgent reviews.

13. It is encouraging also that there have been examples of our members setting up polypharmacy medication pro-forma/review sheets which can be modified by individual practices. These documents will allow care home workers to monitor patient progress and record recommendations for change for patients taking in excess of four different types of medicine. Moreover, reviews have been carried out by specialised teams focusing on the prescription of

anti-psychotic medication for elderly people in accordance with NICE guidelines, the Medicines and Healthcare Products Regulatory Agency (MHRA) recommendations and Local Health Board guidance.

The provision of alternative (non-pharmacological) treatment options;

14. Strategies designed to manage behaviours that often lead to the prescription of anti-psychotic medication services need to be implemented as a whole system approach. This process starts with ensuring the provision of less restrictive and safe therapeutic environments in line with prudent healthcare principles, examples of which may include pleasant outside space or quiet rooms.

15. However, for some care homes and cognitive stimulation groups, it is significantly more challenging to adopt such measures due to an insufficient number of permanent staff members currently employed in local care homes. Reduced occupational therapy resources often mean that opportunities for alternative treatments become even more challenging, despite the fact that our members have made it clear that such functions could be delivered and promoted more effectively by an in-reach worker.

Training for health and care staff to support the provision of person-centred care for care home residents living with dementia;

16. It is encouraging that inpatient dementia wards, in some areas, have activity co-ordinators whose responsibility it is to personalise therapy and patient activities to reduce stress and agitation. It is also encouraging that similar teams have been set up to offer a practical, hands-on approach to integrating non-pharmacological approaches in addressing behavioural challenges for patients living with dementia. Such teams have offered advice and consultation to care home staff to emphasise the importance of exploring alternative treatments in accordance with NICE guidelines.

17. A considerable proportion of training for health and care staff to support the provision of care for residents living with dementia is now done online. It is encouraging that such online resources have incorporated pre-existing materials from the relevant Local Authority and third sector partners, thus developing the integration agenda. There are also a number of projects currently ongoing between GP practices and care homes with a view to identifying residents who show early signs of dementia and the various ways in which carers can respond to their condition. Alternative ways of working have developed in other areas, such as the introduction of a dementia checklist for managing the behavioural and psychological symptoms associated with dementia, and there are a number of good examples of such specialist care being delivered within care homes.

18. However, while it is encouraging to see e-learning on such a scale, a lack of capacity in some areas has meant that it is difficult to provide specialist teaching for staff members to support the provision of care for patients living with dementia. Moreover, while it is undisputed that there are a number of effective initiatives ongoing, there remains considerable space for sharing good practice and training. In particular, there is a great opportunity for Local Authorities and care homes to closer align their ways of working to develop enhanced care settings. This would also be improved by an in-reach role where the training procedures could be repeated, relationships with homes improved and focused on the reduction in the prescribing of anti-psychotic medication.

Identifying best practice, and the effectiveness of initiatives introduced so far to reduce inappropriate prescribing of anti-psychotics;

19. A number of reviews have taken place across Wales in recent years aimed at reducing the prescription of anti-psychotic medication. The results are, broadly speaking, encouraging, though significant challenges around workforce capacity and the sustainability of such measures remain.

20. One of our members in particular is currently piloting the adoption of a new strategy aimed at improving communication on discharge from hospital and ensuring that an indication and a review date is included on any transfer of care documentation to be handed to the patient. This strategy has been brought about following a previous ambitious effort to enhance collaborative ways of working between GPs, pharmacists, care homes, nurses and consultants – while the model was successful in bringing about a reduction in the prescribing of anti-psychotic medication, it was not sustainable and was subsequently discontinued. It is promising however that the Local Health Board in this instance has agreed that an indication and review date will be added to every anti-psychotic prescription for challenging behaviour in dementia.

