National Assembly for Wales
Health, Social Care and Sport Committee

Community and district nursing services
Consultation Responses

March 2019

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National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Hospice UK

1. About Hospice UK

1.1 Hospice UK is the national charity for hospice care. We champion and support the work of more than 200 member organisations, which provide hospice and palliative care across the UK, so that they can deliver the highest quality of care to people with terminal or life-limiting conditions, and support their families. Our vision is hospice care for every person in need and our mission is to enable hospice care to transform the way society cares for the dying and those around them.

2. About Hospices Cymru

2.2 Hospices Cymru is the collective voice of Hospice UK members in Wales. This includes the 13 adult hospices and the two children's hospices in Wales. The group seeks to advance hospice care and enable better palliative and end of life care for more people in Wales.

3. About this response

3.1 We welcome the opportunity to respond to this consultation on district and community nursing services in Wales. Hospice UK provides secretariat to the CPG Hospices and Palliative Care, which drew attention to the need for an inquiry into community and district nursing as the cornerstone of hospice and palliative care delivered to adults and children in their own homes and care homes, in evidence to the Health, Social Care and Sport Committee on 13 December 2018.

3.2 This response draws on the experience of hospices in Wales working in partnership with community nursing services to support people with terminal or life-limiting conditions and those at the end of life. We have therefore limited our comments to the role of community nursing in the delivery of hospice and palliative care.

4. Context: the involvement of community nursing in hospice and palliative care

4.3 District and community nurses organise and coordinate home health care for people with palliative and end of life care needs. For people with specialist palliative care needs, the community nurse is advised and supported by a palliative care clinical nurse specialist (CNS) and/or consultant in palliative medicine. The delivery of hands-on care around the clock may be provided by the community nursing team, including by health care support workers (HCSW) or assistants, or by a hospice at home service. The HCSW or hospice at home service

may be funded and organised by the health board, by a charitable hospice, or a combination of both, dependent on which area of Wales the person resides in.

4.4 Children and young people with palliative care needs are cared for by the health board community children's nursing (CCN) services, who are advised by a specialist paediatric palliative care nurse located in each health board. Each health board organises and funds its own CCNS. Across Wales there is variation in the funding of the paediatric palliative care nurses who advises the CCNS teams delivering hands on care, with some funded entirely by their hosting health board, others funded entirely by all-Wales monies through the End of Life Care Implementation Board, and others part funded by both sources.

5. Policy context

5.5 In line with the Welsh Government's vision in 'A healthier Wales'[i], the End of Life Care Board has prioritised improving access to hospice at home services each year from the End of Life Care Delivery Plan's inception in 2017.[ii] Reporting on progress implementing this priority area in 2018 is expected in the forthcoming End of Life Care Delivery Plan Annual Report (March/April 2019).

5.6 Despite the crucial role that community nursing plays in enabling a person with palliative care needs to remain at home for as long as possible and the reliance of specialist palliative care providers in the community on the community nursing services, very few direct references are made to community and district nursing within the Welsh Government and NHS Wales Palliative and End of Life Care Delivery Plan 2017-20, indicating that strategic planning in these areas are happening in isolation.

5.7 In September 2018, the then Cabinet Secretary for Health and Social Services accepted in full the recommendation made by the Cross Party Group on Hospices and Palliative Care Inquiry, 'Inequalities in access to hospice and palliative care' regarding the provision of community nursing:

> The End of Life Care Implementation Board should develop a robust action plan to address shortages in community nursing for both children and young people, and adults with palliative care needs.
>
> a) The equitable delivery of palliative care in the community for adults at the end of life is dependent on the local availability of an appropriately qualified community workforce. The End of Life Care Implementation Board, in partnership with health boards, adult hospices and third sector providers of specialist nurses, must address the gaps in this workforce, including succession planning. This should consider the District Nursing service as a priority, as well as the appropriate resourcing of Community Resource Teams and the distribution of staff with palliative care skills.
>
> b) Children and young people with life-limiting conditions should have the same choices about preferred place of care and/or death as adults at the end of life. For this to happen, the variation in numbers and skills of community paediatric nurses must be addressed to enable the delivery of

end of life care for children in their own homes. The End of Life Care Implementation Board should work with health boards and children's hospices to identify gaps in extant provision and work together to enhance the skills needed to support current community teams to develop community paediatric nurses with appropriate qualifications in paediatric palliative care. This should involve creating specialist posts to support the development of the existing workforce, where necessary.[iii]

6. Acuity and level of need for district nursing for people with palliative and end of life care need, now and into the future

6.1 The Welsh Government estimates that around 23,000 people die in Wales each year with a palliative care need,[iv] though more recent academic estimates have placed this figure higher at around 28,000.[v] These are people whose deaths could reasonably be predicted because of conditions such as cancer, COPD, organ failure, dementia and frailty.

6.2 In its 'Future Trends Report' the Welsh Government highlights that the number of people aged over 65 is set to be 40 per cent higher by 2039 than in 2014.[vi] With people over 65 accounting for 85 per cent of all deaths,[vii] palliative care providers are likely to see a greater volume of people with end of life care needs by the end of this period.

6.3 Despite these estimates of need, data is not currently available to assess the total number of people in Wales who have received the right hospice or palliative care, delivered by the right services, at the right time. This includes an absence of data on the number of people with palliative and end of life care needs who have been cared for by community nursing services. This is because data at a national level is held on the total number of people who receive specialist palliative care (11,000 people in 2016-17),[viii] and separate data on the total number of people who are known to their GP as needing palliative care (as recorded on the GP palliative care register – 10,000 people in 2016-17),[ix] but it is not possible to cross reference these at an individual level to understand the patient journey. Without greater clarity on who is being cared for, where, and by whom, it is impossible to accurately determine the level of unmet need for palliative care more widely in Wales or to quantify the real, and the potential need for input, from community nursing services to meet every person's need for community palliative care.

6.4 Of the total number of deaths each year in Wales, 24 per cent of people died in their own homes and 16 per cent in a care home.[x] These people would likely have received care from their community nursing service, as well as from a host of other agencies, such as social care, their GP, and hospice and specialist palliative care nurses and consultants.

6.5 The Welsh Government has recognised the value and importance of Advance and Future Care Planning to improve people's experience of end of life care.[xi] Evaluations demonstrate that, where an ACP is in place, the home death rate for people receiving hospice care rises to 40 per cent in comparison with the national average of 24 per cent.[xii]

6.6 While community nursing services support people with palliative care needs in their own home throughout their illness, their input is likely to significantly increase as the person requires end of life care during their final weeks of life. Access to the community nursing service, as well as appropriate social care, around the clock is essential if a person is to remain at home for as long as possible and to avoid unnecessary hospital admissions or a call out to the emergency services, if that is their preference.

Children's numbers

6.7 At any given time, an estimated 1,050 children and young people in Wales will have a palliative care need;[xiii] of these, around 10 per cent, or 105 will die each year.

6.8 Children with palliative care needs may receive routine care from their CCNS throughout their lives but are particularly reliant on the service as they approach end of life, if their family preference is to be cared for at home.

7. Challenges and ways forward: workforce and resource

7.1 General feedback from hospice teams working alongside community and district nursing services report that the service is over-stretched and under-resourced, meaning that district nurses can find it difficult to attend multi-disciplinary team meetings to discuss palliative care patient caseloads.

7.2 Hospice services likewise noted that resource management in the organisation of district nursing teams has seen the service move from a culture of 'calling in' on patients on the caseload to a more task-based approach. This means that if there is no specific task to be undertaken, e.g. administering medication through a syringe driver, then a person may have no contact with their district nurse or healthcare staff and could go a significant period without hands on care.

7.3 With limited resource, greater proportions of community nursing teams are comprised of HCSWs as opposed to registered nurses. While this is an appropriate way to reach greater numbers of people within budget, this can have implications for the provision of hands on palliative care. For example, across Cardiff and Vale University Health Board the hospice at home service is primarily comprised of HCSWs, who are able to provide personal care for people at the end of life but are not able to administer medications, such as for pain relief and symptom control.

7.4 Limited numbers of registered nurses within the community nursing team can have particular implications during out of hours periods. Anecdotally, we hear that district nurses have to manage patient and family expectations about the level of contact and care they can expect during out of hours periods. This, in turn, can make people and their families nervous about the prospect of remaining at home for their care and more likely to seek an emergency admission to hospital. In some areas of Wales the charitable hospice and district nursing service work together to supplement out of hours nursing care. For example, Paul Sartori Hospice at Home retains one registered nurse to work on an evening, seven nights a week. This nurse is not allocated to a patient until late in the afternoon or

evening, leaving them available to deliver urgent, same-day referrals for overnight respite care from the district nursing teams in the area. Similar models rolled out elsewhere could support the delivery of end of life care at home – where registered nursing skills are required – during out of hours periods.

7.5 The Cross Party Group on Hospices and Palliative Care 2018 inquiry into inequalities in access to hospice and palliative care heard that children are less likely to be able to be cared for at home at the end of life than adults because of the significant shortage of CCNs with appropriate palliative care skills.

7.6 While it is recognised that there is an ageing workforce and there is a lack of trained children's nurses throughout Wales, the number of places allocated for training is not considered adequate by those working in community paediatric nursing to address the current and future shortage. Places are limited to 135 each year with upwards of 1,000 applicants.

7.7 End of life care services for children and young people are often time-limited as CCNs cannot be released for longer periods to offer tailored, personalised support to dying children and their families. For example, while the COINS service (Palliative Care Children's Outreach In reach Nursing Service) operating across Hywel Dda University Health Board is to be welcomed as a step forward in widening access to 24 hour end of life care for children and young people in the area, wherever the child resides, it is not sustainable beyond a period of seven to ten days care.

7.8 Working together to address the current workforce shortages in areas most in need, Tŷ Hafan has recently jointly funded CCN posts with Powys Teaching Health Board and Abertawe Bro Morgannwg University Health Board, specifically to support children and young people with life-limiting conditions in the community setting. It is envisaged that the post holders will increase capacity in the community setting to deliver hands-on care as well as benefiting from developing specialist palliative caring skills that can be disseminated to others within the team. The hospice is exploring the potential to partner with other health boards in its catchment to increase capacity in the community nursing workforce where this is feasible.

8. For further information

8.1 Please contact xxxx, Policy and Advocacy Manager (Wales), Hospice UK or xxxx, Head of Policy and Advocacy

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[i] Welsh Government (2018).'A Healthier Wales'.
[ii] Welsh Government (2017).'Palliative and end of life care delivery plan: March 2017'.
[iii] CPG Hospices and Palliative Care (2018).'Inequalities in access to hospice and palliative care: challenges and opportunities'.
[iv] Welsh Government (2017).'Palliative and end of life care delivery plan: March 2017'.
[v] Hospice UK (2018). 'Hospice care in Wales 2018'.
[vi] Welsh Government (2017).'Future Trends Report'.
[vii] Welsh Government (2017).'Future Trends Report'.
[viii] Welsh Government (2017).'End of life care: annual statement of progress: December 2017'.

[ix] Welsh Government (2017).'End of life care: annual statement of progress: December 2017'.
[x] 2016 ONS commissioned report by Paul Sartori Hospice at Home.
[xi] https://beta.gov.wales/written-statement-advance-care-planning
[xii] Age UK (2018).'Later life in the United Kingdom'.
[xiii] Welsh Government (2017).'End of life care: annual statement of progress: December 2017'.

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Ymateb gan Fwrdd Iechyd Prifysgol Betsi Cadwaladr

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Evidence from Betsi Cadwaladr University Health Board

	Betsi Cadwaladr University Health Board response to the Health, Social Care and Sport Committee inquiry into community and district nursing services.
Contact	Gill Harris, Executive Director of Nursing and Midwifery
Date:	25.02.2019

Introduction and Overview

The development of Primary and Community services within BCUHB will be embedded in the Care Closer to Home element within the Health Board's system-wide strategy for health, well-being and healthcare, Living Healthier, Staying Well.

Care Closer to Home is age inclusive, recognising the need to adopt a life-course approach. This is a joined-up approach, with an emphasis on education and early intervention, aiming to address any implications early for long term health gain. The approach views health as a life-long journey, rather than separate disconnected stages.

The "What Matters" conversation is a simple, yet profound concept that is key to creating deeply personal engagements with individual's, carers and their family members, a deeper understanding of what really matters to them, and is the foundation of developing genuine partnerships for co-creating health.

Asking about "What Matters" will improve the individual's care plan and enhance the patient's relationship with their health care provider and in some cases, improve health outcomes. The ambition is to increase clinicians' awareness of important issues in their patients' lives that could drive customized plans of care.

The scope of the Care Closer to Home programme is very broad; it places the person and carer, wherever appropriate, at the centre with all available primary and community services inputting care and support when appropriate to meet identified needs. These range from information, advice and education through to

more specific interventions such as diagnostics, minor injuries services, community-based inpatient “step up” and “step down” care and respite.

The overarching aims of all our work should be to support wellbeing, improve health and address inequalities in health.

The broad scope of the overall Care Closer to Home programme reflects the need to address the broader factors that influence health. Crucially, the programme is one which extends beyond the role of the Health Board in isolation; it embraces work undertaken by partner organisations and importantly communities themselves. A ‘place based’ approach will be used in the development and implementation of the strategy for the future, as each local area will have different needs and also differing assets within the community.

The primary and community services elements of this programme cover a broad spectrum of care and support for all ages. This includes a wide network of services and teams: General Practice (General Practitioners – GPs - and the wider practice team), Pharmacists, Optometrists, Dentists, Therapies, Health Sciences, Community Nursing and Health Visiting teams, End of Life Care and Palliative Care Support, Primary Mental Health Services, Intermediate Care, “step up” and “step down” care, as a bridge between community and hospital care, Community Inpatient Care and Rehabilitation. Integrated Health and Social Care services are also an important part of this network, as is close working with Third Sector, Independent Sector and Community Groups, which are important assets within the community setting.

The vision for better and more sustainable healthcare rests on community based models that are co-ordinated around people’s needs and what matters to the individual.

Terms of Reference

The Health Board have 35 district nursing teams.

Headcount as follows (inclusive of current vacancies):

- Registered nurses (Band 7 – 5) = 346
- ANP/trainee ANP/NP = 21
- HCA (inclusive of Assistant practitioner at Band 4 and band 3 HCAs) = 115
- Matrons = 6
- Deputy Head of Nursing = 3 (1 vacancy)
- Administrative support within teams and senior levels = 27

We currently have registered nurses vacancies of 559.77 FTE across the whole of BCUHB and for District Nursing RN vacancies (inclusive of Band 5 -7 DN and ANP) is 37.1 FTE, this number is included in the above total vacancies.

The Data for the past 5 years Inclusive of registered and unregister District nursing staff are:

2014 – 403.82 WTE
2015 – 425.24 WTE
2016 – 477.73 WTE
2017 – 490.95 WTE
2018 – 494.98 WTE

It must be noted that the service has extended to become 24/7 in the last 2 years with additional staff recruited.

As part of the development of the Care Closer to Home strategy, there is the development of the Community Resource Teams (CRT) where the district nursing workforce plan will sit and develop. Community Resource Teams will provide integrated care (health, social care and third sector services alongside other partners) to people closer to their home and community. A CRT is consistent with Setting the Direction (2010), a locality based multi-agency, multi-disciplinary care model, enabling and enhancing the ability of GPs and the team to provide more care for people at home by promoting earlier discharge from hospital or preventing the admission altogether. This service will also facilitate more efficient use of acute and community inpatient beds whilst treating the right patient in the right place with the right skills. There will be close working relationships between primary and community care and strong links with secondary care. Third sector services will be used to complement this provision and opportunities to commission further services when gaps exist in current provision will be identified.

The CRT will have the skills and competences to meet the needs of the population outside hospital. The purpose of the work that will be to develop an efficient and integrated working model within which community services operate, covering 24 hours each day, 7days per week, supporting more individuals to be cared for in their own homes (including in care homes). The integrated teams will deliver more coordinated, person centred, seamless services to individuals. There will be improved communication, care coordination, integrated assessments and an emphasis on early intervention and “What Matters” to the individual to meet their stated needs.

Referrals into the CRT will be assessed in a timely manner by the multidisciplinary team and the appropriate level of care determined, dependant on need and a care plan developed appropriate to the person’s needs; with a focus on enabling and reinstating independence.

CRTs will include the previous Enhanced Care, Intermediate Care, District Nursing, District Nursing out of hours teams, Therapies, Social Services and the 3rd Sector to ensure a multidisciplinary approach. Mental health practitioners will also be part of the core team. This integration offers further development of the trusted assessor role and discharge to assess principles, which will be embedded in the ethos of the teams’ working culture.

A CRT builds upon the wide range of existing mainstream health, social care and third sector community services available. The team focuses on a shared vision to achieve the best outcomes for the individuals within their own communities.

The CRT will provide a skilled workforce working together across the whole patient journey, reducing fragmentation and disorganisation with robust and consistent governance arrangements. The development of a CRT will ensure specialist advice is always available such as Advanced Nurse Practitioner (ANP) cover.

The development of the Health and Social Care Generic Worker which are already key roles within the CRT role gives an exciting opportunity to develop a post that spans across both organisations, in supporting many aspects of a person's needs. In addition, the role of the Assistant Practitioner into the team will support the nurse and therapy roles in particular, in the delegation of nursing and therapy tasks across both the acute admissions area in the hospital site and in community.

By building a greater capacity of staff, nursing skill mix and clinical expertise, care will be improved, resulting in the ability to support more complex patient's either in their own home or closer to home. The CRT will be able to react flexibly to the changing needs of the patient within their own community setting. For Example in North Wales HCSW with additional training and competencies administer Insulin to patients in the community under specific criteria.

The District Nursing Principles will also influence the District Nursing workforce, in North Wales we have made significant progress in meeting the Principles and will be fully compliant by Late 2019.

Conclusion

In conclusion the vision for Community Nursing is clear in BCUHB with the Care Closer to Home Strategy as the main driver, this model is being led by the Executive Director of Community and Primary Care.The CRT model is being established across North Wales with District/community nursing at the heart of the CRT development and critical to its success.

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Evidence from Cwm Taf University Health Board

	Cwm Taf University Health Board response to the Health, Social Care and Sport Committee inquiry into community and district nursing services.
Contact	Angela Hopkins, Director of Nursing, Midwifery and Patient Care.
Date:	25th February 2019

Introduction

We welcome the opportunity to contribute to the Health, Social Care and Sport Committee Inquiry into community and district nursing from a Cwm Taf UHB.

Overview

Our District Nursing Service provides community nursing services to the 4 localities of Cwm Taf UHB – Cynon Locality, Merthyr Tydfil Locality, Rhondda Locality & Taff Ely Locality. Each team is GP attached and aligned to our Primary Care Clusters. The teams also work closely with Local Authority and 3rd sector partners.

In line with the Interim District Nursing Staffing Principles, each District Nursing team has an identified team leader holding a District Nursing Specialist Practitioner Qualification (SPQ) and at least one deputy team leader, also holding the SPQ.

Our team composition also includes Healthcare Support Workers and community staff nurses with a skill mix ratio of 80:20, (registered: unregistered) which is comparable to the skill mix across Wales.

Our Health Care Support Worker (HCSW) staff are band 3 and undertake a range of delegated duties from the registered workforce. Additionally, we are piloting a band 4 HCSW role as part of the Welsh Government Neighbourhood nursing pilot.

Additionally, we are piloting administrative support for 2 DN teams in the North Cynon cluster in line with the Neighbourhood Nursing pilot. The remainder of the DN teams do not have administrative support.

The UHB currently have a dedicated night service that links with Out of Hours and provides the service across the Cwm Taf footprint.

Terms of Reference

A detailed overview of the skill mix of our community nursing / District Nursing service is detailed in Table 1.

Table 1

Cluster Name or identifier	Team name	Funded establishment of registered nurses (WTE)	Funded establishment of Healthcare Support Workers (WTE)	Total Establishment
North Cynon	Hirwaun & Park	7.64	3.8	11.44
	St Johns	4.8	3.6	8.4
	Aberdare	9.92	2	11.92
South Cynon	Mountain Ash	6.39	1	7.39
	Abercynon	6.4	1	7.4
North Merthyr Tydfil	Merthyr Town	8.6	2.33	10.93
	Pontcae	6.3	1	7.3
South Merthyr Tydfil	Morlais	9.2	2	11.2
	Merthyr Valley	7.4	2	9.4
North Taf Ely	Eglwysbach	6.26	2.12	8.38
	Taff Vale	8.05	1.97	10.02
	Ashgrove	8.15	1.6	9.75
South Taf Ely	Parc Canol	9.38	1.6	10.98
	New Park	7.2	0.8	8
	Old School	6.85	1.65	8.5
North Rhondda	Tonypandy	10	1.68	11.68
	Forestview	8.49	2.66	11.15
	Ystrad	4	0.75	4.75

South Rhondda	Ferndale	8.4	1.65	10.05
	Cwm Gwyrdd	8.09	1.24	9.33
	Porth	9.93	1.7	11.63
UHB wide	Nights	4.13	4	8.13
Health board totals	22 teams	165.58	42.15	207.73

	2019	2018	2017	2016	2015
Merthyr & Cynon	85.38 WTE	85.38 WTE	85.38 WTE	85.38 WTE	85.38 WTE
Rhondda & Taff Ely	122.35 WTE	122.35 WTE	122.35 WTE	122.35 WTE	122.35 WTE
Total	207.73 WTE	207.73 WTE	207.73 WTE	207.73 WTE	207.73 WTE

The UHB do not currently have any vacancies in respect of District Nursing and have recently recruited 8 additional community staff nurses and 8 HCSW to support the transformational model within the UHB which are additional posts, not included above.

These posts are intended to release district nursing time to support the development of the Enhanced Care model currently being considered by Welsh Government.

The UHB are currently participating in the Welsh Government pilot for Neighbourhood Nursing in a valleys, urban and rural setting.

The purpose of the pilots is to test a prototype model, for a comprehensive Neighbourhood District Nursing service. It builds on local and international evidence as informed the interim district nurse staffing principles, and supports the transformation required to reform our community nursing services.

The pilots of neighbourhood focused District Nursing team will be an integral part of the enhanced multi-disciplinary primary care team a person-centred, coordinated and prevention focused nursing service to a local community. These teams will take a public health approach, caring for a designated population, aligned within a cluster, promoting independence, safety, quality and experience with the ethos of home being the best and first place of care.

The quadruple aim quality improvement methodology will be used. There will be clear outcomes developed in partnership with patients and families based on “What matters to me”, linked to a robust evaluation and learning, to answer the question, ‘Can this work in Wales?’

The pilots will take into consideration the prudent healthcare approach and the policy for operating on the basis of multi - professional teams, while drawing on

Buurtzorg principles and approach, this will be adapted to reflect key Welsh policies.

As such the pilots will be part of cluster development and implement the recently published interim district nurse staffing guiding principles and fully comply with the Welsh Audit Office District Nursing Service in Wales – A check list for Board Members.

The Cwm Taf UHB approach will focus on 2 Neighbourhood District Nursing Teams in North Cynon which will be an integral part of the enhanced multi-disciplinary Primary Care Team. This team will care for a designated population, aligned to GP Practices, promoting independence, safety, quality and experience with the ethos of home being the best and first place of care.

To do this the team will work in partnership with patients, carers and their families, General Practitioners, and other health and social care professionals as part of a wider multidisciplinary team. The team will build on our strong links with Local Authority partners in the delivery of social care.

Reviewing the international literature it is clear that Information Technology is the key enabler in supporting community district nursing teams. The Buurtzorg Model is underpinned by a sophisticated IT infrastructure, therefore, as part of the Cwm Taf UHB pilot we are testing an automated clinical scheduling of patient visits which is not linked to WCCIS.

Principles

- Person centred care - putting the person at the centre of holistic care, maximising opportunities for co-production and co-design of service delivery;
- Building relationships with people to make informed decisions about their own care, which promotes well-being and independence with active involvement of family, neighbours and the wider community, where appropriate;
- Everyone, including support functions, will facilitate person-centred care at the point of delivery;
- Small self-organising teams that are embedded in the enhanced multi-disciplinary team in primary care and GP aligned within a geographical location;
- Supportive management structures that enable professional autonomy.

Objectives

There are three main objectives:

1. To provide high quality person-centred care maximising independence;

2. To ensure staff enjoy their jobs and work to their full potential;
3. To ensure the effective use of all resources.

How will the Neighbourhood District Nursing Team transform care in the community?

The Neighbourhood District Nursing team will be the central and first place that patients, families and General Practitioners will go to, to access nursing care at home. This model will ensure sensitivity to the local population needs and maintain a focus on population health and well-being of a geographical/GP location (10,000 citizens) and work as part of the integrated primary care multi-disciplinary team.

The team will be supported to have an in depth understanding of the health needs of their population and the capacity to flex their resources to meet this need. As a result they will strengthen their public health role in the promotion of good health and well-being focusing on disease and injury prevention and healthy aging, and adopting the *Making Every Contact Count* approach. They will support people who have District Nursing care needs, long-term conditions, palliative and end-of-life care needs. This will be with a focus on remaining at home and ensuring that the fundamentals of care are provided in partnership. This model will support work on Anticipatory Care linked to the work on Patient Stratification and Segmentation of a practice population.

The team will work in different ways, and with different groups linking with Local Authority partners, community and voluntary organisations to promote independence and community cohesion.

As the core care team they will draw on the expertise of the enhanced primary care multi-disciplinary team, specialist nurses, and others when required. This will support the development of a strong therapeutic relationship between the Neighbourhood District Nursing Team, the patients and their family thereby reducing the numbers of staff entering a patient's home.

Conclusion

The UHB welcomes the opportunity to contribute to the inquiry into Community and District Nursing Services.

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Evidence from Royal College of Nursing Wales

Executive Summary

- Most Registered Nurses work in the community in a variety of roles and settings including public health. Adults and children with complex conditions receive care in the community as do those recovering from treatment or operations.
- The Welsh Government should set out a renewed vision for primary, community and social care including the role and value of community nursing.
- The Welsh Government should invest in supportive technology for Community Nursing. RCN Wales believes the use of hand-held devices with instant access to patient information should be standard across Wales.
- The Welsh Government, HEIW and NHS Wales should work together to increase the number of District Nurses in Wales
- The Welsh Government should extend the Nurse Staffing Levels (Wales) Act 2016 to community nursing services.
- The Welsh Government, HEIW and NHS Wales should work together to increase the number of Children's Nurses in community nursing Introduction to Nursing in the Community

Introduction to Nursing in the Community

- **Most Registered Nurses work in the community in a variety of roles and settings including public health. Adults and children with complex conditions receive care in the community as do those recovering from treatment or operations.**

1. Contrary to the common and popular image of the nurse on the hospital ward most nurses work actually outside a hospital. Two thirds of the RCN's membership work in the community.

   NHS Nurses working in the community could be District Nurses, learning disability nurses, community psychiatric nurses, specialist nurses, school nurses or a Health Visitor (Specialist Community Public Health Nurse).

Practice Nurses and health care support workers working in GP surgeries form part of this collective nursing workforce in the community.

A third of RCN membership (half of those working in the community) work in the independent sector in the community e.g. for a hospice or a care home. These nurses and the care workers who are part of a nursing team also are part of this collective nursing workforce in the community.

2. Adults and children with complex conditions receive care in the community as do those recovering from treatment or operations. Some of our most vulnerable older people are supported 365 days of the year by community nursing delivering complex care and treatment packages at home.

   Community nurses act as a valuable link between acute services, primary care and promote independent living. Nurses in the community specialise in many areas for example dementia, stroke, palliative care and Parkinson's disease and some have obtained additional qualifications to prescribe medications which ensure that older people receive a quality nursing service. Community nurses also signpost older people to appropriate third sector organisations for support befriending and advice.

   Community Nurses have a holistic philosophy of care. Rather than focusing on a task –based approach (e.g. changing a dressing) it is about a range of caring activities that assess and respond to the whole spectrum of needs of people being cared for in their homes and communities. This fits perfectly with the aspirations of A Healthier Wales. Research clearly demonstrates the detrimental impact of care delivered without nursing input[1].

   In other words, DNs are the present and future solution to community- based health and social care.

   A nursing presence in residential care for older people is essential for:

   - Continuous monitoring and assessment of residents' health and wellbeing; recognising cues to problems, anticipating problems; acting to prevent problems developing; preventing deterioration
   - Managing acute illness and emergencies; preventing crisis situations; preventing unnecessary hospitalisation.

   Nurses promote residents' independence through safeguarding, proactive, rehabilitative care; promote residents' health and flourishing; deliver high quality palliative care and end of life care for individuals; play a key role in advocacy for residents and families. With the increasing complex care needs of people in nursing homes there is a need for greater communication, sharing of professional knowledge and support between Health Boards and independent care providers.

[1] Phelan, A et al 2018 Challenges in care co-ordination: missed care in community nursing. International Journal of Integrated Care, 18(S2):

The role of and vision for Community Nursing

- **The Welsh Government should set out a renewed vision for primary, community and social care including the role and value of community nursing.**

3. Recent years have seen a transformation of NHS healthcare and population need. Our population is living longer and living longer with chronic and complex conditions. For the last decade in Wales Health Boards have been reconfiguring acute hospital services, reducing bed numbers, encouraging shorter patients stays and enabling more complex treatments and care to be delivered at home. There is a renewed emphasis in Welsh Government policy on prevention and public health and an integration between health and social care.

   The Royal College of Nursing is a strong supporter of these policy goals which, if implemented, will improve the experience of care for people and the efficiency of the healthcare system.

4. One of the unintended consequences of this policy shift however has been that 'social care' and 'primary care' are now the term most often used by decision-makers to describe care received outside a hospital. 'Primary care', is grouped and delivered through 64 clusters across Wales. 'Social care' is often used to mean any care delivered outside a hospital. There is a real danger that the contributions of nurses such as community and district nurses, but also groups such as occupational health nurses, school nurses and health visitors are becoming invisible to policy makers and undervalued.

5. The last Welsh Government Community Nursing Strategy was published in 2009 and rapidly superseded by the developments and cluster model of the Primary Care Strategy.

6. The CNO's guidance on District Nurses recommends that community nursing teams in Wales are structured on a cluster basis. However it is not clear if this is always the case in practice. There also is tremendous variation in how included community nursing teams are in cluster discussion, and vision. RCN Wales would like to see greater support from the Welsh Government for the development of non-medical leadership in clusters to broaden their vision.

7. The role of the Executive Nurse Director is community service design is limited and varied across Wales. Aligned community health services (e.g. continence, respiratory, diabetes, tissue viability, lymphedema, palliative and cancer services) are therefore run very differently across Wales. All of these affect the way district nursing teams work in each area and affects their caseload.

8. Regional Partnership Boards (RPBs) have been given a central role in progressing the integration agenda in Wales; 'A Healthier Wales' describes them as having a 'strong oversight and coordinating role' in delivering

change. Given this central role, the RCN would like to see far greater transparency and scrutiny around the work of RPBs. Nursing input into service design is needed and it needs to be clear how and why projects are funded. If projects are successful there should be a mainstreaming process.

9. A plethora of funding initiatives have resulted in a myriad of different specialist nursing teams based in the community. In many areas there will be teams that are integrated with local authority or not integrated, have rapid response within the DN teams or have separated service such as rapid response, Community resource teams, ACAT or frailty. Some teams have specialist chronic conditions leads, some lack any and some teams have access to community based specialists for chronic conditions and work in partnership with them.

10. Many of these new initiatives are excellent in outcomes when their work is viewed in isolation but the wider strategic picture across Wales is unexamined leading to the following problems:

    - The new is prized over the successful: Initiatives are usually funded via a bidding process. This bidding process is in itself capacity-consuming. In addition many of our community nursing members tell us that they can no longer received funding for proven successful mainstream work but only for unproven new schemes or 'rebadging' the old as new.

    - Lack of evaluation and mainstreaming: It a particular model of working is successful then it should be sustainably funded.

    - Lack of succession planning- when a specialist nurse leaves, too often the post cannot be filled or the post is removed resulting in a loss of service and a loss of any improved efficiency.

    - Deskilling of community nursing: Staff can be pulled from community nursing teams into a 'new' team such as frailty. If the new team requires skills such as IV medications this shift of people and/or ways of working can denude the community nursing team of the ability and confidence to deliver these skills. Community Nursing teams then can become dependent on referrals to specialist teams undermining their ability to work flexibly at the level commensurate with need.

11. The current assessment system for Continuing Health care is placing a large burden on the most senior members of the community nursing team. Our members report up to a third of their time is occupied by repeated assessment to distinguish between health and social care needs and confirm this. The patient often gets caught up in this delay as the teams are overwhelmed with assessments that are time consuming.

12. RCN Wales is also calling for a national strategy to encourage student nurse placements in care homes, with practice nurses and in community teams to encourage the pursuit of community based nursing careers. However nurse mentors in community are finding that poor staffing levels and increased

workload mean they are concerned about the education and placement experience that they ae providing for nursing students in community.

13. Over all the RCN is receiving a picture from its members of a significant loss of resources and a constant devaluing of the skills and benefits received from a functioning community nursing service. The Royal College of Nursing believes the Welsh Government should set out a renewed vision for primary, community and social care including the role and value of community nursing. HEIW will launch a workforce strategy at the end of this year and the vision for the future of the service needs to be clear.

ICT Infrastructure, Documentation & Technology

- **The Welsh Government should invest in supportive technology for Community Nursing. RCN Wales believes the use of hand-held devices with instant access to patient information should be standard across Wales.**

14. The core role of the community nurse is to act as an intermediary between secondary, primary health care and also social services. It is particularly invidious therefore that community nursing has long-been at the back of the queue for investment in modern communications technology that can support and make their work more efficient.

    Our members still report carrying large amounts of paperwork around and having to spend many hours updating records at the end of the day. A plethora of different recording methods are in use including handwritten, ipad, pc, phone. Written documentation is usually left in the patient's home but this can be problematic if the patient mislays it. RCN Wales believes the use of hand-held devices with instant access to patient information should be standard across Wales.

15. In a world where the knowledge base is expanding and changing so rapidly, ICT and access to the right technology can give nurses access to a world of knowledge and resources; not only patient records, but also current protocols, guidelines and the latest research findings. This is particularly valuable when delivering care within people's homes and in the community.

16. Welsh Government must show a concerted and expeditious commitment to investing in the use of technology in care delivery in Wales. Whilst any public spending on eHealth and new ICT systems will always require a high level of scrutiny, the NHS in Wales spends less than 2% of its funding on ICT – significantly less that the recommended figure of 4%. It is also essential that nurses are involved in the design of digital records and software systems to ensure their practicality in use.

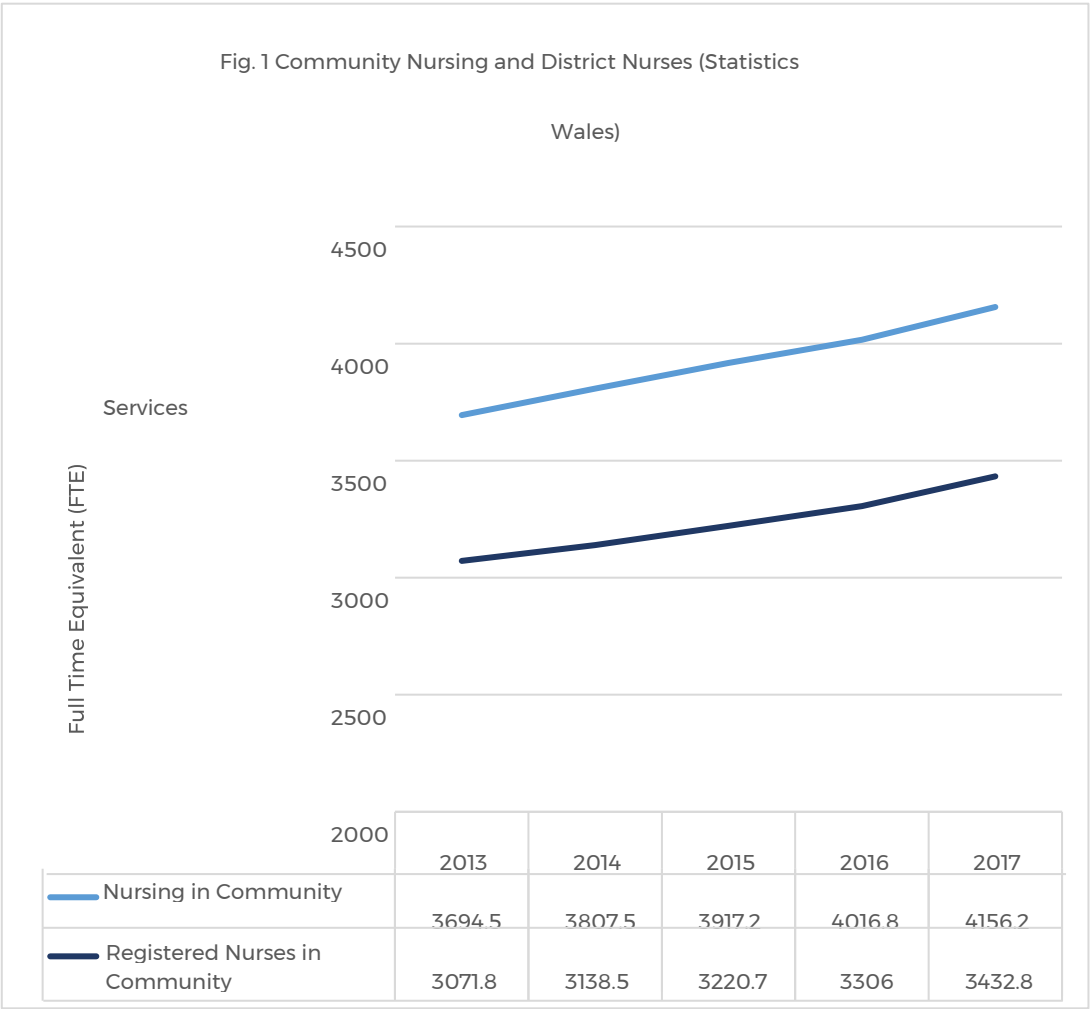
17. There are many examples of good work happening in Wales in the field of eHealth and harnessing the latest technology. For instance, VR (virtual reality) and digital media (tablets, internet, etc.) are being used successfully with care home residents in a variety of ways. Digital Communities Wales has several

examples of best practice on their website, including a case study on Woffington House Care Home in Tredegar. Here, the use of iPads combined with VR glasses, has allowed residents to revisit Aberystwyth in 1965 and experience roller coaster rides. The home has seen a 100% reduction in the use of anti-psychotic medications on an "as required" basis, as well as a reduction in falls and ambulance call outs.

The Community Nursing Workforce

- **The RCN believes that the Welsh Government should improve nationally held activity and outcome information on nursing care in NHS community settings to improve workforce and service planning.**

Fig. 1 Community Nursing and District Nurses (Statistics Wales)



	2013	2014	2015	2016	2017
Nursing in Community	3694.5	3807.5	3917.2	4016.8	4156.2
Registered Nurses in Community	3071.8	3138.5	3220.7	3306	3432.8

18. The graph above (fig.1) shows the increase in the number of registered nurses and nursing staff working in the community over the last 5 years. The RCN believes this increase needs to continue and more information required before need can be properly assessed.

    - We know that there is a growing number of older people and other vulnerable groups needing nursing at home.

- We know there is the rise in the number of people with long-term conditions requiring complex care and support at home.

- We know that Health Boards have reduced the number of acute beds available believing that care in the community will replace this.

19. However the number of people receiving (or requiring) care and the level of their needs is not collated or published at a national level so it is very difficult to judge the level of nursing need required at a national level2. How HEIW will address this is a matter of some concern for the RCN.

    It should also be pointed out that we do not have outcome data on the patients receiving care so it is difficult to judge which models of care are most optimum form a patient perspective and from the perspective of efficiency with public money.

    The RCN believes that the Welsh Government should improve nationally held activity and outcome information on nursing care in NHS community settings to improve workforce and service planning.

- **The Welsh Government, HEIW and NHS Wales should work together to increase the number of District Nurses in Wales**

20. The District Nurse is a title given to those with a Specialist Practitioner Qualification (SPQ). An SPQ is separately recordable on the Nursing and Midwifery Council register. It recognises a level of knowledge and practice that is highly skilled. It is a specialism in general community nursing. These nurses are the experienced pinnacle of a community nursing team providing clinical supervision and leadership to the registered nurses and health care support workers in the team.

21. The position of the Royal College of Nursing is that ultimately the purpose of a qualification is to inform the public and employer of the standard of knowledge, practice and competence care they can expect to receive.

22. As well as the District Nurse qualification Registered Nurses can also undertake a post-registration (i.e. postgraduate) degree in community nursing. The RCN is calling for this to be a recognised and registered qualification. The Royal College of Nursing would expect a national framework to set out clearly the standard of knowledge, practice and competence and qualifications required for a senior leadership position in community nursing in Wales. An extension of the Advance Practice Framework for Nursing, Midwifery and Allied Health Professionals in the community may also be helpful.

23. A recent welcome development has been the publication by the Chief Nursing Officer of the "District Nurse Guiding Staffing Principles". This makes

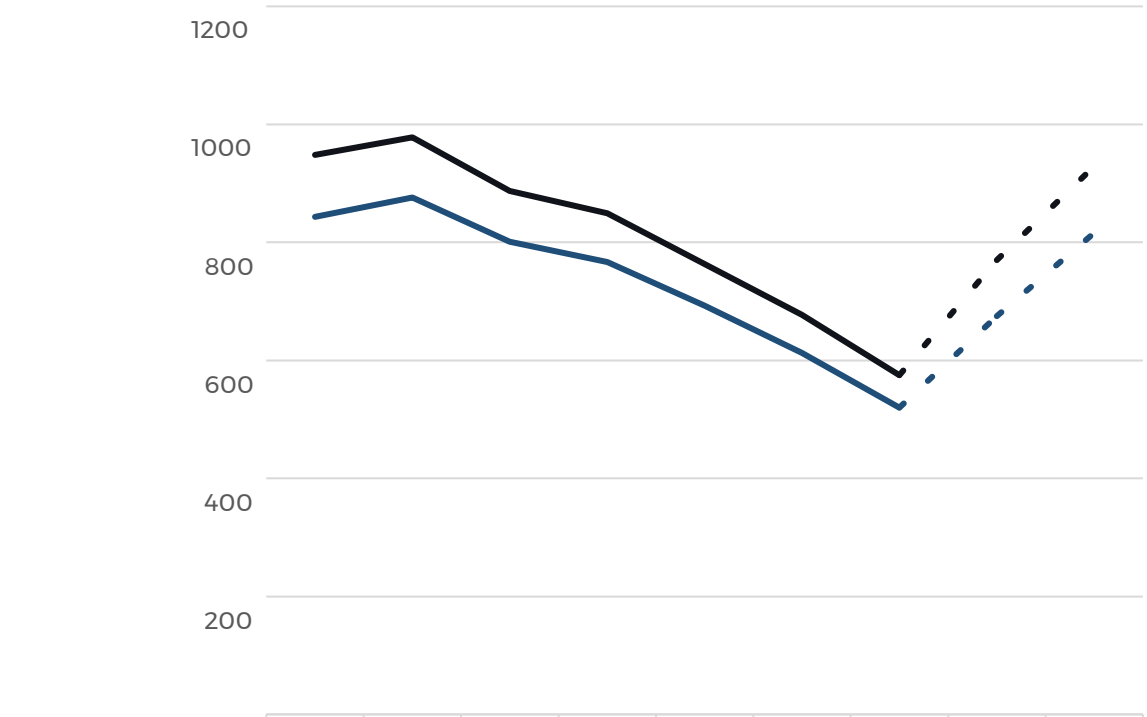
[2] Thomas SJ, Wallace C, Jarvis P & Davis RE (2016) Mixed-methods study to develop a patient complexity assessment instrument for district nurses. Nurse Researcher 23(4), 9-13

a recommendation that all community nursing teams in Wales should be led (and deputised) by a District Nurse or by a nurse possessing a postregistration community nursing degree "aiming towards" supernummary status (i.e. allowing time to be spent on supervision or case management). The guidance also suggests least 15 hours administrative support for the team.

24. The Royal College of Nursing would welcome regularly published information on whether this standard has been achieved. We are aware from our members that this is not always the case. We are also aware of teams with no administrative support. In addition it is our view that each registered nurse working in the community should have completed the core module of community fundamentals but again this is often not the case. There can be no dilution of the quality of care for patients.

25. The graph (fig. 2) below shows the decline in the numbers of District Nurses in Wales. This is alarming and should be of concern to the Welsh Government.

Fig. 2 District Nurses (Statistics Wales)



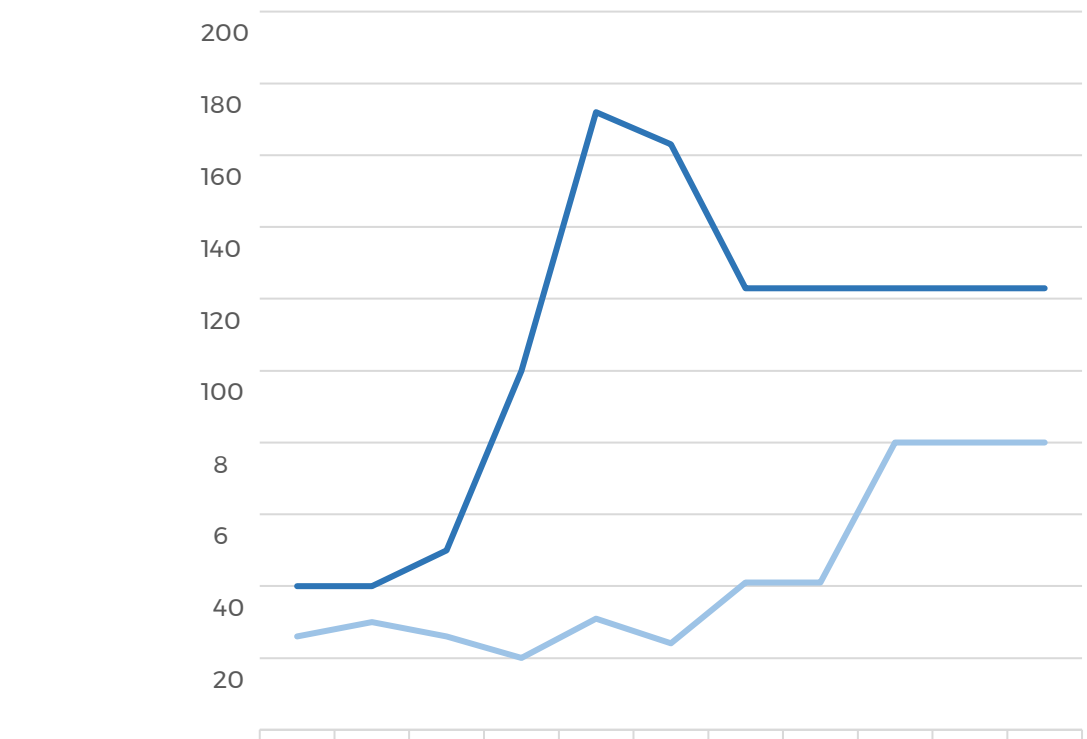
	2009	2010	2011	2012	2013	2014	2015	2016	2017
District Nurses	948	978	887	849	763	677	575	770	929
fte District Nurses	843	876	801	767	693	613	520	675	816

The information in fig.2 is published by Statistics Wales. Statistics Wales is supplied with this Information by Health Boards.