21. It is encouraging also that a number of Local Health Boards have recently undertaken medication reviews in care homes when requested. These practices have proven particularly effective for patients immediately after their hospital discharge or upon the request of a nurse assessor visiting a particular care home. Reviews are conducted in the care home and in front of the patients themselves, thus involving them as much as possible in their own care and with access to the GP record so that changes in a patient's medication can be quickly reconciled and implemented. Additionally, primary care cluster/local pharmacist roles have been developed as extra clinical pharmacist support which has brought about a greater focus on care home medication reviews. Polypharmacy toolkits such as NOTEARS and STOPP START have been developed and utilised to support medicine optimisation in the medication review process too.

The use of anti-psychotic medication for people with dementia in other types of care settings;

22. It is important to note at the outset that the emphasis on the need to avoid hospital admission means that the likelihood of an individual being prescribed anti-psychotics to keep them at a care home invariably increases. It follows therefore that training for care agencies could be improved to enable home carers to be better able to manage the behavioural problems associated with patients living with dementia without asking for medication.

23. Two Local Health Boards have distributed information leaflets to carers with a view to raising awareness of the risks and benefits of using anti-psychotic medication for patients living with dementia. Both have been recognised as best practice and consideration will be made for ways of monitoring service user feedback. Also, mental health liaison practitioners have been made available in some Local Health Boards to improve the management of dementia patients on non-mental health wards.

Conclusion

24. It is positive to see that a range of approaches are being taken to address the ineffective use of anti-psychotic medication in care homes across Wales. It is suggested that frameworks be established to allow for improved communication and the co-ordination of best practice and learning between Local Health Boards and between care homes to maximise learning

opportunities. This will enable consistent and standardised practices. It is suggested also that this work be undertaken in conjunction with dementia care mapping to identify and gather examples of good practice and wellbeing.

[i] Welsh Government/ Statics for Wales, October 2016. General Medical Services contract: Quality and Outcomes Framework statistics for Wales, 2015-16.

Additional information from Community Pharmacy Wales, following the committee meeting on 5 October 2017

1. Out of the seven Health Boards in Wales only three have a community pharmacy care home service being provided by local pharmacies. These are Hywel Dda (15), Abertawe Bro Morgannwg (13) and Powys (3). During the 2016-17 financial year only 31 pharmacies were paid for the provision of this service in Wales. The figures in brackets show the number in each of the three Health Board areas.
2. The support offered to care homes is broadly similar in nature and the attached service specification for the Powys service. The service is fairly basic in nature, focussing in the main on the processes and procedures in the care home and the relevant section (4.20) is reproduced below. :-

The pharmacist shall support the home and provide appropriate advice which may include, but not be limited to:
4.20.1. The proper and effective ordering of drugs and appliances for the benefit of residents in the home, and to minimise waste.
4.20.2. The safe and appropriate storage of drugs and appliances within the home.
4.20.3. The proper and effective administration and use of drugs and appliances in the home.
4.20.4. The safe disposal of medicines.

3. Sam and I mentioned in response to a number of questions that that CPW have produced a template service that is a broader service and that CPW are willing to update the template service to include an element that focusses on the use of antipsychotic medication in care homes and also to ensure that the update incorporates the relevant recommendations arising from the Inquiry.

If you need further information please do not hesitate to ask.

Regards,

Steve Simmonds

Contractor Services Development Executive

Community Pharmacy Wales

COMMUNITY PHARMACY ENHANCED SERVICE: ADVICE TO CARE HOMES

This document describes the specification and standards pertaining to the provision of community pharmacy "Advice to Care Homes" Enhanced Service. This document does not constitute a Service Level Agreement (SLA) although the provisions within the document will be contained within an SLA between the Local Health Board and pharmacy contractor for the provision of the service.

INTERPRETATION

In this document:

Care Home means an establishment providing accommodation, together with nursing or personal care, for any persons who are or have been ill, have or have had a mental disorder, who are disabled or infirm or who are or have been dependent on alcohol or drugs.

Pharmacist means a registered pharmacist, or any person providing any part of the service on behalf of a pharmacist, provided that it is legal for them to do so;

Pharmacy means any premises where drugs are provided by a pharmacist as part of pharmaceutical services;

Pharmacy contractor (or contractor) means a person lawfully conducting a retail pharmacy business.

Registered Pharmacist means a person who is registered in Part 1 of the GPhC register or in the register maintained under Articles 6 and 9 of the Pharmacy (Northern Ireland) Order 1976;

Registered Pharmacy Technician means a person who is registered in Part 2 of the GPhC register.

PART A

1. SERVICE AIM

1.1. To support the effective management of medication within registered care homes by regular audit and the provision of advice & support by pharmacists and/or pharmacy technicians.

2. SERVICE OUTCOMES

2.1. Improved performance against recognised standards of administration and wider medicines management;

2.2. Improved patient safety through the implementation of safe administration procedures and maintenance of clear records;

2.3. Reduction in wastage associated with inappropriate ordering and use of medicines and appliances;

2.4. Improved awareness amongst care home staff of the advice and support available from community pharmacy;

3. SERVICE ELIGIBILITY

3.1. The service may only be provided to Care Homes located in Powys and registered with Care & Social Services Inspectorate Wales (CSSIW) under the provision of the Care Standards Act 2000 to provide residential, nursing or joint care to adults.

3.2. Homes must be registered with CSSIW to provide care to at least 5 residents.

3.3. At any one time, homes may only be provided with the service by a single pharmacy.

4. SERVICE OUTLINE

4.1. The Pharmacist will offer a user-friendly, non-judgmental, patient-centred and confidential service;

PROVIDER RESPONSIBILITIES

Contractors

4.2. Contractors wishing to provide the service shall apply to their Local Health Board in the format set out in Part B.

4.3. For each care home the contractor wishes to provide the service for, an agreement form as set out in Part D shall be submitted to the Local Health Board;

4.4. The contractor shall ensure that the service is provided under the direct supervision of registered pharmacists or pharmacy technicians who:

4.4.1. Meet the requirements of the National Competence and Training Framework for the service; and

4.4.2. Have a current certificate demonstrating compliance with 4.4.1; and

4.4.3. Have their names included in the All Wales Pharmacy Database for the service.

4.5. The contractor shall ensure that pharmacists or pharmacy technicians involved in providing the service have indemnity insurance covering the provision of the service.

4.6. All support staff shall be fully informed and suitably trained in relation to their involvement in the service which may include the provision of any part of the service provided on behalf of an accredited pharmacist, provided that it is legal for them to do so.

4.7. The contractor shall have awareness of, and ensure the service is provided in accordance with any relevant standards (e.g. General Pharmaceutical Council (GPhC), Royal Pharmaceutical Society (RPS) and CSSIW)

4.8. The contractor shall ensure that all standards required by the General Pharmaceutical Council, so far as they relate to pharmacy owners and superintendent pharmacists, are met.

4.9. The contractor shall ensure that, prior to entering into any agreement to provide the service; they are satisfactorily complying with his or her obligation under Schedule 2 to the Pharmaceutical Services Regulations to provide pharmaceutical essential services and have a system of clinical governance that is acceptable.

4.10. The contractor shall participate in any reasonable publicity of the availability of the service required by the Local Health Board and shall not publicise the availability of the service other than with the agreement of the Local Health Board.

4.11. The contractor shall notify the Local Health Board of circumstances which result in the temporary unavailability of the service for any period which would preclude a care home receiving a visit as set out in 4.14 to 4.18.

Registered Pharmacists and Pharmacy Technicians

4.12. Registered Pharmacists and Pharmacy Technicians wishing to provide the service shall apply to their Local Health Board in the format set out in Part C.

4.13. The Pharmacist shall have awareness of, and ensure the service is provided in accordance with any relevant standards (e.g. General Pharmaceutical Council (GPhC), Royal Pharmaceutical Society (RPS) and CSSIW)

4.14. The Pharmacist should arrange a mutually convenient appointment to visit the care home in the first 6 months of the agreed period of service;

4.15. During the visit, the pharmacist must fully complete a paper or electronic copy of the *Medication Management Assessment* and provide advice and support as considered necessary;

4.16. Copies of the completed assessment together with details of any recommended actions should be provided to the care home and Powys tHB Medicines Management dept within 14 days of the visit;

4.17. Where the care home is routinely supplied with medication by a pharmacy/GP dispensary other than the contractor, the Pharmacist should take steps to ensure that where appropriate, the supplying contractor is made aware of relevant actions.