The graph shows an apparent increase in District Nursing numbers from 2016. The RCN has used a dotted line for this increase as unfortunately this information is not reliable. Some Health Boards have incorrectly coded all nurses working in the community as District Nurses. While there has always been an element of accidental miscoding in the data the scale of the problem has become serious enough to destabilise this quality of this series as a whole.

Statistics Wales are aware of the problem and RCN Wales has been informed they will use additional information from the NMC register to correct these figures in March 2019.

Fig.3 Post Registration Education for District Nurses as commisioned by Welsh Govenrment



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
DN Module Places	40	40	50	100	172	163	123	123	123	123	123
DN Course Places	26	30	26	20	31	24	41	41	80	80	80

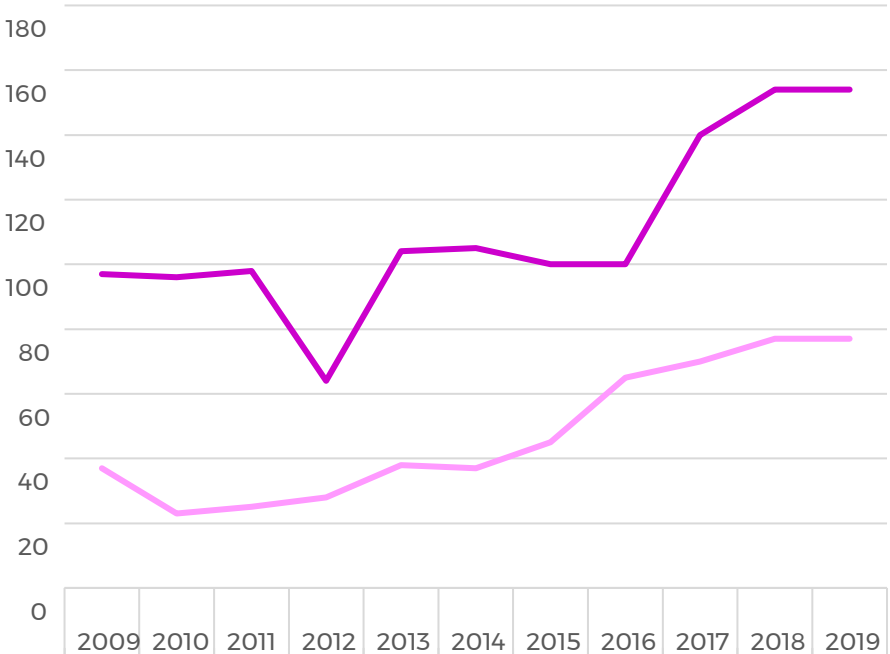
26. Education places for District Nursing are commissioned by the Welsh Government. Modules allow a flexible approach to learning. It can be seen from the graph above that the Welsh Government increased the number of education places commissioned in 2013 but this number has stabilised in recent years. Given the age profile of District Nurses and the increasing

numbers of people being cared for in the community with complex conditions the Royal College of Nursing would argue there is a serious case to be made for increasing this provision.

- **The Welsh Government, HEIW and NHS Wales should work together to increase the number of Children's Nurses in community nursing**

27. Traditionally Children's Nurses were relatively few in number and hospital based. These days' children with complex health needs can receive far more care at home. This means many more Children's Nurses are needed in the community. Wound care & management, ventilation, BP monitoring, IV medication/ line management, enteral feeding support and palliative care are some of the services Childrens Nurses provide, along with vital education for other healthcare professionals and for carers and school staff. Learning Disability Nurses are also in very short supply and are needed to support children and young people with challenging needs.

Fig. 4 Welsh Govenrment Commissioned Student Places for Childrens Nurses and Learning Disibility Nurses



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Student Places for Children's Nurses	97	96	98	64	104	105	100	100	140	154	154
Student Places for Learning Disibility Nurses	37	23	25	28	38	37	45	65	70	77	77

28. In 2017 and 2018 the Welsh Government increased the number of commissioned student places for Children's Nursing but these figures

remained static this year. As well as needing Children's Nurses in the community here is also a sharp demand for Children's Nurses in neonatal services– this means that the rise is by no means yet sufficient to meet need.

29. The RCN is calling for the Welsh Government to publish up to date figures showing the number of Childrens Nurses in the Community. HEIW should demonstrate how it is planning the workforce to meet need.

Extending the Nurse Staffing Levels (Wales) Act 2016 to the community

– **The Welsh Government should extend the Nurse Staffing Levels (Wales) Act 2016 to community nursing services.**

30. During the passage of the Nurse Staffing Levels (Wales) Act 2016 one of the areas much discussed in the Assembly Health, Social Care and Sport Committee was why the Act could not be extended to the cover nursing in community settings.

31. The Welsh Government has committed to extending the Act to more care settings by the end of this assembly term and has taken steps forward in this field. The work stream looking at extension to the community has only recently been supported by the appointment of 2 year administrative support and a project lead. The Nursing Group established to oversee this work is currently looking at developing the Welsh Levels of Care Tool for use in the community. This would allow a consistent assessment of acuity and dependency in patients to allow for the consistent calculation of staffing need. There should be greater investment of support and a clear timeline of progress on this work.

32. It is the Royal College of Nursing belief that this work should be progress by the Welsh Government with a view to extending the Act by the end of this assembly term.

Annex A – RCN Nurse of the Year Community and District Nursing Winners

2018 Community Nursing Award Winner, and overall Nurse of the Year

Winner: Eve Lightfoot, Community Infection Prevention Nurse, Hywel Dda University Health Board

EVE LIGHTFOOT

Eve became concerned that there was no teaching about sepsis or the early recognition of the deteriorating patient in the community, as these were perceived as 'secondary care' issues, so she started to raise awareness of the issue, and then commenced a research internship and undertook a research project. As a result a Community Situation, Background, Assessment, Recommendation template is being implemented; and National Early Warning Score, vital signs and SBAR are being incorporated into community nursing documentation and GP admission criteria. In addition a new out-of hospital Rapid Response to Acute Illness Learning Set group has been set up in HDUHB and there has been a standardisation of monitoring equipment and an increase in education provided to care homes and managers on sepsis recognition. Eve is passionate about this work,

never taking no for an answer and goes above and beyond what anyone would realistically expect, achieving significant change across care sectors and driving to improve patient safety and empower nurses.

2017 Community Nursing Award Winner: Paul Crank, Senior Nurse, District Nursing, Cwm Taf University Health Board

PAUL CRANK

Paul has worked with his colleagues and teams to challenge ways of traditional thinking that have empowered and enabled teams to problem-solve in innovative ways. Paul has led the All Wales work in development of the acuity tool and testing of the principles on behalf of colleagues in Wales. His use of IT solutions to deliver care at home has been transformational and the work has been recognised as an exemplar for others. Through the creative utilisation of modern technology, he has engaged the nursing workforce to deliver responsive, outcome-focused care. Paul has demonstrated leadership, even in times of adversity, implementing learning and taking forward changes in practice on a wider scale, outside his own team and across the other healthcare organisations.

2016 Community Nursing Award Winner: Jacqueline Jones, School Nurse, Hywel Dda University Health Board

Jacqueline developed a simple, yet unique way of engaging children in talking and opening up to professional help and advice in relation to their health and wellbeing by using items that they are familiar with as visual prompts to start conversations. The work is based on sound evidence and has been evaluated and reported on at a national level. Due to its simplicity, it could be effectively transferred across a range of settings and health and social care situations. Jacqueline's passionate, highly motivated approach to her job and team was inspirational. Because of her developmental approach she has been thinking about ways to engage future generations and colleagues in healthcare and how to promote her idea across Wales and beyond.

2015 Community Nursing Award Winners: Ann Bamsey & Susan Grounds, Health Visitors, Powys Teaching Health Board

Ann and Susan recognised a need to support parent and infant relationships within their community. Together they facilitated 'Little Dippers' Aqua Tots group, a parent and baby swimming course which was an innovative project believed to help reduce postnatal anxiety and feelings of isolation for new mothers. The project went from strength-tostrength. Ann and Susan accessed grant monies which helped them to make the necessary changes to an unused area within their local community. They are now able to use this area to facilitate a form of gymnastic play. The peer support and friends gained from attendance has also encouraged parents to become involved in further health enhancing activities. Despite the pressures of austerity, Ann and Susan have sought out and secured funding which has enabled the sustainability of the core project. As well as this they have created a bilingual nursery rhyme book which accompanies and reinforces the songs that are sung throughout the water play. Ann and Susan have demonstrated the rich potential of the health visiting role in a project that combines family focused care, parent support and community development.

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal
HSCS(5) CDN05
Ymateb gan Fwrdd Iechyd Prifysgol Aneurin Bevan

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Aneurin Bevan University Health Board

Community and District Nursing Services

Further to your email of 7 February regarding your request for us to provide a response/comments to the Terms of Reference. Please find below ABUHB's response:

How many District nurse-led community nursing teams are there in your Health Board area?

23 Teams

Information about the make-up of these teams i.e. numbers of staff and skill mix (Registered Nurses and Healthcare Support Workers)?

Please see attached accompanying spreadsheet.

An up-to-date position on the total number of nursing vacancies (registered nurses) within your Health Board.

14.9 wte vacancies District Nursing

330 wte – Health Board total

The Health, Social Care and Sport Committee is calling for evidence about whether community nursing services are likely to play a greater role in the future delivery of healthcare, focusing on: Whether we have a clear picture of the district nursing/community nursing workforce in Wales, and the level of need for community nursing services (including future need). Do we have the evidence base to support effective workforce planning.

Within ABUHB with our Clinical Futures Programme, we are working towards a Place Based Model of Care and District Nurses are key to the success of this model. The aim of this patient centred model is to address the increasing demands on primary care services by moving from a singlehanded uni-professional approach to care to a system based approach whereby multi professionals both Health and Social Care work collaboratively within primary care teams. We have already implemented such a model, in some areas, through co-locating District Nursing and Social Care Teams aligned to the NCN footprint (Blaenau Gwent, Monmouthshire).

Whether there is clear strategy, at National and Local levels, about the future direction for district nurse-led community nursing services. How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in A Healthier Wales.

This Place Based Model of care supports the quadruple aims set out in A Healthier Wales by improving population Health and Wellbeing through the development of a holistic primary care MDT mode which provides a more proactive and preventative approach to care, with patients managed earlier. District Nurses will be the case managers for a majority of these patients and will be working with patients to adopt a self-management approach to patient care.

How effectively Community Nursing Teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services, and the voluntary sector) to deliver seamless, person-centre care.

ABUHB has been selected to be one of the three pilot sites for the Neighbourhood District Nursing Model, with the aim being, to work in partnership with Health, Social Care and Voluntary Organisations to support people to live well for longer at home or in a homely setting of their choice.

If you require any further information, please do not hesitate to contact us.

Yours sincerely

Martine Price

Interim Director of Nursing

		2013/2014				2019			
		Total budgeted WTE	Budgeted WTE for RGN	Budgeted WTE for HCSW	Skill mix	Total budgeted WTE	Budgeted WTE for RGN	Budgeted WTE for HCSW	Skill mix
Blaenau Gwent	BG East	N/a	N/a	N/a	N/a	23.27	20.67	2.60	89:11
	BG West	N/a	N/a	N/a	N/a	22.21	19.80	2.41	89:11
	Cwm	12.21	11.33	0.88	93:7	N/a	N/a	N/a	N/a
	Tredegar	9.27	8.40	0.87	91:9	N/a	N/a	N/a	N/a
	Abertillery	12.87	11.20	1.67	87:13	N/a	N/a	N/a	N/a
	Brynmawr	11.26	10.26	1.00	91:9	N/a	N/a	N/a	N/a
Torfaen	North 1	10.54	8.40	2.14	80:20	10.39	8.60	1.79	83:17
	North 2	9.51	8.03	1.48	84:16	14.41	11.93	2.48	83:17
	South 1	10.53	8.73	1.80	83:17	12.40	10.00	2.40	81:19
	South 2	10.13	8.13	2.00	80:20	12.44	10.07	2.37	81:19
	Central	8.60	6.80	1.80	79:21	N/a	N/a	N/a	N/a
Monmouthshire	Abergavenny	9.63	9.23	0.40	96:4	11.09	10.29	0.80	93:7
	Caldicot	10.30	9.70	0.60	94:6	8.99	8.00	0.99	89:11
	Monmouth	N/A	N/A	N/A	N/A	12.15	10.78	1.37	89:11
	Chepstow	8.96	7.56	1.40	84:16	8.99	7.87	1.12	88:12
	Usk/Raglan	8.37	8.37	0.00	100:0	5.50	4.70	0.80	85:15

Newport	Central East	12.52	11.52	1.00	92:8	14.24	13.24	1.00	93:7
	Central West	9.87	8.58	1.29	87:13	12.36	10.00	2.36	81:19
	North West	9.80	9.11	0.69	93:7	16.78	15.26	1.52	91:9
	North East	8.50	7.37	1.13	87:13	N/a	N/a	N/a	N/a
	South East	9.73	8.40	1.33	86:14	10.40	9.80	0.60	94:6
	South West	15.35	14.15	1.20	92:8	16.36	14.92	1.44	91:9
Caerphilly	Risca	11.51	10.45	1.06	91:9	11.85	10.31	1.54	87:13
	Denscombe	15.00	13.00	2.00	87:13	14.87	13.37	1.50	90:10
	Pontllanfraith	13.64	11.64	2.00	85:15	13.37	11.24	2.13	84:16
	Bargoed	13.40	12.40	1.00	93:7	11.90	10.40	1.50	87:13
	Rhymney	9.51	8.00	1.51	84:16	9.81	8.40	1.41	86:14
	Ty Bryn	8.60	7.00	1.60	81:19	10.62	8.95	1.67	84:16
	Ystrad Mynach	11.40	10.40	1.00	91:9	11.80	10.80	1.00	92:8
Gwent Total		281.01	248.16	32.85	88:12	296.20	259.40	36.80	88:12

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal
HSCS(5) CDN06
Ymateb gan Health Education and Improvement Wales

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Health Education and Improvement Wales

RESPONSE TO HEALTH, SOCIAL CARE AND SPORT COMMITTEE ENQUIRY INTO COMMUNITY AND DISTRICT NURSING SERVICES

Stephen Griffiths, Director of Nursing

1. INTRODUCTION

Health Education and Improvement Wales welcomes the opportunity to provide evidence to the Health, Social Care and Sport's Committee inquiry into *'the activity of district nurse-led community nursing teams and the quality of nursing care provided to people in their own homes'*.

Heath Education and Improvement Wales was established as a Special Health Authority on 1 October 2018, bringing together the Wales Deanery, the Wales Centre for Pharmacy Professional Education and the NHS Workforce and Education Development Service.

HEIW sits alongside Health Boards and Trusts, and has a leading role in the education, training, development, and shaping of the healthcare workforce in Wales, in order to ensure high-quality care for the people of Wales.

2. KEY INFORMATION

2.1 Shape and size of the workforce

The community nursing workforce (registered nurses) has grown significantly over the past decade:

- The overall community nursing workforce (registered nurses across adult, psychiatry and learning disabilities) has **increased by 37%** since 2009 from 3,402 wte to 4,655 wte in 2018
- The number of registered nurses working in the community (adult) **has increased by 48%** since 2009 from 2,090 wte to 3,084 wte in 2018.
- The number of registered nurses with a recordable SPQ qualification has **reduced by 17%** since 2009 from 690 wte to 590 wte in 2018

- **46%** of the community nursing workforce are aged 50 and over

2.2 Education requirements

NHS Wales and the Welsh Government agreed in 2008 that the Specialist Practice Qualification (SPQ) would not be the only qualification which would be recognised to demonstrate an individual can fulfil a community nursing role at band 6/7. Registered nurses without an SPQ can work to the same level as a District Nurse and lead a community nursing team but cannot call themselves a District Nurse.

2.3 Education provision

HEIW provides funding for the following postgraduate education:

- Advanced/Extended Practice education to the sum of £1.25 million, of this £750K is targeted towards staff education within the primary care/community/ general practice environments
- Non-medical prescribing education to the sum of £300,000, this budget allows HEIW to commission approximately 230 programmes from the universities across Wales
- Specialist Practice Nursing and Community Public Health Nurse education £4.3 million

In addition to the above the Welsh Government have committed to investing £2 million per year over 2018/19 and 2019/20 to support a neighbourhood District Nursing pilot. £1.4 million of this funding has been allocated to HEIW to support the education and training programmes required to underpin the pilot and support the release of nurses to train as district nurses or equivalent.

3. SPECIFIC ISSUES IDENTIFIED BY THE ENQUIRY

3.1 Whether we have a clear picture of the district nursing and community nursing workforce in Wales, and the level of need for community nursing services (including future need). Do we have the evidence base to support effective workforce planning.

Response

All health boards and trusts are required to produce a workforce plan (IMTP) each year, which includes completion of an education-commissioning template. This template clearly articulates the numbers of training places the organisation has deemed that will be required to maintain the workforce for the future. This data informs the commissioning process.

There is annual investment in education to ensure a supply of registered nurses to work within community teams. As identified above HEIW commission Specialist Practice Qualifications and Community Health Degrees from universities within

Wales. In addition, HEIW commission modular education to support the acquisition of appropriate knowledge and skills to enhance the skill mix of community nursing teams, which can support the development of new services.

3.2 Whether there is clear strategy, at national and local levels, about the future direction for district nurse-led community nursing services. How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in *A Healthier Wales*.

Response

Welsh Government have commissioned the Neighbourhood District Nursing pilot: with a target to train an additional 80 District Nurses during the period 2018-20.

In 2018 A Healthier Wales: our Plan for Health and Social Care was published; this superseded the previous Primary Care Workforce Action Plan and the key areas of focus going forward were prioritised and outlined in *The Strategic Programme for Primary Care (November 2018).* Within this strategic overview primary care is defined as "…those services which provide the first point of care, day or night… It is about coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs….including a very wide range of staff, such as community and district nurses, midwives…"

3.3 How effectively community-nursing teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services, and the voluntary sector) to deliver seamless, person-centred care.

Response

HEIW commission post graduate education for a broad range of clinicians, which includes a ring-fenced budget for staff working in community and primary care settings.

This funding supports nurses and other professionals to access education to develop advanced or extended knowledge and skills that can support and enhance the services delivered by community nursing services. Increasingly this education is delivered in multi-professional / interdisciplinary training programmes.

4. SUPPLEMENTARY INFORMATION

4.1 Specialist Community Nursing Courses

In the 1990s, the Nursing and Midwifery Council (NMC) developed standards for community nurse education. These Specialist Practice Qualifications (SPQ) are **recordable** with the NMC but are **not registerable qualifications**. The NMC have

recently announced that a review of specialist practice education will be undertaken within the next 2 years.

The specialist community nursing education courses that HEIW currently commissions and funds on a part time or modular route, are those that lead to either:

- a Specialist Practice Qualification (SPQ) recordable with the NMC **or**
- BSc/PG Dip Community Health Studies degree.

Community nursing education courses can be undertaken in a number of specialist areas. These include:

- General Practice Nursing (for those who work in a GP surgery where the GP is the employer **or** those employed by an NHS Organisation), and
- District Nursing; Community Paediatric Nursing; Community Psychiatric Nursing; Community Learning Disability Nursing.

There are two routes to achieving the SPQ/Community Health Studies awards:

- The part time route usually completed over a period of 2 years.

Or

- The modular route, which allows students to undertake one or more specific taught modules over an undefined period. Students following the modular route complete the *Fundamentals of Community Practice*, as their first module. On completion of this module, students can choose whether to complete another module(s) or exit from the programme.

Whilst the SPQ is a recognised position, as identified by the NMC and the profession, fundamentally it is up to the employer to decide and agree with their staff what skills and knowledge are required to discharge their role effectively.

The table below identifies the number of places commissioned for district/community nursing and the uptake of these places across Wales

DISTRICT/COMMUNITY NURSING				
	Part-time commissions	**Part-time uptake**	**Modules commissioned**	**Modules uptake**
2018.19	80	Detail not yet available	123	Detail not yet available
2017.18	80	61	123	128
2016.17	41	39	123	88
2015.16	41	41	123	84

4.2 Primary Care Healthcare Support Worker (HCSW) Development

Developing a flexible and sustainable support workforce requires access to the necessary education, skills and training. Using the skills and talents of existing unregistered HCSWs and offering improved development opportunities, especially to meet new service requirements, is a key component in securing the workforce of the future.

A standardised Level 3 certificate and diploma programme of accredited training for primary care HCSWs in Wales has been developed. The programme enables career progression; facilitates skill mix; supports future service delivery; and aligns with:

- NHS Wales Skills and Career Development Framework
- Royal College of General Practitioners' Competency Framework for Healthcare Assistants

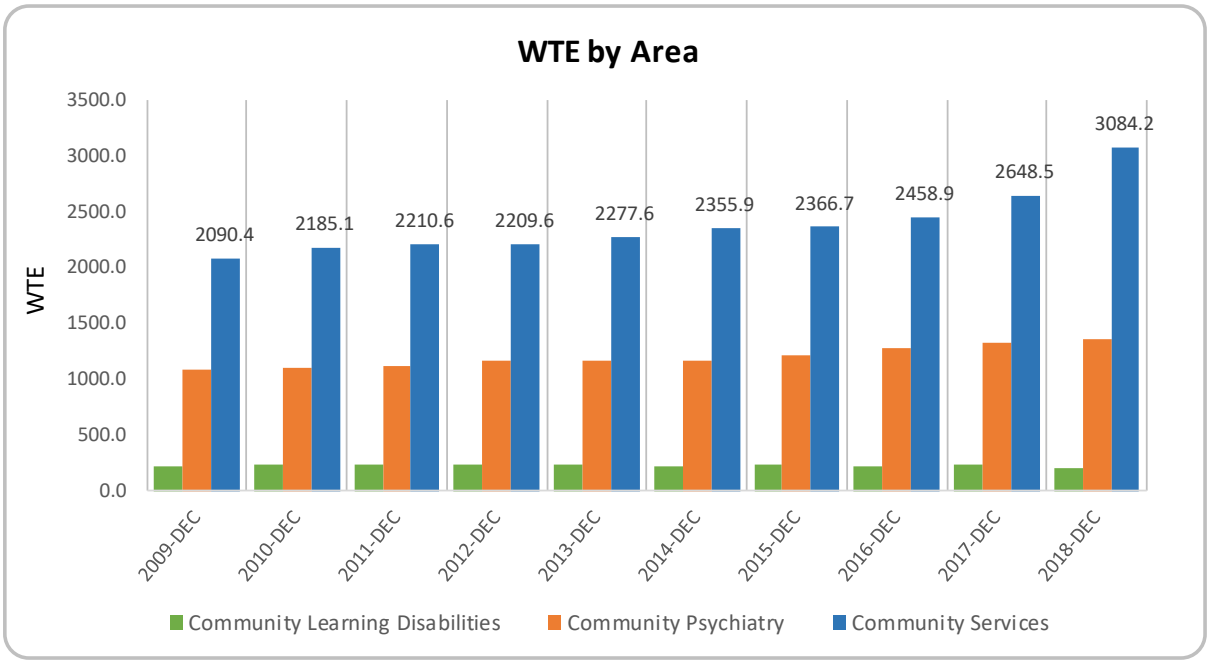
Work is ongoing to broaden opportunities for role development of HCSWs in primary care, with access to wider ranging units of learning that reflect new and emerging service delivery models e.g. HCSWs to support advanced practice physiotherapists; training of navigator reception staff.

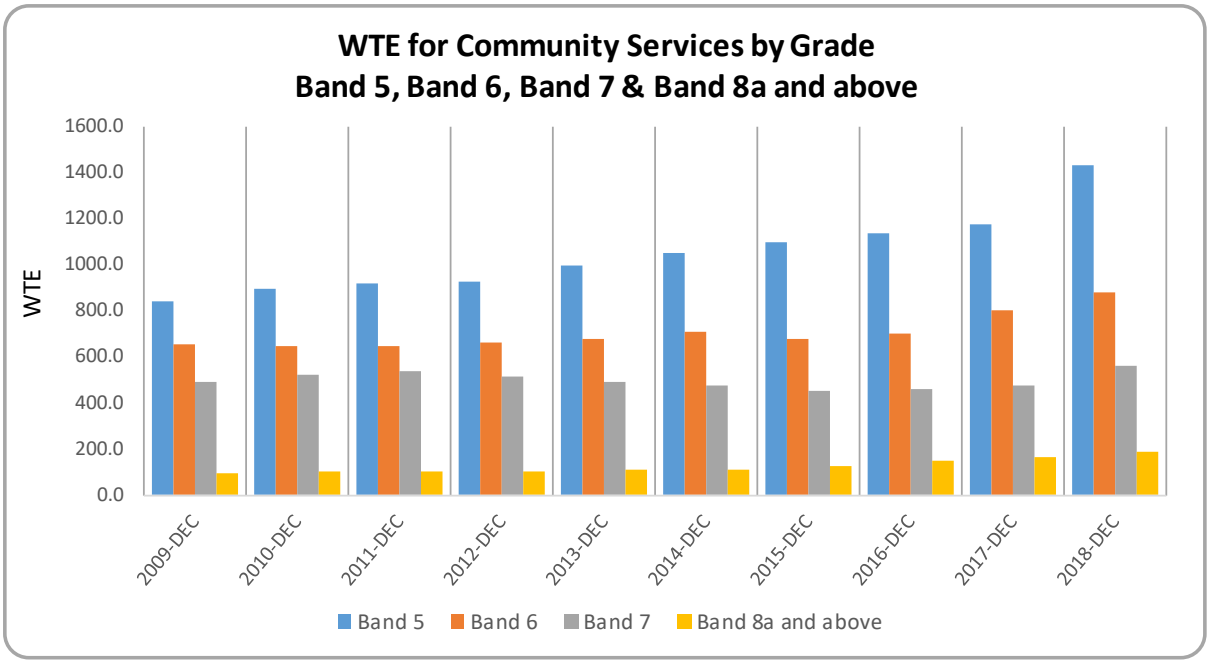
4.3 Workforce information

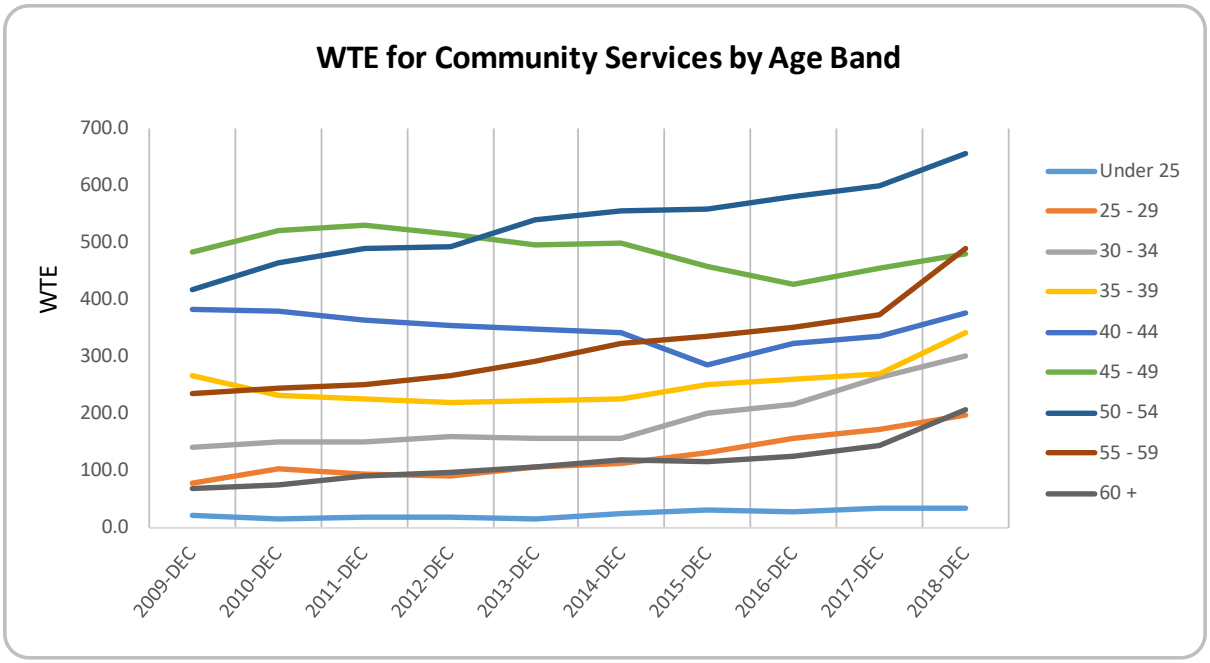
The information within this section has been extracted from the ESR Data Warehouse based on the staff in post at Dec 2009 – 2018.

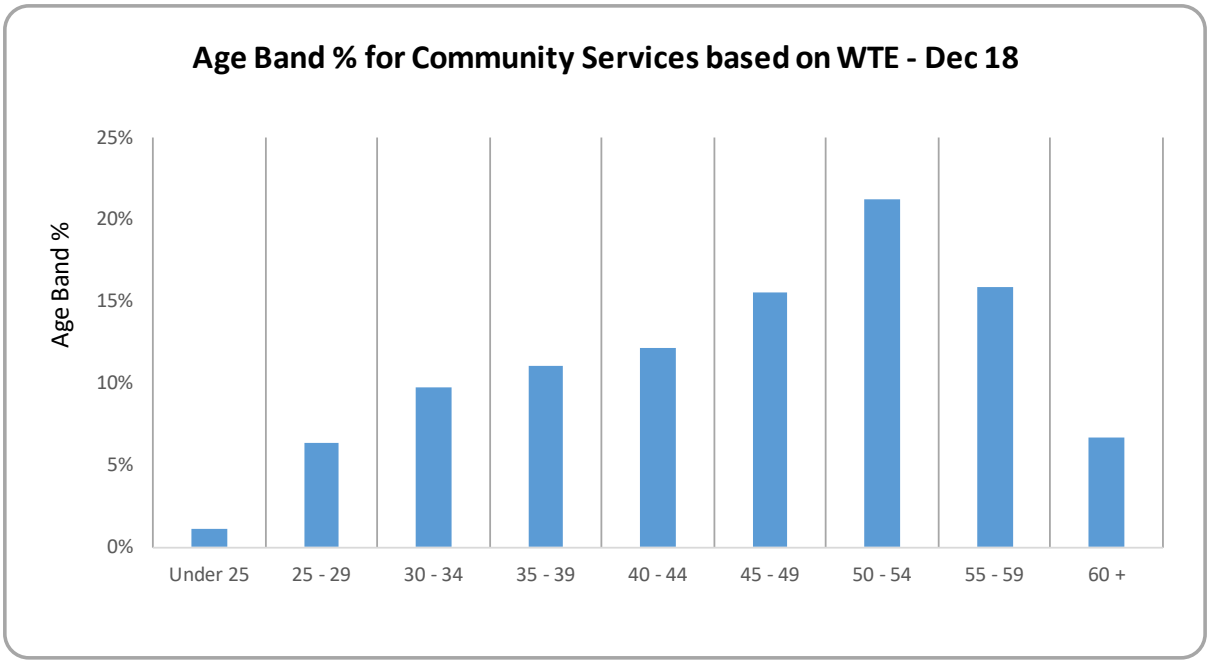
Key points:

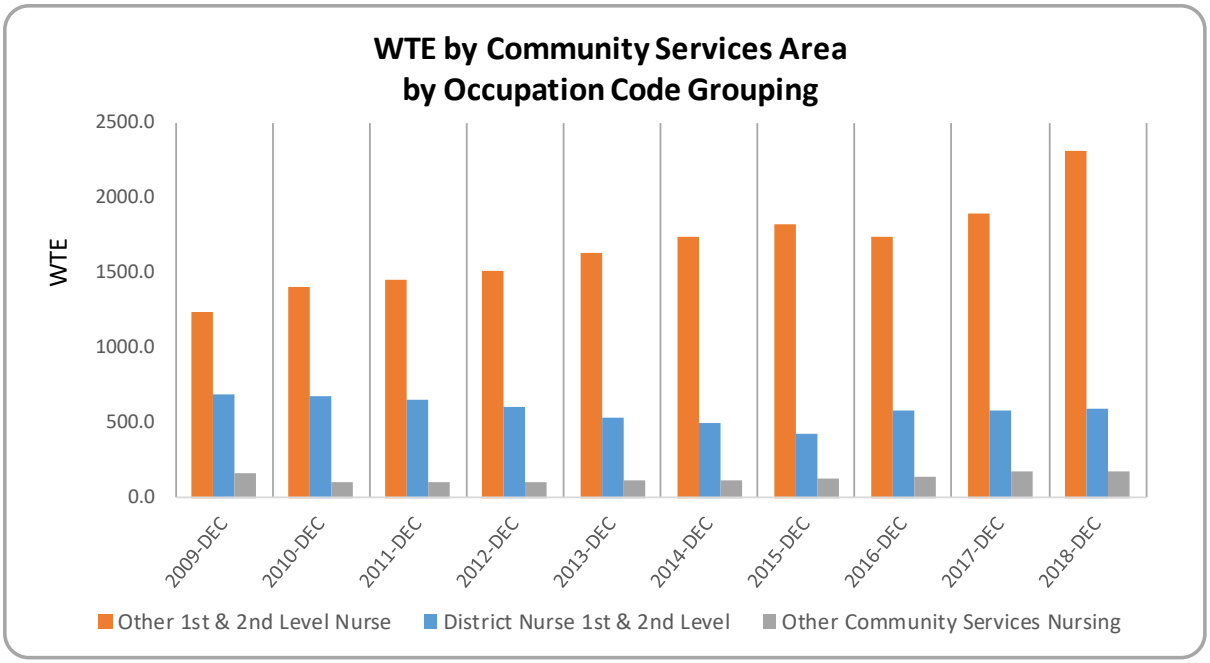
The tables below demonstrate changes to the workforce over this period of time.




WTE for Community Services by Grade
Band 5, Band 6, Band 7 & Band 8a and above
WTE
1600.0
1400.0
1200.0
1000.0
800.0
600.0
400.0
200.0
0.0
2009-DEC
2010-DEC
2011-DEC
2012-DEC
2013-DEC
2014-DEC
2015-DEC
2016-DEC
2017-DEC
2018-DEC
Band 5
Band 6
Band 7
Band 8a and above


WTE for Community Services by Age Band
WTE
700.0
600.0
500.0
400.0
300.0
200.0
100.0
0.0
2009-DEC
2010-DEC
2011-DEC
2012-DEC
2013-DEC
2014-DEC
2015-DEC
2016-DEC
2017-DEC
2018-DEC
Under 25
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 +


Age Band % for Community Services based on WTE - Dec 18
Age Band %
25%
20%
15%
10%
5%
0%
Under 25
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 +


WTE by Community Services Area
by Occupation Code Grouping
WTE
2500.0
2000.0
1500.0
1000.0
500.0
0.0
2009-DEC
2010-DEC
2011-DEC
2012-DEC
2013-DEC
2014-DEC
2015-DEC
2016-DEC
2017-DEC
2018-DEC
Other 1st & 2nd Level Nurse
District Nurse 1st & 2nd Level
Other Community Services Nursing

Introduction

- **Whether we have a clear picture of the district nursing and community nursing workforce in Wales, and the level of need for community nursing services (including future need). Do we have the evidence base to support effective workforce planning.**

Community nursing services play a pivotal role in the assessment, care co-ordination and provision of general nursing care for adult patients requiring care within their own homes, aiming to optimise health and health improvement and our services must be able to have a fundamental role in the implementation of national and local strategies for the future delivery of healthcare. The District Nursing service specification is attached at Appendix 1 to clearly articulate the service it provides to the patients across HDUHB area.

With regards to our district nursing workforce, the services within Hywel Dda are using the All Wales District Nursing staffing principles (issued through CNO's Office) to guide the review and further development of the current district nursing team structures, leadership, capacity, skill mix and supporting roles to ensure that the current District Nursing team structure is based on the best available evidence in order to ensure a solid foundation as it evolves and develops further in the future.

This process, which involves a detailed 'base lining' of each of the DN teams across the Health Board, is currently being undertaken in line with the requirements of Section 25A of the Nurse Staffing levels (Wales)Act (NSLWA)to ensure that 'there are sufficient nurses to allow the nurses time to care for patients sensitively'. The process being used is an adapted version of that required for acute medical/surgical wards which fall under Section 25B of the NSLWA and takes account of a range of variables which impact on the professional judgement required when reviewing district nursing workforce requirements e.g. case numbers, caseload average age, rurality, seasonal trends, clinic commitments etc. (see Appendix 2 for an anonymised working document, work still in progress!)

It is anticipated that this work will then provide the solid basis required for the further evolution and workforce planning of the numbers and skills of the district nursing workforce to be able to make the most effective contribution to the wider strategic direction of community and primary care services, based on the needs of the populations within each cluster and locality across this Health Board. In particular this process is enabling a much more clearly articulated understanding of the number of nurses required who hold the specialist community qualifications, which will in turn enable more targeted commissioning of educational places on such programmes.

As of January 2019, the nature of the district nursing teams/workforce within Hywel Dda University Health Board are as follows:

County	Total number of DN Teams	Total number of staff	No of RN's	No of HCSW	Vacancies
Pembrokeshire	7	67.16 wte	58.72 wte	8.44 wte	2.84
Carmarthenshire	8	102.67 wte	98.53 wte	4.14 wte	3.07 wte
Ceredigion	6	55.2 wte	50.8 wte	2.2wte	4.9 wte

The trends for the workforce for the last 5 years are not readily accessible to be able to provide precise information and although generally there has been little change to the actual District Nursing team workforce over this time, there has been the establishment of a small number of additional community based nursing posts e.g. Frailty Nurse Practitioner, Discharge Liaison Nurse both permanent and time limited (using short term funding sources to test new models/ways of working/professional roles etc.) over this period.

- **Whether there is clear strategy, at national and local levels, about the future direction for district nurse-led community nursing services. How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in A Healthier Wales.**

Hywel Dda University Health Board (HDUHB) provides a Community Nursing Service which is committed to the promotion of holistic nursing care based on clinical excellence; advanced practice; is needs led and responsive to patients within the Hywel Dda footprint. In addition to the current service specification that is outlined within Appendix 1, various documents that reflect and provide the strategic direction of each of our Community services have been recently presented to the HDUHB Board meetings (Appendix 3,4 and 5) These documents reflect the future direction of our community services and demonstrate the fully integrated approach that the community and district nursing services are adopting within their locality-based health and social care services.

The need for high quality care delivered as close to home has been recognised within the Transforming Clinical Services Strategy for Hywel Dda University Health Board. This new health and care model puts community services clearly at the forefront of this strategy with a population health approach that aims to meet local care needs and support people to take control of their own health.

Focussing on improving and extending services to meet the health and care needs of an increasingly older population and to provide services which may have previously been provided within the acute sector and underpinned by risk assessment of the entire population to ensure proactive interventions which maintain wellness, avoid illness, or avoid deterioration, the core principle of the model is to advise, support and treat people in their own home or a community setting wherever possible ensuring that hospital admission only takes place when absolutely medically necessary

The following policy, legislation and guidance inform our service development strategies and include*: The Parliamentary Review of Health and Social Care (2018), Well Being and Future Generations Act (2016) and the subsequent Quadruple aims of influencing and improving the social, physical and mental health of local populations; supporting the development of a sustainable health and care system focussed on prevention and early intervention as well as building and mobilising knowledge and skills to improve health and well-being across Wales.*

Additionally, in line with The Social Services and Well Being Act (2014) the service recognises the duty on health boards to focus on what matters to both the individual and their carers, placing statutory duty to recognise carers as individuals in their own right, a theme which is embedded throughout the service.

The Transforming Clinical Services strategy is reliant on an effective and efficient Community Nursing Service, without which this vision cannot be achieved. Strong community services are paramount for adult patients to remain in their own communities and in their homes; maximising their independence and improving their health outcomes and quality of life.

The service aims to help professionals, commissioners and stakeholders understand the scope of the service. It builds on a range of strategies such as the Together for Health and end of life care directives.

- **How effectively community nursing teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services, and the voluntary sector) to deliver seamless, person-centred care.**

Care provision in the community is becoming increasingly complex, with services once previously delivered within the acute hospitals now provided in community and primary care services. With increasing service demands and challenges of capacity, there are opportunities for community nursing practices to be further developed and provided within a variety of community settings, increasingly in collaboration with key partners across health, social and 3rd sector partnerships. The development plan of one cluster/locality at Appendix 6 is attached as an example of evidence of this.

There are already examples of significant alignment of District/Community nursing services with primary care and other community based agencies, with examples of co-location of teams within our services already showing a significant positive impact on potential for conjoined working.

In addition, the HDUHB Transforming Clinical Services strategy is underpinned by the principle of ever greater collaboration between community nursing services and the acute sector and there are numerous examples of the community/district nursing contribution to this contained within the various evidence documents attached, including the establishment of discharge liaison nurses based in the community and in-reaching into the acute services as one example.

Through such collaboration, efficiencies can be improved through more effective use of resources. With the introduction of various integrated teams within the community settings across HDdUHB, in particular the Community Resource Teams (CRTs) and the establishment of regular multi-disciplinary team meetings, stronger partnerships are being realised and are embedded within practice to maximise resources and improve patient outcomes.

One such example of an integrated approach which the Community/District Nursing services are fully involved with in developing a person-centred care approach to services, is summarised below:

> We are currently re-modelling our community intermediate care service offer against the four pillars of the National Audit for Intermediate Care (NAIC) and specifically focussing on developing a robust crisis response which will respond within 2-4 hours when someone hits crisis. This pathway will be managed through our Single Point of Access – Delta Wellbeing - and will provide a multi-disciplinary assessment and deployment of response at locality level.

Appendix 1

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Community Nursing Service Specification (2018)

This specification provides an outline of the services, operating framework and performance measures for the Community Nursing Service within Hywel Dda University Health Board (HDUHB).

Tracey Evans, Sarah Cameron, Ceri Griffiths
Updated January 2019

Contents

SERVICE SPECIFICATION FOR COMMUNITY NURSING SERVICES ACROSS HYWEL DDA UNIVERSITY HEALTH BOARD

Hywel Dda University Health Board (HDUHB) consists of three Counties, these being Carmarthenshire, Ceredigion and Pembrokeshire; which are divided into 7 operational localities covering a large geographical area (5,781 square kilometres), and consist of both rural and urban communities. The community nursing service provides care for the resident population of the Health Board (385,000) and a high number of visitors who may require the expertise of the community nursing service. These visitors will require to be registered as temporary residents within HDUHB footprint in GP Practices.

1.0 INTRODUCTION

Hywel Dda University Health Board (HDUHB) provides a Community Nursing Service which is committed to the promotion of holistic nursing care based on clinical excellence; advanced practice; is needs led and responsive to patients within the Hywel Dda footprint.

The need for high quality care delivered as close to home is self evident and has been recognised within the Transforming Clinical Services Strategy for Hywel Dda University Health Board. This new health and care model put community services clearly at the forefront of this strategy with a population health approach that aims to meet local care needs and support people to take control of their own health

Focussing on improving and extending services to meet the health and care needs of an increasingly older population and to provide services which may have previously been provided within the acute sector and underpinned by risk assessment of the entire population to ensure proactive interventions which maintain wellness, avoid illness, or avoid deterioration, the core principle of the model is to advise, support and treat people in their own home or a community setting wherever possible ensuring that hospital admission only takes place when absolutely medically necessary

2.0 SERVICE OVERVIEW

The following policy, legislation and guidance have informed the development of this service specification and include*: The Parliamentary Review of Health and Social Care (2018), Well Being and Future Generations Act (2016) and the subsequent Quadruple aims of influencing and improving the social, physical and mental health of local populations; supporting the development of a sustainable health and care system focussed on prevention and early intervention as well as building and mobilising knowledge and skills to improve health and well being across Wales.*

These aims link closely to the mission statements for our community nursing service within the health board which recognise the key aims of the service to:

- *Provide care closer to home*
- *Focus on quality, safety and improving outcomes*
- *Ensure we have a flexible, skilled and motivated workforce*

- *Invest in prevention*
- *Eliminate waste, duplication and ensure value for money*.

Additionally, in line with The Social Services and Well Being Act (2014) the service recognises the duty on health boards to focus on what matters to both the individual and their carers, placing statutory duty to recognise carers as individuals in their own right, a theme which is embedded throughout the service.

The transforming clinical strategy is reliant on an effective and efficient Community Nursing Service, without which this vision cannot be achieved. Strong community services are paramount for adult patients to remain in their own communities and in their homes; maximising their independence and improving their health outcomes and quality of life.

The service aims to help professionals, commissioners and stakeholders understand the scope of the service. It builds on a range of strategies such as the Together for Health and end of life care directives.

3.0 SERVICE AIMS AND OBJECTIVES

Community Nursing Services across Hywel Dda are committed to meeting the following service principles:

- Develop dynamic services consistent with the strategic vision set by Welsh Government.

- Provide consistently high quality and advanced professional assessment and nursing care to patients within the community, which is clinically safe, evidence based, and consistent with National and Local Policy, Clinical Guidelines and the Health Care Standards.

- Reduce unnecessary hospital, residential and nursing home admissions, supporting timely and safe discharge which maintains people in their own homes for as long as possible.

- Through provision of effective education and management, ensure availability of a skilled, and qualified/trained nursing workforce that has adequate capacity and skill mix to deliver an equitable and accessible range of services across the health board.

- Utilise mobile technology when available to support direct patient care and release capacity within the service. This will also support audits and reporting in a timely manner.

- Provide seamless services with a focus on joint working and inter-agency involvement through adoption of the revised unified assessment processes, Integrated Assessment, effective partnerships with Primary Care practitioners, Local Authority Social Services colleagues and participation in the multi-disciplinary assessment process.