4.18. The pharmacist should arrange a mutually convenient appointment to visit the home 5-7 months after the first visit. During this second visit the pharmacy should undertake an assessment as specified in 4.14 to 4.17 and assess the care home's progress with any previously recommended actions;

4.19. Where the pharmacist has cause for concern about one or more aspects of the care home's medication management, or the home fails to address significant actions, they should immediately notify CSSIW and/or Powys tHB;

4.20. The pharmacist shall support the home and provide appropriate advice which may include, but not be limited to:

4.20.1. The proper and effective ordering of drugs and appliances for the benefit of residents in the home, and to minimise waste.
4.20.2. The safe and appropriate storage of drugs and appliances within the home.
4.20.3. The proper and effective administration and use of drugs and appliances in the home.
4.20.4. The safe disposal of medicines.

4.21. Advice provided should not deliberately undermine confidence in or compromise relationships between the care home and other healthcare providers, including other community pharmacies.

4.22. Where the home requires advice and support considered to be beyond the scope of this service the pharmacist should inform Powys LHB Medicines Management Dept. as soon as practical

5. LOCAL HEALTH BOARD RESPONSIBILITIES

5.1. The Local Health Board shall provide contractors with sufficient copies of the *Medicines Management Assessment* in paper or electronic format as required;

5.2. The Local Health Board, or its authorised officers, shall determine the fees and allowances payable in respect of the service;

5.3. The Local Health Board shall enter into a Service Level Agreement (SLA) with all pharmacies commissioned to provide the service.

5.4. The Local Health Board, or its authorised officers, shall support the resolution of difficulties so far as they relate to issues within the control of the Local Health Board;

5.5. The Local Health Board, or its authorised officers, shall support the handling of any complaints or issues relating to the service so far as they relate to issues within the control of the Local Health Board.

6. WELSH GOVERNMENT RESPONSIBILITIES

6.1. The Welsh Government shall make provision for the details of each pharmacy providing the service to be included in the All Wales Pharmacy Database;

6.2. The Welsh Government shall make provision for the details of each pharmacist, approved to provide the service, to be included in the All Wales Pharmacy Database and shall ensure reasonable access for contractors wishing to verify the accreditation of pharmacist;

7. CONFIDENTIALITY AND DATA PROTECTION

The Provider will ensure that any Named Person shall not, whether during or after their appointment, disclose or allow to be disclosed to any person (except on a confidential basis to their professional advisers) any information of a confidential nature acquired by the Provider or any Named Person in the course of carrying out their duties under this Agreement, except as may be required by law or as directed by the Commissioner.

The Provider must protect personal data in accordance with the provisions and principles of Data Protection Act and the Confidentiality: NHS Wales Code of Practice, and must ensure that all staff that have access to such data are informed of, and comply with this requirement.

The Provider shall at all times ensure that appropriate technical and organizational security measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

The Provider must be aware that the any information held by the Welsh Assembly Government, Local Health Boards or their authorised officers, may be subject to disclosure under the Freedom of Information Act.

8. AUTHORISED OFFICERS

For the purpose of the service the Welsh Government and Local Health Boards shall inform the provider immediately, in writing, of the details of any officer authorised to act on its behalf. Any notice, information or communication given by the authorised officer shall be deemed to have been given by the Welsh Assembly Government or Local Health Board as the case may be.

9. REVIEW VARIATION AND TERMINATION

The service specification shall be reviewed at least annually.

Variation to the service specification can only be made following consultation with Community Pharmacy Wales.

Contractors will be notified of any variations to the service specification in writing. No variation to the specification will be made until 90 days after that notice is received.

Providers, as signatories to the SLA, may cease to provide the service by giving notice in writing to the Local Health Board. In the event of such notice the service will be terminated 90 days after that notice is received.

10. FEES AND ALLOWANCES

10.1. The contractor shall receive a payment following completion of the second visit as set out in 4.18;

10.2. The level of payment is determined by the number of registered places in the care home as set out below;

5-10 places	£175.00
11-30 places	£245.00
31-50 places	£310.00
51+ places	£400.00

10.3. Claims for payment shall be subject to Local Health Board arrangements for Post Payment Verification.

10.4. Fees for the provision of the service are based on the requirements of the Community Pharmacy National Enhanced Services Competency and Training Framework.

PART B – PREMISES LISTING FORM

NHS PHARMACEUTICAL SERVICES – ENHANCED SERVICE ADVICE TO CARE HOMES

Contractor application form which is to be submitted to the Local Health Board (LHB) by a pharmacy or contractor requesting approval to provide the Enhanced Service – Advice to Care Homes

TO BE COMPLETED BY OR ON BEHALF OF THE PHARMACY CONTRACTOR

Name of pharmacy contractor: _____

Correspondence address: _____

_____

_____

Postcode: _____

Pharmacy Stamp

Prescribing Service Unit number: _____

Date of application: _____

CERTIFICATIONS, AGREEMENTS AND DECLARATIONS (please tick to confirm)

I / We confirm that the pharmacy contractor has an acceptable system of clinical governance and is complying with any obligation under Schedule 2 to the Pharmaceutical Services Regulations to provide pharmaceutical essential services ☐

I / We confirm that the pharmacy contractor will comply with any relevant service specification relating to the provision of this Enhanced Service ☐

I / We confirm that I / We shall notify the Medical Director of the relevant LHB of any significant adverse incident which arises due to or related to provision of this Enhanced Service ☐

DECLARATION

I / we declare to the best of my/our belief that the information on this form is correct and request that the contractor named herein be included in the list of contractors who may provide this Enhanced Service.

Authorised Signature: _____ Date: / /

Name: _____

Please submit this form to:
Medicines Management Dept
Powys Local Health Board
Basil Webb
Bronllys
Brecon
Powys
LD3 0LU

Fax [redacted]

E mail [redacted]

For Office Use Only

Application Checked by: _____ Date: / /

Authorised: Yes ☐ No ☐

Reason if not authorised: _____

PART C – PHARMACIST/ PHARMACY TECHNICIAN LISTING FORM

NHS PHARMACEUTICAL SERVICES – ENHANCED SERVICE ADVICE TO CARE HOMES

Pharmacist /Pharmacy Technician application form which is to be submitted to the Local Health Board (LHB) by a pharmacy or contractor requesting approval to provide the Enhanced Service – Advice to Care Homes.

TO BE COMPLETED BY OR ON BEHALF OF THE PHARMACIST

Name of pharmacist / pharmacy technician _____

General Pharmaceutical Council Registration number: _____

Correspondence address: _____

_____

_____

Postcode: _____

Telephone number: _____

E mail address: _____

Date of application: _____

CERTIFICATIONS, AGREEMENTS AND DECLARATIONS (please tick to confirm)

I confirm that:

I have been assessed as meeting the requirement of the National Competence and Training Framework for the service and have a certificate confirming this to be correct ☐

I enclose a copy of relevant WCPPE certificate ☐

I agree to the details included in this form being included in the All Wales list of pharmacists approved to provide this service ☐

I agree to provide the community pharmacy advice to care homes service in accordance with the service specification ☐

I shall notify the Medical Director of the relevant LHB of any significant adverse incident which arises due to or related to provision of this Enhanced Service ☐

DECLARATION

I declare that the information on this form and any evidence provided is correct and I seek acceptance as a provider of this Enhanced Service.