- Promote independent functioning and self care through signposting or providing appropriately tailored programmes of education targeted at patients/clients and where appropriate informal carers.

- Develop individualised care plans, specific protocols and pathways in partnership with the individual, their families, carers and other organisations to maximise optimum outcomes.

- Develop and strengthen joint protocols and working arrangements within primary care practitioners and Local Authority Social Services colleagues to maximise patient outcomes through the provision of seamless services with the individuals consent.

- Work closely with Public Health to increase opportunistic public health interventions, supporting the health and well being agenda and to support carers, recognising the importance of prevention and self care.

4.0 SERVICE DELIVERY

Community Nursing Services are provided by teams of community based registered nurses and health care support workers led by qualified District Nurses providing both assessment and care management for people that need unscheduled, long or short term care as well as palliative and terminal care.

District Nurses are generalists with specialist skills and are highly skilled qualified autonomous practitioners. They have undertaken additional qualifications which enable them to make risk based intelligent decisions in supporting patients to remain within their own homes and communities.

Patients on the caseload may have a variety of complex conditions and include: Palliative & Terminal Care, Chronic Conditions Management, Complex Needs Assessment, Wound Care, Pressure Ulcer Management, Continence Management, Catheter Management and Medication Management. This list is not exhaustive.

The service promotes healthier lifestyles, physical, psychological and social wellbeing, encouraging and supporting people with disability and chronic conditions to live as independently as possible. In addition, professional advice and a comprehensive range of treatments/interventions are provided which aim to achieve the following outcomes:-

- *Maintain individuals within their own home for as long as is feasibly possible*
- *Avoidance of unnecessary or inappropriate admissions to hospital*
- *Promote self management of chronic conditions within the community*
- *Facilitate timely and safe transfer of care back into the community where hospitalisation has been required*
- *Promote quality, safety and improve patient outcomes*
- *Facilitate care closer to home*
- *Ensure a flexible, skilled and motivated workforce is in place and*
- *Eliminate waste and duplication and to ensure value for money.*

Care in the community is becoming increasingly complex, providing services once previously delivered within the acute hospitals or primary care. With increasing service demands and challenges of capacity, there are opportunities for community nursing practices to be further

developed and provided within a variety of community settings, increasingly in collaboration with key partners across health, social and 3rd sector partnerships.

Through such collaboration, efficiencies can be improved through more effective use of resources. With the introduction of Community Resource Teams (CRTs) stronger partnerships are realised and multi disciplinary meetings are embedded within practice to maximise resources and improve patient outcomes.

The service plays a pivotal role in assessment, care co-ordination and provision of general nursing care, aiming to optimise health and health improvement. It plays a fundamental role in the implementation of national and local strategies. The service supports the transitional period for children into adulthood and there may be times when younger people are supported through the service when the need dictates.

The Community Nursing Service is diverse; it is operational throughout the 24 hour period and consists of various components including an Acute Response Team (ART), Chronic Conditions Management and District Nursing Team. The District Nurse Team Leader holds a post registration Specialist Practitioner Qualification (SPQ) and they are the leaders of the nursing teams within the community.

5.0 REFERRAL PROCESS AND CRITERIA

The referral criteria for accessing community nursing are based on the three point patient priority criteria shown below.

Referrals into the service are received via a variety of routes including referral forms, telephone, fax, emails and will require all relevant personal information about the patient, reason for referral, treatment required and urgency of response required etc. Referrals are received from a number of sources including:

- Acute hospital (within and outside the Health Board)
- Community hospital
- General Practitioner
- Members of the primary care team
- Local Authority
- Self referral/family for patients previously known to the service
- Community Resource Teams
- Independent sector
- Voluntary organisation

Where additional information is required from referrers, referrals may be returned or contact made to ensure information received is correct. Any hospital referrals should be written and sent in advance for that community nursing services can be involved in any complex discharge planning prior to the patient's discharge home. However, this should not inhibit the provision of timely patient care.

The service acknowledges that there are opportunities to review the referral mechanism into the service, via central access, and this development will be further explored. An example of the current referral form can be found in Appendix 13.1.

6.0 ELIGIBILITY, EXCLUSION, PRIORITY AND RISK MANAGEMENT

6.1 ELGIBLTY CRITERIA

The Community Nursing Service is available to residents of HDUHB who are aged 18 years and older and who are deemed housebound. A housebound patient can be defined as, *'an individual who is unable to leave their home environment due to a physical of psychological illness'.*

An individual is not deemed housebound if they are able to leave their home with minimal assistance. Each individual will be individually assessed to determine their eligibility for the service. Wherever possible those individuals will be transferred to practice based clinics or to an appropriate agency.

There may be occasion for the Community Nurse to visit a patient who is not housebound. This will be based on professional judgement of the nurse and the individual needs of the patient. There may also be times when community nurses will operate a clinic/club service to deliver a service which is more cost effective and beneficial to the well being of the individual, maximising efficient care and reducing duplication of time or effort.

Where appropriate, the Community Nurse will provide a service to those younger than 18 based on clinical need and professional judgement and will support during the transitional period of a person's life. Signposting to children's services will be utilised as appropriate

6.2 EXCLSION CRITERIA

The community nursing service will not routinely accept referrals for:-

- Patients who are under the age of 18*.
- Visits as an alternative to urgent medical assessment.
- Covering practice nurse absence due to annual leave/sickness etc.
- Individuals requiring medication to be dispensed into pre-filled containers or the collection or delivery of medication.

Patients who have expressed the wish for a community nurse visit but who do not meet the housebound or other stated referral criteria.

It is expected that in cases where a referral is not considered appropriate that the Community Nursing Team will liaise with the referrer to discuss the referral and to signpost to other agencies/organisations/community alternatives.

**For patients under 18 years old with complex nursing care needs, advice and support can be obtained from the Community Paediatric Nursing Service.*

6.3 PRIORITY

Priority 1
(Urgent, where contact is necessary within 4 hours)

- Patients who are terminally ill who require symptom control.
- Patients who have been discharged home who are expected to die within 24 hours.
- Patients in discomfort who require an urgent home nursing intervention.
- Patients who require a nursing intervention which, if not delivered would result in a deterioration of their condition or an admission to hospital.
- Patients who require essential clinical visits (patients who are insulin dependent, patients needing bladder or bowel management urgently, patients relying on nurse to administer medication via syringe drivers, peg tubes etc).
- Patients requiring complex or multiple dressings each day.

Priority 2
(Non-urgent, with contact established within 24 hours and a visiting time agreed)

- Patients who may or may not be registered on the caseload and require clinical visits (removal of sutures, routine wound care, central lines, catheter or bowel care).

Priority 3
(Routine, with contact made within 48 hours and a visiting time agreed within one week)

- Patient support or monitoring visits.
- Reassessment for continence aids such as disposable pads.
- Clinical visits which are scheduled weekly or less frequently (3 monthly injections, flu vaccinations, phlebotomy calls).
- Requests for equipment that is likely to be needed for less than 4 months such as commodes, bed cradles, back rests.

6.4 RISK ASSESSMENTS

All teams and community nurse services with undertake individual patient risk assessments where appropriate to ensure the safety of both patients and staff.

All risk assessments will be undertaken in line with Health Board Policies, including the Lone Working Policy to ensure that nurses are kept as safe as possible and are protected at all times. Additionally the Health Board's statements relating to violence and abuse against staff will apply in the community.

There may be times when, in order to reduce the risk of harm, nurses will be expected to visit in pairs or, where there is a lone female, it may be a requirement for a male to attend or in extreme cases, police presence may be required. Following discussion with all relevant health and social care staff there may be times when, in order to maintain a nurse's safety, the service will be withdrawn. It is expected that this will be an exception and the service will ensure patient care and safety is not compromised.

6.5 FAILURE TO GAIN ACCESS PROCESS

Given that Hywel Dda Community nursing services offer home visits predominantly to house bound patients within their own homes, it is inevitable that some appointments will result in failed access to the home for a variety of reasons.

To minimise any risk to patients following failed access, A Failure to Gain Access Policy has been developed for community nursing staff. This guidance has been kept in general terms and each service must ensure that they adapt the main points of the guideline for their own service guideline.

The flowchart identifying processes to be followed in with a failure to gain access can be found in Appendix 13.4

6.6 CHAPERONE PROCESS

In line with the proposed 'Good working practice principles for the use of Chaperones during intimate examinations or procedures within Wales NHS', all community nursing staff are advised to offer patients undergoing such examinations or procedures access to a chaperone, ensuring patients dignity and respect is maintained at all times.

7.0 ESCALATION PROCESS

A Community Escalation Plan has been developed to enable improved communication of the daily risk position of community services within Hywel Dda, ensuring that this information is shared openly across acute, community and primary care. It is the responsibility of the team lead / senior nurse for each team to escalate service pressures and demands to the relevant county management team.

With clear and daily communication proposed between acute, primary and community care services, the escalation plan will enable early awareness and discussion of potential risks within community services which may escalate to impact on patient safety and patient flow.

8.0 STAFFING:

The All Wales Interim District Nursing Principles (2018) endorsed by both Chief Nursing Officer for Wales and the Directors of Nursing for Wales aims to provide baseline guidance for the sustainability of the workforce whilst more robust tools are being developed.

A workload measurement system is currently being explored to objectively assess the workforce/skill mix requirement for the population to meet the current and projected demand. This measurement of quality, complexity and activity will provide a mechanism to influence workload and the workforce required to meet this demand.

Teams will be led by a qualified District Nurse Team Leader, whose role will be to manage and lead the team, co-ordinating the care in collaboration with health and social care colleagues, allocating the work according to assessed priorities, liaising with other services and ensuring care is safely delivered across the 24 hour period, seven days a week. To support the role of the registered nurse and to ensure protected time for managerial responsibilities, the need for administration support will need to be explored.

All District Nursing teams should include a skill mix of the following staff:

- Specialist Practitioner District Nurses
- Registered Nurses
- Health Care Support Workers
- Administration support

The above skill mix is supported by access to appropriately qualified Advanced Nurse Practitioners, and Clinical Nurse Specialists to ensure evidence based practice is provided to patients with more complex needs.

Each team has access to a Clinical Practice Teacher and/or sign off mentor who has responsibility for planning and managing the education, provision to, and assessment of, general and specialist students and for practice and skills development

9.0 MANAGEMENT AND ORGANISATION OF THE SERVICE

Each Community Nursing Team will be grouped within defined localities to form a geographical area. This complies with the locality model which has access to a range of health and social care practitioners.

The Community Nursing Service as the term implies, will be based in the community setting in premises such as primary care/community clinics, GP practices, Community Resource Teams, health centres and community hospitals. Teams will be grouped in geographical areas/localities. The requirements within each County may vary depending on need and work practices.

Currently the IT system is historic and does not meet the needs for a modern Community Nursing Service. There is much variation between the Counties and a single IT system is vital in order to ensure consistent reporting and ability to manage workload, undertake activity analysis and inform training requirements of the teams and to support audit. It is to be noted that additionally, more emphasis must be given on the development of IT systems which allow for data sharing and transfer.

Each geographical locality will have a number of teams of generic District Nurses, (which may be required to support each other within their locality) working with other members of the primary health care team, specialist nurses, therapy staff and Local authority colleagues. The Health Board will ensure however that the long standing GP practice attachment arrangements will be maintained. Appropriate communication will be maintained with each General Practice by the following methods:-

- Each General Practice will have a clearly identified team leader to communicate with.
- MDT attendance, GSF meetings and regular visits to the practice as required.
- Telephone contact as required.
- Palliative care meetings.

10.0 RECORDS AND DATA MANAGEMENT

The District Nursing Services has moved towards a single, standardised documentation format which will maintain individual patients records to the standard specified in the NMC Record Keeping Guidance (2015) and the Health Board policy on Record Keeping.

Standards of community nursing documentation will be scrutinised using the audit tool incorporated within the HDUHB Nursing and Midwifery Record Keeping Policy.

Appropriate records management systems and information sharing polices and protocols will be in place to ensure the protection of confidential patient information and compliance with the Data Protection Act and Caldicott principles.

Documentation will be Integrated Assessment compliant.

Utilise and further develop current electronic community information systems to ensure that relevant information is available and accessible. This is currently being explored on a national level.

Storage of patient records after an episode of care is closed, must be stored in line with the Information Governance Standards.

All records must remain confidential as stated within the Caldicott Guidance.

11.0 MANAGEMENT AND SUPERVISION ARRANGEMENTS

Appropriate management and supervisory arrangements are in place for all community nursing staff including yearly objective setting and performance appraisals. This is undertaken via PADRs and encompasses the revalidation requirements required for NMC compliance and pay progression.

Annual training needs analysis will be undertaken and a training plan developed that supports skill development across the Community Nursing workforce. Emphasis will be placed on revalidation requirements. Mandatory Health Board training must be completed to support the nurse/HCSW within their functional roles.

Measuring outcomes is essential within the community nursing service to monitor the impact on the population health and the individuals under the care of the service. These measures will then inform future service improvement in terms of quality and patient satisfaction. Outcomes will need to be further developed but will include:

12.0 CLINICAL & CORPORATE GOVERNANCE FRAMEWORK

The services described in this service specification will deliver high quality services that are responsive to Healthcare Standards for Wales and with the Health Board's Strategic Objectives.

The service will work within the governance framework; operational within the divisional / directorate structure to ensure best practice; patient, staff and organisational needs are met and governance processes adhered to.

12.1 ANNUAL KEY PERFORMANCE MEASURES

Standards for DN Teams have been reviewed to include the following measures:

- All patients referred to the team are seen within time frame specified at referral
- All patients are seen by a RN on 1st visit (excluding 1st or one off phlebotomy visits)
- All patients have a full holistic assessment within 2 visits (72hours)
- All patients have risk assessments completed and updated at least 6 monthly
- All patients to been seen by a RN at least every 3rd contact
- All patients to be aware of their DN team and contact details
- All patients with a package of care to have a contingency plan in place
- Management plans and advanced care plans are initiated by community teams where appropriate
- Cancelled visits
- Monthly documentation audits are completed and compliance with documentation over 85%
- Annual participation in the Health and Care Standards Audit
- All teams have an up to date and relevant risk register
- Caseload data including numbers on caseloads, dependency, acuity, number of visits and numbers of missed visits to be reported monthly

Performance measures for teams will include:

- All teams to be managed by a B7 Team Leader
- All team members to be over 85% compliant with mandatory training
- All team members to have a PADR annually
- Sickness % to be below national average and health board average
- All teams to ensure they have access to Clinical Practice Teachers and that staff are compliant and in date with Mentor updates.
- All team leaders and deputy team leaders to have a post graduate qualification (i.e SPQ)
- Staff questionnaires and feedback to be encouraged

Quality, Safety and Assurance measures will include:

- Numbers of incidents, serious incidents and safeguarding referrals
- Patient experience, questionnaires, feedback and complaints

These outcomes will be measured and further supported by audits to ensure all aspects are incorporated to provide the assurance of a quality service which can then be measured and benchmarked against other community nursing services. An example of the proposed reporting template can be seen in Appendix 13.5.

13.0 APPENDICES

13.1 Community Nursing Referral Form

<table>
<tr><td>Patient Details:</td><td>GP Details</td></tr>
<tr><td>NHS number:

Hospital Number:

Name:

Address:

Telephone Number:</td><td>GP Name:

Surgery:

Telephone Number:

Next of Kin Name and Contact:</td></tr>
<tr><td>Reason for Referral / Nursing Intervention Required</td><td>Carer Details / Care Package Information:</td></tr>
<tr><td>Priority of Referral (please circle)

Urgent
(Same day / Within 4 hours)

Non-urgent
(Contact made within 24hours and visit arranged)

Routine
(Contact made within 48hours and visit arranged)</td><td>Previous Medical History</td></tr>
<tr><td>Have Any Other Referrals Been Made (i.e. OT / Physio / Social Services)</td><td>Medications on Discharge / Referral</td></tr>
<tr><td colspan="2">Advance Care Planning or Preferred Priorities of Care (PPC)

Is this a palliative care or end of life care referral?

Have discussions relating to advance care planning or DNACR been documented in discharge letter and the original DNACPR issued to the patient on discharge?</td></tr>
<tr><td>Could Patient Attend GP / Practice Nurse Appointment by Car / Taxi / Public Transport?
Yes / No</td><td>Is Patient Housebound

Yes / No

Please State Reason Why:</td><td>Has Patient Given Consent for Referral to District Nursing Service

Yes / No</td><td>Has Patient Been Provided with the DN Information Leaflet

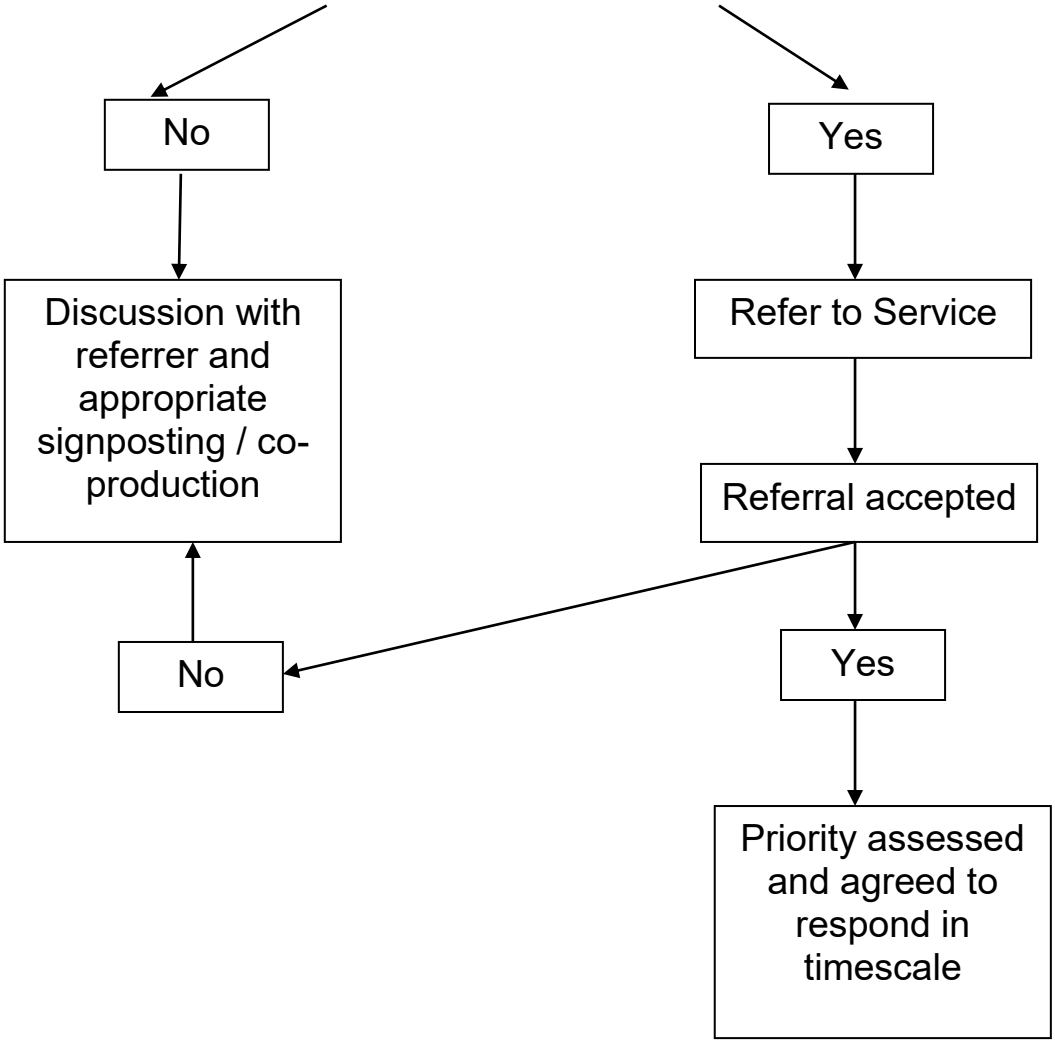
Yes/No</td></tr>
<tr><td colspan="2">Has Patient Been Provided with Sufficient Supply of Medications / Dressings to Take Home with Them

Yes / No
Please give details:</td><td colspan="2">Please ensure that a discharge letter / treatment plan has been attached to referral or sent home with patient.

Please advise patient that the DN Service is between the hours of 9am and 5pm. Patient will be contacted with date of visit but specific times cannot be provided.</td></tr>
<tr><td colspan="4">Details of Referrer – please give your name and contact number for further information if required</td></tr>
</table>

13.2 Process for referral into Community Nursing Services

Patient has identified nursing needs and meets eligibility for Community Nursing Service



13.3 District Nursing Communication Process

The communication flowchart aims to support three key principles in ensuring District Nurses and General practices work effectively together.

Communication → Continuity of Care → Equity of service → Patients Safety

All Patient referrals should be communicated through the normal route for each relevant area.

↓

Each GP practice has a named District Nurse Team member Monday – Friday for urgent referrals.

↓

Each District Nurse Team has a Team Leader responsible for the Team.

↓

Each District Nurse Team has qualified and unqualified nurses responsible to support each GP practice.

↓

Some District Nurse Teams provide support to more than 1 GP practice within a designated sector in a locality.

↓

During normal office hours, Monday to Friday a qualified team member will make contact with each GP practice.

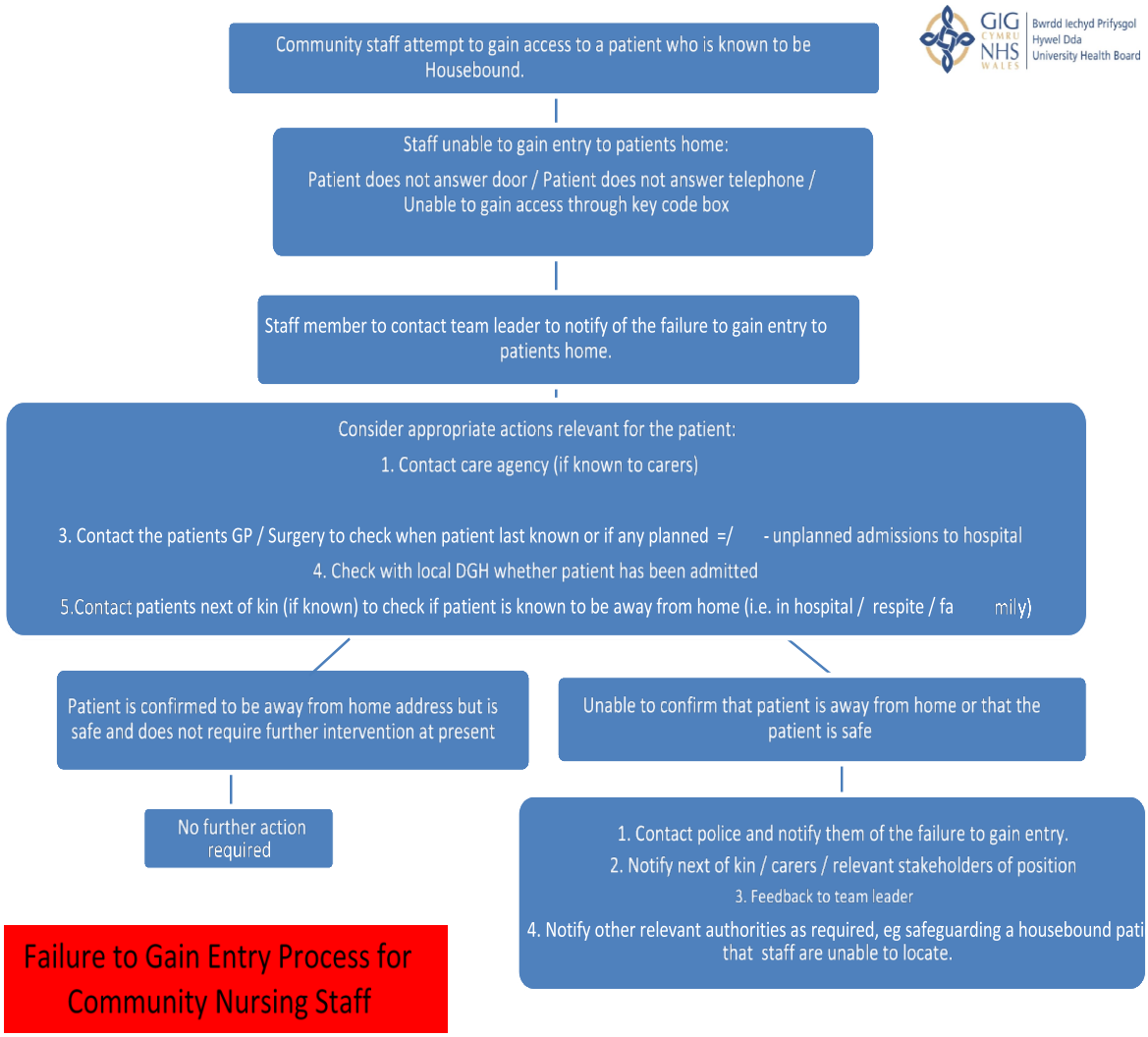
↓

Patients known to community nursing can self refer.

↓

For urgent referrals Out of Hours, contact the Acute Response Team for the relevant area.

13.4 Unable to Gain Access Flowchart



13.5 Key Performance Metrics Reporting Tool

MONTH	Target
Workforce Performance	
PADR compliance for Team as a % (ESR)	**85%**
Mandatory Training compliance for team as a % (ESR)	**85%**
Sickness % to be below national average and health board average	
Current vacancy rate	
% of teams managed by a B7 Team Leader	**100%**
All teams to ensure they have access to Clinical Practice Teachers	
All staff to be compliant and in date with Mentor updates.	**85%**
All team leaders and deputy team leaders to have a post graduate qualification (i.e SPQ)	**85%**
All teams to have 90% compliance in Bronze IQT	**90%**
Number of NHS Wales Staff Surveys completed	**50%**
Operational Performance	
Number of total visits	
Current caseload	
Current budgeted establishment	
Cancelled visits (by staff not patients)	
Number of acute hospital avoided / prevented admissions	
Number of referrals received	
Caseload Data (Primary reason for being on caseloads)	
CHRONIC CONDITIONS	
COMPLEX CARE (INC CHC PATIENTS, DSTs, NNAs ETC)	
CONTINENCE CARE	
MEDICATIONS	
PALLIATIVE CARE (INC EOL, SYRINGE DRIVERS ETC)	
PRESSURE DAMAGE CARE (all grades)	
SOCIAL CARE	
VENEPUCTURE	
WOUND CARE (all non pressure damage wounds)	
Quality, Safety and Assurance	
Total number of Datix open to team	**<15**
Total number of open Serious Incidents	**<5**

Total number of open complaints	**<2**
Total number of safeguarding concerns	**0**
Number of medication errors (if any)	**0**
Number of Health Care Acquired Infections	**0**
Teams to ensure compliance with attendance and participation in monthly MDT meetings	**85%**
Complaint responses to be completed within 30 days	**85%**
Patient feedback / questionnaires received	
Number of compliments received by team	
Monthly clinical supervision / team meetings in place	
Staffing	
Bank shifts requested	
Bank shifts allocated	
Agency shifts requested	
Agency shifts allocated	
Excess hours worked	
Specific standards for DN Teams assessed via Documentation Audits	
% of monthly documentation audit completed	**85%**
Minimum of 5 sets of notes audited per team (including audit of % of patients who are seen by a RN on 1st visit, % of patients who have received a full holistic assessment within 2 visits (72hours) / % of patients who have have had risk assessments completed and updated at least 6 monthly	**85%**
% of patients seen by a RN at least every 3rd contact	**85%**
% of patients who know who their DN team and contact details are	**85%**
% of patients known to have a CHC package of care with a contingency plan in place	**85%**
Each team to ensure they have participated and completed Health and Care Standards Audit each year	**100%**
Each team to ensure that caseload data including numbers on caseloads, dependency, acuity, number of visits and numbers of missed visits to be reported monthly	**100%**

District Nurse Team Review Template

Section 1:

Health board/trust	HDUHB	Ward/department/ team Name	Community	Site	

Planned Roster (Current)

Ward Nursing Staffing Calculator

(Manual Version - enter details in green cells)

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/Shift	Total Hrs	Uplift 26.90%	Management Days (Hrs)	Total WTE
Qualified												
Early	6	6	6	6	6	2	2	7.50	255.00			
Late	0	0	0	0	0	0	0	-	-			
Other	0	0	0	0	0	0	0	-	-			
Night	0	0	0	0	0	0	0		-			
									255.00	**68.60**	**15.00**	**9.03**
Unqualified												
Early	1	2	1	2	1	1	1	6.00	54.00			
Late									-			
Other									-			
Night									-			
									54.00	**14.53**	**-**	**1.83**
											Total Nursing Staff	**10.86**

No weekend cover currently

Tuesday and Thursday – half day leg ulcer clinic. Case load managed via

13 hours of budget for leg ulcer clinic (Band 5 and Band 2 cover). Covered by rest of team when on leave.

0.4 WTE phlebotomy (unfunded). 2 days a week (mornings).

15 hours management: current roster based on 15 hours management (typically 0.2 WTE taken).

Work being undertaken to look at admin support

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Totals	Caseload	Ratio
Current	**9.03**			**1.83**			**10.53 (Quick view)**	**475**	
Proposed	**10.17**			**4.48**			**14.65**		
Difference	**1.14**			**2.65**			**4.12**		

Summary of discussion:	
Plan is to develop catheter clinic	
Speciality/case mix:	Population 17,000 Caseload averages: 450-500 Visit numbers: 1250 visits per month Elderly retired population (% patients over 65 is 28%) Higher % of frail elderly with multiple co-morbidities, higher than average number of patients with long term conditions requiring support as well as higher than average number of palliative and EOL patients) High number of catheter patients – identified need to develop continence clinics with additional staffing (double in comparison to other teams) Generally affluent area with small pockets of deprivation Highly complex patients requiring intensive support (eg, currently around 5 patients) Leg Ulcer Clinics x 2 weekly managed centrally but requires backfill CHC patients – around 5 9 DN case holders for these patients High numbers of care homes – currently 9 (residential) which require large proportion of caseload time taken up with patients in these care homes including additional workload for NNA's / DST's etc Also provide cover and support to residential home side on a daily basis (any nursing care requirements). Challenges are managing restricted access to town centres, difficulties with holiday makers - logistical challenges Additional patients come onto caseloads during peak season from out of area (often for palliative care and diabetes) which poses significant operational and organisational challenges GP practices covered are 3 Geographical area – mainly urban, not large geographical spread
Shift /session Pattern	Monday to Sunday 9am – 5pm (7.5 hours shift patterns). Unable to cover weekends with HCSW due to complexity of caseloads on weekends B4 would allow for more complex work to be delegated, complex wound care / compression bandaging, continence assessments, reassessments of patients with LTC's etc – pick up RN workload rather than HCSW

	Team mix 1 x B7 2 x B6 (currently runs on 1 x B6 due to vacancies and this would be the preferred model moving forward) – in establishment. Being reviewed and consideration being given to appointing Band 5 rather than inexperienced Band 6.
Best Practice Standards for Staffing Requirements for the specialty	All Wales DN Principles B6 vacancy at present – to review benefits of converting this to B5 (experienced B5) Admin and B4 roles identified as benefiting the team most moving forward. Current re working of phlebotomy hours would support this With additional B5 cover then the B6 could take more clinical leadership responsibilities and would allow B7 to manage managerial responsibilities in 15 hours. Additional staffing would allow a more proactive rather than reactive approach to development of service / team / quality / safety etc
Patient dependency and acuity information	All data being collected is in early stages and needs additional evaluation to ensure this is most effective measurement. Awaiting All Wales DN Levels of Care to be trialled. Current data used to evaluate dependency and acuity includes; Units of time - predicted vs actual staff / workload – captures vacancies / sickness / unplanned work etc; measures dependency of patients with more complex patients requiring more units Monthly dashboard data (breakdown of caseloads into categories eg, Complex care, wound care, continence care, end of life care etc.
Patient Flow Data: consider admissions/discharges/ attenders/number on the case load/ average length of stay or on caseload/bed occupancy	Variable – unplanned work cannot be predicted, unit of time attempting to capture this on a monthly basis. More data and evaluation is needed. All teams are encouraged to review caseloads regularly to ensure caseloads are appropriate and in line with the service specification.
MDT input to the ward/department/team/ service	1 x MDT session per month ART support with unplanned and out of hours work Care at Home Team support with end of life care (hospice at home) picking up some CHC patients (band 7 (coordinator role) Band 5 and Band 3s). In place alongside DNs (DN the case holders). No formal CRT in place
CNS input to t he ward/department/team/ service	All CNS / ANP's are encouraged to support teams with patients Long Term Conditions CNS / ANP Heart Failure CNS Palliative Care CNS Continence CNS

	TVN CNS Frailty: not being assessed routinely currently. Refer on to others at the moment. Having to be reactive currently rather than proactively managing patients

Quality Indicators (review the incident data for the previous two quarters and trend data for the previous 12 months)

All are required to consider medication errors and complaints/concerns/redress and any other quality indicators which are deemed to be nursing sensitive for their area (e.g. delay in escalation around a deteriorating patient).

Medication errors	None
Complaints/concerns/redress	Small number of complaints / concerns. No serious allegations / complaints Care home – personalities rather than nursing care
Other nurse sensitive quality indicator	Datix generally well managed and in timely manner.

For those areas that capture data on the Health Care Monitoring System (monthly indicators and annual audit data) then this data should be considered.

professional judgement

Students numbers (audited and actual)	1-2 students No current SPQ Students No current pre reg students No CPT in the team (Band 6 and 7 have shown interest)
Mentor number compliance	Compliant
Student feedback	No concerns raised – very good feedback – enjoy their placements Induction booklet being developed
Staff mix (NRN/Experienced)	Mixed team: Several new members of staff with little community experience, additional experienced B5 staffing required to support Band 5 induction booklet being developed and standards on preceptorship
Use of temporary staff (access/mix)	Bank to cover vacancies (regular bank staff).
Specialist training needs/achievement	TNA is ongoing to identify the training needs of the team Majority of team have not had any opportunity for personal or professional development due to constraints of the team B6 / B7 as well as B5 need to be able to access training to develop roles within team

	Need to develop link nurses / champions Gaps in training availability (e.g. wound management training). Continence promotion day & updates. No training on diabetes – poor support for diabetes in Pembs generally.
Mandatory training needs/compliance	81%
Sickness %	No long term sickness
PADR compliance %	90%
Vacancy number %	24.5 hours vacancy Band 5 - currently being backfilled by bank
Welsh language speakers	%
Admin Support	2 Hours
Geographical region	Generally urban with some rural /coastal areas
General Population numbers	17002
Number of adults >75 yrs	2324 (14%)

Planned Roster (proposed after review of evidence/data above)

Ward Nursing Staffing Calculator

(Manual Version - enter details in green cells)

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/Shift	Total Hrs	Uplift 26.90%	Management Days (Hrs)	Total WTE
Qualified												
Early	6	6	6	6	6	2	2	7.50	255.00			
Late	0	0	0	0	0	0	0	-	-			
Other	0	0	0	0	0	0	0	-	-			
Night	0	0	0	0	0	0	0		-			
									255.00	**68.60**	**15.00**	**9.03**
Unqualified												
Early	1	2	1	2	1	1	1	6.00	54.00			
Late									-			
Other									-			
Night									-			
									54.00	**14.53**	**-**	**1.83**
										Total Nursing Staff		**10.86**

Ward Nursing Staffing Calculator
(Manual Version - enter details in green cells)

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/Shift	Total Hrs	Uplift 26.90%	Management Days (Hrs)	Total WTE
Qualified												
Early	6.5	7.5	6.5	6.5	7.5	2	2	7.50	288.75			
Late	0	0	0	0	0	0	0		-			
Other	0	0	0	0	0	0	0	-	-			
Night	0	0	0	0	0	0	0		-			
									288.75	**77.67**	**15.00**	**10.17**
Unqualified												
Early B4	1	1	1	1	1	0	0	7.50	37.50			
Early B3	2	2	2	2	2	0	0	7.50	75.00			
Early B2	1	1	1	1	1	0	0	4.00	20.00			
Night	0	0	0	0	0	0	0	-	-			
									132.50	**35.64**	**-**	**4.48**
											Total Nursing Staff	**14.65**

Band 2 admin/phlebotomy role

No weekend cover required from team leader perspective

Need additional RN Tuesday & Thursday for leg ulcer clinic

Audit being undertaken to look at demands from practice for weekend work

RN: Monday & Wednesday 6, Tuesday, Thursday and Friday 7, 2 on weekend

Band 3 to work 7 days – one every day Mon-Sun, 2 on Tuesday and Thursday leg ulcer clinic and 2 on Friday to cover.

Bid for falls coordinator role

Incidents linked to lack of training

Section 2:

Summary of discussion:

Actions required		
Action required	**BY whom**	**Outcome**
Share the paper on champions		

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 November 2018
TEITL YR ADRODDIAD: TITLE OF REPORT:	Report on Quality and Safety of Community District Nursing Services in Carmarthenshire 2017/18
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joe Teape, Deputy Chief Executive/Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Neil Edwards, Interim Head of Integrated Services Rhian Dawson, Interim County Director & Commissioner

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper is presented to the Board to provide the 2017/18 reported position of quality and safety of Community District Nursing Services in Carmarthenshire. The report outlines service alignment with Welsh Government policy, University Health Board strategic objectives and King's Fund characteristics of good quality care.

Cefndir / Background

The purpose of this paper is to describe and explain the importance of community nursing in meeting the policy objectives of both Welsh Government and Hywel Dda University Health Board, in particular its role in the transformation of services needed to meet the current and future challenges facing the healthcare system. Also, to provide both assurance and evidence of an accessible, safe, reliable and quality-driven approach to patient care against key quality characteristics of a community nursing health care service. Finally, to highlight the challenges and issues facing community nursing.

The scope of the report covers the community district nursing service including the 24/7 Acute Response Team (ART) for the county of Carmarthenshire. It excludes both community hospitals and the specialist palliative care unit Ty Bryngwyn.

Welsh Government policy and our own Health and Care Strategy has endorsed a vision for health and social care in Wales where community services are integral to achieving the transformation in services which is needed to meet the current and future challenges facing the health care system. They are an essential component in efforts to provide person centred, co-ordinated care closer to people's homes, focusing on keeping people well and independent and minimising hospital stays wherever possible.

However, the King's Fund (2016) report that despite their crucial role, community district nursing services can be overlooked in terms of robust national indicators to benchmark and monitor performance. Information technology and infrastructure are not well developed to support quality measurement, which poses a risk for the future as the service experiences growing demand and faces acute workforce challenges.

This report provides evidence that, despite challenges, the Carmarthenshire community nursing service is of a high standard, based on a highly trained and capable workforce, a sound professional ethos and good systems of working including service development and innovation.

Asesiad / Assessment

Carmarthenshire Community Services has 3 locality community district nursing teams; Llanelli, Amman Gwendraeth and Carmarthen (3Ts). These teams consist of community nurses, nurses with special interest (falls and frailty), and healthcare support workers led by clinical leads caring for patients within a local area alongside GP clusters. The county has an Acute Response Team (ART) working alongside the locality teams consisting of community nurses with advanced skills.

As explained, there is a national absence of good quality reliable benchmarking data for community district nursing. Notwithstanding this challenge, it is possible to argue that the district nursing service when evaluated against King's Fund characteristics of a quality service can evidence it provides a safe and quality service for patients in the community. The key strengths of the service can be summarised as a strong focus on patient safety and a person centred and holistic approach to care, supported by a stable, reliable and highly trained workforce. Positive outcomes are reported by patients and families supported by excellent partnership working arrangements, in particular with primary care, healthcare professionals and local authority social care staff. There is evidence of a low incidence of safeguarding incidents and complaints.

The service has continued to develop and improve its systems and processes including improvements in care plans and the accuracy of clinical record keeping. There have been local advances in electronic records and shared care plans, releasing patient contact time for community nurses. Each community nursing team has a data capture system (CONNIS) for patient care and intervention that also acts as a rota and shift management system.

Recent performance data on community nursing staff compliance with mandatory training reported high levels of compliance with Personal Appraisal and Development Reviews (PADRs) and the team is working diligently to improve compliance with all statutory and mandatory training. Staff development and training is pivotal, alongside recruitment and retention of a skilled workforce. Workforce pressures in the community nursing service within Carmarthenshire include 45% of the workforce being eligible for retirement within the next five years. These are highly experienced people and not easily replaceable.

Argymhelliad / Recommendation

The Board is requested to acknowledge assurances within this report that Carmarthenshire community district nursing service provides an accessible, effective, safe and quality service for people living in the county.

The Service has continued to grow and develop, and has demonstrated it has met the challenges and, importantly, has the capability and potential to meet the future challenges facing the healthcare system. There is a culture of service development and innovation throughout the Carmarthenshire Community nursing healthcare system.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Risk Register Reference:	Community Services: 1,3,4,5,7,11,13,17,23,26,28,30,31,32 Acute Services Risk Registers Operational Therapies Risk Registers
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	1. Staying Healthy 2. Safe Care 6. Individual care 7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	1. To encourage and support people to make healthier choices for themselves and their children and reduce the number of people who engage in risk taking behaviours 8. To improve early detection and care of frail people accessing our services in cluding those with dementia specifically aimed at maintaining wellbeing and independence. 10. To deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working: Hyperlink to Well-being and Future Generations Act 2015 - The Essentials Guide	Please explain how each of the '5 Ways of Working' will be demonstrated
	Long term – can you evidence that the long term needs of the population and organisation have been considered in this work? Long term - the importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs. The strategic context section of the report outlines our approach to balancing the needs of our population
	Prevention – can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health? A preventative approach is at the heart of our delivery model and the report describes delivery against three broad tiers of provision to our population: Prevent 'Help to Help yourself' (the prevention of illness or injury), Reduce 'Help when you need it' (reducing impact of illness and injury) and Delay 'Ongoing Help when you Need It' (delaying the impact of frailty with an outcome focused approach to care planning).

	Integration – can you evidence that this work supports the objectives and goals of either internal or external partners? Many of the community initiatives are financially supported through the Integrated Care Fund, therefore are underpinned with the need not only to meet the Health Boards well-being objectives, but also the West Wales Care Partnership Outcomes Framework as agreed by Welsh Government and the agreed Mid-Wales priority themes.
	Collaboration – can you evidence working with internal or external partners to produce and deliver this piece of work? The report demonstrates the collaborative working across community, primary care, statutory service providers, private service providers and fundamentally across professional disciplines.
	Involvement – can you evidence involvement of people with an interest in the service change/development and that this reflects the diversity of our population? Understanding individual's needs and community resilience is key to many of the initiatives listed. Working with the individual community to enable it to realise its capacity is becoming a new way of working. This could be through discussions with community groups, or through the 'what matters' conversation with individuals.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Social Services and Wellbeing (Wales) Act 2014 Future Generation (Wales) Act 2015 Prosperity for All: the National Strategy (Welsh government) 2017 King's Fund Characteristics of Good Quality Care in District Nursing 2016
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Carmarthenshire County Management Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	There is a risk that Integrated Care Fund and Cluster Funding from WG may cease in 2020. This funding has been critical to modernising our approach to population health in community services.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Our model has been developed in consideration of the evidence base relating to service provision that improves quality of patient care, improving individual outcomes while delivering 'care closer to home'
Gweithlu: **Workforce:**	There is a risk that the future workforce may be compromised due to potential cease of ICF and cluster funding in 2020. To mitigate this we are already planning contingency. However, workforce modernisation is a key focus when planning service delivery to meet population need both now and in the future
Risg: **Risk:**	Risks associated with finance, patient care and workforce are articulated within our County Risk Log along with mitigating actions
Cyfreithiol: **Legal:**	Our strategic model is compliant with both the Social Services and Wellbeing (Wales) Act as well as the Wellbeing of Future Generations Act. We have had a Section 33 agreement in place for some years which has allowed us to develop a joint management structure
Enw Da: **Reputational:**	Four of Carmarthenshire's service areas have been identified as exemplars by the Bevan Commission. We have also been commended for our implementation of the Welsh Language Standards 'Active Offer' for our Single Point of Access 'Dewis Sir Gar'
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	Equality Impact Assessments are routinely undertaken on consideration and implementation of new or reviewed services

Integrated Services in Carmarthenshire
November 2018

Report on Quality and Safety of Community District Nursing Services in Carmarthenshire

Reporting on 2017/18 position

Contents

Purpose and Scope of Paper

The purpose of this paper is threefold:

- To describe and explain the importance of community nursing in meeting the policy objectives of both Welsh Government and Hywel Dda University Health Board, in particular its role in the transformation of services needed to meet the current and future challenges facing the healthcare system which are aligned to the work undertaken as part of the development of the Health and Care Strategy;

- To provide both assurance and evidence of an accessible, safe, reliable and quality-driven approach to patient care against key quality characteristics of a district nursing service;

- To highlight the challenges and issues facing community nursing.

The scope covers the community district nursing service including the 24/7 Acute Response Team (ART) for the county of Carmarthenshire. It excludes both community hospitals and the specialist palliative care unit Ty Bryngwyn.

Policy Context

Welsh Government policy and our own Health and Care Strategy has endorsed a vision for health and social care in Wales where community services are integral to the vision:

The vision should be “of care organised around the individual and their family as close as home as possible, be preventative with easy access and of high quality, in part enabled via digital technology, delivering what users and the wider public say really matters to them. Care and support should be seamless, without artificial barriers between physical and mental health,

primary and secondary care, or health and social care." *The Parliamentary Review of Health and Social Care in Wales. A Revolution from Within: Transforming Health and Care in Wales.*

The King's Fund research (2016) suggests staff, patients and carers have strongly aligned views about the "components" of good district nursing care, valuing a whole person approach with a focus on relational continuity, involvement of family and carers, patient education and self-management support and care co-ordination.

Community district nursing services are crucially important to achieving the transformation in services which is needed to meet the current and future challenges facing the health care system. They are an essential component in efforts to provide person centred, co-ordinated care closer to people's homes, focusing on keeping people well and independent, and minimising hospital stays wherever possible.

However, despite their crucial role, community district nursing services "can seem strangely overlooked by the general national agenda on assuring and improving quality" (*Managing quality in community health care services,* King's Fund 2014). The report and subsequent King's Fund report *Improving Quality in Community District Nursing: Listening to patients, carers and staff* (2016) argues that community nursing is "severely hampered by a lack of robust comparable national indicators that would enable them to benchmark their performance…. Information technology and infrastructure are not well enough developed to support quality measurement." A "lack of data means that the quality of community services and the outcomes it is providing for patients remain to a large extent unknown at the national level… This is particularly dangerous in the coming years as the community district nursing service experience significantly growing demand and face acute workforce challenges. There is a serious risk that poor or declining quality will not be identified promptly."

This report provides evidence that community district nursing is of a high standard, based on a highly trained and capable workforce, a sound professional ethos and good systems of working including service development and innovation.

Local Context

At a policy and strategic level, the University Health Board endorses the principles and ideas of the Parliamentary Review, a Healthier Wales and Prudent Healthcare.

For purposes of improving quality, the University Health Board's approach relies on consistent and well understood use of methods and tools to continuously improve the way we do things. The following quality improvement goals have been identified as they underpin the University Health Board's Quality Improvement Strategic Framework 2018-2021, and the strategic objectives and organisational values:

- No avoidable deaths
- Protect patients from avoidable harm from care
- Reduce duplication and eliminate waste
- Reduce unwarranted variation and increase reliability
- Focus on what matters to patients, service users, families, carers and staff

Outcomes include:

- The identification of gaps in service delivery and solutions to fill them
- Collaborative approach to reflect on significant events and risk and implementing pathways to reduce risk
- Reporting risk and serious untoward incidents (SUI)

Each of these objectives, values and outcomes are implicitly considered within the scope of this Report.

Governance

There is good evidence of quality management systems and processes to oversee accountability, quality and safety of the community nursing service.

An Operational and Performance group chaired by the Head of Integrated Services, with the Head of Community Nursing and the five designated lead nurses in attendance, meets monthly to consider quality and safety issues. The themes and issues of this report provide the focus for this Group.

At the meeting held on 3 October 2018, considerable attention was allocated to the effectiveness of community nursing and its approach to patient quality and safety. A specific group has been introduced to report to the Operational and Performance group where all aspects of patient safety matters can be considered in detail, thereby providing greater opportunity to improve and learn from practice.

Carmarthenshire Community Services

Carmarthenshire County has 3 locality community district nursing teams; Llanelli with 58 staff, Amman Gwendraeth with 45 staff and Carmarthen (3Ts) with 66 staff. Staff teams include bespoke Continuing Health Care (CHC) support workers who focus on CHC patients only. These teams consist of community nurses, nurses with special interest and healthcare support workers, led by clinical leads caring for patients within a local area alongside GP clusters. The county has an Acute Response Team (ART) with 36 staff consisting of community nurses with advanced skills and health care support workers, the ART team works seamlessly together with both the acute service and their community nursing colleagues, handing over patients between teams and alongside the locality teams.

Community District Nursing: The Service and what it provides

The community district nursing service provides the following services in the county of Carmarthenshire:

- Advice and support
- Bowel care
- Continence management
- End-of-life care
- General nursing care
- Health education
- Injections (intramuscular/intravenous/subcutaneous)
- Intravenous therapy, including chemotherapy
- Leg Ulcer care
- Medication administration
- Pain control
- Percutaneous endoscopic gastrostomy (PEG) feeding (artificial feeding through a tube inserted directly into the stomach)
- Phlebotomy (blood taking)
- Prescribing
- Pressure area care (to prevent the development of pressure ulcers)
- Referral to other services
- Risk assessment
- Skin care
- Urinary catheterisation and ongoing catheter care
- Wound care

Nine Characteristics of Good Quality Care in District Nursing (King's Fund 2016)

The first three characteristics of good care that were most commonly described, and often the most intensely felt, were:

- caring for the whole person

- continuity of care
- the personal manner of staff

In addition, people receiving care and their carers spoke of:

- the importance of visit times being predictable and reliable
- being able to contact services between appointment times

Additional characteristics that were important to all participants, but to a lesser degree, were:

- valuing and involving carers and family members
- nurses acting as co-ordinators and advocates
- clinical competence and expertise

Staff also emphasised the importance of their role in supporting and educating patients to manage their own health and care needs.

Each of these characteristics is integral to the ethos and standard of care delivered by the Carmarthenshire community nursing service.

For illustration, “Caring for the whole person” involves:

- holistic person-centred care rather than task focussed care
- seeing the person, not the need
- considering the person’s other health conditions, social issues and wider circumstances not just a particular condition.

Quality can improve because people who receive care and the carers

- feel supported
- benefit from the social interaction of visits

Measuring the Quality of Carmarthenshire's Community Nursing Service

As explained, there is a national absence of good quality reliable benchmarking data for community district nursing. Notwithstanding this challenge, it is possible to argue that the district nursing service when evaluated against the above nine characteristics of a quality service can evidence it provides a safe and quality service for patients in the community. The key strengths of the service can be summarised as follows:

Strong focus on patient safety

- A person centred and holistic approach to care supported by a stable, reliable and highly trained workforce
- Positive outcomes for patients as reported by patients and families (In order to provide more tangible evidence of satisfaction, the Service has developed in 2018 a patient information leaflet to provide patient and carer information on how to both raise issues of concern as well as provide feedback on the service.)
- Excellent partnership working arrangements, in particular with primary care, healthcare professionals and local authority social care staff
- Low incidence of safeguarding incidents
- Low incidence of complaints

Continuous Improvement and Effectiveness-related Priorities

The community service has continued to develop and improve its systems and processes. For example:

- Improvements in care plans and the accuracy of clinical record keeping verified by spot checks
- Developing electronic records and shared care plans
- Efficiency improvements to release more patient contact time for community nurses
- Integrating or partnership working to: enable single point of access for patients (for Llanelli with further work planned countywide); improve

care pathways; develop more innovative or collaborative ways of working (Sharepoint)

- Actions to support people with long term conditions to manage their conditions better
- Improvements in reporting of compliance with National Institute for Health and Care Excellence (NICE) guidelines. For community nursing services, however, Excel spreadsheets are used for recording of care provision, and this is noted as an area for development.
- The Service is engaging currently in the National Fundamentals of Care Standards Questionnaire

High Focus on Staff Engagement, Organisational Culture and Quality Improvement

It is important that there is a culture of staff engagement and the promotion of a positive work culture. A failure to achieve this will have a significant adverse effect on patient safety (The Francis Report 2013).
Within community nursing services, structures and processes are in place led by the Head of Community Nursing and the senior nurse management team, where professional values and ethos are shared and cascaded to staff. In addition, staff surveys are undertaken across the University Health Board in which community nursing staff engage fully.

Key Data 2017/18

Acute Response Team (ART)

Total number of referrals: 3,852 referrals as compared with 3,435 in 2016/17 (12% increase on previous year).

The ART facilitated 236 early discharges (31% increase on the previous year) from secondary care for the treatment of patients with IV antibiotics at home.

The ART avoided 146 admissions to secondary care (33% increase on the previous year) through GP referral for IV antibiotics.

382 patients treated with IV antibiotics at home (32% increase on the previous year), attending 5,794 house calls to administer IV antibiotics. This in turn has freed up 3,805 bed days in both general hospitals.

The amount of referrals received from General Practitioners to commence their patients on IV antibiotics has risen year on year. In 2017/18, 146 patients were referred from GPs for the commencement of IV antibiotics at home, a 33% increase on the previous year. This has been the case year on year, and can only prove that the confidence and awareness of the service by clinicians in the primary care setting continues to grow and patients are being referred to ART as a safe and effective alternative to admission.

The ART service provided 10,940 home visits for other interventions such as supporting palliative/end of life patients in the out of hours period and preventing Accident and Emergency attendances from patients with blocked indwelling urinary catheters. In total 16,727 house calls were performed during the year.

The cost of operating the ART is approximately £2,000 per day; £712,000 per year. Based on 3,805 saved bed days (£1,434,485), the ART has saved approximately £722,485 on the provision of intravenous antibiotics alone. This does not take into account any cost savings associated with the ART teams 10,940 home visits for all other interventions.

Case Study of the ART Intravenous Antibiotic Service

Each year since the inception of the ART there has been an increase in the volume of patients treated at home with IV antibiotics.

- 196 patients were treated with IV antibiotics during 2013/2014

- 262 patients were treated with IV antibiotics during 2015/2016
- 289 patients were treated with IV antibiotics during 2016/2017
- 382 patients were treated with IV antibiotics during 2017/2018

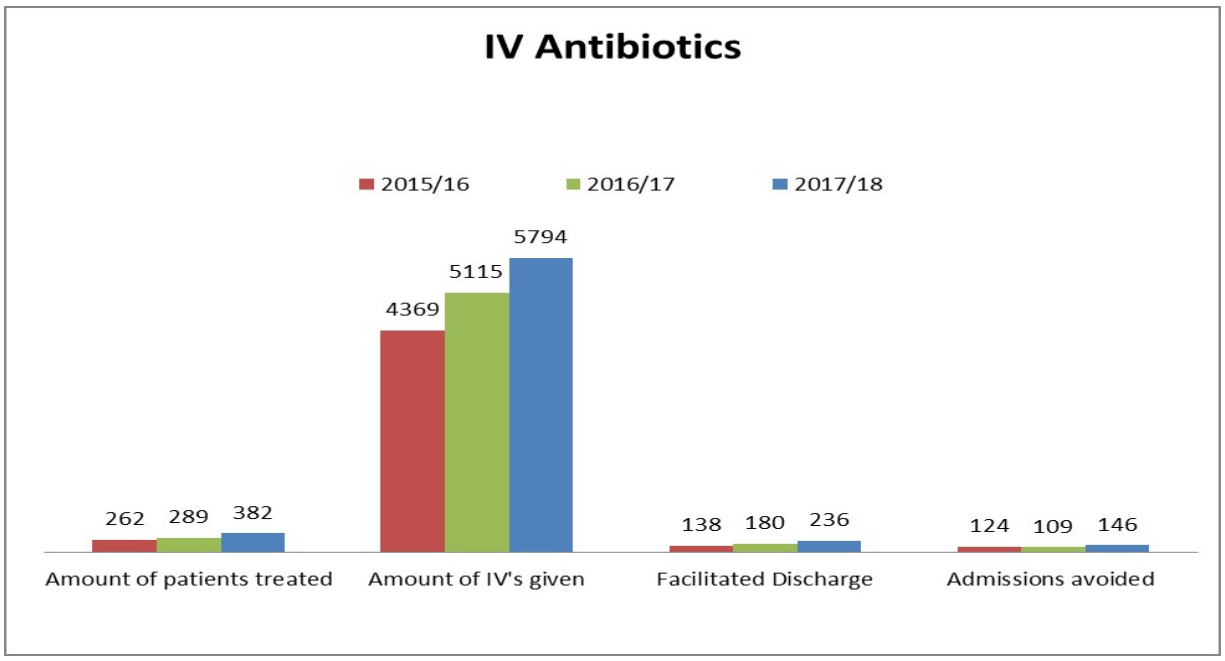
In the past five years, there has been a 105% increase in the amount of patients treated in a year on IV antibiotics.

The length of stay of patients on ART's IV antibiotic caseload has also increased. In the first few years of the ART service, where there was only one team working in the county, the service was a time limited 7-10 day intervention service. However, since service expansion and due to the service's ability to care for more than double the amount of patients, this has changed. Many patients are being referred for 4-6 weeks of IV antibiotic treatment for complex and ongoing infections which necessitate longer term treatment regimes. These patients are all treated for the extended time period in their own home, whereas, prior to the introduction of the service, these patients would have remained as in-patients for the duration of the treatment. Evidence suggests that increased lengths of stay in the acute sector can result in deconditioning of patients which further compromises the patient's recovery.

The ART team is also seeing more patients exercise their rights and choose (with clinician agreement) to have their treatment in their own home.

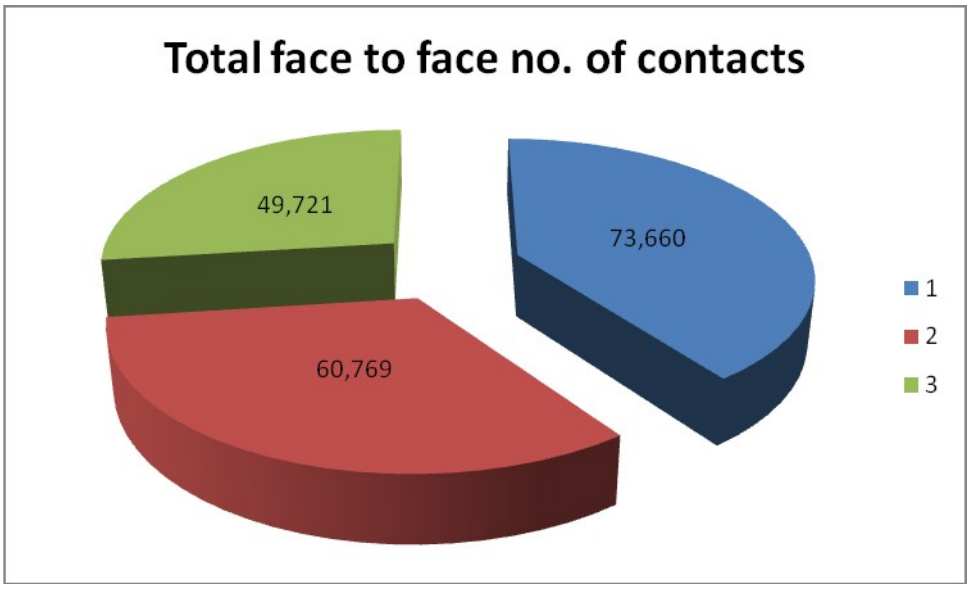
Lastly, and most importantly, 382 patients were treated with IV antibiotics at home last year, an increase of 93 patients as compared to the previous year (32% increase). The total amount of bed days saved to the University Health Board in 2017/18 is 3,805 bed days. This is an increase of 421 bed days saved compared to the previous year.

The chart below demonstrates the amount of IV Antibiotic house calls performed by the ART during the last 3 years:



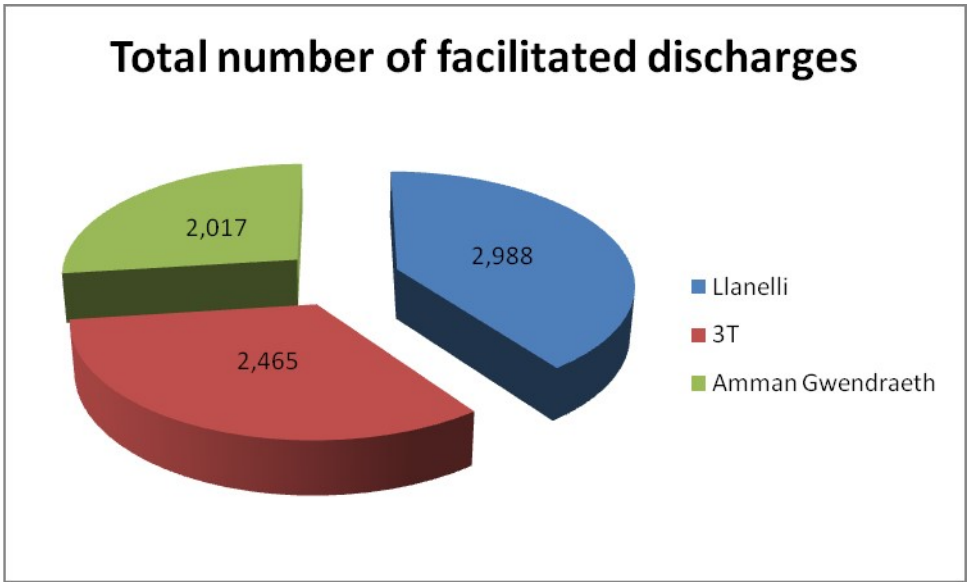
Community Nursing

The 3 localities have seen a significant increase in activity, with a total increase of 12% on the previous year as detailed in the table below:



Total face to face contacts: **184,150** in 2017/18

Number of facilitated discharges: 7,469 divided between the 3 localities with Llanelli having the highest discharges as identified below:



In addition, a high proportion of patients fulfilled their expressed wish to die at home (89.15%) whilst supported by the Continuing Care Team with their End of Life care; equating to 128 patients. This translates into an enormous number of scheduled visits via a small team for end of life care at 5,376 (as the majority of the patients receive over 4 calls per day).

Community Nursing and Leg Ulcer Clinics

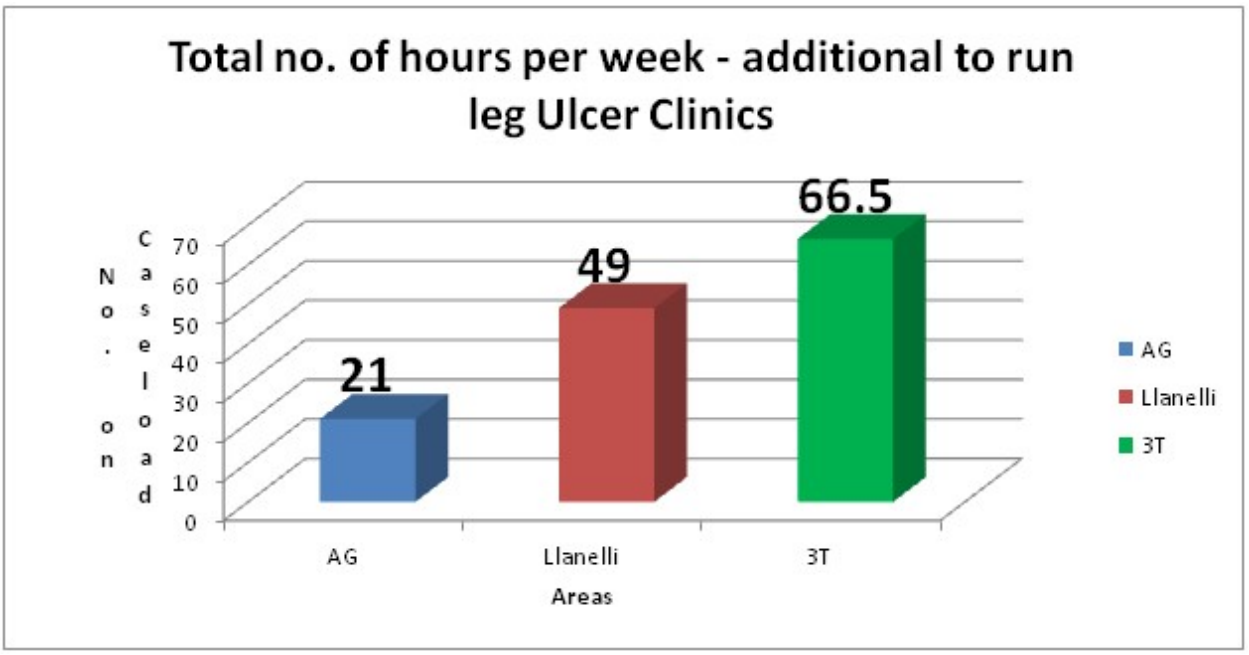
There are currently 10 Leg Ulcer clinic venues, providing 40 sessions of clinics per week across Carmarthenshire in the localities of; Amman Gwendraeth (AG), Carmarthen (3T) and Llanelli. These clinics are currently providing care for approximately 157 patients per week.

This support has a requirement of an additional 136.5 hours of direct care per week, equating to:

Amman Gwendraeth team 21 hours per week
Llanelli team 49 hours per week
3T (Carms area) 66.5 hours per week

As the chart below indicates:

Carmarthenshire Community Services 2017/18



The community staff are supported by the nurses with a special interest in Tissue Viability, who support the leg ulcer clinics, as well as supporting patients who are housebound with pressure damage, complex non healing wounds, investigating pressure damage, training and education.

In the past 12 months the nurses with a special interest have also been involved in a project teaching residential care home staff employed by Social Services in non complex wound care following the Agored Cymru framework of assessment. This project has been highly successful; the evaluation has evidenced the release of qualified nurse hours attending the care homes within the project.

Key areas of Quality Priorities for the Service

Risk management

As noted above, risk management is an explicit priority for the University Health Board. There is clear evidence of high standards of professional practice based on regular training of staff. In addition, the Service has seen

the introduction of new University Health Board community nursing documentation including risk assessment with reference to Sepsis

Strengthening safeguarding systems

The community district nursing service plays a full part in meeting its safeguarding obligations as required by both the Social Services and Well-being (Wales) Act 2014 (Part 7: safeguarding) and its own professional standards of care towards people requiring care and support. Members of the community service attend the appropriate level of safeguarding training and comply with all aspects of the safeguarding process. This will include providing information as requested, attending safeguarding strategy meetings and general advice and co-operation to enable the protection of adults at risk. Appendices 1-3 demonstrate high levels of compliance for safeguarding training.

Moreover, members of the service attend the various strategic safeguarding meetings or specific task and finish groups as required e.g. University Health Board Safeguarding Sub-Committee, the recently established whole system approach to pressure damage. The University Health Board has a robust governance system for safeguarding led by the Director of Nursing, Quality and Patient Experience.

Relationships with partners to drive forward quality goals

In Carmarthenshire, where community nursing service sits within a joint health and social care structure, the conjoined services have built up strong links between the two principal organisations responsible for driving forward quality goals. This is evidenced by the professional relationships which are well embedded within a mutually respectful and supportive environment where nursing, occupational therapy, physiotherapy and social care staff are co-located in each of the Community Resource Teams. This collaborative approach enables the achievement of improved outcomes for patients and users of services with evidence of closer working relationships with both primary care and third sector organisations.

Root cause analysis of incidents

Investigations are undertaken by the service to ensure it learns lessons and shares good practice. Historically, the service has been output focussed, however more recently, a more outcome focussed approach has been applied. Examples include the work undertaken in learning and improving on healing rates of venous leg ulcers, and the percentage of people who die in preferred place of death.

Sharing learning

There is a positive culture towards learning and disseminating such learning across the service. It is an expectation that the Community Lead Nurses lead this process and share amongst their teams. These arrangements are strengthened with the Datix reporting systems to the Director of Nursing, Quality and Patient Experience..

Measuring Quality through data

Data and metrics

Each community nursing team has a data capture system (CONNIS) for patient care and intervention which also acts as a rota and shift management system. This is a sophisticated system which enables excellent collation and analysis of patient quality and safety data.

As a whole, the service operates a data repository system as opposed to a data reporting system.

Workforce Development and Training

It is a prerequisite, in order to deliver a safe and quality service for patients and families, that the workforce is suitably trained in all aspects of health care provision. The University Health Board's *Improving Quality Together* (IQT) provides a quality standard for its staff. (This consists of three 20 minute e-learning modules.) It is positive to report that all community nursing staff

have reached the Bronze level and will be commencing training on the Silver level from April 2019.

In addition to this, the recent performance data on community nursing staff compliance with mandatory training reported exceptionally high levels of compliance. There is strong evidence of high levels of compliance with Personal Appraisal and Development Reviews (PADRs), safeguarding, health and safety and other relevant requirements.

Issues affecting Quality in Community Services

Workforce issues

The importance that the organisation must attach to developing and supporting the workforce has been noted above. The King's Fund has argued that:

- System leaders must recognise the vital strategic importance of community health services in realising ambitions for transforming and sustaining the health and social care system
- There is an urgent need to create a sustainable district nursing workforce by reversing declining staff numbers, raising the profile of district nursing and developing it as an attractive career
- Robust mechanisms for monitoring resources, activity and workforce must be developed alongside efforts to look in the round at the staffing and resourcing of community health and care services for the older population.

The nature of workforce pressures in the community nursing service within Carmarthenshire which are most noteworthy include:

- 45% of the workforce are entitled to retire currently or within the next five years. These are highly experienced people and not easily replaceable
- In contrast, a new "junior" workforce is being developed; while positive, this can create practical challenges.

Professor Don Berwick of the Bevan Commission maintains that workforce is one of, if not **the top challenge** and priority facing the NHS. Investment in capability and supporting the workforce is fundamental, however more than this he argues that “there is no route to excellence other than through joy and work. You can’t beat, exhort, incent a workforce to achieve excellence. You can achieve compliance but not excellence.”

The service has a strong commitment to the provision of training and continuous professional development among the Service. Alongside this, the Service is reviewing its workforce and measures that can be developed to improve the well-being of its staff. What is absolutely fundamental for the Service to evolve and face the challenges is continued development, investment and support in the community district nursing service. This is achievable based on its track record of performance.

Conclusion

Carmarthenshire community district nursing service provides an accessible, effective, safe and quality service for people living in the county of Carmarthenshire.

There is evidence of committed, well-motivated and highly reliable staff providing a service in line with the nine characteristics of a quality district nursing service, in particular the three key quality characteristics that matter to patients and their families: caring for the whole person; continuity of care and the personal manner of staff.

The Service has continued to grow and develop and has demonstrated it has met the challenges and, importantly, has the capability and potential to meet the future challenges facing the healthcare system. There is a culture of service development and innovation.

The Service can provide an important role in the Welsh Government and the University Health Board's ambition to achieve the vision of the *Parliamentary Review* and *Transforming Clinical Services* respectively.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	31 January 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Focus on Healthcare Services in Pembrokeshire
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Executive Director of Operations/Deputy Chief Executive Jill Paterson, Director of Primary Care, Community & Long Term Care Alison Shakeshaft, Executive Director of Therapies & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Elaine Lorton, County Director - Pembrokeshire

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In June 2018, Pembrokeshire County provided an update to the Board on the current model of services, new innovations and outcomes for our population. We gave a commitment to provide an update on the development of our integrated service model and how we are working together to enhance outcomes and experience for our population.

On 28th November 2018 the Board approved the future vision and strategy for the Health Board - A Healthier Mid and West Wales : Our Future Generations Living Well. This paper provided an update on our approach to integrated planning and our first year plan for delivering against the Strategy.

Cefndir / Background

In November 2018 the Board approved the future strategy for the Health Board: A Healthier Mid and West Wales Strategy. A significant element of this was the development of an enhanced community model of care and a refocussed social model for health.

Our strategy comes at a time when Welsh Government have also set a clear ambition for A Healthier Ways (2018), reinforcing the messages in the Well-being of Future Generations Act (2015) and the Social Services and Wellbeing Act 2014.

The University Health Board (UHB) Teams, along with colleagues from the third sector, Pembrokeshire County Council and the Welsh Ambulance Service Trust (WAST), have been working together to translate this vision into a development plan. Although the challenge is significant, there is tangible enthusiasm to work differently and build on the strong foundations of collaboration. Through monthly meetings and workshops, the initial structure of our plan has been developed and this paper seeks to provide an overview as well as provide some examples where our model is emerging.

Asesiad / Assessment

To ensure our plan was co-produced, co-owned and co-delivered, it was developed across the County, Acute, Mental Health and Learning Disabilities, Therapies, Medicines Management, Clinical Support Services and Corporate teams within the UHB, as well as with our key partners in Pembrokeshire County Council, Pembrokeshire Association of Voluntary Services (PAVS), Public Health Wales (PHW) and WAST. Both Localities were involved through their Leads and four jointly agreed themes for successful whole system delivery were established :

- Compassionate teams & leadership
- Enabling the right response for each person
- Integrated teams around the person
- Equitable outcomes and quality years to life

It was felt that these four themes, if delivered, would ensure that fulfilled and empowered staff, working in multi-disciplinary teams around a person's needs, would be delivering a high quality, positive experience for our population with equitable outcomes and added years to life.

Recognising that this is in its entirety a longer term goal, the initial 5 high impact actions for 2019-20 were agreed as :

Compassionate, Resourceful & Resilient Communities: We will focus on strengthening our communities to care for themselves through embedding community connectors and co-ordinators into our Integrated Community Networks. This relates to the wider determinants of health and wellbeing and ensures that we retain a strong and clear focus on the co-production needed with and within our communities.

Integrated Community Networks & Care Co-ordination: We will develop five Integrated Community Networks around populations of 20-25,000 people that will deliver integrated care seamlessly at a local level by aligning our services and co-ordinating our care around our population, based on their needs and the shared understanding of what matters most. These networks, once established, will provide the stable foundation for the wider system to be built upon.

Integrated Localities: We will develop the two Integrated Localities in order to ensure delivery is seamless at a locality level, that there is evolved governance in place to empower the Localities to identify, plan and deliver based on the care needs of the population, both resident and temporary. This will require a focus on business support, facilitation and governance to support a Locality driven system which works across organisational boundaries of the existing UHB, Local Authority and Third Sector.

IMPACT: We will develop, implement and embed a new Integrated Team which delivers for the Intermediate Care needs of our population to co-ordinate step up, step down care and flow through acute services for our population. It will ensure a reduction in length of stay and an improved outcome position in terms of delivery targets and patient experience.

Palliative Care Plan: We will work with our population and stakeholders to develop a system wide plan for Pembrokeshire which will align the existing services around a shared ambition for our population in order to enable high quality, compassionate and dignified care at the end of life for our population and their families / carers.

More detailed plans for delivery of the Integrated Community Networks and Teams, along with what Health and Wellbeing Centres or Community Hospitals would be needed, would be co-

produced through continuous engagement with our communities and stakeholders.

The first of the stakeholder events was held on 14th December 2018, with four more being planned between January and March 2019. These will provide the structure both for ongoing engagement but also the detail of the evolving and emerging models of care.

The model for Integrated Localities, and the leadership required for system and service delivery, is in development with Local Authority Partners and a commitment has been made to integrating health and social care. Integrated Localities will be responsible for the delivery of seamless care to our population and will require support from a range of business support functions.

Representative examples of the current service developments have been provided to highlight that the plans are more than words on paper, they are meaningful and accessible services and care provided within our communities. The examples are not intended to assure the Board of the totality of service delivery across Pembrokeshire, rather to highlight some of the current ambition, dedication and delivery undertaken by our teams.

Argymhelliad / Recommendation

The Board is asked to note the content of the report and to support the plans and initiatives identified which will strengthen services and provide integration on all levels, across organisations and between individual services in improving the health and wellbeing of the population of Pembrokeshire.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Risk Register Reference:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working:	Please explain how each of the '5 Ways of Working' will be demonstrated **Long term** The Integrated Pathway considers the wider, holistic and whole system needs of our population, this includes Long Term Care and how we need to deliver this together with Local Authority, Third and Independent Sector partners.

Hyperlink to Well-being and Future Generations Act 2015 - The Essentials Guide	**Prevention** The Integrated Pathway considers the wider, holistic and whole system needs of our population, this includes Prevention and how we need to deliver this together with Local Authority and Third Sector partners.
	Integration Integration is at the heart of this paper, both in terms of the work already undertaken, the system wide approach to planning and delivery and the future model for providing care around our population with a wide range of stakeholder partners.
	Collaboration How we collaborate across our system is a key element of this paper, both in terms of what is currently being delivered as well as the importance in planning our future model of care.
	Involvement Critical to the development of our plan and the evaluation of our existing service delivery is the engagement and involvement of our communities. Some patient stories and feedback have been used to evidence outcomes of pilots as well as ongoing and continuous discussion in our communities through our provider servicers and the TCS programme.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Various – outlined where evidenced in the body of the report.
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Various dependent upon each element in the report.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	This paper has no direct financial impact however the emerging model will require additional resource, this has been specified in the Annual Plan.
Ansawdd / Gofal Claf: Quality / Patient Care:	The aim of the emerging model is to improve the quality of patient care and the equity of outcomes. Where there is specific evidence this has been provided in the body of the report. It will be essential to ensure that the Integrated Pathway clearly identified metrics which assures improvement for our population.

Gweithlu: **Workforce:**	This paper does not directly impact the workforce however it does reference changes which will be needed to both bring integrated teams together, and develop elements of these teams where there are gaps identified. Additional workforce will be required in the community in order to deliver on the plan.
Risg: **Risk:**	The risks to not improving and developing our community model of integrated care have been articulated in the Strategy case for change.
Cyfreithiol: **Legal:**	This paper does not present any direct legal risks however dependent on the final model of integration, there will be legal issues regarding employment and accountability for service delivery which will need to be resolved.
Enw Da: **Reputational:**	Failure to deliver an integrated community model of care will reputation ally damage the Health Board both in terms of the mandate and expectation from Welsh Government, but also the needs and assurances given to the population through the approved Strategy.
Gyfrinachedd: **Privacy:**	No direct impact from this paper.
Cydraddoldeb: **Equality:**	No direct impact from this paper however as part of any future service change proposal, a full Equality Impact Assessment will be undertaken.

Delivering the Pembrokeshire Integrated Plan
January 2019





Introduction

In June 2018, Pembrokeshire County provided an update to the Board on the current model of services, new innovations and outcomes for our population. We gave a commitment to provide an update on the development of our integrated service model and how we are working together to enhance outcomes and experience for our population.

On 28th November 2018 the Board approved the future vision and strategy for the Health Board - A Healthier Mid and West Wales : Our Future Generations Living Well. This paper provided an update on our approach to integrated planning and the plan for delivering against the Strategy.

Planning for our population together

It is the ambition of the Pembrokeshire Integrated Plan to effectively reflect the population health and social care needs within our communities and specific areas for delivery to meet these current needs and improve the population's wellbeing in the longer term. This will ensure alignment throughout the region and reduce the risk of conflated or contradictory plans. The themes are also reflective of the priorities of the Public Services Board and West Wales Care Partnership, as identified in the Well-being Plan and Area Plan respectively.

To ensure our plan is co-produced, co-owned and co-delivered, it has been developed across the County, Acute, Mental Health and Learning Disabilities, Therapies, Medicines Management, Clinical Support Services and Corporate teams within the University Health Board (UHB), as well as with our key partners in Pembrokeshire County Council, Pembrokeshire Association of Voluntary Services (PAVS), Public Health Wales and Welsh Ambulance Service Trust (WAST).

For the past 3 years, the Cluster Plans have described the way clusters / localities will embrace the assets of individuals, communities and organisations to deliver a health and care system that supports residents to be well and independent. These plans have predominantly been informed by the GP practices, working within clusters, however these are increasingly changing to become integrated. It is our ambition in 2019-20 to develop specific Integrated Locality Plans which will reflect the whole system and build on the strong foundation of the Cluster Plans. The learning from the previous years' Locality funded projects has been used to inform this Integrated County Plan.

Our jointly agreed priorities for Pembrokeshire, to ensure integrated delivery to our population based on their needs by effective and skilful teams, can be summarised by the 4 key themes below.

- Our Teams function effectively and each individual delivers to the best of their ability for our community
- We utilise our time efficiently, creating opportunities for development and minimising duplication

- The flow of care for our population is right across the whole system with each person getting an appropriate, timely and high quality response based on their needs
- We understand the demand in the system and we align our Teams to deliver in the most effective way

- Integrated Teams stratify the needs & respond in a multi-professional & agency with the patient and their families / carers
- Integrated Teams are co-located in Hubs and outreach to spoke sites and people's homes to deliver care

- We understand the population needs and where there are inequalities in the system and actively plan in an integrated way to meet these
- We ensure our clinical and patient pathways are delivering the most effective outcomes

To support the overarching delivery of these key themes our 5 most impactful actions are:

Compassionate, Resourceful & Resilient Communities: We will focus on strengthening our communities to care for themselves through embedding community connectors and co-ordinators into our Integrated Community Networks. This relates to the wider determinants of health and wellbeing and ensures that we retain a strong and clear focus on the co-production needed with and within our communities.

Integrated Community Networks & Care Co-ordination: We will develop five Integrated Community Networks around populations of 20-25,000 people that will deliver integrated care seamlessly at a local level by aligning our services and co-ordinating our care around our population, based on their needs and the shared understanding of what matters most. These networks, once established, will provide the stable foundation for the wider system to be built upon.

Integrated Localities: We will develop the two Integrated Localities in order to ensure delivery is seamless at a locality level, that there is evolved governance in place to empower the Localities to identify, plan and deliver based on the care needs of the population, both resident and temporary. This will require a focus on business support, facilitation and governance to support a Locality driven system which works across organisational boundaries of the existing UHB, Local Authority and Third Sector.

IMPACT: We will develop, implement and embed a new Integrated Team which delivers for the Intermediate Care needs of our population to co-ordinate step up, step down care and flow through acute services for our population. It will ensure a reduction in length of stay and an improved outcome position in terms of delivery targets and patient experience.

Palliative Care Plan: We will work with our population and stakeholders to develop a system wide plan for Pembrokeshire which will align the existing services around a shared ambition for our population in

order to enable high quality, compassionate and dignified care at the end of life for our population and their families / carers.

In order to deliver our services seamlessly at a local level within Pembrokeshire, we will develop a series of Integrated Community Networks (ICN). These are complex and interwoven collections of information, groups, services and professionals which may interact with our population face to face, on the phone or through digital platforms. At the centre of each network, which would serve approximately 20 – 25,000 people, there would be a Health & Wellbeing Centre or Community Hospital; although these are likely to be a physical presence within the ICN, they will also link virtually through the use of technology.

It is expected that care will be co-ordinated through Integrated Community Teams aligned to the ICN. These teams may include members of staff directly employed by the UHB, however staff may also be employed by the Local Authority or other public or third sector organisations. Team work will be governed by a shared ambition on outcomes, along with collaborative operating procedures.

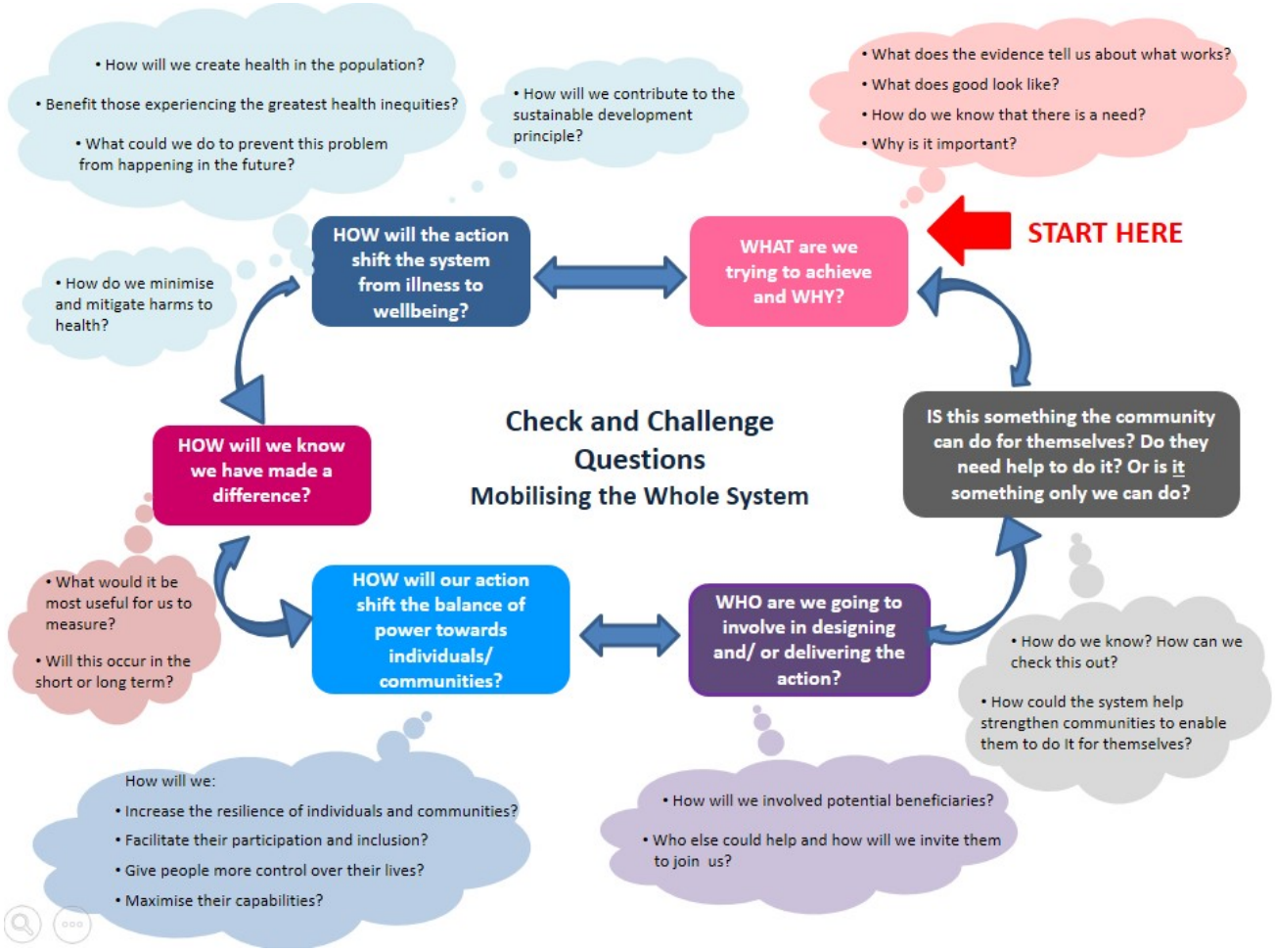
In Pembrokeshire we expect our Community Model to deliver the following key outcomes:

- Integration of teams to work across the Network to deliver seamless care for our population
- Co-ordination, both of care for those with multiple needs and of information regarding the opportunities available across the network for both our population and staff
- Co-location of teams and services to improve our seamless approach to deliver
- A focus within communities for wellness, community resilience and networking. This should provide opportunities for communities in terms of resilience and wellness to use other forms of community currencies such as: ***Time, Social contact, Information, Skills and learning, Space & Objects***

Health & Wellbeing Centres within a Locality or County, or across the whole Region, may also take on specific purposes which complement the whole needs of our population and therefore will form part of a wider integrated network across the County.

The Board has approved the development of a plan for the existing Community Hospitals, working with local communities. This plan will be focussed on the provision of ambulatory care including out-patient services, diagnostics, treatment, observation, rehabilitation and end of life care. The need for beds as part of Community Hospitals will be considered as part of the emerging plan.

In order to progress delivery of this strategy in Pembrokeshire five initial workshops will be held with key stakeholders before the end of March 2019. These will define our approach to further co-production with the local communities. The first of these was held in Goodwick on 14th December 2018 and a positive discussion took place that supported the ongoing development and enablement of community based initiatives which are connected and accessible. The discussion tool below was used to support the workshop :



The five Integrated Community Networks for Pembrokeshire are:

South East Pembrokeshire Community: A registered population of 25,800 (13.2% > 75 years) of Narberth, Saundersfoot & Tenby Surgeries. This group will also develop a plan for the development of Tenby Cottage Hospital and how this links with Narberth and across this large rural area. A key focus in this area will be on same day and urgent care access for the local and temporary population, with particular reference to meeting the needs of the older age community.

South West Pembrokeshire Community: A registered population of 23,000 (9.9% > 75 years) of Argyle Medical Group. This group will also develop a plan for the development of South Pembrokeshire Health & Social Care Resource Centre, South Pembrokeshire Hospital (SPH). A key focus in this area will be on rehabilitation services within the community building on the existing services co-located in SPH. It will be important for this group to rapidly identify the need to community beds as part of the long term model.

Milford Haven & Neyland Community: A registered population of 20,700 (9.8% > 75 years) of Robert Street, Barlow House and Neyland & Johnston Surgeries. This group will consider a development plan for the Neyland community in 3-5 years and the networked approach with Manchester Square. A key focus in this area will need to be considered by the group but could include key elements of long term chronic condition management.

North Pembrokeshire Coastal Community: A registered population of 21,200 (12.1% > 75 years) of Solva, St David's, Fishguard and Bro Preseli Surgeries. This group will consider a development plan for the Fishguard community which links effectively across this wide rural area. A key focus will be on the longer term wellness and prevention opportunities of working across statutory and third sector organisations with a key focus on reducing social isolation for the older age community.

Haverfordwest Central Community: A registered population of 27,000 (9.5% > 75 years) of St Thomas and Winch Lane Surgeries. This group will consider the central network needed to support wider county clinical teams that respond urgently to the step up and step down care of our population.

Over the next year, the future model for Pembrokeshire will be further aligned to the Transforming Mental Health and the Women and Children's plans. This will ensure we have an integrated health and care system that works for our whole population and all their needs.

We have aligned our plan with the 6 components of the Integrated Pathway, reported on in the previous report. Some of the examples of projects and services may currently be locally provided and the evaluation and expansion of these services will depend on the co-produced Integrated Community Networks and resource availability.

STEP 1: Help me to choose and age well

Our Plan: It is particularly important that preventative services are easy to access as maximum benefit is achieved if used before individuals reach a crisis and have more intensive needs of support or care. Focusing on strengthening communities is vital for services aimed at maintaining and enhancing community connections and providing support at an early stage. Being able to get support locally is often high on an individual's list of what is important to them. Our overall aim is to ensure that Pembrokeshire keeps improving as a place to grow and age well. We also want to support our residents to manage long term health conditions or physical disability effectively. An understanding of the range of services available within the community will be key to this, especially the role of Community Pharmacies in offering "Walk in" services.

We aspire to become a Resilient & Compassionate County, whereby our community resilience is effectively supported from within and we enable neighbours, carers and community groups to help themselves and each other to stay well, choose well and age well.

2018 Progress & Activity

Most Significant Change: hearing what matters most for our population is critical in the current delivery and future design of services. In Pembrokeshire a project has been running with Swansea University to capture the "Most Significant Change" (MSC). The following two stories have been chosen as both illustrate how fragile we humans are and how quickly life's circumstances and the response of people around us can bring us down or lift us up – whether we are young or old, our confidence can be so easily undermined and without it we cannot go far. They also illustrate how what might be perceived as 'little things' can have such a big impact – a Sunday roast or a reassuring word.

A panel has been convened to review each submission with membership from the Local Authority, UHB and Third Sector senior officers as well as elected members.

The learning from this approach has been significant:

- A lot of professional practice is made less human by risk aversion. We need to foster 'common sense' and really listen to people about what matters to them
- Risk aversion can also creep into community-based activities and stifle naturalness and humanity – 'the quest for perfection drives out the good'
- Kindness goes a long way – 'what more do any of us want than others to be kind to us'
- People only seek information help when in a crisis. Whilst some of the stories seem low key, they clearly illustrate how people are building networks of support that will come into their own when a storm hits. Without these networks of support that can respond 'in the moment', people can quickly end up in services. We should not underestimate their value and cost-benefit
- People generally blossom when grow within the local context

- Normal and ordinary services like libraries could be the new 'social services' so think twice before you cut them. They may deliver the outcomes you want at a fraction of the cost of traditional services
- We must seize the moment – the policy context is ripe for putting humanity before bureaucracy
- We often focus on the big stories about what has gone wrong – but learning and vitality can come out of focusing on the everyday good; the 'magic moments' from everyday practice
- Different things work for different people, but the fundamental approach is the same

What's out there? Dare to dream

Background to my story: I moved into Perrott's Lodge 7 months ago after spending a period of time in a mental health hospital. I am prompted to wake up and prepare for the day, starting with breakfast. I help with daily living skills within the house. I see my dad often and try to help him when I can. Support staff drop me off there. I also walk with staff most days. I love archaeology and am currently studying geography, German and Welsh and I do speak a small amount of Welsh. I enjoy eating and will often buy beef for Sunday dinner and help prepare it.