Applicant Signature: _____ Date: / /

Please submit this form to:
Medicines Management Dept
Powys Local Health Board
Basil Webb
Bronllys
Brecon
Powys
LD3 0LU

Fax [redacted]

E mail [redacted]

For Office Use Only

Application checked by:			Date:	/ /
Approval requirements met:	Yes ☐	No ☐		
Request approved:	Yes ☐	No ☐		

PART D – CARE HOME AGREEMENT FORM

NHS PHARMACEUTICAL SERVICES – ENHANCED SERVICE ADVICE TO CARE HOMES

Contractor / care home service agreement form which is to be submitted to the Local Health Board (LHB) by a pharmacy intending to provide the Enhanced Service – Advice to Care Homes

Pharmacy Contractor _____

Care Home _____

Address _____

_____

Telephone No. _____

Person in Charge _____

Type of Home Nursing / Residential / Mixed

Number of Registered Beds _____

Agreement	The pharmacy agrees to provide the home with advice and support as specified in the *Advice to Care Homes* enhanced service. The care home has been informed about and agrees to the pharmacy being the single provider of the enhanced service. The home agrees to the pharmacy sharing relevant information with Powys tHB.

Signed on behalf of Pharmacy _____ Date: _____

Signed on behalf of Care Home _____ Date: _____

Agreement Checked by: _____ Date: / /

Authorised: Yes ☐ No ☐

Reason if not authorised: _____

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA/P/VG/3498/17

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

10 October 2017

Dear Dai,

Thank you for your letter of 2 October regarding the upcoming Committee inquiry into suicide prevention.

The Welsh Government's 'Talk to Me 2' strategy is overseen by the National Advisory Group chaired by Dr Ann John. To confirm, a mid-point review of the implementation of the strategy will be published in February 2018.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

Cynulliad Cenedlaethol Cymru
National Assembly for Wales
Public Accounts Committee

Dr Andrew Goodall
Director General Health & Social Services/NHS Wales
Chief Executive
Welsh Government
Cathays Park
Cardiff CF10 3NQ

11 October 2017

NHS Finance (Wales) Act 2014

Dear Dr Goodall,

Thank you for attending the Public Accounts Committee on 10 July 2017 to discuss the NHS Finance (Wales) Act 2014. The Committee considered this to be an important topic for scrutiny given that at the end of first three year period, four out of seven University Health Boards were in deficit and had had their accounts qualified. Following the meeting, the Committee agreed it was useful I wrote to you with our observations, which I have copied to the Chair of the Health, Social Care and Sport Committee as they will be relevant to the ongoing scrutiny of the Health and Social Services budget.

The Committee welcomes the moves within health boards to start planning on, at least, a medium term that the act has introduced. However, we have some concerns about an over-reliance on in year funding, which is an issue we have raised as a Committee previously. We found the experience set out by Mr Brace while he was in Aneurin Bevan interesting, particularly that it was '…a reinforcement to take a medium-term look'. We would encourage best practice from those Health Boards functioning within the act to be shared to those that have failed to discharge their duties under the act.

Cynulliad Cenedlaethol Cymru
Bae Caerdydd, Caerdydd, CF99 1NA
SeneddArchwilio@cynulliad.cymru
www.cynulliad.cymru/SeneddArchwilio
0300 200 6565

National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA
SeneddPAC@assembly.wales
www.assembly.wales/SeneddPAC
0300 200 6565

The Committee were interested to hear about the Finance academy, which seems to be a good model, and we intend to follow this as it develops a model for sharing best practice. In addition to ensuring those who work for the NHS receive the necessary training, we also believe it is important to ensure that there are also mechanisms to ensure everybody accountable e.g. Board members also have the necessary understanding of NHS finance to monitor and hold the staff effectively to account.

As a Committee, we welcome that Welsh Government are now using escalation framework to set out their expectations and provide support to those organisations not meeting them. We believe that it is very important that the deficits are shown clearly on balance sheets to aid comprehension of the financial situation within each Health Board. Moving forward, the Committee will be expecting to see improvements for the next reporting period. In particular, we anticipate marked improvements in Hywel Dda following the implementation of the zero budgeting report which was imminent when we took evidence from you in July.

Yours sincerely,

Nick Ramsay AM
Chair

Cc: Dr Dai Lloyd AM, Health, Social Care and Sport Committee