What changes have happened:

- Staff here are good – they support and listen to me
- I was able to spend Christmas with my dad, which I was unable to the year before as I was in hospital and was not granted leave.
- Originally, I was subject to a Section 3 of the Mental Health Act and came to Perrott's Lodge on a Section 17, which has now been removed
- I find Perrott's Lodge a place of safety and security, which has helped to stabilise my mental health

Which of these changes are most significant to me?
Removal of Section 17 and being able to live in a calm and supportive environment. As a result I have not needed to have PRN (as and when required) medication

What it was like before
During my stay in the psychiatric units I felt afraid and isolated. Often, there was conflict between me and the staff and sometimes other patients. No one supported me to feel good about myself and I was allowed to become very dishevelled. I was restricted in what I could and could not do and felt that staff guarded me. I felt very vulnerable.

What it is like now
I feel secure and independent and take more pride in how I dress and appear. I am able to go out, and most importantly I have choices and I feel 'free'. I am not the person I was – I have my life back. Staff listen to me, but know that I need support to maintain routines that are important to my well-being. We work together. I feel able to study again, where I could not before due to the levels of stress in the psychiatric units. My Section 17 has been lifted and I don't have to see professionals so often. I am able to be with my dad a lot more. Our relationship is good and he is not worried now.

What happened to make the changes come about
I found myself in a safe, secure place that really carers for me. I need consistency and routine in my life, but also peace and Perrott's Lodge is the perfect place. The most important thing for me is there are no more 'locked doors'

Knit one, purl one, see my confidence grow

Background to my story
I am an older person who attends a 'knit and natter' group in a local library in South Pembrokeshire every Tuesday

What changes have happened

- My confidence has increased
- I walk to the library instead of taking the car
- I really look forward to the weekly sessions, the chatter, tea and biscuits
- I love to share patterns, ideas and skills
- My knitting has improved
- I am helping others by knitting 'chip shop' baby sweaters and hats

Which of these changes are most significant to me?
Regaining my confidence and courage. It took a lot of courage for me to join the group. I felt I may be seen as stupid if I couldn't knit what the group were all knitting. I hadn't knitted for 15 years as my children and grandchildren didn't need anything knitted. I was nervous – could I fit it?

What it was like before
I have always relied on my husband's company since we retired. I think I was getting to feel that I couldn't do things on my own anymore. I was apprehensive about going out on my own. I didn't think people would have anything to say to me.

What it is like now
The 'knit and natter' sessions allow me time for myself. They have increased my confidence and I love knitting once more. I have something to look forward to! I am also looking out for ideas to share with the group. I also share what I have been doing with my family. Last weekend, when my son called, we were watching a TV programme on Africa and as he moved closer to the TV, I asked him why? He said "I am looking for the 'chip shop' baby jumper you knitted" We all laughed!

What happened to make the changes come about
The volunteer who leads the knitting sessions allows us to be ourselves and the sessions are very much about enjoying our time together. She suggests things for us to knit, so we can choose what to do. I have found my long lost knitting skills and now really look forward to our Tuesday morning get-togethers over a cup of tea and a biscuit.

I have also shared my concerns about my recent bout of pneumonia. Before, I was worried that the doctor had said that my lungs had been affected by the condition, but my fellow knitters have reassured me. I am not so worried now.

Compassionate Communities Pembrokeshire is a whole community approach to End of Life Care (EOLC) where caring for one another at times of need, loss and/or crisis becomes the task and responsibility of everyone. It takes a community development approach and seeks to engage and

encourage communities to plan for their future needs and to support each other through stages of ageing, dying, death, grief, loss and caring.

The project has been running for 18 months and involves reaching out to 5 communities within Pembrokeshire with a range of inclusive and inviting Advance Care Planning (ACP) workshops, humorous film shows, pop up cafes and events to explore Compassion, how we can learn from and support each other and also to identify gaps in community supports around EOLC.

This project arose from a 4 year ACP collaboration with Paul Sartori Foundation (2013-2017) raising awareness of ACP, training Volunteer Facilitators and supporting people to think about, talk about and write down their wishes and priorities for their future care. Additional funding was secured from the Localities to employ ACP Nurse Practitioners to work with patients who are critically ill and need to write an ACP urgently. The Compassionate Communities initiative was set up to look at ways to engage with people in communities to look at their needs before they reach end of life care.

The next phase for the Compassionate Communities project is seeking to meet the identified gaps in community support and we are setting up a NOSDA (No One Should Die Alone) pilot scheme in Pembroke area covering people living alone in Care Homes and in South Pembrokeshire Hospital. We see further potential to develop a Compassionate Neighbour's scheme in Crymych and Fishguard to address loneliness and isolation amongst elderly people with life limiting illnesses and planning to launch a Charter for Compassionate Communities in Pembrokeshire.

North Pembrokeshire Bowel Screening Update: The cluster is undertaking a project to increase the response rate for bowel screening in North Pembrokeshire. Data provided by Public Health Wales for 2016-2017 showed the uptake of Bowel Screening in Hywel Dda Primary Care Clusters as 54% (target of 60%). The rate for North Pembrokeshire is 53.6%. This is compared to above average uptake for other screening initiatives - Breast Screening (74.6% against a target of 70%); and slightly below average for Cervical screening at 75.5% against a target of 80%.

The screening programme for Bowel Screening includes men and women aged 60-74 who are sent a test kit and invited to take part every two years. Targeted work will be taken with non-responders to screening. The aim is to prioritise the promotion of bowel screening to try and increase uptake rate amongst patients in North Pembrokeshire.

Development Actions: Further work is needed to ensure that we are enabling our communities to develop their own solutions, build resilience and grow their resourcefulness. This work is being led

through the Preventions Programme Board and a joint work programme has been developed and is summarised below:

Theme	Key Actions & Outcomes
Integrated education plan - across primary, community & acute care	Enhanced team development Achieving best practice in clinical and pathway care
Enabling our population to be better informed to make choices	To develop public awareness of care and services closer to home through the Choose Well scheme Integrated Information, Advice & Assistance
Full implementation of Choose Pharmacy and Pharmacy led walk in services	All pharmacies on Choose Pharmacy and all pharmacies offering the Common Ailment Service Two pharmacies developed into Pharmacy Walk-in Centres
Integration of components of social prescribing	Alignment of community connectors, healthy lifestyle advisors and health psychology & primary care occupational therapy
Compassionate communities	Communities that publicly encourage, facilitate, support and celebrate care for one another during life's most testing moments: chronic illness, frail ageing, dementia, dying, loss and long term caring

STEP 2: Support me to stay well & support myself

Our Plan: The 'All Wales Emerging Model for Primary and Community Care' acknowledges the need to embrace a much greater focus on self care, healthy living and the use of community assets that support people outside the traditional medical approach. Promoting independence and mental well being through access to a range of local community resource will be integral to future service design. This model provides our framework for review and realignment / development of our primary care and community service provision.

To deliver cohesive and integrated primary and community service there needs to be a stable foundation within General Medical Services (GMS). For Pembrokeshire, there has been significant instability within our GMS infrastructure due to challenges in recruiting replacements for retiring GPs and this has impacted our population's access and trust in local service delivery. Building trust in service provision, and flexible, adaptive and integrated systems will be essential.

At a time of growing population need, mitigating the challenges faced by GMS will be essential in order for it to continue to be the 'bedrock' of population health. This can only be achieved by thinking differently about the service model and the needs of the population and how the system can work collaboratively through the Integrated Community Network model. How we educate and enable our patients and support carers will be critical in our future Integrated Community Networks. To enable this development we will invest in Community Co-ordinator roles who will work with local Multi-Disciplinary Teams to ensure the needs of our population are effectively planned, communicated and implemented.

We will deliver care for our permanent population and our temporary population. We will ensure our service meet the needs of those who may be newly resettled in the area, for example through the Syrian resettlement programme. This will mean we have systems in place to support translation for non-English or Welsh speaking communities and for those with sensory impairment. We will endeavour to ensure Welsh Language services are available and accessible for our population.

2018 Progress & Activity

North Pembrokeshire Locality Pharmacists: Cluster Pharmacists continue to support GP Practices across North Pembrokeshire. In addition to the work plans commenced in the previous year the pharmacists have run NOAC clinics for annual reviews or initiation as per enhanced service, bisphosphonate reviews, audit work, dressing prescription review, liaison with COBWEB (a clinical system for the procurement of dressings) and ran flu clinics.

The Pharmacists have reported activity for the first six months of 2018/19 as follows:

2018/19	**Q1**	**Q2**	**TOTAL**
Reauthorisations	1,168	912	2,080
Acute medication requests	151	464	615
Medication reconciliation from secondary care	230	791	1,021
Face to face appointments	23	60	83
Total quantifiable patient contacts	**1,967**	**2,227**	**4,194**

North Pembrokeshire Counselling Services: Pembrokeshire Counselling Service is commissioned by the Cluster and received 290 referrals during 2017/18. During the same time period 262 patients completed a series of counselling sessions. In addition, a number of counselling sessions for the 8 – 25 year old group were commissioned.

North Pembrokeshire Practice Based Social Worker
The Cluster is piloting the use of a Practice Based Social Worker in one Practice within the locality to work as part of the primary care Multi-Disciplinary Team (MDT). The project will be evaluated however expected benefits to the Cluster could include:

- Social Workers will be seconded; therefore there will be no employment responsibilities for the Cluster.
- Joint working to improve communication with Social Services, currently a source of frustration and time consuming for all parties.
- Social workers as part of the Multi Disciplinary Team could fit in well with existing and new Cluster projects, such as Paul Sartori, Frailty, Counselling and 8-25 Youth & Community Project.
- Future possibility of the Social Worker working alongside Cluster Pharmacist.

North Pembrokeshire Diabetes Prevention Programme: The Cluster is undertaking a Diabetes Prevention Programme with a service aimed at patients already identified with non-diabetic hyperglycaemia, and who are therefore at high risk of developing Type 2 Diabetes. This high risk group will be offered the service to enable them to reduce their risk of developing Type 2 Diabetes through weight loss, improved diet and increased levels of physical activity.

The aim of the project is to reduce the incidence of Type 2 diabetes in individuals referred to the service thus reducing blood glucose parameters in service users at 12 months and beyond and reducing weight of service users at 12 months and beyond.

North Pembrokeshire Practice Based Community Psychiatric Nurse: Mental Health Innovation & Transformation money has been secured to fund a primary care pilot within a GP cluster in Pembrokeshire. This pilot will build upon a successful pilot in Cardiff & Vale UHB that has reported significant improvements in mental health care and a dramatic impact on referrals to primary and secondary mental health services. Two Community Psychiatric Nurses (CPNs) will be employed by mental health services to work within a GP cluster and undertake all initial assessment and ongoing care of individuals with mild to moderate mental health problems. To date the following has been achieved:

- Funding secured.
- Agreement with the Pembrokeshire County Director to develop the project cooperatively
- GP cluster identified
- Job descriptions agreed

The anticipated benefits of this project include:

- Improved service user and carer experience in more appropriate and timely assessment.
- Outcome measuring will be consistent with the Cardiff & Vale pilot to ensure that any results are comparable. We are consciously piloting this in a part of Wales with different demographics and increased rurality.
- Reduction in workload for GPs
- Improved integration across primary and secondary care, reduced delays in referral to assessment.
- Reduction in Community Mental Health Team (CMHT) referrals
- Reduction in Primary Care Mental Health referrals
- Reduction in Primary Care Counselling referrals

This has been positively received within primary care with a number of GP clusters expressing an interest in extending the pilot.

General Medical Services Sustainability: Across Pembrokeshire there are currently 6 Practices where there is a medium or high risk to their sustainability or whereby the Practice has become directly managed by the Health Board.

	High Risk – single handed contractors or practices with a high sustainability score using the WG risk matrix
	Medium Risk – practices with a medium sustainability score using the WG risk matrix
	Low Risk – practices with a low sustainability score using the WG risk matrix
	Manage Practices – those Practices the Health Board directly manages, or those who have serviced contract notice **Tenby Surgery** – became managed on 1st August 2018 **Goodwick Surgery** – planned transfer to Fishguard in early 2019

Goodwick Surgery has been managed by the Health Board since April 2015. An agreement is in place with neighbouring Fishguard Surgery for the two practices to amalgamate on one site upon completion of

refurbishment works at Fishguard Health Centre. The completion date for the building works is on target for March 2019.

Goodwick Surgery continues to be dependent on regular locums for its medical rota, supported by GP Hub telephone consulting and on-site support from the Primary Care Support Team (Pharmacist). Support from Fishguard Surgery continues with regular clinics running in conjunction with the Clinical Pharmacist to address the management of some of the most complex patients. Work on aligning processes with those in Fishguard Surgery continues and the interface between the teams is developing well.

Extensive public engagement has taken place with the community in association with the Community Health Council with the number of concerns received from patients about both the future of services and the experience in the Practice has declined in recent months. Communication continues to be supported with the publication of a monthly newsletter available in hard copy at both practices and the three local community pharmacies, on the practice websites and is also communicated to all of the local councillors, AMs and MPs.

Solva Surgery: The Royal College of General Practitioners, at a recent awards ceremony, announced that Solva Surgery was to receive the highly prestigious Royal College of GPs Wales Practice Team of the Year Award, 2018. This is the second time that the Surgery has won the award where practices are nominated by patients.

This Award recognises the positive impact on patients' lives and outstanding level of care delivered by the whole healthcare team working within a practice including the practice nurses, community nurses, administration staff and the wide variety of other attached healthcare professionals.

South Pembrokeshire Healthy Lifestyle Advisors: The South Locality have invested in two Healthy Lifestyle Advisors who manage a caseload of clients who require support to make changes to their lifestyle that will improve their health. The Healthy Lifestyle Advisors have targeted community settings businesses and school settings with staff. The project has been well received and empowering to clients that have use the service. The Healthy Lifestyle Advisors have been linking in and signposting clients to third sector organisations and Community Connectors. Since starting the Healthy Lifestyle Advisor project our Screening uptake has increase through signposting and advising the client.

South Pembrokeshire Physiotherapist: The cluster is investing in a Musculo-Skeletal (MSK) Physiotherapist who will work alongside the GP as a first point contact practitioner for their MSK patients. The potential value and impact of extending this approach is expected to be significant and will be monitored. Physiotherapists seeing patients at an earlier stage when they first present with a problem enables prompt treatment for the patient. This is the next step for the Integrated Locality Team across the 5 practices. The cluster is optimistic about the positive impact that the Physiotherapist can offer to educate the wider Primary and Community Team. The expected benefits include:

- Reduce referrals to secondary care orthopaedics,
- Reduce unrequired investigations,
- Reduce onward referrals to physiotherapy in community and secondary,
- Increase the number of patients able to self-manage effectively,
- Increase the number of referrals to leisure centres and other forms of physical activity
- To link in with the Cluster Occupational Therapist project

Neyland Primary Care Development: In November Neyland and Johnston Surgery moved from the Charles Street premises to St Clements and absorbed almost 2,000 patients from the neighbouring Argyle Medical Practice. The transition of patient care, and retaining a service within the local area, was actively support by local patients and community groups and the feedback to date has been positive:

Everyone mentions the kindness, willingness to help, efficiency, ease of appointments, and the neatness and tidiness of the waiting room and foyer.

Paediatric Speech and Language Therapy: With a strong emphasis on early intervention and tackling inequalities, the paediatric speech and language therapy service continues to build upon its history of strong partnership working with the local authority.

Language difficulties predict problems in literacy and reading comprehension, they are also associated with problems in children's behaviour and mental health. Evidence shows that children with poor vocabulary skills at age 5 are more likely to have reading difficulties as an adult, more likely to have mental health problems, and more likely to be unemployed.

Speech and language therapists (SLTs) and band 4 assistants in South Pembrokeshire are fully integrated into the Flying Start team. They support the development of communication skills in pre-schoolers who live in areas of deprivation by empowering families and staff in preschool settings to identify warning signs and provide timely interventions.

The schools' SLTs work within multidisciplinary teams around pupils, parents and settings (TAPPAS). They have introduced an early communication screen into all nursery classes in the county, which is supported through training sessions and termly teacher network meetings. All referrals for school aged children are triaged at a multi-agency Communication Forum ensuring intervention is provided by the most appropriate professional. New referrals into the paediatric service have reduced by 29% since 2015.

Take Control Day for People with Parkinson's: Recently Parkinson's UK organised a 'take control day' in collaboration with the local branch of the Parkinson's society in Haverfordwest Leisure Centre. Local third sector groups were invited to demonstrate activities for patients to experience to maintain functional ability, a healthy lifestyle and support. The local health team was also invited to allow patients an opportunity to ask questions to the MDT.

The day was well attended with 87 people booked for the day. The MDT decided to take this opportunity to ask the patients their view on current services and where they would like to take future services. Questionnaires were developed and idea cards were also made available for short suggestions.

"I have had Parkinson's for now for 12 years and although difficult at times with the help and understanding of the multidisciplinary team, life has been approached with hope, interest, humour and love; not easy but essential if you want to have a decent relationship with those you love and respect. My sincere thanks to all in the 'team"

The feedback received has enabled the service to tailor its plans for the future:

- Regular MDT early diagnosis clinics with written information for education and self-management strategies.
- Provide patients with written information when to refer back and development of open access self referral to health services.
- Explore early vigorous and high intensity exercise opportunities within Day Hospitals including 'PD Warrior' principles. These are provided for a short period of time in-house before patient extend the exercise pathway with a follow up programme in the LA Leisure Centres providing a prolonged, targeted and intensive exercises programme or the newly diagnosed and early stage Parkinson's patients in Pembrokeshire.

Development Actions: Resilience of Primary and Community based services is key to enable our population to stay well and have confidence in accessing care at the right time. The next steps therefore need to ensure that there is a clear alignment between Primary, Community, Social Care and Third Sector providers.

Theme	Key Actions & Outcomes
Integrated Community Network Development	Provide seamless care, delivered locally with an initial focus on step up/down & flow
Implement Community Co-ordinator	To provide first point of contact and co-ordination support to

role as part of ICNs	MDTs for specific patients
Community Nursing Leg ulcer Clinic service	To ensure patients receive evidence based care To improve healing rates To ensure service provided meets NICE guidelines To improve the patient experience To provide a service that is prudent, value for money and providing positive outcomes for the patient and family
Education Programmes for Patients	Proactive patient education & increase GMS and CIN referrals. All people living with LTC or CC and their carers have self-management as part of their usual care pathway. All people waiting for a first routine OPD appointment attend a self-management programme whilst waiting for their appointment. SMP to support the delivery of routine care to areas such as podiatry, continence, medicines management to ensure complex patients have rapid access to relevant care. Parallel planning occurs this is whilst we support LTC/CC we also deal with prevention e.g. 5 ways to wellbeing.
Improve supportive self-care and reduce USC by targeting ACS conditions	Increase reach through pro-active, supportive, targeted patient education / training for those living with Chronic Conditions
Commitment and alignment to Investors in Carers	To increase the identification and support for unpaid carers through a commitment by community service teams and commissioned providers to achieving Investors in Carers accreditation.
Primary Care	GMS Access Community Pharmacy Enhancing Access and Services Dental & Orthodontics Access Optometric Enhanced Services

STEP 3: Assess and monitor me closely

Our Plan: At a time of increasing need for our older population, we need a model of care which will effectively focus on developing better services for people who are living longer with a higher level of complexity, particularly those with Dementia. This will deliver improvements in patient flow in acute hospitals, as well as reducing demand for residential care. We need to ensure that the right care is provided at the right time by the right person for those with chronic conditions, multi morbidity & frailty. This will be supported through the Dementia Action Plan. Over the next three years this will be delivered through Multi-Disciplinary Team working with named GP Practices, around their more complex population, developing, implementing and communicating anticipatory care plans or advance care plans for those people towards the end of their life. We will seek to use digital solutions to aid communication across the system.

Where people have specific need for care, we will endeavour to increase the opportunities to receive these in community based clinics, working collaboratively with the third sector to create opportunities for reducing social isolation within our communities. Where appropriate we will seek to introduce new approaches to diagnostic testing to reduce the need to travel to an acute hospital and we will work across therapies to enhance community based models of care, enabling people and their families to maintain function within their home environment.

2018 Progress & Activity

North Pembrokeshire Community & Primary Care MDT Facilitator: Following the successful pilot with Solva & St Davids Practices three additional GP Practices were successful in obtaining Pacesetter funding to employ a Community & Primary Care MDT Facilitator to widen the roll out MDT working across the locality.

The key function of MDT Development Officer role would be to build upon learning in other areas to support individual GP practices in the initial stages to set up, co-ordinate and facilitate community MDTs in their area.

The establishment of regular community & primary MDT meetings within GP practice supports the identification and treatment of vulnerable people in the community who would benefit from an integrated approach to care. This approach will contribute to easing pressures further “up” the system as patients will receive the appropriate intervention necessary to maintain their independence at home for as long as possible.

These meetings will ensure that patients receive the most appropriate care from the most appropriate person in the shortest time possible. The increased communication between professionals because of a closer working relationship could potentially result in shortened lines of referrals, improved awareness of individual roles whilst also contributing to saving staff time as better co-ordinated services can result in fewer professionals overall needing to visit patients.

Working with locality colleagues, the MDT Development Officer will facilitate the delivery of the “Community & Primary Care Project Plan” in supporting GP practices for a time limited period across the North Cluster. The role of the postholder is critical for the effective establishment and roll out of regular community & primary MDT meetings in GP practices that support the identification and treatment of vulnerable people who would benefit from an integrated approach to care. This approach will contribute to easing pressures further “up” the system as patients will receive the appropriate intervention necessary to maintain their independence at home for as long as possible.

South Pembrokeshire Locality Outreach Nurse for the Elderly: This project offers baseline health checks for those most at risk in Care Homes and the Community the project started in October 2018 which will continue until March 2020. The service will undertake a health and wellbeing review for each identified patient, provide key vaccinations and undertake Advance Care Planning. It is expected that the project will review all elderly patients not seen in the past 12 months – these patients may be dependent on a family member or neighbour, but could have undiagnosed complex needs. This will also inform an accurate Housebound Patient Register within the locality to support MDT working practices.

Saundersfoot Surgery: The Practice Team at Saundersfoot Surgery, in collaboration with the District Nursing Team, decided to do Christmas a bit differently and put our community first, especially those who face challenges at this time of year. All Secret Santa presents were donated, along with fundraised monies, to buy “little hampers of festive joy” for some of the more vulnerable patients in the community. The Team cares passionately about the community that they serve and demonstrate a commitment to building upon for the future.

South Pembrokeshire Locality Occupational Therapists: continue to be valued as part of the practice teams, adopting a proactive, preventative approach to supporting people at home with frailty and multiple conditions. 96% of those seen in primary care were not previously known to core occupational therapy services and referral rates to core teams have not been impacted. This indicates we are addressing functional issues with people earlier, when impact on outcome is likely to be greater. The approach supports self management, with only 7% of those seen being referred onto statutory services.

This alternative approach has demonstrated that seeing the right person at the right time to address and resolve what matters to an individual, can help to

- Reduce multiple and frequent contacts with the surgery (80% reduction in contacts with practice in those sampled).
- Avoid escalation of crises in primary and secondary care.
- Support community engagement and resilience, by enabling people to reengage in communities and social activity and supporting the emerging social prescriber workforce.

The Health Board is recognised nationally as an innovator in occupational therapy in primary care. We have been invited to participate in a research study testing the effectiveness of an occupational therapy vocational clinic in primary care to support people to return to and remain in work. We are planning to build on our partnership approach to undertake this research in Pembrokeshire. As work is an important determinant of health and well-being this area of research will help inform our future planning both locally and more widely.

Bladder & Bowel Service: This collaborative and patient focussed service consists of three specialist nurses/prescribers who each independently manage a caseload of adults with complex bowel & bladder problems across primary and secondary care. Previously known as the continence service, it was felt that this title was a barrier to people experiencing bladder and bowel problems from seeking help and alluded to the belief that it was merely a 'free pad' service. The service is available for any adult experiencing complex bladder and bowel problems, irrespective of disability or diagnosis via referral from health and social care professionals as well as self-referrals.
A range of services are provided, including:

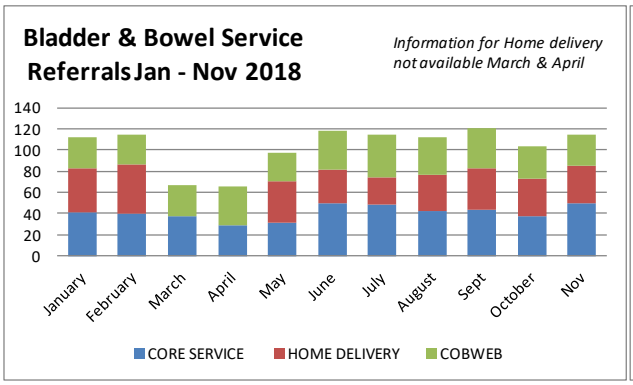
- The assessment of individuals with bladder & bowel problems from diagnosis, investigation, treatment and follow-up
- Prescribing suitable appliances e.g. catheters, containment pads, Transanal Irrigation (TAI)
- Initiating interventions and care pathways such as Intermittent Self Catheterisation (ISC), TAI
- Outpatient consultations in nurse led clinics which address physical, sexual and psychosocial issues related to bladder & bowel care
- Acting as an advisory service to patients, relatives and carers and telephone follow-up service to reduce need for outpatient follow up & unnecessary presentation and admission into emergency care
- Home visits to patients with complex bladder & bowel problems, often preventing unplanned admissions
- Supporting community health teams in the management of bladder & bowel symptoms

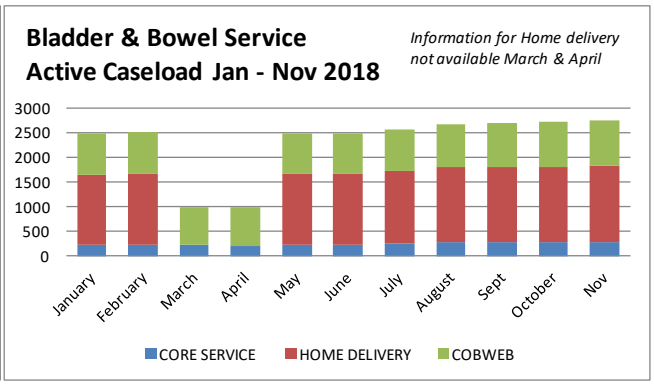
- Delivering Health Board wide training days e.g. continence promotion, catheterisation and bowel management

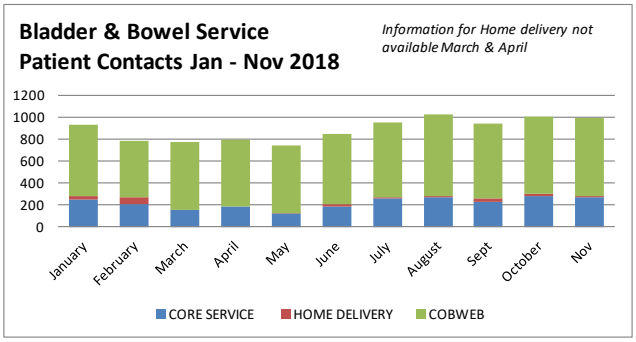
- Development of patient information/ Health Board policies, formularies and care pathways, research and development

In 2018 the team delivered 67 training sessions to professionals across the Health Board and provided on average 128 episodes of 1:1 advice per month to other health practitioners.

The Team have an average of 888 patient contacts each month, of which 58% by the Core Team are face to face. With 104 new referrals each month, there is a steady growth to the caseload and this has increased by 10.5% in the last 11 months.







The Team has ambitious plans for future developments and how they can better support the wider Primary and Community Teams as well as acute specialist outpatient clinics. Changes in population demographics, in particular a rise in older people, means that the demand for containment products such as pads, from patients with bladder & bowel problems in the community will only increase. Irrespective of their ongoing complex health issues, the continence status of these patients can be improved by staff who have the skills to perform comprehensive continence assessments. A business case is being developed to enhance and expand the service to enable greater integration and to be able to offer specialist services across the county.

Pembrokeshire Single Point of Assessment (SPoA): The Pembrokeshire adult mental health community teams are replicating a successful service development from Cwm Taf University Health Board, developing a SPoA. They will pool their resources to provide a single point of assessment for all referrals during the week.

Benefits to staff, service users and carers will be:

- More timely access to a mental health assessment, potentially same day in most cases
- An agreement at the end of the assessment on what service is required with no need for further repeat assessments within non-specialist mental health services.
- Anticipated reduction in DNA rates

- Greater collaboration among teams, providing a more seamless service with a reduction in artificial barriers to care

Each of the above projects has a project board established to oversee its implementation and to ensure that outcome measures are collated and reviewed and these will inform future service developments. All findings will be reported to the Mental Health Implementation Group (MHIG) and its relevant work streams. It has been a pleasure to note the enthusiasm and motivation behind the clinical teams, service users, carers, third sector, local authorities and other key partners, all of whom have demonstrated the vision, drive and commitment in developing and volunteering to pilot these new ways of working.

Development Actions: There is well documented evidence which suggests that aligning multiple professionals and agencies around a risk-stratified group of our population enables co-produced, proactive care to be planned and delivered in the community. Some good progress has been made, however further development of the Integrated Locality and Community Resource Teams are key; these will be aligned to the Pembrokeshire vision for the development of Community Hubs.

Theme	Key Actions & Outcomes
Integrated Localities for planning and delivery assurance	To ensure our Localities continue to develop as a whole system, ensuring the highest impact for their communities
Care co-ordination and MDT proactive care planning	To risk stratify the population in order to identify those whose care may most benefit from an integrated proactive care plan with delivery and communication across system
Palliative Care Plan	To agree across all integrated providers, a clear strategy and implementation plan for Pembrokeshire – then to ensure implementation.
Integrated frailty & dementia model	To ensure our workforce and processes work seamlessly across the system to support those with the most complex needs in our communities.
S&LT training programme to care homes in order to prevent hospital admissions / reduce GP callouts due to complications from dysphagia.	If dysphagia is untreated, the consequences are significant and can result in dehydration, malnutrition, and ultimately aspiration, choking, chronic chest infections and pneumonia Ensure timely and appropriate referral into service. No additional funding required – to be delivered as part of core service
Improving nutrition and hydration in the community to reduce unscheduled care demand.	It is estimated that 1 in 10 people over 65 living in the community are malnourished or at risk of malnutrition. Research has shown that malnourished people; • see their GP twice as often • have 3 times the number of hospital admissions and stay more than 3 days longer than those who were well nourished NICE identified better nutritional care as the 4th largest potential source of cost saving to the NHS
Specialist community based clinics	To deliver care in a prudent way for those people who are not completely housebound and who may benefit from an alternative model of care.
Enhance Point of Care Testing in primary & community settings	To ensure we can deliver appropriate interventions locally, reducing the need for patients to travel for routine care or diagnostics, where possible
Shifting settings of care	To bring planned acute services into the community

STEP 4: Step up my care and keep me at home

Our Plan: Over the next three years we will enhance and strengthen our joint commissioned intermediate care pathways in order to ensure that where safe and appropriate, people can be provided with enhanced levels of care within their home in a timely way. The Pembrokeshire Intermediate Care Strategy will ensure an integrated and systemic approach which works across secondary and primary care and community health, social care and the third and independent sectors.

The Integrated Multi-Professional Assessment and Care Team (IMPACT) will be key to the delivery of Intermediate Care and will be formed in Year 1 through the amalgamation of previous teams including the Acute Response Team, MAST, Care at Home Team and Joint Discharge Teams. Their focus will ensure that rapid response is available and appropriate based on the needs of the patient and in consideration of their home situation. To enable this to happen, specific focus will be given to the pathways which need to be co-designed and implemented through IMPACT.

We will work proactively with the Ambulance Service to identify integrated pathways which can treat and keep people within their communities as well as ensure timely response for those who live in our rural areas when they need it most.

2018 Progress & Activity

Pembrokeshire County Council (PCC) Care Provision: At the end of November 2018, Allied Healthcare gave notice to the Local Authority and the Health Board that they would be ceasing to operate. PCC undertook to set up direct care provision and TUPE staff to support continuity of care for the individuals receiving social care packages. The handover of care from Allied healthcare to PCC has been complex and staff involved have done an amazing job to develop a registered service in 4 weeks, and to support the transfer on the deadline date of 14th December 2018. Some staff did not transfer to PCC, due to choice, or because transfer rules (TUPE) did not apply to their role, some also moved to supported living provision and some to a provider of Children's continuing health care.

The local Allied branch were under an embargo in line with the escalating concerns process, the concerns centred on missed calls. As per partnership process, this embargo remains in place post transfer until reviewed and improvements are evidenced and sustained. The new service has been supported by day centre and other PCC staff in order to ensure delivery of care; this reflects the commitment of staff involved.

The future scope and size of the service is yet to be agreed, and any expansion must be completed in a sensitive manner with care taken to minimise any of risk destabilising the independent sector by recruitment from within their services. PCC are therefore looking at alternative recruitment and training models via Workways+, and are considering interdepartmental opportunities across council services.

Longer term we envisage the intermediate care strategy will describe the model for integrated working at this front line level where a wide range of services can be brought together to share skills and resources to the best effect to meet the needs of people in Pembrokeshire with a coordinated health and social care response.

For those patients receiving health packages from Allied Healthcare, the Care at Home Team and the Acute Response Team have provided initial bridging care whilst long term alternative solutions are sought. Feedback from families about the transition of care has been very positive.

Acute Response Team: The Acute Response Team in Pembrokeshire currently work 24/7 although numbers are limited and there is the potential to grow the pathways and interventions they offer. In the past year the team has offered 1907 patients 6895 interventions in their own home of which 67% supported step up of care and 33% step down from wards or Emergency Department (ED).

Patients requiring Intravenous Medication (IV) at home have been the historic group requiring support who may otherwise have been admitted however increasingly the workload supports patients discharged earlier from acute requiring Miami J Collar care. On the average day they support 15 people in their own home to reduce the pressure on the acute hospital.

North Pembrokeshire Acute Visiting Service: Following the successful pilot using an Alternative Healthcare Professional to work with GP Practices to undertake an Acute Home Visiting service an advertisement has been placed for an Advanced Practitioner – Nurse or Paramedic and it is anticipated that the post will be filled in February 2019. The Service will operate for three days a week across the

nine GP Practices in North Pembrokeshire providing care for patient in their own home and linking in with the wider multi-disciplinary team.

Falls Risk Assessment and Balance & Strength Training: In December 2017 a reform within the Pembrokeshire Community Physiotherapy Service and Rehab Day Hospital was created to connect the identified clinical gap in the pathway between the Acute and Community settings for falls, injury and admission prevention of a growing elderly population in Pembrokeshire. The aim of the service is to deliver the latest evidence based practice, supported and underpinned by the HDdUHB, National and International Strategies and Guidelines.

The Community Physiotherapy team screened their in-house referrals to select suitable patients from the Community Physiotherapy waiting list to offer an initial comprehensive geriatric and falls risk assessment within the Rehab Day Hospital (RDH) in Withybush General Hospital (WGH). These assessments also include several relevant clinical and physical Outcome Measures.

Based on the outcome of the assessment, patients been offered a 6 week exercise program, individually tailored with a program of twice a week individually targeted home exercises. Those not selected for the group program were followed up at home with an individual targeted evidence based (EB) OTAGO exercise program.

All candidates been provided with evidenced based information from the Chartered Society of Physiotherapy and individual advice and information on multifactorial aspects of Falls Prevention and the importance of exercises as set out by the (new) UK Guidelines for Physical Activity for Older Adults.

Since December 2017 the team have provided 5 groups with a 6 weeks exercise EB program with support of an OTAGO and trained Physiotherapy Technician and a RDH Support Worker.

The same Outcome Measures are performed again on the last day of the exercise program in RDH WGH. Based on these and an individual conversation with the participants, a further individual plan of continuation of the exercise pathway is discussed. These can include continuation of home exercises, referral to the NERS program in Haverfordwest leisure centre or relevant and EB community exercise programs including (Nordic) walking groups, community exercise classes or e.g. senior dance classes.

So far 28 participants from Pembrokeshire have gone through the program with an average age of 81.5 years old. One third were men, 2 third women.

Of those who have been discharged longer than 6 months, none have been re-referred to the Community Physiotherapy service or did attend A&E with a falls related injury.

An improvement on Balance and Strength takes on average a minimum of 6 weeks to be developed with targeted exercises. An overall improvement of 13.6% in hand grip strength, 11.9% in the Berg Balance Score and a 10.2% in the Timed Get Up and Go test is already showing a positive physical effect on the participants.

Fear of falling and loss or lack of confidence in indoor and outdoor activities is a major factor of concern within the elderly, leading to further physical decline and deconditioning, social isolation and poor health predictions. Though, the participants of the exercise program have expressed an overall improvement within their confidence and the team anticipates that this would further increase by continuation of their targeted ‘exercise prescription’.

After discharge and with consent, the Community Physiotherapist performs a 3 months post-discharge telephone follow-up to allow the participant to discuss any concern and inform on any further progress.

Further development of this service is paramount to deliver an evidenced based pro-active and preventative health care service grounded on the needs of our communities in Pembrokeshire to allow all to Age-well.

The professional and enthusiastic Community Physiotherapy Team within Falls & Frailty Management is looking further to extend the scope and delivery of an evidenced based pathway on Falls and Injury Prevention and rehabilitation within the Community and Primary Care.

Development Actions: How we respond to individuals in our community when their needs increase is key to managing more people within their own home. Some significant developments have been piloted and as part of the Transforming Clinical Services Programme the evaluation of these are critical to inform the wider integrated community model. This will align with the Regional Partnership Board's Transformation Programme.

Theme	Key Actions
IMPACT – improve Step Up capacity	To ensure the resource is available to meet rapid access to service, preventing unnecessary admission and facilitating earlier discharge.
Rapid access to OOH care support	To ensure a robust primary and community response to the urgent care needs of the population.
Effective CHC, FNC, rapid reablement and longer term social care	To ensure patients receive care to meet the identified health or social need appropriately. To ensure scrutiny and review process meets framework requirements and fairness for the population. To ensure model of service provision is consistent with care closer to home and fully integrated with locality model.
Enhanced support to care homes	Provision of advance care plans and training/education for care home staff on producing ACPs to improve patient experience, reduce unwanted treatment and avoidable hospital admissions.
IMPACT – rapid home visiting service (pilot)	To improve the response to urgent care needs and positively impact the flow through WAST and the front door
WAST Pathways	Fallers Breathing problems Care needs Confirmation of death
Respite support for people with long term/complex needs and their carers	To enable people to stay at home and manage their conditions and caring role sustainably
EHEW – Urgent Care service	Promote and consider expansion of the EHEW service

STEP 5: Good hospital care

Our Plan: The service delivered by the MAST has demonstrated the potential to enable patients arriving at hospital to be transferred safely home without the need to be admitted and this function will be embedded into IMPACT. It is widely acknowledged that a long length of stay for frail older adults in hospital compromises their wellbeing and independence. National and local evidence has also demonstrated that this vulnerable population group is currently predisposed to a higher average length of stay. Our aim, by working together, is to reduce admissions and length of stay for our frail population by ensuring we can rapidly assess and provide community based support to enable transfer home. This approach will be applied to Community Care Beds and Acute Hospital Beds to ensure equitable provision for our whole population.

Our plan for the future requires us to carefully consider the number of beds needed to serve the population of Pembrokeshire in Withybush as well as SPH and Tenby, a commitment has been made to continuously engage with our population through this process. Enabling patients to return home to recover and ensure they receive the appropriate reablement and recovery support is critical and there will be an enhanced focus on how we are supporting people to return home utilising SPH as a rehabilitation unit.

2018 Progress & Activity

Pembrokeshire Haematology & Oncology Day Unit (PHODU) at Withybush General Hospital opened in February 2017, it relocated the old chemotherapy day unit from the second floor into a refurbished ward area (Ward 5) on the Hospital's first floor. An evaluation of the redesign has now been completed.

Patients noted that the treatment area was calming, airy and spacious with room for relatives to sit. They appreciated the design of the Unit in particular being able to sit next to patients who shared similar illnesses/treatments. Appreciation was also expressed for the separation of the outpatient clinic space to the main treatment area noting the benefits of sensitively managing newly diagnosed patients and those in advanced treatment separately.

Interestingly, patients who received treatment in both the old and new unit missed the intimacy and social interaction the old unit had promoted due to its much smaller size. Alternatively, staff raised previously difficulties with concentration in the old unit due to the flow through the unit and the level of interruptions.

Areas of benefit to patients were noted including having a dedicated reception point, the availability of recliners (previously patients queued to get a certain chair or location), the availability of beds and a side room, benefits of the co-location of teams (particularly Oncology CNS's and the Research Team) and the availability and closer location of w/cs.

There have been teething problems such as the reliability of the automatic doors (now resolved), the creation of a small waiting area outside two of the consultation rooms (staff are considering alternative use). There were also suggestions for future schemes that certain rooms (drugs treatment rooms, MDT and office space) could be bigger and problems with car parking.

Ambulatory Care Unit - The introduction of an Adult Ambulatory Care Unit within a new capital build at Withybush has provided rapid access through the Emergency Department for defined cohorts of ambulatory patients. The unit allows patients to commence interventions earlier and to be discharged with an allocated follow-up to the unit. This enables patients to be discharged to their own home rather than requiring an Inpatient admission for the same course of treatment.

Early Supported Discharge Team - 2018 has seen a reconfiguration of the Surgical Wards with the introduction of an Early Supported Discharge Team which allows for patients that are suitable to be discharged early with some home support. Criteria led supported discharge criteria has been developed and the team will work with the patients leading up to discharge and continue into the community for a maximum period of time. The early results of this initiative has been encouraging with excellent feedback from patients and a high volume of activity being managed under this arrangement.

Surgical Assessment Unit - A Surgical Assessment unit has opened on Ward 4. This is a 6 bedded unit which allows for direct access from A&E for assessment and earlier treatment. This initiative materially reduces the time spent for patients in the emergency department and allows for patients to be discharged and return to the unit for any follow-up review without going through the emergency pathway.

Acute Frailty Network (AFN) is an organisation which supports and enables service change to enhance the care of frail patients to maximise and optimise outcomes. Output from this project, along with the Integrated Pathway for Older People (IPOP), have enabled a new Care of the Elderly model in Withybush, which includes a Geriatrician of the Day at the front door of the hospital to complete an early geriatric assessment that will both deliver better outcomes for patients but to also direct patients to the best point of care. This may include to an Inpatient bed, a community bed or back to the patient's own home.

Emergency Department Improvements - In addition the AFN and IPOP work, Withybush Hospital has also run a weekly ED improvement Task & Finish Group to improve performance of the department but also improve outcomes for patients. This initiative has yielded improved waiting times for Minor Injury patients, seen improvements in ED recruitment and also introduced a new GP and Advances Nurse Practitioner model into the department which has improved patient flow and waiting times.

Recruitment at Withybush – There have been significant successes over the past 12 months with recruitment of clinical staff in all specialties. This includes:

- An A&E Consultant
- A Consultant Cardiologist
- A Care of the Elderly consultant
- A Respiratory Consultant working within the Acute Clinical Decisions Unit
- Over 40 new Nursing appointments
- 5 new Middle Grade doctors in Medicine and 3 new Middle Grades in A&E
- A GP to work in A&E
- 1.8 WTE Advanced Nurse Practitioners to work in A&E/ACDU and within the Front Door Model

Ward 9 and 10 Refurbishment - The building works for the refurbishment of Wards 9 & 10 are progressing ahead of schedule. Ward 9 refurbishment is due to be completed by the end of January 2019. This will allow for a decant facility for Ward 10 to enable the start of the Ward 10 refurbishment in April 2019.

The Jeffery Northcote wing Sunderland ward, South Pembs Hospital: During 2018, Sunderland Ward have worked hard to develop a dedicated 3 bedded unit for end of life care. The official opening of The Jeffery Northcote Wing was on 19th December 2018. The Northcote Wing has been named in memory of the late Mr Jeff Northcote, a former charge nurse on the ward who himself chose Sunderland Ward as his preferred place of death.

With the beds dedicated to patients approaching the last days of life, the emphasis will be on comfort and making end of life care less clinical and more homely but with the reassurance that the wing is staffed by nurses and healthcare assistants who have had experience and training in end of life care.

The middle corridor has 3 rooms; each room has been individually decorated making them less clinical and more relaxing, with local paintings and matching duvets and curtains. The rooms have non-clinical furniture with a riser recliner chair enabling a loved one to stay over night plus they have tea and coffee making facilities for the patient and their families. The refurbishment of the rooms has been supported by a local firm in Pembroke Dock – Parfitt's Carpets and Interiors following the ward staff winning a competition.

The ward is supported by the specialist palliative care nurse with training. Throughout 2018 palliative care study days have been held for the healthcare assistants and study sessions for the qualified nurses on the Care Decisions guidelines for the Last days of Life. The palliative consultant, Dr Edwards, visits the ward to support the nursing team as well as the General Practitioners who provide the main stay of the medical cover.

Multiagency Care Assessment Meeting (MACAM): The MACAM project is a piece of collaborative work between the Joint Discharge Team and Ward 12 enhancing Learning Disability care on acute wards. The MDT attached to Ward 12 recognised the need to introduce a seamless transfer of care system for people with Learning Disability to help ensure a smooth transition 'home to home', through the system when acutely unwell.

The ward team scrutinised the available literature to examine and explore key themes to understand patients' journeys through the system and any key areas of concern. It became apparent the 4C

framework offered an opportunity to provide a structured system of support, if it was applied in a formalised structure to care and assessment.

The team identified that there was a lot of emphasis on education of ward staff, often involving the individuals or their carers but the team wanted to take this a step further. They introduced a system which actively involved people with learning disabilities and their carers in learning through an individualised action process, set out to constantly provide care assessment and reviews during an acute episode.

Development Actions: Our in patient care needs to evolve to ensure we have the whole system in place to reduce the time that people spend in hospital to that which is required to deliver specialist and complex care. Bringing the whole team together around the patient at the earliest appropriate point will enable a more streamlined flow through the hospital and better manage a safe return home. Part of our plan will be to ensure the appropriate bed base ot meet our population needs with the ambition to increase the level of care available within the community.

Theme	Key Actions
IMPACT – patient flow	To enable the earlier identification and support for those patients whose transfer home may be more complex
Reduce Length of Stay in Community Care Beds	Improve patient experience through appropriate LOS to meet their needs. Consistent process, measurement and evaluation of all community bed based offer. Consistent multidisciplinary support offer to bed based care.
Reduce Length of Stay in Acute Hospital Beds	To reduce the risk of deconditioning and hospital acquired infection for those people medically ready to transfer to a more appropriate setting
Enhanced hospital based rehabilitation and discharge to recover/assess (D2RA) process	People have access to rehabilitation, delivered by skilled staff at a level appropriate for their needs to recover, regain abilities, confidence and independence. Rehabilitation is delivered in most appropriate setting, underpinned by Home First philosophy.
Review and enhance day surgery services	To maximise scheduled and unscheduled care benefits of a 23:59 service with a view to opening 4 days per week to improve RTT.
Improve Cardiology services commissioned to ABMU	To ensure patients receive their intervention in a timely way and to reduce the need for surge bed. To also bring down DTOC's and improve patient flow in WGH
Redirection at front door 24/7	To improve the appropriate utilisation of services across the system by people attending the front door for example, Community Pharmacy, GMS, OOH, MH&LD
Paediatric service improvements	To resolve the current temporary Paediatric pathways to a sustainable solution.
Maximising clinical pathways strength at WGH working with the other acute sites	To build on the clinical capacity and strengths of each site to enable quality, experience safety and finance benefits.
Align with TCS pathway review/ workforce redesign for the future	To initiate service redesign in line with TCS outcomes
Develop and enhance the frailty Model within WGH	To support those with the most complex needs in our communities.
Enhanced inpatient EOL care	Commission End of Life beds on Sunderland Ward – December 2018

STEP 6: Get me home and step down my care

Our Plan: In addition to the vision and actions outlined in themes 3, 4 and 5, we will continue to progress work streams with our Regional Partnership colleagues. This will improve joint commissioning care arrangements with our independent care providers (both domiciliary, residential social and nursing care) in order to ensure delays in the acute and community hospital associated with such care

commissioning is reduced. Home First pathways will be efficient, effective and contribute to an improved unscheduled care performance and progress our alignment to the Transforming Clinical Services (TCS) vision.

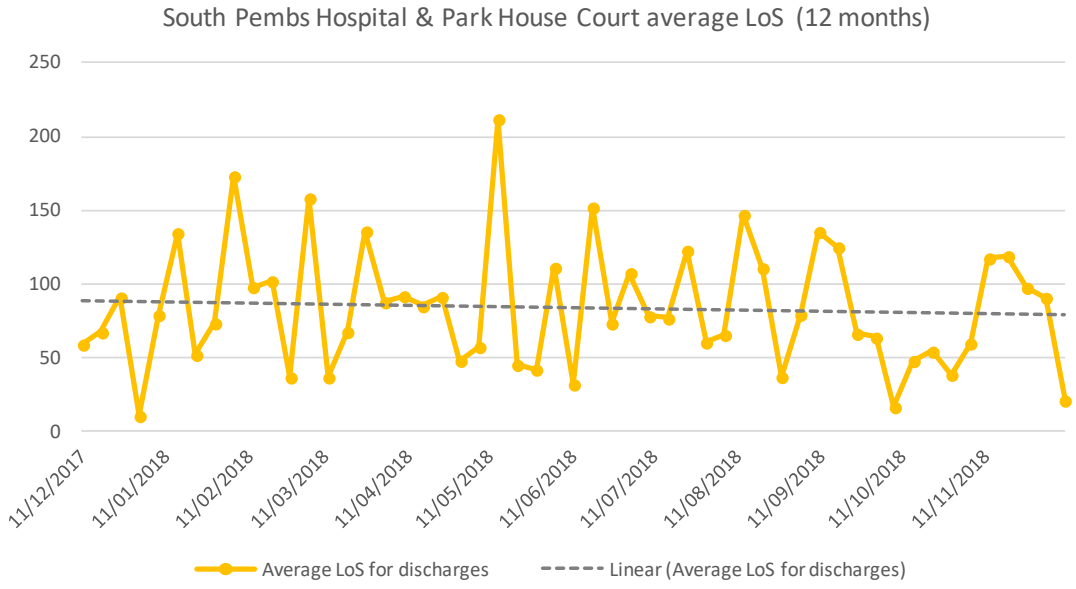
2018 Progress & Activity

IMPACT: the Integrated Multi Professional Assessment and Support Team brings together previous teams and professions with a focus on supporting flow through the acute and community hospitals in Pembrokeshire to support safe and timely transfer. There may be new or additional care needs following hospital admission, this may be due to the cause of admission or the functional decline experienced whilst an inpatient. The result is that we have increased numbers of patients waiting for packages of care or new placements within our provided beds.

Over the past 5 months, the average number of people classed as medical optimised in Withybush is 27 per day with this ranging from 14 to 46. Although someone may no longer need the specialist input from the medical team, there may be a number of nursing, therapeutic or discharge planning needs that a patient has prior to the Multi-disciplinary team advising that they are safe to discharge. Over the same time period, an average of 5 patients per day have been approved as ready to transfer by the MDT, although this may be an understated position due to the coding used, this is now being reviewed.

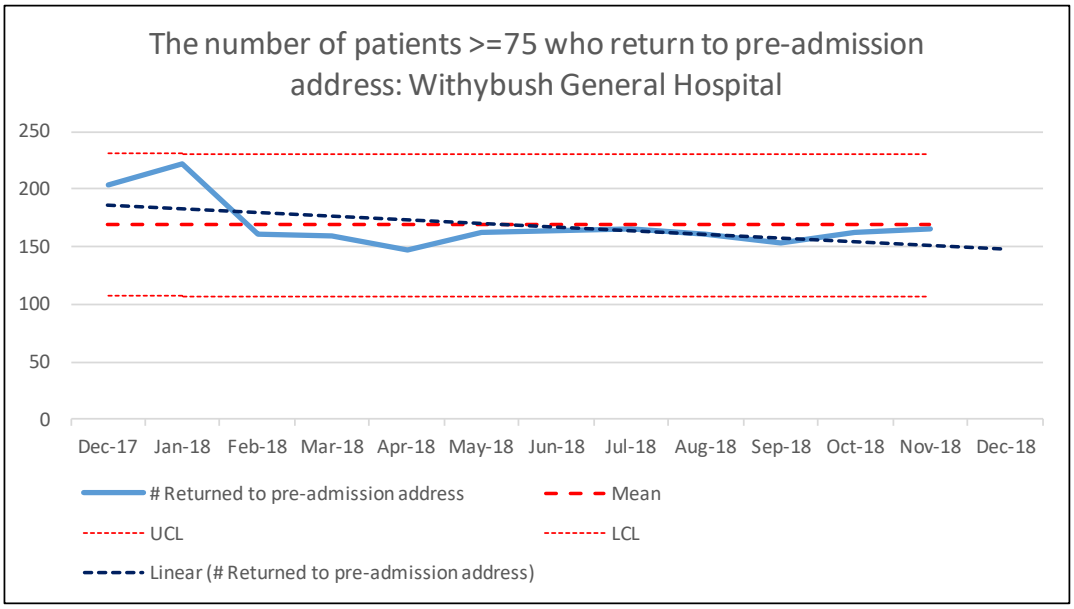
In October 2018, Sharepoint was introduced, this IT system supports the earlier identification and management of patients who may need support to transfer home, the actual number of those on the list is less essential than the number of bed days they have been in an acute or community setting. On 27th December 2018, immediately after the Christmas period, there were 33 people in Withybush who were considered medically optimised, however only one of these was assessed as safe for transfer by the MDT. These 33 people had been in hospital for a total of 1129 days, or an average of 34 days each. 23% of these days were post medically optimised and this varies significantly between patients based on their individual circumstances and needs which need to be met prior to going home.

To support more timely transfer from Withybush Community Care Beds have been commissioned (see below) and the appropriate transfer to Community Hospital beds is being reviewed. Over the past 12 months, there has been a marginal decrease in the Length of Stay, this will be a key focus over the next 6 months.



Care at Home Team: The Care at Home Team has been developed utilising ICF resource and have supported, since April, 79 patients, the majority of which are fast track referrals. This team has the ability to respond quickly to both step up and step down needs and plans are in development to merge Care at Home and the Acute Response Team (ART) to create a more responsive community based service.

Community Care Beds: these are additional spot purchased beds in residential and nursing homes which support transfer of patients from Withybush or Community Hospital Beds who may not be ready to go home. There may be social reasons for this, for example a package of care or reablement it pending, or a health reason where a period of further recovery, assessment or intermediate care is needed. With an increase in the availability of these beds, it is important to ensure that we retain a clear focus on admission "Home First" as the numbers are reducing from Withybush, this is a consistent Health Board trend. This may be linked to the challenges in commissioning social care within the County over the past six months.



Releasing Time to Care: This Occupational Therapy led project is in its second year and continues to support people at home to regain independence, choice and control over their lives and reduce their need for care support. The project has been recognised as worthy winner of the Social Care Wales Accolades 2018 (Category – Use of data and research to support prevention, early intervention and effectiveness). The project works across health, social care and the independent sector and aims to embed the single handed care approach into everyday practice. This has been achieved through a partnership approach, demonstrating successful outcomes and utilising education and a champions network to support long term sustainability. The success of the project in promoting independence and reducing care costs has been recognised with Pembrokeshire County Council supporting an Invest to Save Bid for an additional post to scale up the work in 2019.

Development Actions: Enabling our population to return home safely, quickly and with the appropriate support is key. At present, individuals are frequently in inappropriate settings, potentially with over-prescribed care and we need to work together to ensure that we can care for people in a timely and effective way when they leave hospital.

Theme	Key Actions
IMPACT – Step Down care	Extended scope of practice with increased availability
Handover of care documentation	Integrated handover of care documentation and timely communication
Long Term Conditions pathways	To meet the long term health care requirements of the ageing population
Community Care Beds to support recovery	To ensure commissioning of bed based placements offer the level of care required to support recovery. To ensure patient experience meets reduced requirement for longer term care
Enhancing Carer involvement and support in patient discharge	To increase the number of Carers identified and involved in the discharge process. Increase the number of Carers who are sign posted to Carers Information Services for further help and support.

Rapid access to equipment and adaptations	Facilitate early discharge and prevent admission Ensure patient's needs are met in a safe environment Support patient's independence and wellbeing Ensure safe working environment for staff
Technology enabled care	Promote independence and wellbeing for patients within their own home. Promote self-management of long term conditions. Prevent admission and facilitate discharge.

Conclusions & Delivering the Pembrokeshire Integrated Plan

This paper seeks to provide an overview of the Integrated Plan for Pembrokeshire for the next 3 years. Pivotal to our success will be the continuous engagement we undertake within and with our communities, across a wide range of partnership organisations and with a relentless focus on improving the short, medium and long term outcomes and experiences for our population.

This is not a plan we can deliver alone. We cannot focus on the development of the community model to the exclusion of acute needs of our population, physical and mental health needs must be met holistically, understanding the whole person across their entire life course.

Although we are not at the start of this journey, and we have endeavoured to demonstrate some of the ongoing and new services within our communities, how we integrate delivery within networks, wrapped around communities, families and the individual will determine our success.

Our next report will focus on the development of our Integrated Networks and the Integrated Teams within them.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD

UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 September 2018
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Healthcare Services in Ceredigion: Health and Wellbeing (HWB)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape Deputy Chief Executive/Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Peter Skitt County Director & Commissioner (Ceredigion)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The previous Ceredigion County report provided a focus on the County's approach to delivering care at home. This report explores the impact of using the Continuing NHS Healthcare National Programme for Wales' "10 High Impact Changes for Complex Care" to develop an integrated service model to support people who fall, which although a relatively simple mechanical process, can be symptomatic of the increased complexity of a person's care needs.

The report then describes how Ceredigion County's estates development plans have approached delivering care closer to home and focusses on the development of the Aberaeron Integrated Care Centre which, when completed in Autumn 2019, will be Hywel Dda's first Community HWB as envisaged in the Transforming Clinical Services programme.

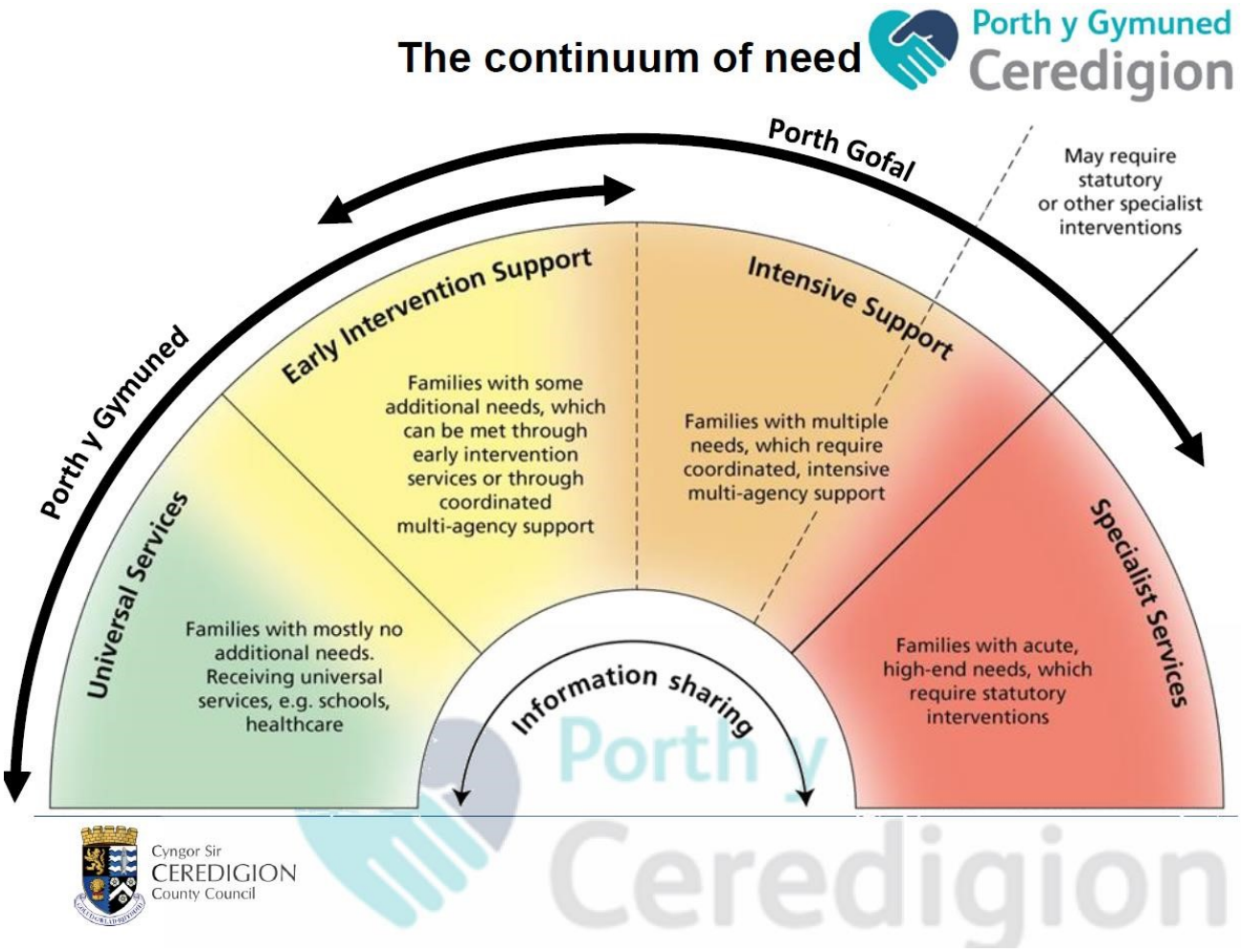
The opportunities provided by a modern building to catalyse multi-agency and multi-professional working to create a whole-person multidisciplinary approach, based around Porth Gofal, are fundamental to developing community and individual resilience by simplifying patient/client access to services while allowing professionals to better respond to presenting needs.

Cefndir / Background

The development of integrated, safe and responsive services across Ceredigion is a key strategic objective which is essential to enabling delivery of care closer to home.

The Ceredigion approach to falls demonstrates how an integrated approach can deliver significant benefits for patients while meeting the need to avoid admission to and promote discharge from acute hospital settings.

The approach ensures that patients can access the appropriate service at the appropriate time across the continuum of need with timely response reducing the likelihood of escalation and minimising disruption to a person's "usual" circumstances.



Whole-service integration allows a personalised response to be agreed with and delivered to patients/clients, families and carers and efficiency and effectiveness is driven through the principle of making every contact count while feedback loops allow intelligence regarding gaps in services and provision to be learned from and responded to.

This model of partnership will be embedded in the community HWB and will support services reaching out into isolated communities, where provision of some types of support can be challenging. Additionally, it will follow patients/clients across statutory boundaries so that there is a consistent and seamless approach to delivery of care for patients across the mid-Wales area with shared pathways, shared resources and shared governance assuring delivery.

The strategic significance of community HWBs as set out in Hywel Dda's Transforming Clinical Services plans fuels a will to build connections between services, communities and people with the person being at the centre of, and involved in conversations and agreements about, what will happen and is best for them. The colocation of primary care in this setting is an important driver to providing a consistent, coordinated approach to service delivery for all.

Asesiad / Assessment

- Whole system integration is key to providing care closer to home.
- The development of community HWB services in Ceredigion is a significant step towards attainment of the Health Board's overall strategic objectives.
- A concept of "care" will replace traditional silos of health and social services driven by the team of professional working together in the best interests of the individual.
- Measurements of need in community services are not yet fully established and need support to be tested and fully functioning.
- The services presented in the report are key to the attainment of the Health Board's strategic vision of true shift in care.
- The development of HWBs provides an opportunity to develop local responses to local needs including the challenges of providing services across three Health Boards that uniquely impact upon services in North Ceredigion.
- The promotion of independence and normal living will support the delivery of individual, family and community resilience and better equip people to live well for longer.

Argymhelliad / Recommendation

The Board is asked to acknowledge the multi-professional, multi-agency approach to addressing falls in Ceredigion and the example this gives of how services can deliver comprehensive care to allow patients/clients to be as close to home as possible.

The Board is asked to note the significant progress on delivering a community HWB model in Ceredigion to support the future sustainable delivery of care and the important links being built with neighbouring statutory organisations to deliver a consistent model of care across mid-Wales.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Risk Register Reference:	1, 3, 4, 5, 7, 11,12,13,16,17,19, 20, 23, 26, 28, 30
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply 3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.1 Planning Care to Promote Independence

Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	1. To encourage and support people to make healthier choices for themselves and their children and reduce the number of people who engage in risk taking behaviours 3. To improve the prevention, detection and management of cardiovascular disease in the local population. 5. To improve the early identification and management of patients with diabetes, improve long term wellbeing and reduce complications. 8. To improve early detection and care of frail people accessing our services in cluding those with dementia specifically aimed at maintaining wellbeing and independence.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working: Hyperlink to Well-being and Future Generations Act 2015 - The Essentials Guide	**Long term – can you evidence that the long term needs of the population and organisation have been considered in this work?** By enabling patients to be cared for in an appropriate setting the patient has potential to reach their maximum independence. This also enables capacity in the health system to care for other residents in the appropriate setting by enabling patient flow. **Prevention – can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health?** The driver for new initiatives is sustainability of services, both in regards to finance and workforce.

	Integration – can you evidence that this work supports the objectives and goals of either internal or external partners? The core principle of the service delivery and development is integration of both teams and facilities to deliver improved care.
	Collaboration – can you evidence working with internal or external partners to produce and deliver this piece of work? The report demonstrates the collaborative working across community, primary care, statutory service providers and private service providers and fundamentally across professional disciplines and statutory boundaries.
	Involvement – can you evidence involvement of people with an interest in the service change/development and that this reflects the diversity of our population? Understanding individuals' needs and community resilience is key to many of the initiatives listed. Working with the individual community to enable it to realise its capacity is becoming a new way of working. This could be through discussions with community groups, or through the 'what matters' conversation with individuals

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Each scheme is underpinned by specific evidence bases.
Rhestr Termau: Glossary of Terms:	Contained within body of report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.
Gweithlu: **Workforce:**	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.
Risg: **Risk:**	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.
Cyfreithiol: **Legal:**	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.
Enw Da: **Reputational:**	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.
Gyfrinachedd: **Privacy:**	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.
Cydraddoldeb: **Equality:**	This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers.

HEALTH SERVICES IN CEREDIGION

Health & WellBeing

September 2018

As part of the NHS's 70th Birthday Celebrations, primary school children in Ceredigion were invited to send a picture around a theme of why they thought the NHS was great.

Over 700 pictures were received and all were put on display in the hospital and we would like to thank all the young artists who contributed.

A small sample of the pictures is included to help illustrate this report and give a reminder of a wonderful day of celebration for the NHS.

Identifying Appropriate Intervention for Patients with Complex Care Needs

"10 High Impact Changes for Complex Care" have been identified by the Continuing NHS Healthcare National Programme for Wales:

- Avoid disruption to the usual care setting
- Identify complex needs as early as possible
- Agreed triggers and timely assessment
- Effective multidisciplinary working
- Proactive discharge planning
- Rapid systems of escalation
- Responsive long term care
- Focus on the data for complex care
- Integrated services and effective partnerships
- A workforce designed to serve complex needs

By focussing on these areas, people living with complex needs will be given opportunities for adding both years to life and life to years within their local community and with impacts that reflect the person as a whole, rather than as a patient.

The improvement areas are reflected in Hywel Dda University Health Board's overall strategic intent and Ceredigion has been addressing the challenge given by:

- Developing whole system integrated services that align primary and secondary health care with social services and third sector services
- Maximising proactive interventions to address changes to condition
- Establishing a central point of contact for accessing services to promote rapid escalation
- Developing plans and gaining support for facilities that will promote the resulting models of care
- Adopting new methods to providing rapid assessment of care needs to inform the response provided

Falls, although a relatively simple mechanical process often caused by identifiable and preventable hazards, can be a first indicator of a person's needs becoming greater and more complex. The response to falls adopted within Ceredigion is an example of where services responding to the 10 high impact changes make a real difference to people's lives.

Falls

It is estimated that approximately 1 in every 15 people in Ceredigion are at risk of falling each year. The risk of falling increases with age and if a person has a long-term health condition. Falls in older adults can have a significant impact on the health and life expectancy of a person, but are, in many cases, preventable.

The Falls Strategic Partnership was established in 2010 as a multi-agency, multi-sectoral group comprising primary and secondary care, community health services, Ceredigion Council's leisure, social care and housing services, third sector services including, care and repair, Age Cymru and Ceredigion Association of Voluntary Organisations together with Aberystwyth University to provide research support to the initiative.

The vision for falls was that it should be:

- Preventative rather than just reactive
- An approach which enables people to start thinking about falls prevention years before they happen
- A system which responds to the first fall, not wait until the injuries are severe
- A single process which can be initiated by the individual, their carer or the community
- Learning from interventions that work

The approach to falls prevention in Ceredigion arose from this direction and is a network of services supporting patients in the community. It is, in once sense an inextricable part of that network and, in another sense, a way of life for all services.

CASE STUDY 1: EARLY INTERVENTION TO MAINTAIN INDEPENDENCE

A female in her 60s (Mrs W) was referred with a history of frequent falls following an accident in 2009, a fear of falling and concerns about getting into and out of the bath. Following a session at the Safe and Steady Clinic, her physiotherapist referred her to the occupational therapy service for a home assessment.

A Specialist Therapy Support Worker reviewed Mrs W's history and arranged a home visit for an assessment and falls prevention interventions. Mrs W is a very determined and independent woman, managing all personal care and daily living activities, but had concerns getting in and out of the bath and using her front access safely.

The assessment resulted in:

- A request to Care and Repair for the installation of a grab rail in the bathroom
- A plan to manage entrance/exit from the house through the level entrance to the kitchen; Mrs W was planning to sell the property so the service would not be able to provide adaptations to the front entrance

The Specialist Therapy Support Worker followed up the installation of the grab rails via a telephone call with Mrs W who said that it was very useful. Mrs W then said that she was no longer planning on moving and was worried about the risk of fire in the kitchen compromising her ability to exit safely in an emergency and would like adaptations to the access.

SPECIALIST THERAPY SUPPORT WORKERS

Specialist Therapy Support Workers work as part of the occupational therapy and physiotherapy service to deliver therapeutic intervention as prescribed, and undertake simple patient assessment following agreed guidelines, protocols and care pathways

The Specialist Therapy Support Worker discussed the case with an Occupational Therapist and a joint visit was arranged.

During the assessment, access points were discussed and it was concluded that because she wanted to access the garden as an aid to her well-being, a rail would be installed to the steps so she could do so safely. Although there is an alternative level access, this is longer and it was assessed that the exercise and mobility benefit of negotiating several steps daily would improve Mrs W's general strength and exercise tolerance and would contribute towards reducing her risk of falling.

Mrs W's concerns about fire were also discussed, but since she had been visited by the fire service in the past two years, she did not feel that any further action was necessary at this point.

The Occupational Therapist advised Mrs W of the falls risk associated with a considerable amount of clutter on the floors throughout the house. Mrs W reported that this was solely due to works that were being carried out in the kitchen and they were soon to be removed.

Mrs W's concerns regarding falling when using the bath and getting into and out of her home have been addressed and she is able to continue to partake in activity that contributes to her general well-being, with risk of falls reduced.

The service has improved awareness of risks while encouraging participation in activity so as reduce her fear of falling.

Mrs W has been appropriately advised regarding prevention of fire by the fire service.

CASE STUDY 2: RESPONSE TO PRESENTING CLINICAL CONDITION

A lady in her 70s, Ms G, was referred to the Safe and Steady Clinic by a hospital Consultant. Ms G had abnormal gait and history of recurrent falls, lived with a sibling, was self-caring and independent, although experiencing increasing difficulties with higher-order activities of daily living such as stepping onto and off buses and was reliant on taxis for transportation. She was generally well, but complained of feeling "tired".

The patient was seen by a physiotherapist for a comprehensive multi-factorial falls risk assessment. Screening of medical risk factors was generally unremarkable, but revealed that the patient was borderline vitamin B12 deficient which may be contributory to both her tiredness and movement disorder. This may have been caused by the patient's diet; nutritional screening showed that the patient consumed no meat and very little dairy product.

The primary cause of Ms G's falls was her abnormal movement, partly due to severely abnormal postural alignment developed over many years. This impacted upon her balance which was also affected by a reduced neural response to movement and impaired strength and power of the trunk, pelvis and upper quadrant.

Outcome measures demonstrated that the patient was at high risk of falls, of which Ms G had a severe fear, particularly outdoors. When asked what was most important to her, Ms G responded "the way I walk in town and in the garden" and a care plan was agreed to address these concerns.

SAFE AND STEADY

Proactive, preventative clinic for reducing falls risk in the adult population, giving positive messages and promoting independence.

Physiotherapist-led, multi-agency collaboration

Community clinics cross-county in Aberystwyth, Aberaeron, Tregaron, Lampeter, Cardigan

Offer advanced clinical assessment and personal care plan, screening, intervention, signposting and onward referral – postural stability, home safety assessment.

Multi-factorial falls risk assessments, outcome measures, advice, education rehabilitation and early screening

Compliant with National Institute for Clinical Excellence and 1000 lives+, funded from Integrated Care Fund

- GP contacted in order to consider vitamin B12 supplementation
- Comprehensive advice and information on reducing the risk of falls generally
- Course of skilled movement rehabilitation to address movement impairments

Within 4 sessions of treatment, Ms G's outcome measures, gait and balance were significantly improved. Ms G said that she was very happy with her progress, that her fear of falling has reduced and she feels more confident going into town. She has the potential for further improvement and, therefore, the support provided will continue.

"I'm feeling much, much better in myself. I'm very grateful"

CASE STUDY 3: MULTIDISCIPLINARY RESPONSE TO FAMILY REFERRAL

Mr P is a male in his 80s with COPD, asthma, chronic anaemia, osteoarthritis and atrial fibrillation. He has a history of prostate cancer, an ileostomy in situ and had recently suffered with urinary tract and lower respiratory infections. He had also recently fallen sustaining a graze to his forearm. He was referred to the Community Occupational Therapy service by his daughter.

A home visit was arranged and Mr P described his main concern as his increased fatigue levels during, and following completion of, personal care tasks. Upon assessment by an Occupational Therapist, Mr P was observed to be mobilising with a shuffling gait supported by a thin wooden walking stick with a metal ferrule and he reported that his recent fall had been caused by mobilising prior to ensuring he was balanced following a change of position. Although he reported being able to manage all transfers, Mr P said that he was having increasing difficulty with managing the access at the front of his home.

Following the assessment, a plan was agreed with the patient, including:

Referrals to:

- Enablement for short term intervention to support personal care routine
- District nurse for the provision of a pressure relieving cushion
- Physiotherapy for provision of a more appropriate/supportive walking stick and advice regarding gait and improving general strength
- Care and Repair for construction of step and wall-to-floor fixed rails at front of property and provision of grab-rail at rear

Advice given regarding:

- Mobilising following a change of position and strategies for safer mobility
- 'Long lies' (reduced frequency of mobilisation)
- Trip hazards posed by rugs within the property and removal of some rugs
- Use of perching stool whilst undertaking personal care tasks rather than remaining standing
- Pacing of activities
- Pendant alarm system and carrying portable phone when mobile at night

EXERCISE REFERRAL AND POSTURAL STABILITY

Postural stability instruction classes in place since 2012

Average annual number of referrals 2013-17 = 77

Funding received from Integrated Care Fund

County-wide availability in 5 areas of the county

5 trained Postural Stability Falls Instructors

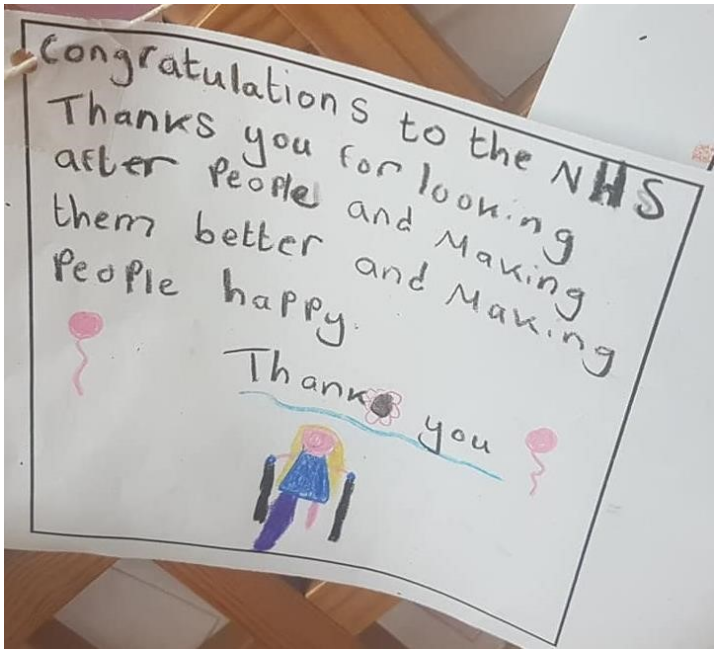
48 week programme running weekly, progressing to level 3 generic class if appropriate

Referrals are increasing:

2017-18 = 110 (out of a total of 998 across all pathways)

2018-19 (q1) = 37

Mr P is pleased with the support he has received to enable him to live safely at home.



Following intervention, Mr P feels that the enablement team support has reduced his fatigue and that he now able to undertake other tasks throughout the day.

The pressure relieving cushion supplied by the District Nurse has maintained his skin integrity.

The installation of rails and step at the front door by Care and Repair have enabled Mr P feel more stable when entering property.

The sturdier walking stick provided by Physiotherapy better supports him and he is informed on how to maintain safer mobility.

The examples above demonstrate the significance of the focus on falls not as a service, but as a way of life for teams within Ceredigion.

CASE STUDY 4: SUPPORTING DISCHARGE

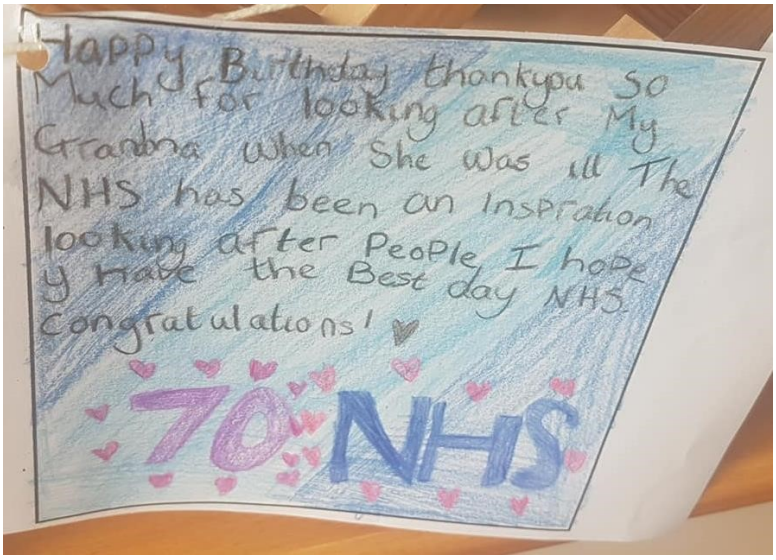
A GP contacted Porth Gofal regarding a patient in her 90s, Mrs L, who had recently become frail and had slipped in the bathroom falling heavily on the toilet causing her extreme pain in an intimate area. Mrs L was subsequently diagnosed with skin cancer in the same area which was extremely painful and, at times, affecting her mobility. The skin cancer was due to be removed but the location of the tumour resulted in concerns about how she would manage with activities of daily living after the operation. An Occupational Therapy referral was made.

Following review of the clinical notes, a home visit was arranged, with her son present.

The patient reported that she is a strong minded, independent person who is managing all personal care and daily living activities

independently, but her son was concerned how she would be after the operation and, due to the intimate area that the wound would be in, was unsure if she would need help with personal care.

An initial assessment at home together with a toilet transfer assessment were carried out to ascertain areas where support might be required.



A provisional referral to the Community Resource Team was made in case wound care was required after the operation in addition to information on support services available locally.

After the patient was discharged on the day of her operation, the Specialist Therapy Support Worker visited Mrs L to check how she was managing and whether there was a need for the Community Resource Team or Enablement Team to provide support.

Mrs L needed support in managing her clothing around her catheter and her Thrombo Embolism Deterrent (TED) stockings were re-applied, her son having put them on upside down.

Two days later Mrs L saw her consultant and the catheter and TED stockings were removed.

After two more visits, the Specialist Therapy Support Worker found Mrs L to be managing independently and did not require any further intervention.

RISK STRATIFICATION FOR COMPLEX CARE

As part of the work to develop the 10 High Impact Changes, it became clear that the complexity and variety of individual health needs stretched the capability of the existing tools, assessments and information systems and, in order to provide effective, responsive care, a simple way of describing a person's current status was required to support choices and decisions regarding the level and type of care they require.

The ANGEL "taxonomy" is a response to this need that is being trialled in Ceredigion as a Bevan Exemplar which stratifies a patient across 5 themes against 5 levels of information or support. The result is a picture that illustrates a person's status as a snapshot in time against which past and future snapshots can be compared.

ANGEL Taxonomy Score	Activities picture of typical life, activities and social relationships	Needs scale and scope of existing needs and level of support	Goals possible longer term changes and personalised goals	Escalation type of care plan required to align needs and goals	Location a choice of where and when the care will be delivered
5 Save Life	Isolated and vulnerable to immediate harm	Constant professional supervision	Rapid irreversible decline or nearing end of life	Imminent crisis or failure to progress plan of care	Specialist bed based care or placement
4 Serve Needs	Limited social activity or contact beyond ADLs	At least daily professional supervision	Ongoing instability or significant long term decline	Rapid referral or application for specialist service	Hospital or other bed based care institution
3 Support Living	Social support or activities available when needed	Scheduled intervention and observation	Some decline but stable functional ability over time	MDT led care plan assessment and intervention	Intermediate bed or supported living scheme
2 Share Care	Regular social activities with informal support	Stable within an agreed plan and review process	Predictable return close to or as good as before	Planned ongoing assessment and intervention	Domestic home with extra support or services
1 Show How	Socially active with a range of strong relationships	Self caring with minimal support or intervention	Typically better or more stable than before	Routine task oriented day to day care and support	Private domestic home with minimal follow up

(ADL = Activity of daily living)

An example of ANGEL in use can be seen in the case study below.

Male in his 80s, Mr G

Following a recent admission to Glangwili Hospital with a diagnosis of lung cancer, Mr G, aged in his 80s, was discharged to the care of Community Resource Team. Due to the extent of the disease, a palliative care plan had been agreed and he was not expected to improve.

About a month after discharge (day zero), Mr G fell at home. Mr G had not been compliant with physiotherapy input whilst in hospital and had become increasingly unstable following discharge.

Mrs G, his wife, was his main carer and reported that he sits a lot at home and is now struggling with walking.

Day 1: Community Resource Team Referral to Community Physiotherapy

Referral received and screened same day.

Information gathering completed by Specialist Therapy Support Worker against ANGEL themes:

Activities: Able to attend appointments but increasingly reliant upon his wife for all social activities. Becoming more house bound due to difficulties with walking.

Needs: Package of care being delivered by domiciliary care provider, Community Resource Team recently involved – discharged patient to package of care. For mobility assessment.

Goals: Significant decline in ability to manage personal care, walking becoming more difficult. Now palliative care for lung cancer.

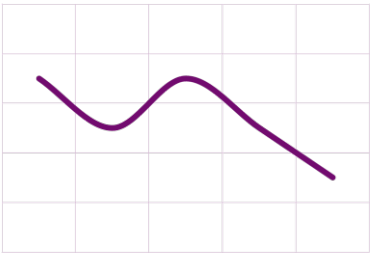
Escalation: Consultant oncologist involved – now for symptom management only, Community Resource Team referral to manage recent deterioration in health and ability to manage at home. Multidisciplinary Team involvement in community – social worker and referral to physio.

Location: Living at home with his wife and sister. (Sister has her own 24 hour carer for complex learning disabilities.)

Triage by physiotherapist: Rapid response physiotherapist assessment required

Appointment arranged for the following day.

Initial ANGEL Score: 14



Day 2: Physiotherapy Home Visit

Patient very confused, unable to orientate in time or place.

Mobility has deteriorated since referral.

Now struggling to stand from chair or transfer from bed to chair.

Needs constant assistance to walk with wheeled Zimmer frame.

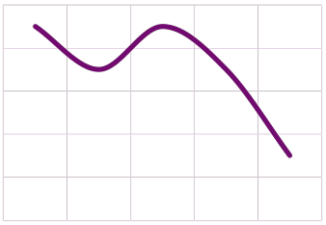
Mrs G struggling to manage despite the 2 x day package of care.

Mrs G also informal carer for her sister in law (also in the property who has complex care needs for learning disability – 24 hour care normally provided through direct payments, however the carer has been off sick and Mrs G has been unable to find alternative support).

Review: Mr G is not safe to walk by himself. Mobility is variable however this has deteriorated rapidly. Mr G is very confused which is new, possibly acute infection or metastatic spread to brain.

Plan/Needs: Requires urgent GP review and referral to district nurses/palliative care team for support.

ANGEL Score: 20



Activities: 5 vulnerable – unable to be left on his own due to confusion, high risk of falls.

Needs: 4 Requiring GP/District Nurse/ professional input daily at present to manage needs.

Goals: 5 Rapid deterioration in condition since referral.

Escalation: 4 Requiring rapid referral to palliative care team, medical review and end of life planning.

Location: 2 At home with package of care.

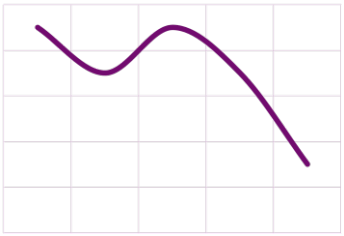
End of day 2

Physiotherapy team spoken to GP to arrange urgent visit. District Nurses made aware of the change in condition and GP visit, District Nurse visit planned with physiotherapist for the next morning.

Occupational Therapy assessment sent to Porth Gofal, physiotherapy team spoke with Occupational Therapy community lead to discuss urgent equipment needs for safe transfers; awaiting referral from Porth Gofal.

Physiotherapist contact with named social worker to escalate the needs of this patient and to highlight the fragility of carer and possible consideration for urgent respite. Also to inform Social Worker of patient's deterioration and confusion and likely continued deterioration in condition with impact on carers being unable to safely manage patient's personal care transfers.

ANGEL Score: 20



Activities: 5 Unchanged

Needs: 4 Unchanged

Goals: 5 Unchanged

Escalation: 4 Unchanged

Location: 2 Unchanged

Day 3

Morning:

9am: GP visit; cancer likely spread to brain. Bloods taken, urine to be dipped by District Nurse, otherwise stable and unlikely to be infection.

Plan to put just in case box into property, liaise with District Nurses and manage symptoms to allow Mr G to remain at home and comfortable given history and prognosis.

9.45am: Joint visit with District Nursing team, further agitation overnight

Just in case box provided for patient. District Nurse to order hospital bed and pressure relieving equipment for chair and bed.

Mr G continues to attempt to walk unaided and remains at high risk of falls. Requiring almost 1:1 care.

Multidisciplinary team discussion to support wife to remain main carer for her husband. Social worker to arrange increase in package of care to 3 calls a day with current provider and urgent respite support.

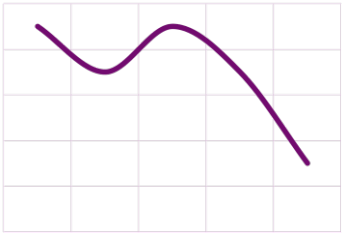
Afternoon:

2 pm: Occupational Therapist visit with Specialist Therapy Support Worker for continuity of care. Options discussed re hoist for when patient unable to manage transfers. At present unsafe to mobilise with frame, however able to transfer from bed to chair with assistance of wife and carer.

Advised not to walk with patient now, only transfer due to high risk of falls and likelihood of pathological fracture. Wheeled commode arranged and hoist discussed to be supplied urgently.

Hospital bed agreed with District Nurse Occupational Therapist with pressure relief to be provided to maintain safety and comfort once patient bed bound.

ANGEL Score: 20



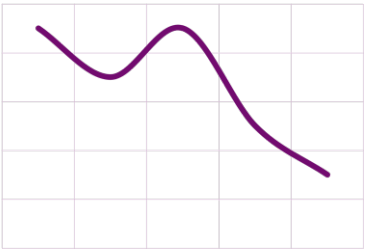
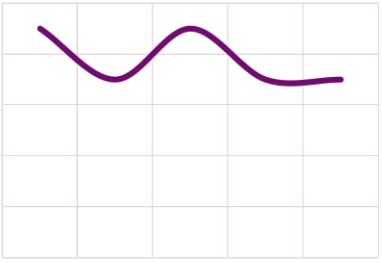
Activities: 5 Unchanged

Needs: 4 Unchanged

Goals: 5 Unchanged

Escalation: 4 Unchanged

Location: 2 Unchanged

Day 4 Equipment delivered to property. Package of Care increased by care agency. DNs visiting daily. Mr G now sleeping more and seems more settled over night. Now becoming less continent during night. Remains continent during the day. Continence assessment undertaken and DNs to provide pads. Mrs G already has a portable bottle for Mr G.	ANGEL Score: 19  **A**ctivities: 5 reduced falls risk however becoming increasingly bed bound. **N**eeds: 4 Requiring DN / SW professional input daily at present to manage needs, these are variable and monitored daily. **G**oals: 5 Ongoing irreversible decline in condition. **E**scalation: 3 Multidisciplinary team plan now in place to manage needs, these are variable and monitored daily. **L**ocation: 2 Unchanged
Day 7: Respite – Skanda Vale Hospice Admitted to Skanda Vale for 5 days for symptom management and to allow Mrs G to have time to sort problems with care for her sister in law. Palliative care team managing clinical issues as well as admission with social worker. Mr G is now sleeping more and has stopped trying to walk unaided. Now doubly incontinent at night and at times during the day. Pain increasing. Anxiety / agitation now well controlled.	ANGEL Score: 22  **A**ctivities: 5 Unchanged. **N**eeds: 4 Unchanged **G**oals: 5 Unchanged **E**scalation: 4 referral for specialist care (Marie Curie) when home. **L**ocation: 4 Respite Bed.

Day 11: Patient returned home with end of life plan in place

Patient to return home with 3 x day package of care

Hospital bed at home, now nursed in bed.

Doubly incontinent and confused all the time.

Palliative care team working with Mrs G, GP and DNs with end of life care planning/pathway.

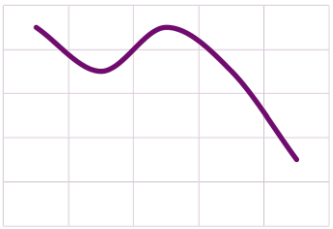
GP and DNs providing day to day EOL support.

Marie Curie sit-in service overnight to allow Mrs G to get some sleep.

Symptom management for pain and agitation ongoing, now increasingly sleepy.

No further involvement of physiotherapy service for rehabilitation; referral to remain open for multidisciplinary team/patient to be reviewed if needs change.

ANGEL Score: 20



Activities: 5 Now bed bound.

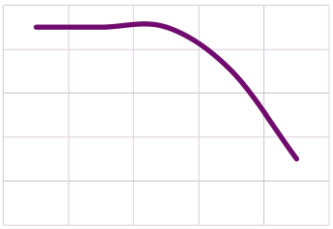
Needs: 4 Requiring daily DN / GP / palliative professional input to variable manage needs and symptoms.

Goals: 5 Unchanged

Escalation: 4 specialist service referral in place for Marie Curie and increased packaged of care.

Location: 2 Home

ANGEL Score: 21



At night with Marie Curie
Needs: 5 Increase in needs
Remains at home with constant professional support over night.

The ANGEL methodology supports clinicians in providing rapid assessment of patients and their caseload allowing them to direct resources and prioritise interventions as most appropriate.

Work is also underway on the development of tools to support the Integrated Pathway for Older People (IPOP) and a key goal is to ensure the ANGEL and IPOP work streams are aligned and share good practice.

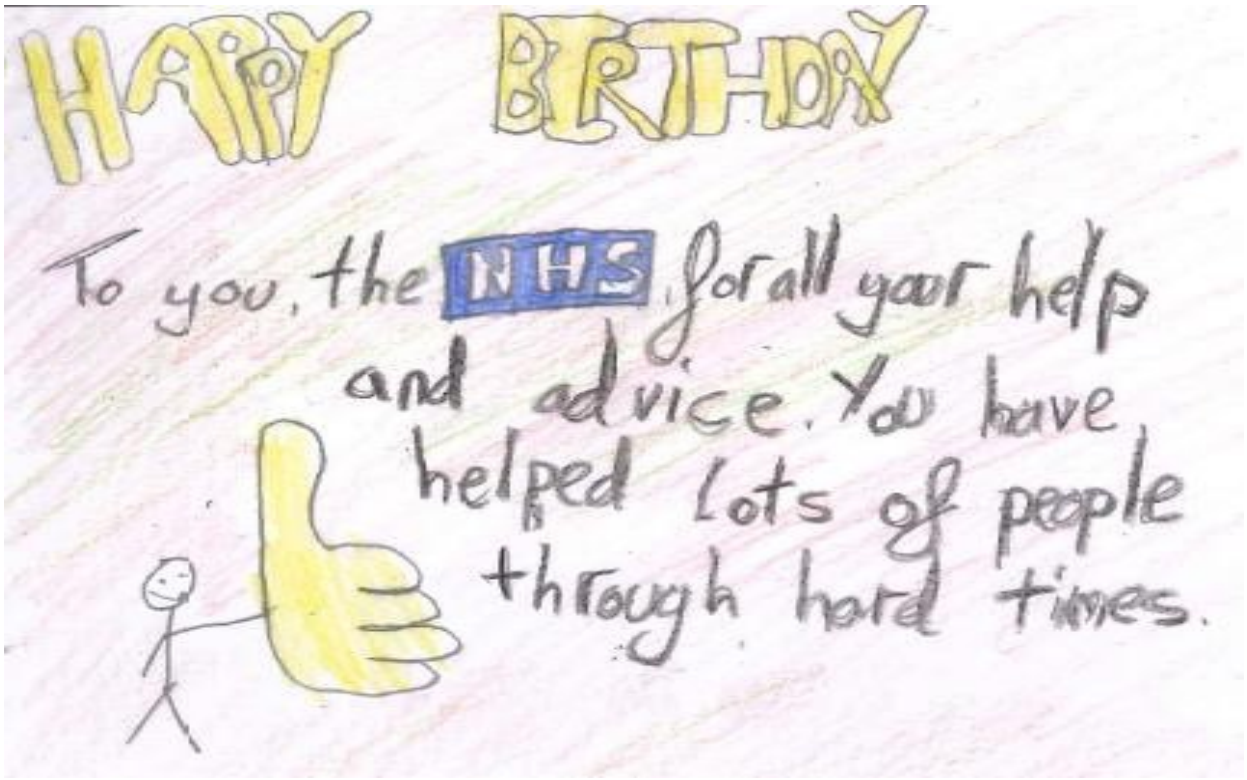
Developing the Falls Strategic Approach:

The collaborative approach to falls has delivered significant benefit to patients. There are, however, areas or work that require development.

- Reinforcing and raising awareness of the referral pathway – Porth Gofal, Porth y Gymuned
- Falls Brief Intervention Training - cascade to housing associations, third sector (home cleaning), Porth y Gymuned (Community Connectors)
- Maximising research opportunities – working with Aberystwyth University and regionally - Well-being and Health Assessment Research Unit. www.waru.org.uk
- Linking in with strategic direction – regional and national falls prevention, IPOP, Healthier Wales; a "falls" workshop planned for Autumn 2018 will help deliver this

To improve flexibility and quality, it is proposed that smart-phone video-conferencing will be used where appropriate to allow the Physiotherapy Lead to review patients across the county when face-to-face review is not practical or possible. Referrals, where appropriate, will be made into Ceredigion County Council's accredited National Exercise Referral Scheme.

The National Exercise Referral Scheme Community Falls Prevention Programme is led by qualified Postural Stability Instructors and provides an opportunity for patients to attend an evidence based exercise programme which is designed to reduce the risk of further falls and build confidence for fallers.

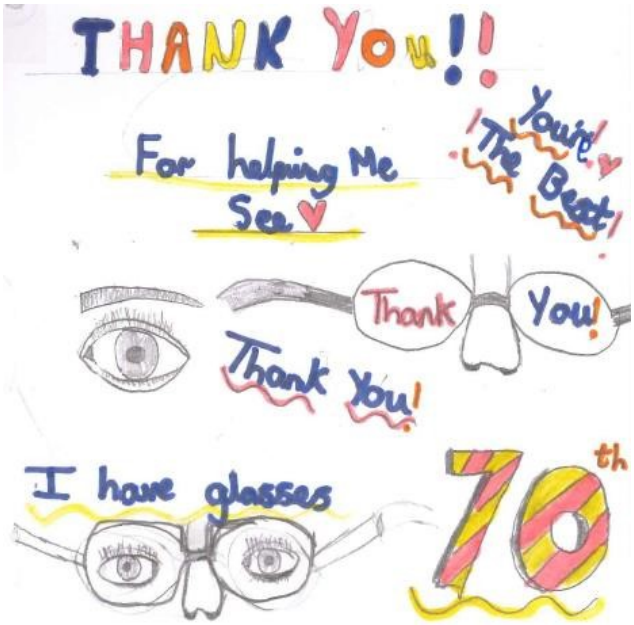


In summary, the Physiotherapy-led Community Safe and Steady (Falls) Clinics provide multi-factorial falls risk assessments, screening, triaging, advice, interventions, case management and onward referrals where appropriate.

Having a transparent approach to care planning will reduce duplication and ensure a holistic approach is taken with the patient's needs centred to the care plan.

- Taking a proactive approach will reduce unscheduled demand on secondary care services
- The holistic approach will ensure appropriate and timely referrals are made into both statutory and third sector organisations
- Reduce the number of Ceredigion residents who are admitted to hospital with a fragility fracture
- Increase the number of Ceredigion residents ageing well without a fear of falling
- Promote the benefits of physical activity and healthy lifestyle habits among older residents of Ceredigion
- Improve the bone health of older residents of Ceredigion
- Ensure prudent and appropriate medicines use among older residents of Ceredigion

Ceredigion Community Health Services aspire to deliver continual improvement and ensure all residents have access to high quality services that meet their individual needs. Integrated services do not, necessarily, require buildings to deliver their services, however teams from different specialities and organisations who are working towards this common objective do benefit from being close in order to provide opportunities for team development, information sharing, peer support, review and a focus for patient/client related discussions to promote proactive intervention to maximise patient wellbeing.



This ethos has directed the capital investment strategy in recent years around the county's community hospital estate which will result in the first community HWB, as envisaged in the Health Board's Transforming Clinical Services Strategy, opening in Aberaeron in autumn 2019 closely followed by the Cardigan HWB with Cylch Caron completing the programme in 2020. We are now given the opportunity to put the future in focus by describing the story of Aberaeron Hospital and the way in which the new HWB will provide a template for the delivery of whole-system care services going forward.

Future in Focus

The building that is now known as Aberaeron Hospital was built in 1838 at a cost of £1,200 (approximately £954,000 today). It served as the Aberaeron Union Workhouse, as was required under the Poor Law Amendment Act of 1834, housing 80 "inmates" when it became a hospital for injured servicemen at the end of the First World War, prior to it becoming a cottage hospital in 1930.

Over the next 60 years a range of services were provided from the hospital and continued to so be after the inpatient beds were closed in the 1990s.

The hospital remains a much valued and in demand centre for health services, including consultant outpatient clinics, physiotherapy, audiology and podiatry, but at 180 years of age is of a construction, size and condition that is no longer suitable for the delivery of modern health services.

Aberaeron was also served by two GP practices until retirement resulted in the closure of the smallest practice with the patients transferring to the remaining Tanyfron Surgery.

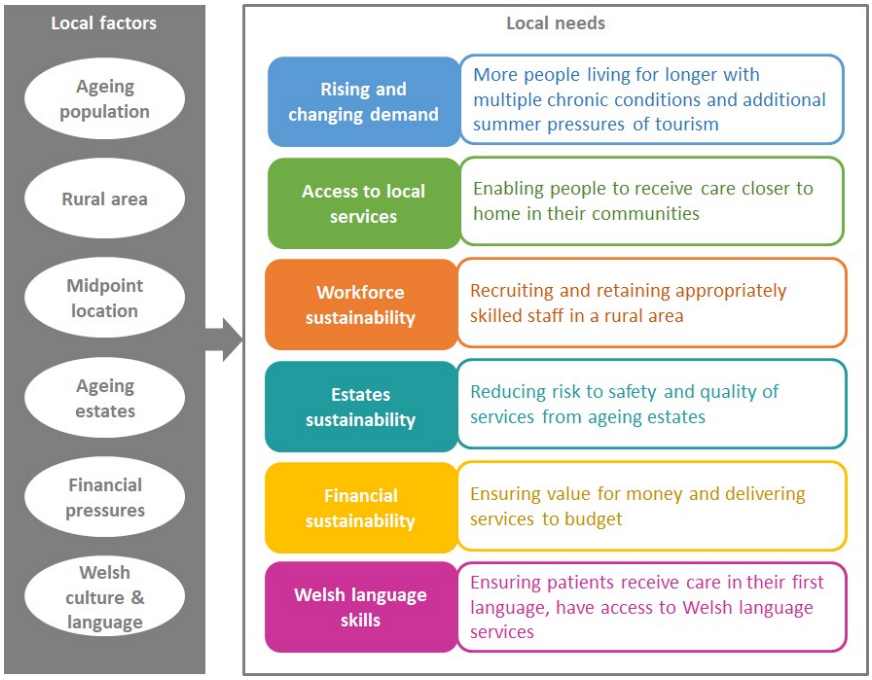
The provision of services in Aberaeron, which is a centre for the surrounding population, has significantly outstripped the space available with staff and teams being spread over a wide geographical area. These teams have to respond to the continually increasing needs presented by a population that is living longer, with greater comorbidities, surviving conditions that were once deemed "end of life". There are also challenges presented by an area where "young" people move away, but which attracts older people who wish to retire to the countryside, but who do not necessarily have established social or support networks at a time when these would be of benefit.

The Ceredigion County Primary and Community care Annual Plan, 2018/19, sets out a plan for an integrated network of services that deliver population health:

- **Continuity of care:** relentless focus, especially for those with ongoing or complex conditions or needs
- **Reducing the need for travel:** unless the need is more complex or specialised
- **Population empowerment and enablement:** supporting wellness, self-care and community cohesion
- **Trust in relationships:** developing trust with and between service providers, clinicians and our communities
- **Delivering excellence:** in patient outcomes, care and experience
- **Professional prestige:** creating learning and fulfilling working environment for staff and contractors based on a multi-disciplinary team approach

The model puts GP services at the heart of the network of local care provision and a seamless model of care provision to deliver truly holistic, patient centred care.

Over the past two years, discussions with our Local Authority partners, resulted in the Health Board being able to secure title to the Minaeron building, that was the Social Service Headquarters, and secure £2.4m from Welsh Government to develop the site and, on the 25 July 2018, a significant step forward was taken when Hywel Dda University Health Board's Chairman, Mrs Bernadine Rees OBE, handed over the keys of Minaeron to the contractors to commence work on the development of Aberaeron's Integrated Care Centre (HWB).



The HWB will provide a focal point for services for the residents of the mid-Ceredigion area.

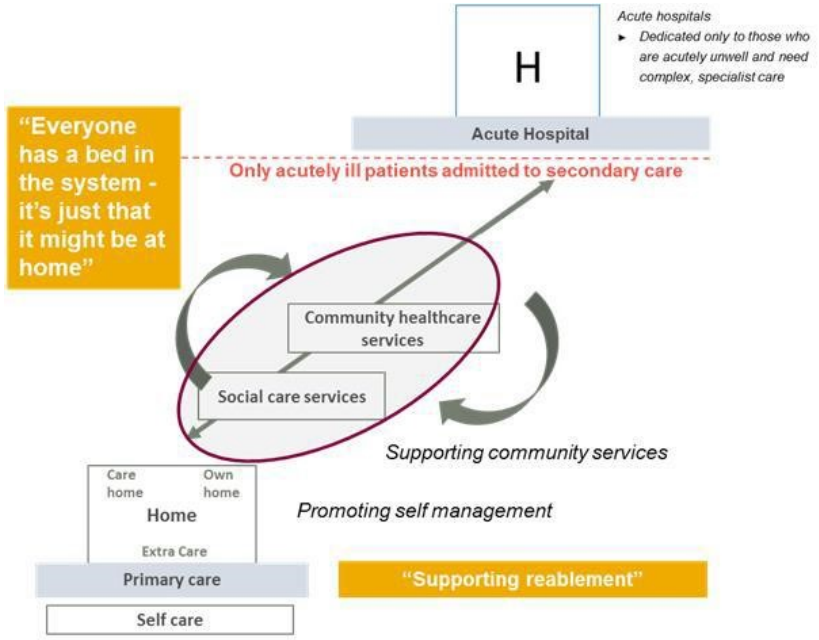
It will provide much needed bases for multi-agency/multi-disciplinary professionals who are currently scattered across the area which is not always conducive to enabling team working for best patient outcome.

Currently, time and resource is spent in enabling essential communication between professionals and services and the HWB will facilitate effective and efficient communication allowing the time and resource saved to be directed to benefit service users in the area.

Importantly, the colocation of the GP practice in the HWB, together with the outreach consultant clinics, will take services beyond those of a traditional health centre and into agile, proactive and truly holistic care provision and support the delivery of the North Ceredigion GP Cluster's priorities:

- **Sustainability:** Ensuring sustainability of core GP services and access arrangements, including through agreed collaborative arrangements
- **Strengthen pathways:** Prudent planned care pathways that facilitate rapid, accurate diagnosis and a strong primary/secondary care interface, including development of shared protocols
- **Coordinating care:** High quality, consistent urgent care including better coordination of care resulting in fewer inappropriate admissions and improved discharge
- **Managing chronic conditions:** Improved management of chronic conditions including a new service model for diabetes
- **Collaborate and federate:** Developing stronger collaborative and federated ways of working to build sustainability and ensure continuity of service provision

The service design envisaged is consistent and compatible with the Health Board's vision set out in its Transforming Clinical Service strategic programme and with completion of the building works set for early summer 2019, it will provide an early example of what the future healthcare services will look like.



One of the key principles underpinning the HWB is that, while a patient may need a bed in which to receive their care and that everyone will have a bed in the system, the integrated model of care, supported by technological opportunities, will allow for more of that care to be provided in their home.

The ethos is to advise, support and treat people in the community, with hospital admission only considered when absolutely necessary so that people's needs are met in the most appropriate way, with care and treatment provided by the right person at the right time, in the most appropriate setting.

The HWB will support realisation of the benefits of a whole system approach to care delivery that challenges traditional models of care:

Improved clinical decision making

- Increased number of multidisciplinary discussions
- Patients able to access most appropriate services
- Community based diagnostics to inform decision making

Increased capacity to enable collaboration and improve access to care closer to home

- Increased range of services available
- Increased number of Outpatient contacts
- Increased patient education sessions available
- Increased participation in patient education sessions
- Increased involvement of third sector partners
- Increase in children's referrals within Porth Gofal
- Increased access to children's social worker
- Access to care in first languages without obstacles

Sustainable Workforce

- Increased opportunities to develop shared roles

Better quality of care

- Improved clinical outcomes reducing emergency admissions
- Improved patient and service user experience
- Improved patient access and attendance

Estates sustainability

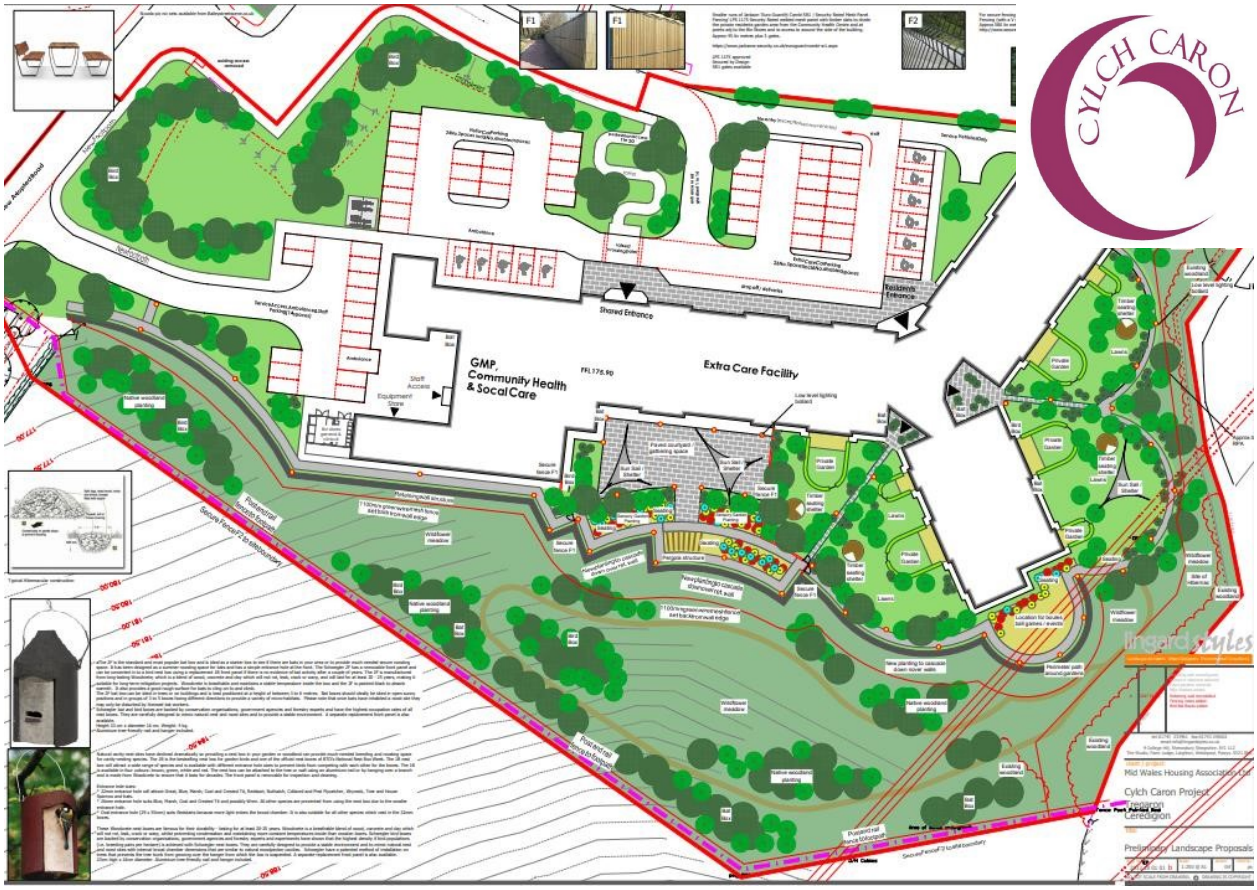
- Designated parking spaces
- Reduced health and safety risks
- Provision of DDA compliant facilities
- Facilities that provide functional suitability
- Facilities that provide privacy and dignity
- Facilities that meet infection control standards

Financial sustainability

- Remove backlog maintenance liability from Health Board
- Improved care within same recurring revenue envelope

Alongside the Aberaeron HWB, Ceredigion County has been actively pursuing the developments to replace two other community hospitals which have similar challenges to Aberaeron Hospital Construction in Cardigan is underway and due for completion in December 2019 and planning for Cylch Caron is progressing with completion expected in 2021.

When complete, the focussed investment on community services in Ceredigion will put the county at the forefront of delivery of the future models of care that are essential to ensure the long term success and sustainability of services required to meet people's needs.



This significant progress in the development of the community health service in Ceredigion has been enabled by resources released by the reduction in community "inpatient" beds that has been invested in community nursing to support patients being cared for in their own homes with a flexible commissioned bed provision for patients who require additional support. Partnership with third sector providers to provide flexible, safe and appropriate care settings for patients is an essential element of this "bed-less" model of care and the utilisation of non-NHS providers for this element of care promotes prudent provision of services with elements of risk transferred to the third sector, but also with a rehabilitative and reablement focus on care driving a reduction in patient deconditioning and dependency thus promoting return to independence and independent living.

MID WALES HWB

The development of integrated models of care reach beyond Hywel Dda and in line with recommendation 3 of The Mid Wales Healthcare Study work is underway to explore a shared approach to providing consistent services across mid-Wales.

Recognising the position of Bronglais Hospital as serving the populations of Powys and Gwynedd requires us to work with neighbouring Health Boards to explore opportunities to develop services that enable care across the mid-Wales area.

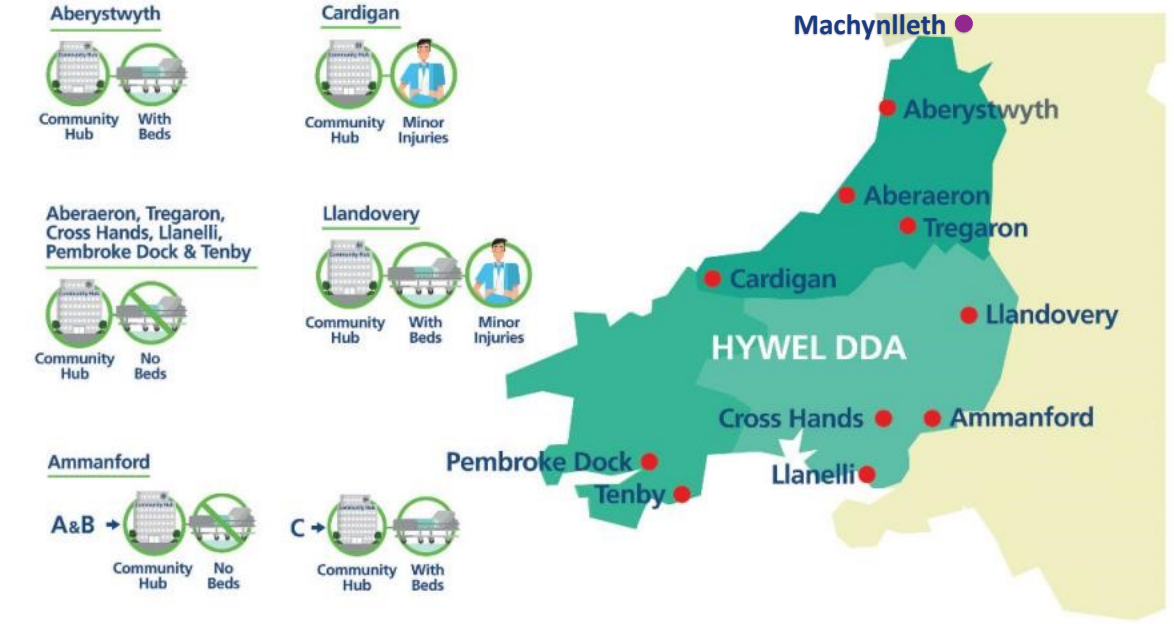
Bro Dyfi hospital is geographically situated in a strategically important location being at the crossroads of routes to Tywyn and Dolgellau hospitals to the North, Welshpool and Newtown hospitals to the East, Llanidloes hospital to the South East and, Mid-Wales' only District General Hospital, Bronglais in Aberystwyth to the South. This significant location factor delivers opportunity to propose a model of care where services provided across these six hospitals can be coordinated to provide the best possible access to as wide a range of high quality services as possible.

RECOMMENDATION 3

"The three Health Boards should re-double their efforts to address the pressures facing local primary care, developing complementary services, creating new models, sharing functions and providing business support, looking at new organisational models for general practice, and where possible providing targeted financial support. There is traction to be gained by the Boards coordinating their efforts to meet the specific circumstances of Mid Wales, and considering shared solutions where appropriate."

In taking such an approach there is a need to blur traditional organisational boundaries in the pursuit of the best outcome for patients and the promotion of "care" to the population.

Location of Bro Dyfi Hospital, Machynlleth in Relation to Proposed Hywel Dda Proposed Community Hubs



The space offered by the Bro Dyfi development provides opportunity for partnership, joint working, service extension and enhancement to create a seamless service for patients in mid-Wales. An extension of medical and surgical outreach into Powys would enable opportunities for enhancing rehabilitation pathways post stroke, cardiac, and cancer treatments provided at Bronglais and improved integration with the co-located GP practice. Bro Dyfi is ideally situated to:

- Be the local centre of health and social care, actively outreaching into local communities to maintain people in their homes and local communities without the need for formal admission to residential or inpatient care except when that is absolutely necessary
- Providing gravitational pull to repatriate patients from acute care and to provide an alternative for patients who do not required acute care services, but for whom there are currently limited options
- Delivering medical and surgical treatments transferred from acute settings, networked with the local DGH
- Providing a technology hub for the provision, delivery and monitoring of care

The Mid Wales Joint Committee's Operational Forum have identified several pathways where an integrated mid-Wales approach would benefit patient care promoting appropriate intervention and access to services to prevent admissions and support discharges and are in the process of developing a plan to deliver this.

Ceredigion Adult Mental Health Service

North Ceredigion CMHT

A multidisciplinary morning clinical hub meeting is held daily with both Community Mental Health Team and Crisis Resolution and Home Team attending. The purpose is to review patient flow and prioritise patient care, risk management and allocation of the team's resource. This has proven to be highly successful and has contributed to the lower levels of admission to acute wards.

The team have started a project with the Coleg Ceredigion staff and students to tackle the stigma around mental health and young people.

The team continue to have weekly meetings with Aberystwyth University where the student direct referral pathway has helped students in need of support to access the service.

The de-commissioned Art Room at Gorwelion has been transformed in to a large cafe style waiting area with tables, chairs and sofas. This is a significant improvement on the old waiting area where service users had to sit in a row facing a wall. Refreshments are provided and initial feedback is that there is better engagement amongst staff and service users in this big, open space.

Unscheduled care services continue to be provided on Friday, Saturday, Sunday and Monday night. This will be extended to 24/7 once the service has recruited to the vacant posts.

Transforming Mental Health Programme

The Mental Health Implementation Group has established sub-groups to inform implementation with staff from Ceredigion attending each one. Transforming Mental Health Champions have also been identified in all teams to support implementation.

As part of the implementation in Ceredigion, there has been an integration of the North Community Mental Health Team, Crisis Resolution and Home Team and Local Primary Mental Health Support Services into one team. This will provide the 24/7 service in Aberystwyth with a self-referral process for advice, assessment or intervention.

Transforming Mental Health Sub-Groups

- Workforce Roles and Cultural Change
- Pathways and Access Design
- Estate, IT/Infrastructure and Design
- Transport and Community Networks

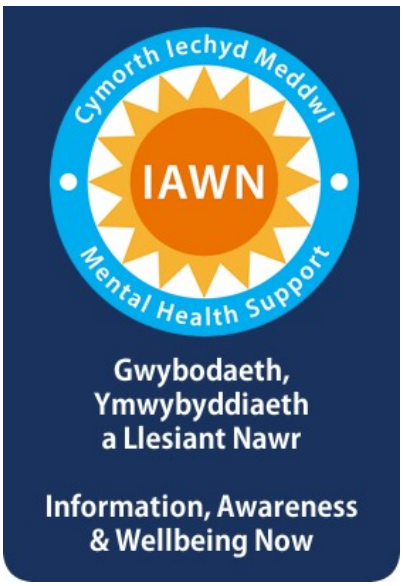
A workshop is planned to start defining the roles, responsibilities and new job descriptions. For this team there is a nurse commencing on the non-medical prescribing course in September 2018 and a nurse commencing on the advanced nurse practitioner course in March 2019.

Base for Aberystwyth Community Mental Health Centre

Eight options have been identified for the Aberystwyth Community Mental Health Centre. An option appraisal workshop has been held from which a shortlist will be developed.

Awel Deg Business Planning Programme Group

Awel Deg, in Llandysul is currently the base for Mental Health and Learning Disability services in South Ceredigion. This has provided us with more appropriate accommodation and increased space for our staff. However there is a need to identify further office space and clinical areas. The MHLD Directorate and Ceredigion County Council are reviewing further options which may provide greater flexibility in the future.



MENTAL HEALTH (WALES) MEASURE 2010

Law passed by the National Assembly for Wales. Rather than being about compulsory powers and hospital admissions, it focusses on the support that should be available for people with mental health problems wherever they may be living.

The Measure is intended to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs. It has four main parts that place legal duties on Local Health Boards and Local Authorities to improve service delivery:

Part 1 seeks to ensure more mental health services are available within primary care.

Part 2 gives all people who receive secondary mental health services the right to have a care and treatment plan.

Part 3 gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.

Part 4 offers every in-patient access to the help of an independent mental health advocate.

Local Primary Mental Health Support Service

The team consistently meets the Part 1 Mental Health Measure targets for assessment and intervention. The IAWN website has proven to be very successful, all Ceredigion GP surgeries have been sent the promotional materials.

Acute Care

Bronglais General Hospital

The Board's performance report provides information on the delivery of acute services at Bronglais General Hospital (BGH) against national targets and shows that performance has deteriorated over the last quarter.

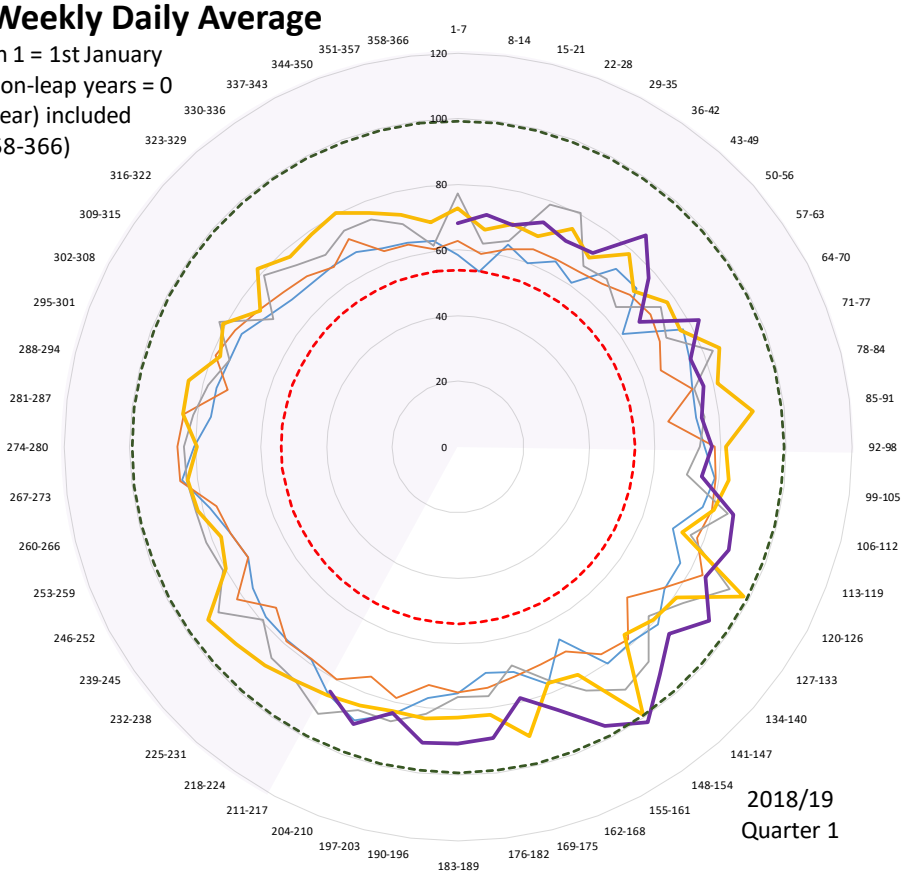
This is attributed to a number of factors:

- Most common reason for breach is no available medical or surgical bed
- Formal shortage of residential and nursing care capacity in Ceredigion
- Significant pressures experienced in the North (Gwynedd) which impacts on Bronglais
- General continuation of the trend for increased age and acuity of patients attending A&E

The chart below shows that Accident and Emergency (A&E) attendances have been increasing year on year over the past 4 years.

BGH A&E Attenders Weekly Daily Average

Weekly Year on Year Comparison 1 = 1st January
Values for 29th Feb (day 60) in non-leap years = 0
Last day of year (2 days in leap year) included in last week of calender year (358-366)



The operational actions intended to drive improvement described in the last Ceredigion Board Report continue with additional areas of emphasis. Focus continues to be on discharge planning at an early stage in the pathway, working with nursing and medical

teams to improve process. This includes making patients, carers and families aware of discharge intentions to ensure they can be part of the plan and make arrangements for discharge.

Additionally there is increased collaborative working between acute and community colleagues as well as weekly meetings with social services to ensure actions are timely to drive discharge for patients with complex needs.

Release of capacity sufficiently early in the day is our greatest priority and embedding this practice daily would ensure patients who require admission can flow from A&E to the wards each morning, clearing the site and enabling the clinical teams to meet A&E demand as it rises through the day.

A&E FUNCTION AND FLOW

Work with A&E team in the physical environment is planned. The Clinical Lead for the Health Board will spend a week at Bronglais later in the year in order to support the team to improve focus and practice. A consultant in emergency medicine post will be out to advert.

ELDERLY FRAIL PATIENTS

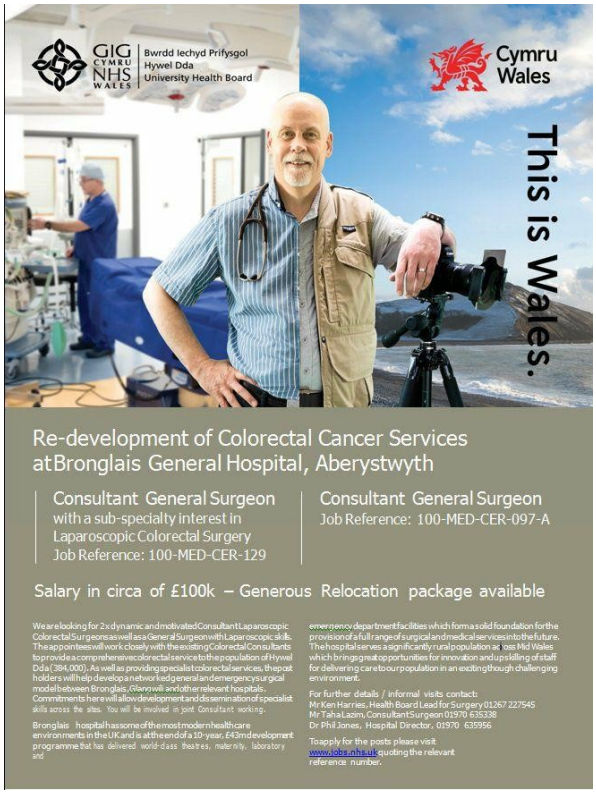
A part time Care of the Elderly Consultant and an Advanced Practice Nurse for Frailty have been recruited. They will focus on front door flow, admission avoidance and support for this patient group which represents a significant proportion of urgent care demand.

A short-stay Elderly Care model will be explored for those who require admission for short term intervention with a promotion of returning home to reduce the risks of deconditioning, optimise outcomes and maintain patient dignity and independence.

Some improvement has been seen, but it is still not delivering as required because of a lack of substantive staff, in particular nursing. Bronglais has had some success in medical recruitment to doctor posts who will take up posts in the autumn and the nursing vacancy factor remains the biggest workforce risk.

There is increased and sustained focus on the list of patients who have a length of stay of over 20 days. However pressures in the North and shortage of nursing home placements and challenges in providing packages of care in a rural setting have meant an overall increase in this patient group. On average Bronglais houses approximately 30 medically optimised patients at any one time who could leave hospital if options such as placements and care packages were available. This represents 23% of the Bronglais bed base, which is significant impact on the ability to sustainably improve flow.

Recruitment and Workforce



We are exploring innovative staffing arrangements to respond to recruitment challenges and make best use of the skills of our staff and support career progression and development. These include making flexible appointments across the whole care system in Ceredigion and with our partners in Powys and Gwynedd. It may, however, also be necessary to explore overseas recruitment in the future to ensure ongoing provision and sustainability of services.

Some of the consultant input for our services will be as part of a network within Hywel Dda and in some cases as part of a network arrangement with other Health Boards and NHS Trusts in England to reflect the care pathways for patients living in Powys and Gwynedd.

Medical Consultants

A dedicated and bespoke Recruitment Campaign for Bronglais which commenced in March 2018 resulted in recruitment to a number of consultant posts – Acute Medicine, Part Time Care of the Elderly Consultant, Diabetes and Endocrine Consultant, Cardiologist and Respiratory Consultant. Most join the team in the autumn but the Respiratory Consultant is unable to join until January 2019.

Surgical Consultants

Two Consultant Surgeons have been appointed, (one general and one colorectal) with a third planned which will facilitate the reinstatement of colorectal surgical and cancer services to Bronglais.

Other Medical Posts

Bronglais has for some years worked with only 7 Middle Grade medical doctor posts filled. During 2018, culminating in the autumn, this number will increase to 11 due to successful recruitment. The ability to place a Middle Grade doctor in teams who have, for some time managed without, will make a significant difference.

Additionally the Deanery fill rate has improved and the August 2018 rota will be full for the first time in recent memory. Collectively these appointments will not only improve patient experience and reduce pressure on an existing depleted workforce, but they will reduce cost since we will have a lower level of reliance on ad hoc variable pay to cover out-of-hours rotas.

Nursing and Physician Associates

Two Advanced Nurse Practitioners have been recruited, one in Frailty/Care of the Elderly and one in Cardiology. This supports succession planning for clinical nurse specialists. Three physician associates have also been appointed who join the team in September 2018.

We are already realising benefits from the Advanced Nurse Practitioners posts in some of our services and we plan to develop more of these posts to enhance and strengthen our medical teams and the three Physician Associates will be placed within our clinical teams where they will receive clinical supervision and development to support the delivery of new workforce models of care.

Workforce Development

Significant education opportunities exist for links to national training centres to support both upskilling of existing University Health Board staff and recruitment of new staff. These links will allow staff to rotate to maintain and develop skills will be of benefit to the whole Health Board.

Options are being explored with universities to support local training for nurses and therapists building upon the links already established with Cardiff Medical School as an aid to recruitment and retention of a local workforce who currently have to travel to access training.

We aim to create a career pathway for Health Care Support Workers who wish to progress to nurse training and this will help us to grow our own future workforce recognising the importance of responding to the evidence that qualified staff tend to stay local to where they trained.

Clinical Strategy

A series of Clinical Engagement Forums are being held with operational directorates to set out the models of care that will underpin the delivery and enhancement of services provided to the residents of Ceredigion, Powys and Gwynedd who access services from Bronglais.

These will inform the Clinical Strategy for Bronglais Hospital and its associated services and will form the plan for Bronglais as part of the overall Transforming Clinical Services delivery plan.

Estates Plan

The Bronglais estates plan builds upon successful investment which has provided the hospital with state of the art laboratories, day surgery unit, A&E, maternity unit and two inpatient theatres to be commissioned in September 2018.

The 2018-20 estate plan will deliver a new Chemotherapy Unit for Bronglais, enabling repatriation of some care currently provided in Shropshire and bringing patients back who currently travel to Swansea, provision of a collaborative mental health/dementia care unit, increased space for co-located therapies, cardiorespiratory, diabetes and endocrinology team and ultimately a new Medical Day Unit and Ambulatory Care Unit.

Progress on specific capital projects and service development is set out below.

MRI

The plans for the installation of a state-of-the-art MRI scanner were complicated by the lack of available space options at Bronglais. This has resulted in an increase in the cost of the scheme because a new building is required to house the unit. A business case has been submitted, feedback on which is expected soon.

A risk assessment has been provided to Welsh Government to set out both the clinical and financial risk of not progressing a plan to replace the unit at BGH. It also outlined the risk to neighbouring Health Boards, notably Powys, which uses BGH for this diagnostic test and has no MRI resource of its own.

MRI is an area of diagnostics which is seeing a 10% year on year increase nationally. Historically complex cases have been referred to the south, however Carmarthen and Swansea are now unable to provide additional support due to their own demand pressures. The current MRI at BGH is at the end of its life and the images it produces are not in line with those delivered by modern equipment. A clinical assessment of the existing machine is about to take place, the result of that may well be to agree that a mobile interim option is required to serve patients until a new scanner is installed.

Chemotherapy Day Unit

Plans are progressing for the delivery of a modern Chemotherapy Day Unit for Bronglais Hospital. An options appraisal exercise is underway and will recommend the preferred choice of site for the unit.

Once completed, the preferred option will be presented to Board for consideration of the capital funding required alongside the existing charitable sources identified for the development and the current fundraising underway being led by Dr Elin Jones, locum Oncologist at Bronglais.

The expected time frame for delivery is April 2020.

Cardiac CT Guided Angiography

In March 2017, Bronglais became the first hospital in the Health Board to offer CT Angiography (CTA) to patients providing a fortnightly list with plans to increase to weekly.

CTA is a diagnostic test which is considered first line intervention by the National Institute for Clinical Excellence. CTA is “image guided” and, as the name suggests, is non-invasive and is a reliable test for ruling out coronary artery disease. It is also used for excluding cardiac origin in low to medium risk chest pain.

Patients with a normal CTA can be assured that their pain is not caused by coronary artery disease and can avoid having to undergo interventional angiography. This has a positive impact for suitable patients who might otherwise wait in a hospital bed for transfer to South Wales for conventional angiography and for those who are electively referred who can avoid the need for admission at all.

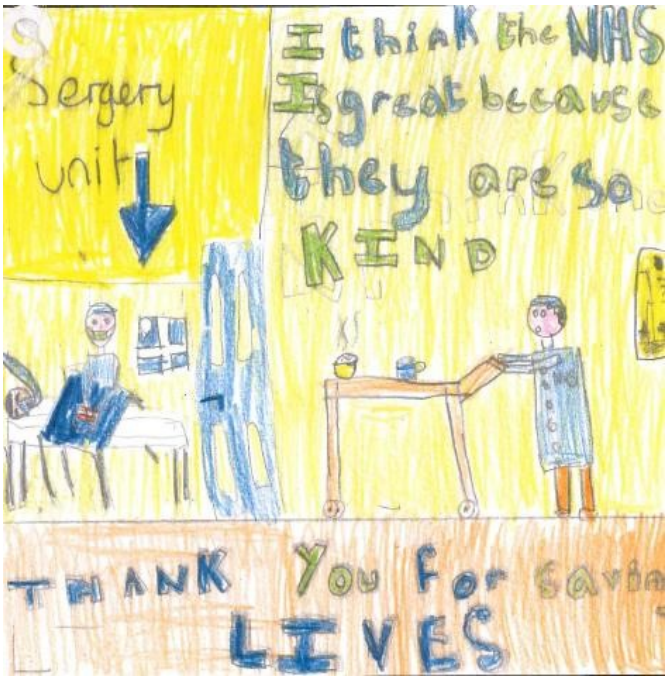
This development promotes care closer to home and is a marker for what can be delivered in relatively isolated settings and can also act as aids to recruitment. An additional cardiologist joins the team in October 2018.

Scheduled Care

Scheduled care performance is set out in the Board's performance report.

Scheduled care continue to work collaboratively with the BGH triumvirate with regard to the vision and strategy regarding the consultation on Transforming Clinical Services.

The main theatre services at BGH have benefited from an extensive refurbishment and a plan is with the Executive Team with regard to extending the template utilisation of these theatres however it should be noted this will include significant investment in staff.



Discussions are underway regarding the continuing use of the Day Surgery Unit 3, which is housed in a demountable unit. Options are being considered for its future utilisation and will be presented to the Executive Team in the near future.

Concerns continue regarding the environmental footprint of North Road clinic, backlog and ongoing maintenance costs. The Estates department are doing some initial recovery works and the Directorate are currently concluding an options appraisal SBAR as to the future delivery of eye services at this facility in response to these issues. The Health Board's Transforming Clinical Services plans open up new opportunities for a combined approach as part of the development of the Aberystwyth HWB.

Consultant recruitment continues at BGH with the recent appointments of two Consultant Surgeons which will support the return of colorectal services at BGH.


Thank you for Looking after me when i cut my head open. you were fantastic!
Congratulations to you.

HDdUHB - Carmarthenshire Community Health & Social Care Joint Working 2016/2019
3T's Action / Objective Plan moving forward

Actions: - In Progress, completed, embedded and continuous improvement.

The following actions will inform and direct our work for the coming two years:

*CD = Continuous Development *CI = Continuous Improvement

Firstly are the objectives recorded as part of the 2016 – 2019 Locality Plan which will remain in the forward work plan.

The new actions under our 3 Offers/Tiers follow, the whole appendix is a working document.

Locality Priority Areas	Aim	Objectives	Timeline Delivery	Lead Officer
Care Closer to Home	• Further develop the integrated locality Community Resource Team in order to ensure multidisciplinary diagnosis, advice, assessment, and interventions for individuals who have long term conditions to support more people to live healthily and safely in their own homes and community.	To develop hot clinics in conjunction with geriatricians.	2018/19 A Frailty clinic commenced in GGH & PPH with 5 sessions per week	Dr Kerry Phillips
		District Nurses to assess using frailty tool and report monthly in order to further develop services	Embedded	Sian Green

		To work with the Community Mental Health Teams in order to integrate services with the final aim of co-locating with the Community Resource Team and to work to the same principles.	Oct 2018	Jayne Thomas/ Janet Scarrott/ Lydia Hayward
		To continue joint working with GPs and the multidisciplinary teams	Embedded with continuous development (CD)	Kerry Phillips/ Jayne Thomas/ CRT Leadership
	• Enable more people to live in their own homes for longer and to regain skills for independent living following a crisis.	To actively promote use of the Telecare and Careline services in order to minimise risk for individuals who live at home.	Embedded with continuous development	All CRT
		To continue to develop and make use of the Rapid Response service within the locality	Continuous development	CRT Staff
	• To embed a frailty approach to the management of our ageing population	To promote the use of Delta Wellbeing service available to the public for assistance and advices on wellbeing and health and social care services	Embedded with continuous development	Sam Watkins / Dean Jones
		To promote the concept of a Health & Social Care Worker in the Llandovery area working across health and social care.	In situ	Sarah Cameron
		To develop appropriate accommodation across the locality for chronic leg ulcer clinics.	Embedded	Sarah Cameron/Sian Green
		To support the development and introduction of extra care facilities in the 3Ts e.g. Cartref Cynnes	Embedded with continuous improvement.	3T's Locality Management Team
		To support improved access to primary care and community services	Embedded	3 T's Locality Management Team
		Integrate Dementia Support Worker role to community care services	April 2018 – update required	Julia Wilkinson

		Support the introduction of Dementia Toolkit across primary care and community services	April 2018 – update required	Julia Wilkinson
		Enhance anticipatory care in the 3Ts by strengthening GP based MDT meetings	Continuous Improvement	3Ts Locality Management Team
		Development of GP MDT best practice guidance. Review of GP MDT best practice guidance	Completed Sept 2018 Oct 2018	Jayne Thomas/Victoria Edwards
		Evaluate Transfer of Care Advice and Liaison Service (TOCALS) at both PPH and GGH and explore options for sustaining if successful.	Embedded with Continuous Improvement	TOCALS Board
		Medical in-reach into Towy Ward by physiotherapist covering 10 rehabilitation beds to facilitate discharge. Scheme re-profiled. Greater separation of two posts involved, one in hospital with some outreach when necessary, one in community with some in reach, but greater degree of collaboration.	Pilot scheme started October 2016 –	Menna Thomas / John Walpole
		Continue to support care pathways in falls prevention, dementia (early identification) and End of Life	Embedded	Kerry Phillips/ Victoria Edwards
		To identify Carers Lead in each practice	Completed	GP Practices
		To ensure all GP practices have attained Bronze level carers award	Completed	GP Practices
		To work towards all GP practices attaining Silver level carers award	In progress	Victoria Edwards/Kerry Phillips
		To continue to improve chronic conditions management - IMTP bid submitted but rejected so proposal unable to move forward at present time	Continuous Improvement	Sian Green

		Clinical Psychologist for Chronic Conditions and Frailty develop supportive services for informal carers and individuals with chronic conditions.	Embedded	Sian Dallimore
		Ensure the sustainability of existing chronic conditions programmes (rehabilitative and self care) in the 3Ts community	April 2019	Claire Hurlin
		Enhance psychology skills in Health & Social Care workforce	Embedded into practice with rolling programme	Bethan Lloyd
		To develop a community tissue viability / continence role.	Completed	Sian Green
		To develop expansion of continence clinics.	Completed – rolling programme	Sian Green / Llinos Walters
		To develop single point of access for community nursing referrals.	April 2019	Sarah Cameron/Sian Green
		To develop a Cluster Patient Participation Group	Currently on hold due to lack of engagement from patients	Jayne Thomas/ Victoria Edwards/Laurence Jackman
IM&T	• To improve information management and technology to make more effective use of staff resources	To develop the IT infrastructure. This includes: - Video conferencing facilities to avoid travel time in a rural cluster.	April 2010	Locality Managers / GP Leads / ICT leads in both health and social care organisations
		Mobile devices in order for the GP records system Vision can be accessed in the community setting	Completed	
		The development of a Mobile working proposal will support the delivery of MDT working in practice.	Completed	
		Wi-Fi access in all 3Ts GP practices	Completed	

Quality and Safety	• To ensure prudent health and social care services	To work with contracting and monitoring team to ensure current good standards of care are maintained within the care sector	Embedded	Janet Scarrott
		Implement the Performance Measures and Community Resource Team measures	Continuous Development	Jayne Thomas in conjunction with Process Board
		Electronic discharge summaries to be provided at time of discharge giving required information	Pilot underway in GGH – as of June 2018 only 4 wards in GGH using EDALS	IT GGH
		To ensure equity and consistency of service provision at individual and organisational level (rural challenge)	Embedded with continuous improvement	Jayne Thomas
Workforce	• To strengthen and develop primary, community and social care workforce to meet the needs of current and future populations	Participate with workforce planning in partnership with key stakeholders (Primary Care, Local Authority, Community Health Services e.g. nursing and therapy) and support development of Business Case to redirect resource from acute to community by developing Workforce Plan.	Completed	Locality managers / Workforce & OD in both health and social care organisations
		To better understand the skills of existing staff and develop them to work in effective multi-agency teams and provide integrated and personalised care by developing Short Term Assessment pathway for provision of care.	Embedded with continuous improvement	All
		To acknowledge Welsh language issues and staff cultural competence by working through the More Than Just Words action plan.	Continuous Development	All
		To establish a Psychology Clinical post integrated into intermediate care	Complete	Bethan Lloyd

		Explore the development of GPwSI role in Frailty	Complete	All GP Practices
Health and Wellbeing	▪ To ensure the locality's work is fit-for-purpose, person-centered and provides value for money.	To implement fully the Social Services and Wellbeing Act 2014 and to actively promote a new culture of expert patients and informed decision making.	Embedded with continuing development.	Jayne Thomas/3T's Locality Management Team
		Continue to work to ensure that service users and carers receive a personalised service. This will involve active promotion of Community Resilience Strategy, Direct Payments and support for those who lack capacity.	Embedded Continuous Improvement	All
		To work with the whole family which include carers' issues as an integral part of all work undertaken. This involves promoting use of Direct Payments to support carers.	Embedded Continuous Improvement	All
		To ensure that appropriate information and advice is easily available to the public in a variety of formats.	Embedded Continuous Improvement	All
		To assist people who fund their own care to make informed decisions about their long term choices, risks and their implications.	Embedded Continuous Improvement	All
		To strengthen links with the Safeguarding service by providing more education, joint working and awareness raising sessions.	Embedded Continuous Improvement	All
		Continue to ensure people are able to leave hospital as soon as they are 'medically fit' and functionally stable to do so by providing in-reach community services and ensuring continuity of professional involvement where possible.	Embedded Continuous Improvement	All
		To work with primary care in promoting uptake of the flu vaccination.	Embedded Continuous Improvement	Sarah Cameron / Kerry Philips / Jayne Thomas

	• To improve communication (all levels) across the health and social care system	To improve access and take up of the exercise referral scheme.	Embedded Continuous improvement	John Walpole/ Menna Thomas
		To work with 3rd sector organisations in order to develop dementia friendly communities in order to ensure accessible and supportive community living for individuals with physical and cognitive impairments	Embedded with continuous improvement	Jayne Thomas
		To work with the police service and community alarm service in order to raise awareness of dementia and associated issues	Embedded with Continuous Improvement	Jayne Thomas
		Continue to develop services in relation to End of Life Care.	Continuous Development	Sian Green
		Improve the timely exchange of information between primary care and community services in the 3Ts	Complete	3Ts Locality Management Team
		Ensure that the new local authority website for adult services provides the appropriate information, advice and assistance to meets citizens' requirements	Continuous Development	Joel Martin
		Develop services that will satisfy the needs of the Welsh speakers and their families or carers by ensuring they are able to receive services in their first language in line with the active offer.	Continuous Improvement	3Ts Locality Management Team
		Implement Lifestyle advisors in each practice to advice patients.	Complete	All GP Practices
		Continue to increase the numbers of people having reviews of their care and support plans	In Progress	Jayne Thomas / Janet Scarrott
		Use the Welsh Government's Intermediate Care Fund to develop and enhance a range of enabling services for frail, older people including step up/down beds, Telecare, reablement and rapid response services	Embedded with continuous improvement	Sian Green / Locality Managers
		Promote carers assessments and strengthen support for carers	Embedded with Continuous Development	All

	• Streamline and strengthen Assessment and Care Management • Develop more early intervention and prevention services to embed a frailty approach to the management of our ageing population, build on our strong track record of collaboration, integration and joint working with our partner organizations.	Continue to use reablement and residential reablement (convalescence) as strategies to delay or avoid the need for long-term care services for older people	Embedded with Continuous Development	Jayne Thomas
Eliminating Waste	• To ensure that systems and processes are lean and enable practitioners to carry out their professional work with as little hindrance as possible from bureaucracy • To support the principles of prudent health and social care	To ensure continuous improvement within the locality and to support the principles of prudent healthcare.	Embedded	3T's Locality Management Team
		To review the ongoing pilots of seven day working in order to understand its benefits and to consider further implementation.	Ongoing	Menna Thomas
		Enable information sharing across agencies by using common streamlined procedures and working with IT	Continuous Development	Jayne Thomas

		departments in developing information sharing protocols and systems.		
		To work with the IT departments in order to further pilot mobile working and to support Wi-Fi availability in strategic areas across the locality	Continuous Development	3T's Locality Management Team
		To ensure effective budget management at a time of financial pressure:	Embedded	3T's Locality Management Team
		To analyse demand in order to attempt to predict future demand in order to plan resources effectively through review of the population assessment	Ongoing	Locality Managers
Estates	• To ensure that current estates portfolio across health and social care meets the current and future needs of the population.	Support future development of community resource centres	Continuous Development	All
		To work collaboratively with community councils and community groups to ensure the availability and access to community venues which support the delivery of health and social care services `closer to home' (e.g. Llandybie Hall model)	Continuous Development	
		To support the development of extra care facilities in the 3Ts	Embedded with Continuous Development	
		To support the planning and development of primary care and community services to support housing developments in the 3Ts locality	Continuous Development	

New Actions / Objective List as of November 2017

Date Added	Tier 1, 2 or 3	Action / Objective	Timeline	Lead Officer
28/11/2017	1	Whitland Laugharne and St. Clears to be Dementia Friendly communities	Embedded with continuous development	PCSO Sarah Thomas, Jayne Thomas Sarah Cameron
28/11/2017	1	Work with Public Health Wales to promote healthy lifestyles	December 2018	Jayne Thomas and lead managers.
28/11/2017	1	To work with the Community Mental Health Team to integrate services with the final aim of co-locating with Community Resource Team and to work to the same principles.	April 2020	Janet Scarrott/Lydia Hayward/GP's/Jayne Thomas
28/11/2017	2	Develop Short Term assessment pathway within the CRT to include a multi-professional decision making process with 2 to 4 hour response time for urgent referrals.	Completed with ongoing review	Jayne Thomas/Kevin Rees/Janet Scarrott/Menna Thomas/Sian Green/John Walpole

Date Added	Tier 1, 2 or 3	Action / Objective	Timeline	Lead Officer
		New Access process for Physiotherapy opinion to ensure rapid response without physical presence within short term Pathway		John Walpole
28/11/2017	2	Develop an OT approach to reablement including an enhanced OT functional assessment disseminating across all OT's with the community and hospitals. Therapy based competency training for reablement staff to enhance outcomes and effectiveness being developed jointly between OT and PT	Under development	Jane Wood/Kevin Rees/Jayne Thomas John Walpole
28/11/2017	2	To continue to develop and enhance the reablement pathway to ensure an outcome focused approach	April 2018	Jayne Thomas/Kevin Rees/Reablement Managers.

Date Added	Tier 1, 2 or 3	Action / Objective	Timeline	Lead Officer
		promoting independence and well-being.		
28/11/2017	3	To ensure a consistent approach to the implementation of the Social Services and Well-being (Wales) Act 2014 to meet legal requirements. Ensuring compliance with regulations and codes of practice for equity of eligibility across the County.	Continuous application	Jayne Thomas
28/11/2017	3	To continue to work to achieve actions within the Workforce Locality Plan for the 3T's.	Continuous application	All lead officers
28/11/2017	2	To develop psychology services for frail older adults and their carers	April 2019	Bethan Lloyd
14/06/2018	2	Training for social care residential care staff through Agored Cymru Framework in non complex wound care	Rolling programme Awel Tywi complete. Commenced in Dolyfelin	Sian Green

Date Added	Tier 1, 2 or 3	Action / Objective	Timeline	Lead Officer
14/062018	2	Integration of access of specialist psychological service for complex cases	September 2019	Bethan Lloyd
14/06/2018	1	Development of GP Cluster website providing appropriate information, advice and assistance for patients	March 2019	Kerry Phillips / Laurence Jackman
14/06/2018	2	Prevention of emergency hospital admissions where appropriate. Pilot launched in Coach & Horses Surgery in May and extended to Whitland Surgery from Mid June 2018	September 2018	Jayne Thomas
14/06/2018		Audit of response times to #NOF discharges. Possible cross linking of Community Physiotherapy team and in-patient physiotherapy team to improve response times in line with national guidance	Beginning July 2018	John Walpole
14/06/2018		Physiotherapy input to reablement pathway to	Started March 2018	John Walpole

Date Added	Tier 1, 2 or 3	Action / Objective	Timeline	Lead Officer
		provide advice and screen for issues requiring physiotherapy input		
14/06/2018		Development of frailty 'tool kit' for physiotherapy staff to guide best practice	3Ts Frailty pathway within Physiotherapy mapped May 2018. Multi factorial assessment development and agreed June 2018	John Walpole
14/06/2018	1	Appointment of a cluster based asthma nurse on a one year fixed contract to standardise procedures within practice, up-skill practice nurses, etc.	September 2018	Kerry Phillips / Claire Hurlin

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal
HSCS(5) CDN08
Ymateb gan Fwrdd Iechyd Addysgu Powys

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Powys Teaching Health Board

Community and District Nursing Services

Dear Dr Lloyd

Re: Community and District Nursing Services

Thank you for your letter of 8 February 2019 addressed to Carol Shillabeer, Chief Executive, regarding Community and District Nursing Services. I have been asked to provide you with the information requested. Please find enclosed an excel spreadsheet detailing:

The number of district nurse-led community nursing teams

The skill mix (registered nurses and healthcare support workers) covering 2014 to date.

In terms of the vacancy rate for Registered Nurses across Powys Teaching Health Board, for all specialties, the number at the 31 January 2019 was 79.5 whole time equivalent (WTE).

If you require any further information, please do not hesitate to contact me.

Yours sincerely

Rhiannon Jones

Executive Director of Nursing

Powys Teaching Health Board Community and District Nursing Services

Skill Mix 2014-2019

District Nursing Team	Jan-14			Jan-15			Jan-16			Jan-17			Jan-18			Jan-19		
	RN's	HCSW	Total	RN's	HCSW	Total	RN's	HCSW	Total	RN's	HCSW	Total	RN's	HCSW	Total	RN's	HCSW	Total
District Nursing Ystradgynlais	8.09	4.00	12.09	8.91	4.00	12.91	8.91	3.20	**12.11**	9.51	5.27	**14.77**	9.71	4.27	**13.97**	9.1	4.3	**13.3**
District Nursing Brecon	8.40	0.80	9.20	6.60	0.00	6.60	8.20	1.30	**9.50**	8.04	1.60	**9.64**	8.56	1.00	**9.56**	9.0	1.8	**10.8**
District Nursing Crickhowell	6.05	0.80	6.85	5.88	0.80	6.68	5.88	0.50	**6.38**	5.17	0.99	**6.17**	6.08	1.56	**7.64**	6.2	1.6	**7.7**
District Nursing Haygarth	5.00	0.80	5.80	5.67	1.60	7.27	4.71	1.29	**6.00**	5.07	0.80	**5.87**	5.83	1.60	**7.43**	6.6	1.6	**8.2**
District Nursing Llandrindod & Rhayader	8.05	1.41	9.47	9.26	1.41	10.67	8.01	1.41	**9.42**	8.23	2.21	**10.45**	7.76	2.21	**9.97**	10.5	2.2	**12.7**
District Nursing & In Reach - Glan Irfon Builth	11.34	4.20	15.54	12.25	5.40	17.65	10.31	6.40	**16.71**	8.91	5.82	**14.73**	10.03	6.40	**16.43**	9.9	6.4	**16.4**
District Nursing Knighton & Presitgne	6.11	1.12	7.23	6.91	1.52	8.43	7.51	1.92	**9.43**	4.91	2.45	**7.36**	6.91	2.45	**9.36**	7.7	2.0	**9.7**
District Nursing Llanidloes	4.60	0.80	5.40	4.60	0.80	5.40	3.60	0.80	**4.40**	3.60	0.80	**4.40**	4.60	0.80	**5.40**	4.6	0.8	**5.4**
District Nursing Machynlleth & Cemmaes Rd	4.13	0.60	4.73	4.13	0.60	4.73	4.13	0.60	**4.73**	4.13	0.60	**4.73**	4.13	0.60	**4.73**	4.3	0.6	**4.9**
District Nursing Montogomery	4.80	0.80	5.60	5.60	0.80	6.40	4.80	0.80	**5.60**	5.00	0.80	**5.80**	4.20	0.80	**5.00**	5.3	0.8	**6.1**
District Nursing Newtown	5.45	0.91	6.36	5.60	0.91	6.51	5.40	0.91	**6.31**	7.49	0.91	**8.40**	5.71	0.91	**6.61**	6.5	0.9	**7.4**
District Nursing Welshpool	6.23	0.96	7.19	6.07	0.96	7.03	6.07	0.96	**7.03**	5.49	0.96	**6.45**	6.08	0.96	**7.04**	6.2	1.0	**7.2**
District Nursng Llanfair Caereinion	4.32	0.00	4.32	4.32	0.00	4.32	4.32	0.00	**4.32**	4.12	0.00	**4.12**	4.32	0.00	**4.32**	4.3	0.0	**4.3**
District Nursing Llanfyllin	5.69	0.93	6.63	5.59	0.93	6.52	4.73	0.93	**5.67**	5.75	0.93	**6.68**	5.75	0.93	**6.68**	5.7	0.9	**6.7**
District Nursing - North EveningTeam	0.00	2.53	2.53	0.00	2.53	2.53	0.00	3.39	**3.39**	0.00	3.39	**3.39**	0.00	3.39	**3.39**	0.0	3.4	**3.4**
Grand Total	**88.27**	**20.67**	**108.94**	**91.37**	**22.27**	**113.64**	**86.57**	**24.41**	**110.99**	**85.42**	**27.53**	**112.96**	**89.66**	**27.88**	**117.54**	**95.87**	**28.25**	**124.12**

Cynulliad Cenedlaethol Cymru Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal HSCS(5) CDN09 Ymateb gan British Lung Foundation	National Assembly for Wales Health, Social Care and Sport Committee Inquiry into Community and District Nursing services Evidence from British Lung Foundation

1. Treatment of respiratory conditions has improved in Wales since the first Respiratory Health Delivery Plan in 2014. However, a Public Health Wales Observatory Report (2018), *Health and its determinants in Wales* found that the respiratory disease continues to place a huge burden on Wales.

2. 8% of the Welsh public, a higher proportion than the UK average, are living with a respiratory condition, contributing to around 16% of all deaths in Wales.

3. 70,000 people are living with COPD and 250,000 are living with asthma, which includes nearly 60,000 children.

4. Respiratory illness is twice as likely to be reported amongst individuals living in the most deprived communities (11% in the most deprived areas compared to 6% in the least deprived).

5. Chronic respiratory disease contributed to more than 16,000 years lived with a disability, nearly 31,500 years of life lost, and nearly 48,000 Disability-adjusted life years in Wales in 2016.

6. Projections suggest that there could be more than a 20 per cent increase in chronic, life limiting diseases by 2035.

7. Hospital and GP Admissions

   7.1 Admissions related to respiratory conditions have increased by 27% over the last five years.

   7.2 Emergency admissions have increased by 28% over the same time period.

   7.3 The number of readmissions within 30 days of discharge for respiratory conditions has increased by 35% in the last five years. This increases to 55% for pneumonia patients.

   7.4 The cost to the NHS per admission can be between £1,900 and £5,000 per patient each time.

   7.5 The table below demonstrates the annual increases in the number of emergency admissions by Local Health Board between 2012/13 and 2017/18.

LHB	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
ABMU	8,215	7,652	8,461	8,964	10,124	10,100
Aneurin Bevan	9,214	9,636	10,365	11,657	11,742	11,143
Betsi	10,939	10,022	11,341	11,952	12,290	13,443
Cardiff & Vale	6,437	6,921	6,985	8,013	8,162	8,189
Cwm Taf	5,764	6,041	6,256	6,617	6,946	7,225
Hywel Dda	5,657	5,199	5,720	6,053	6,512	5,994
Powys	1,617	1,634	1,794	1,915	2,018	2,180
Total	47,843	47,105	50,922	55,171	57,794	58,274

8. We therefore need to see greater investment in initiatives to reduce the risk of patients needing unnecessary and avoidable hospital admissions.

9. Community nursing support would ensure that more patients can access support, advice and care in the community, reducing the need for hospital admissions.

10. It also contributes to better self-management and self-referral as and when needed to more accessible community-based services. As noted above, with respiratory disease more prevalent in more deprived communities, access to localised services rather than DGHs would benefit those communities.

11. Equipping patients with the knowledge to identify symptoms of exacerbation and rapid use of antibiotics or corticosteroids, or both, can also reduce the need for those living with COPD or other conditions to visit their GP for care.

12. Integration and Referral

13. Pulmonary Rehabilitation

14. Pulmonary rehabilitation is an NHS run exercise and education programme specifically for people with a lung condition. PR is typically offered to those diagnosed with chronic obstructive pulmonary disease (COPD), however there is growing evidence that PR is cost effective for other chronic respiratory conditions such as interstitial lung disease (ILD), chronic asthma and bronchiectasis.

15. ‘Gold standard’ PR programmes give patients access to the range of professions, contains exercise and education and includes links with National Exercise Referral Scheme (NERS) professionals. This includes education on self-care, dietary advice, occupational therapy, psychology and social support.

- The range of support on offer is provided by a team of;
- Occupational Therapists
- Specialist Respiratory Nurses
- Dietician
- Pharmacist
- Psychologist

16. Unfortunately, not everyone is able to access appropriate exercise services such as this; in fact, just 1 in 10 people with chronic lung disease access PR in Wales. Referral rates also vary significantly between LHBs and GPs.

17. Community nursing would aid in improving awareness of and referral to initiatives such as Pulmonary Rehabilitation and the National Exercise Referral Service which are proven to have long-term benefits for self-management, isolation and loneliness, and slowing decline of the condition.

18. <u>Referral to stop smoking services</u>

19. Smoking causes over 80% of instances of COPD and lung cancer and causes or worsens all other respiratory conditions. However, no Health Board succeeded in achieving a major performance target; namely that 5% of all smokers are treated by a specialist service.

20. We want to see improved referral of those with a lung condition to specialist stop smoking services. Stopping smoking is important as it leads to improvements in COPD symptoms and delays disease progression. Stopping smoking at age 30 can lead to 10 years extra life expectancy, with quitting at age 60 leading to three more.

21. Improving access to community-based services through community nursing support may help to improve uptake with Help me Quit among respiratory patients and improve the rate of successful quit attempts.

22. <u>Improving take-up of influenza vaccination</u>

23. People with Chronic Obstructive Pulmonary Disease (COPD) and other chronic respiratory diseases are at increased risk of serious influenza related complications.

24. Vaccinations can reduce the number and severity of acute exacerbations in those with COPD, which in turn may reduce the chance of hospitalisation.

25. Despite this, uptake of influenza vaccine among those aged six months to 64 years in any clinical risk group was only 46.9% in the 2016/17 flu season in Wales against a target of 75%. For those with chronic respiratory disease the uptake of influenza vaccine was 46.5%, which has remained static for the last five years.

26. In the winter of 2017/18, Wales saw the highest number of winter deaths anywhere in the UK. The figure was 32.8% more - higher than anywhere else in the UK.

27. Of these deaths respiratory diseases were the primary cause of death, with more nearly 17,500 deaths across the UK. This is 84.9% more respiratory deaths in the winter months compared with the non-winter months in 2017 to 2018. This is likely associated with a higher prevalence of influenza during the period.

28. The number of excess winter deaths in 2017 to 2018 was the highest recorded since winter 1975 to 1976.

29. We want to see an increase in the number of those diagnosed with a chronic respiratory disease receiving an annual influenza vaccine to reduce the risk of influenza related complications and of hospital admissions.

30. Access to community-based nursing support which will improve self-management and self-referral would help improve uptake of the flu vaccine among at risk groups.

About the British Lung Foundation

The BLF is the only UK charity looking after the nation's lungs. We offer hope, help and a voice. Our research finds new treatments and cures. We help people who struggle to breathe to take control of their lives. And together, we're campaigning for better lung health. With your support, we'll make sure that one day everyone breathes clean air with healthy lungs.

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HSCS(5) CDN10
Ymateb gan Unigolyn

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from an Individual

Data relating to Community Children's Nursing Services scoping exercise August 2017

	ABM	**AB**	**BC**	**C & V**	**Cwm Taf**	**Hywel Dda**	**Powys**
Population - 0-15 yrs Wales: 557,079	92,476	108,637	123,619	90,282	55,708	**2019 data** 75000	**2019 data** 21,264
Number of children's nurses within your CCN service (whole time equivalent - wte)	15.4 wte	28.55 wte	9.3 wte	26.57 wte	10.7 wte	15.3 WTE	5.51wte
RCN Recommendations 20 RN's per 50,000	Require 37 In post 15.4 **Deficit 21.6**	Requires 43 In post 28.55 **Deficit 14.45**	Requires 49 In post 9.3 **Deficit 39.7**	Requires 36 In post 26.57 **Deficit 9.43**	Requires 22 In post 10.7 **Deficit 11.3**	Requires 30 In post 15.3 **Deficit 14.7**	Requires 8.5 In post 5.51 **Deficit 2.99**

1. Whether we have a clear picture of the district nursing and community nursing workforce in Wales, and the level of need for community nursing services (including future need). Do we have the evidence base to support effective workforce planning.

   From this scoping exercise undertaken in August 2017, there is a very clear picture of the deficits in the children's community nursing workforce. More often than not Children Community Nursing Services are the forgotten workforce when it comes to care in the community, yet they provide an essential and critical life line of support, education and clinical service to children and young people within the community setting. This is a serious omission, which requires urgent attention. We believe that because the numbers of children are small within each health board area (though increasing), a whole Wales planning strategy is required to address this need.

2. Whether there is clear strategy, at national and local levels, about the future direction for district nurse-led community nursing services. How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in A Healthier Wales.

   There are concerns that as this demographic group is small and highly specialised they will remain under the care of community, secondary and tertiary paediatricians and so may become lost to the planning and funding opportunities within the clusters. However, the impact on GP services from family related stress and anxiety for this client group is substantial. The drive is for care closer to home from a welsh government perspective and children and young people should be no exception. There is a huge potential with the right education, training and investment in children community nursing services to limit admission to hospital with support from a children community nurse and GP, reduce length of stay in hospital , reduce stress and anxiety for families and associated costs of stays in hospital (lost work days, child care, travel etc). directives from the RCPCH advocate in all standards care at home with support from a children community nurse.

3. How effectively community nursing teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services, and the voluntary sector) to deliver seamless, person-centred care.

   The children's community nursing teams across Wales work well and effectively for highly vulnerable children and young people. However, they struggle to be able to meet the demands for care in the community due to numbers of nurses and the ability to maintain competency due to the small numbers of children in each area. A broader planning approach is required within the IMT's or at an all-Wales level.

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HSCS(5) CDN11
Ymateb gan Macmillan Cancer Support

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Macmillan Cancer Support

Thank you for this opportunity to feed into the inquiry process. A sustainable, well skilled district nursing service is aligned to Macmillan's aims for improving the outcomes of people with cancer. While Macmillan Cancer Support does not directly fund district nursing services - in the way that we adopt and invest in clinical nurse specialists, we fully support the concept that care should be delivered where it is wanted and most appropriate; that generally means outside acute settings. We know that district nurses are critical to delivering care in this way. We wish to provide the committee with some general observations and analysis from our experiences of working in partnership with health and social care in Wales.

Macmillan is committed to supporting our stakeholders, including the National Assembly for Wales, NHS Wales, Health Boards, Velindre NHS Trust, Welsh Government and other third sector organisations to improve care for people living with cancer across Wales.

More than 19,000 people are diagnosed with cancer every year in Wales (WCISU, 2017[1]), a 10% rise over the past decade. There are now over 130,000 people living with and beyond cancer (4.5% of the population) and this number is expected to rise to 250,000 by 2030 (8% of the population).

The health and care workforce plays a critically important role delivering a quality experience to people living with cancer. Annually, Macmillan invests in the order of £5m on services in Wales to improve cancer care and supports the development of more than 340 Macmillan professionals.

The practice nurse and community workforce will grow in prominence and importance to the delivery of Macmillan's new strategy for people living with cancer Right There With You. In Wales there are already a number of pilots running to support practice nurses to undertake Holistic Needs Assessments and Cancer Care Reviews (predominantly a GP role). The Macmillan Cancer Quality Toolkit for primary care for Wales is due to roll out in May 2019 and will promote the extended role that practice nurses can undertake to care, support and signpost people diagnosed with cancer throughout the clinical pathway. Information concerning the toolkit will be rolled out to the Macmillan Framework

[1] Average cancer incidence (All malignancies excluding NMSC) in 2014 to 2015. Welsh Cancer Intelligence and Surveillance Unit, (2017) Incidence Extract http://www.wcisu.wales.nhs.uk/cancer-incidence-in-wales-1

for Cancer in Primary Care Programme webpages in due course. Information concerning our work with primary care in Wales can be accessed in this way[2].

The Welsh Government's strategy, A Healthier Wales, aspires to care for people closer to home. This is commendable but historic under-investment in primary and community care presents a significant challenge. The strategy needs a workforce that is available and able to care for people in their local communities, yet Wales faces a general workforce shortfall in GPs and nurses[3].

Staff numbers need to increase, and a different skill mix is required to deliver seamless high quality care to the people of Wales. To ensure this workforce can deliver the best possible seamless healthcare strategic workforce planning and recruitment that reflects the complex interplay between skill mix, specialist training and targeted investment is required. We look forward to engaging with Health Education and Improvement Wales (HEIW) to discuss and shape this work.

We note that in England "A five-year framework for GP contract reform to implement The NHS Long Term Plan" was recently published which commits to increasing nurses and doctors as part of the GP Contract:

> "Increasing the number of nurses and doctors working in General Practice will be boosted by increased funding for the core GP practice contract, which rises by £978 million a year by 2023/24 as a result of investments under this agreement"[4]

Feedback from professionals within Macmillan raised the following points which the committee may wish to consider for the purposes of this inquiry:

- Whether to extend the scope of the inquiry to include GP practice nurses? This part of the workforce is growing in number and expertise and are crucial in delivering care 'closer to home'. Through their various clinics they will support the of delivery of 'A Healthier Wales'.
- Will this work link with/inform the safe nurse staffing levels legislation in Wales?

The community and district nursing workforce is crucial and have specific professional needs to be supported to work in their specialist area. However, we suggest that any review of district nursing is not done in isolation, the wider primary and community workforce is integral to the delivery of holistic high quality joined up healthcare for the people of Wales.

Should you have any comments or questions relating to this letter, please do not hesitate to get in touch.

Policy & Public Affairs Officer (Wales)

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[2] http://www.primarycareone.wales.nhs.uk/recovery-and-rehabilitation-toolkits
[3] https://www.rcgp.org.uk/-/media/Files/RCGP-Faculties-and-Devolved-Nations/RCGP-Wales/PDF-Documents/2018/RCGP-transforming-general-practice-dec-2018.ashx?la=en
[4] NHS England.(2019) "A five-year framework for GP contract reform to implement The NHS Long Term Plan".pg9 https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

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HSCS(5) CDN12
Ymateb gan Gomisiynydd Pobl Hŷn Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Older People's Commissioner for Wales

Thank you for the opportunity to respond to the Health, Social Care and Sport Committee's consultation regarding community and district nursing services in Wales.

Community and district nursing services play an integral role in supporting an individual's independence and maintaining their health (including the management of long-term conditions and acute illnesses) outside of hospital[i].

There has been a drive in recent years to deliver more, and increasingly complex care to individuals outside of hospital and within the community. Whilst this is welcomed by many older people, who may not wish to unnecessarily stay in hospital or travel to a hospital appointment, it presents challenges and increases the importance of a workforce that is appropriate in size, quality and support.

I am aware, from the casework support provided by my office and through meeting with older people, how highly valued community and district nursing services are by older people.

However, a small number of older people have contacted my office raising the difficulties they have had in contacting their community and district nursing service. For example, individuals have wanted to change/rearrange appointments, raise concerns about their conditions or seek advice on treatments but have been consistently unable to contact their nurse.

By the nature of their roles, I understand that community and district nurses will spend little time in the office - yet the contact number that older people were provided with was an office based answerphone system. This not only caused stress and anxiety, but also creates the risk that these individuals will need to subsequently access unscheduled care services.

An older person relying on these services may be in a particularly vulnerable position, for example with limited mobility or existing care and support needs. Given this vulnerability, and the increasingly complex care that is provided through community and district nursing services, it is important that an effective method of contact and communication between nurses and older people is established across Wales.

A small number of older people have also raised concerns with me about disagreements between themselves and community and district nurse services being removed from them/their loved ones. For example, when the service has

proposed that an individual is well or mobile enough to stop receiving community and district nurse services and travel to a GP for routine appointments whereas the individual/ their family has felt that continued input is needed.

These services are an integral and highly valued part of healthcare delivery within our communities, to some of our most vulnerable older people. However, I am concerned that there may be increased pressure placed on community and district nurse services as a growing number of complex health services are moved out of hospitals and into the community.

I am aware that 1000 Lives are undertaking work on establishing the evidence and approach needed to extend the Nurse Staffing Levels (Wales) Act 2016 to district nursing. In addition to this, ongoing monitoring of the quality of these services, patient outcomes, workforce numbers and staff wellbeing is needed to ensure that they're sufficiently resourced and that patients receive high quality care within their home and community as the nature and complexity of this care changes over time.

I hope that these comments are helpful. If I can be of any further assistance, please don't hesitate to contact xxxx, my Health and Care lead, on xxxx, or by emailing xxxx

Helena Herklots

Older People’s Commissioner for Wales

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HSCS(5) CDN13
Ymateb gan Fwrdd Iechyd Prifysgol Caerdydd a'r Fro

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Cardiff and Vale University Health Board

	Response to the Health, Social Care and Sport Committee inquiry into community and district nursing services. Cardiff and Vale University Health Board
Contact	Kay Jeynes Director of Nursing. Primary, Community and Intermediate Care
Date:	5th March 2019

Introduction

Cardiff and Vale UHB welcomes the opportunity to contribute to the Health, Social Care and Sport Committee's inquiry into community and District Nursing Services. The Cardiff and Vale University Health board 'Shaping our Future Well-being strategy' 2015-2025 aims to create a joined up and integrated approach to care for our resident population based on a 'home first' principle. Avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them based on and informed by a robust understanding of our population need. District and community nursing are core to this approach and we continue to develop our services to deliver high quality evidence based patient centred care that is planned around the diverse needs of our population

Overview

The Health Board's District Nursing Service provides nursing services to the 3 Localities within the Cardiff and Vale UHB footprint – Cardiff N&W, Cardiff S & E and the Vale of Glamorgan. Each Locality aligns to 3 cluster/neighbourhood areas and District Nursing teams are aligned geographically as far as possible.

The District Nursing Service works to a single service specification which was developed in partnership with key stakeholders to ensure consistency and standards of care and service across the UHB.

The overall aim of the District Nursing Service is to work in collaboration with Community Directors, Primary Care Practitioners and Intermediate Care Services to provide clinically effective and safe, evidence based care to patients who are

deemed as house bound, with the focus of care being promotion and maintenance of health, support through ill health, promoting and maximising independence recovery and/ or the terminal stages of life. The service is consistent with the strategic vision set by the Welsh Assembly Government in Setting the Direction, Community Nursing strategy 2009, Primary Care Services for Wales up to 2018 and the Framework for the Management of Chronic Conditions.

The District Nursing service is underpinned by the following principles:-

- The availability of an appropriately skilled, competent, qualified and registered nursing workforce
- To work in the best interest of the patient/client, providing high quality generalist and specialist services as part of a whole system approach to intermediate and community care service provision
- The delivery of an equitable and accessible range of services which provides continuity of care and services to individuals
- The delivery of services based on the principles of Prudent Healthcare
- The delivery of services by the relevant professionals at the right place at the right time in the patient pathway.
- Utilisation of new technologies in the delivery of community based healthcare and the development of IT systems that support information sharing within the confines of relevant policy and guidance
- Compliance with the requirements of the All Wales Policies and Procedures for the Protection of Vulnerable Adults

The District Nursing Service provides predominantly home based services as a single agency or in partnership with other agencies and specialist services, to residents of Cardiff and Vale who are aged 16 years and older through provision of both scheduled and unscheduled care activities

There are a range of specialist nursing teams who operate across the UHB footprint and work closely with the District Nursing and Community Services including specialist wound care, continence and acute response teams.

There are also community nursing roles in the UHB Locality based Community Resource Teams and at cluster level focused on reablement and frailty and the UHB's vision is to continue to develop the wider community nursing teams in line with the further development of cluster and locality based planning and management of services

Terms of Reference

Health Board TOR

- How many district nurse-led community nursing teams are there in your health board area?
- Information about the make-up of these teams i.e. numbers of staff and skill mix (registered nurses and healthcare support workers)?

There are a total of 14 district nursing teams plus a District Nursing Night service which operates across the entire Health Board footprint providing 24 hour access to District Nursing Services.

The Locality make up is described below

- North and West Locality – 5 teams
- South and East Cardiff – 5 teams
- Vale of Glamorgan - 4 teams
- The night visiting service covers the whole UHB area

Each team is made of a Band 7 Sister/Charge Nurse who is an experienced community nurse and who has a recognised expertise and knowledge of working within the community setting and is expected to have achieved academic credibility to SPQ/Masters level.

There are a number of Band 6 deputies within each team who are responsible for caseload management and coordination of patient care within a specified zone in a cluster area and who are linked to named GP practices.

The teams also includes band 3 Healthcare Support Workers and band 5 community staff nurses with a skill mix ratio of at least 80:20, (registered: unregistered)

All team also include phlebotomists and administrative support in line with the District Nursing Principles 2017

The health board is working towards all Sisters/Charge Nurses and Deputies having a specialist practitioner qualification (SPQ) in line with the district nursing principles. Currently each team has at least one individual qualified at this level.

Opportunities are being taken currently to expand and develop the workforce and skill mix with the development of a Band 4 HCSW role.

A full break down of District and community nursing staffing over the last 5 years can be seen in Appendix 1

The district nursing service is continually recruiting to posts and is working hard to improve retention levels by focusing on staff and student development programmes across all staff groups.

Wider TOR

The Health, Social Care and Sport Committee is calling for evidence about whether community nursing services are likely to play a greater role in the future delivery of healthcare, focusing on:

- Whether we have a clear picture of the district nursing/community nursing workforce in Wales, and the level of need for community nursing services (including future need). Do we have the evidence base to support effective workforce planning.

For the District Nursing Workforce, a clear understanding of the workforce is emerging through the implementation of the CNO District Nursing Principles. Cardiff and Vale has utilised an electronic patient based system for over 10 years which has proved an advantage in being able to more robustly analyse activity and performance information and help to understand and to begin planning to redesign and shape the district nursing workforce in order to comply with the Eight Principles.

A District Nursing Novice to Expert Educational Pathway has been developed and this has enabled the UHB to triangulate this with other performance information to develop more effective workforce plans at a Health Board and Locality level.

The quarterly submission to the CNO reporting adherence and progress against those principles is allowing a National picture to be better understood and co-ordinated.

There is a need for the implementation of an effective and validated workload acuity tool across Wales and the All Wales District Nurse Workload and Workforce Group is supporting ongoing collaborative testing of acuity tools with a view to having something in place within the next 2 years which will assist in more effective and improved workforce planning in the future. The rolling out of electronic and mobile IT working solutions to all Health Board areas will also assist in being able to more effectively performance managed and plan.

- Whether there is clear strategy, at national and local levels, about the future direction for district nurse-led community nursing services. How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in A Healthier Wales.

Nationally the Welsh Assembly Government has set out a clear vision for District and Community Nursing Services with the publication of strategic documents such as Setting the Direction 2009, Community Nursing strategy 2009, Primary Care Services for Wales up to 2018 and the Framework for the Management of

Chronic Conditions and in particular with the publication of the CNO District Nursing Principles in 2017.

The CNO Principles include a clear direction that district nursing teams should be aligned with Clusters and the UHB has started to work toward better integrating them and the wider community nursing workforce into cluster and IMTP development and planning. It is acknowledged that there is further work to do locally in this area.

- How effectively community nursing teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services, and the voluntary sector) to deliver seamless, person-centred care.

Locality/cluster based working and the development and progress on co-location and integration of Local Authority and community based Health Staff has improved the ability and effectiveness of working with a range of community based professions and services. Work continues locally on this with ICF investment affording the opportunity to take forward projects across the primary/secondary care interface with the development of patient pathways and discharge to assess models of care and on a cluster basis with the creation of virtual MDT and social prescribing models.

As with any effective multidisciplinary and agency working the ability to access and communicate across IT platforms is key to improved communication and partnership working and the national work WCCIS to develop an integrated health and social care system for Wales is welcomed. For District and Community Nursing Services effective communication with GP services is key the UHB would welcome work being taken forward to improve electronic communication and access across this interface.

Conclusion

The UHB is grateful for the opportunity to contribute to this inquiry. There have been a lot of developments over the last 5 years locally to develop and improve District and Community services but it is acknowledged that there is more work to do in developing and integrating this will all of our primary and community based services to realise the vision set out in A Heal heir Wales

Cardiff and Vale UHB

- How many district nurse-led community nursing teams are there in your health board area?
- Information about the make-up of these teams i.e. numbers of staff and skill mix (registered nurses and healthcare support workers)?

Locality	Team	2018-19 WTE			2017-18 WTE			2016-17 WTE			2015-16 WTE			2014-15 WTE		
		RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE
Cardiff North & West Locality	North Cardiff District Nursing Team	15.91	2.17	**18.08**	15.91	2.17	**18.08**	14.82	2.01	**16.83**	14.62	2.01	**16.63**	14.00	2.01	**16.01**
	Ely District Nursing Team	11.60	1.83	**13.43**	11.64	1.83	**13.47**	11.84	1.83	**13.67**	12.03	1.83	**13.86**	12.14	1.83	**13.97**
	Radyr District Nursing Team	12.89	0.53	**13.42**	12.89	0.53	**13.42**	12.22	1.20	**13.42**	13.20	1.20	**14.40**	13.22	1.59	**14.81**
	Whitchurch District Nursing Team	13.42	1.48	**14.90**	13.42	1.48	**14.90**	14.22	1.62	**15.84**	14.30	2.28	**16.58**	14.29	2.28	**16.57**
	Riverside District Nursing Team	13.77	1.73	**15.50**	13.89	1.85	**15.74**	14.20	1.85	**16.05**	14.98	1.85	**16.83**	14.70	2.31	**17.01**
Cardiff North & West Locality Total		67.59	7.74	**75.33**	67.75	7.86	**75.61**	67.30	8.51	**75.81**	69.13	9.17	**78.30**	68.35	10.02	**78.37**
South & East Locality	Butetown District Nursing Team	10.20	0.88	**11.08**	10.20	0.88	**11.08**	9.60	0.88	**10.48**	9.60	0.88	**10.48**	9.46	1.06	**10.52**
	Splott District Nursing Team	12.12	2.20	**14.32**	12.12	2.20	**14.32**	13.09	2.20	**15.29**	13.09	2.58	**15.67**	13.09	2.58	**15.67**
	Roath District Nursing Team	10.33	1.76	**12.09**	10.33	1.76	**12.09**	10.20	1.96	**12.16**	10.12	2.87	**12.99**	10.07	2.87	**12.94**
	Pentywn District Nursing Team	9.39	1.60	**10.99**	9.39	1.60	**10.99**	9.39	1.59	**10.98**	9.39	1.59	**10.98**	9.39	1.59	**10.98**
	Llanrumney District Nursing Team	14.72	1.59	**16.31**	14.81	1.59	**16.40**	14.81	1.59	**16.40**	14.81	2.12	**16.93**	14.81	2.12	**16.93**
South & East Locality Total		56.76	8.03	**64.79**	56.85	8.03	**64.88**	57.09	8.22	**65.31**	57.01	10.04	**67.05**	56.82	10.22	**67.04**
Vale Locality	Western Vale District Nursing Team	10.00	1.03	**11.03**	10.00	1.03	**11.03**	10.00	1.03	**11.03**	10.23	1.56	**11.79**	9.65	1.56	**11.21**
	Penarth District Nursing Team	17.94	2.00	**19.94**	17.71	2.00	**19.71**	18.20	2.00	**20.20**	18.28	2.00	**20.28**	20.45	1.00	**21.45**
	Barry Team 1 District Nursing Team	12.50	1.53	**14.03**	12.50	1.53	**14.03**	12.50	1.53	**14.03**	12.70	1.53	**14.23**	13.10	3.14	**16.24**
	Barry Team 2 District Nursing Team	12.44	1.51	**13.95**	12.44	1.51	**13.95**	12.24	1.51	**13.75**	12.38	2.32	**14.70**	11.75	0.44	**12.19**
Vale Locality Total		52.88	6.07	**58.95**	52.65	6.07	**58.72**	52.94	6.07	**59.01**	53.59	7.41	**61.00**	54.95	6.14	**61.09**
Cross Locality and Specialist Community Nursing	District Nursing Night Visiting Service	9.40	10.37	**19.77**	9.40	10.66	**20.06**	9.54	10.73	**20.27**	9.54	10.60	**20.14**	9.80	10.03	**19.83**
	Vale Community Resource Team	5.00	0.00	**5.00**	5.00	0.00	**5.00**	5.00	0.00	**5.00**	5.00	0.00	**5.00**	5.00	0.00	**5.00**
	Cardiff Community Resource Team	8.00	0.00	**8.00**	8.00	0.00	**8.00**	8.00	0.00	**8.00**	8.00	0.00	**8.00**	6.00	0.00	**6.00**
	Continence Team	6.22	1.95	**8.17**	5.49	2.96	**8.45**	5.60	2.96	**8.56**			**0.00**			**0.00**
	Wound Healing Team	4.40	1.24	**5.64**	4.40	1.27	**5.67**	3.40	1.27	**4.67**			**0.00**			**0.00**
	Contenence & Wound Healing										8.60	4.23	**12.83**	7.40	3.48	**10.88**
	Acute Response Team	11.44	0.00	**11.44**	11.44	0.00	**11.44**	12.52	0.00	**12.52**	12.52	2.11	**14.63**	11.84	3.27	**15.11**
	Community Phlebotomy Service			**0.00**			**0.00**			**0.00**			**0.00**			**0.00**
	Homelessness Nursing Service	1.00	0.00	**1.00**	1.00	0.00	**1.00**	1.00	0.00	**1.00**	1.00	0.00	**1.00**	1.00	0.00	**1.00**
	Diabetes Service	1.20		**1.20**	0.60		**0.60**			**0.00**			**0.00**			**0.00**
	Oxygen Nursing Service	2.00	0.00	**2.00**	2.00	0.00	**2.00**	2.00	0.00	**2.00**	2.00	0.00	**2.00**	2.00	0.00	**2.00**
Cross Locality and Specialist Community Nursing Total		48.66	13.56	**60.22**	47.33	14.89	**60.22**	47.06	14.96	**60.02**	46.66	16.94	**61.60**	43.04	16.78	**57.82**
Total		**225.89**	**35.40**	**259.29**	**224.58**	**36.85**	**259.43**	**224.39**	**37.76**	**260.15**	**226.39**	**43.56**	**267.95**	**223.16**	**43.16**	**264.32**

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HSCS(5) CDN14
Ymateb gan Fwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Abertawe Bro Morgannwg University Health Board

ABMU Overview Assessment

Do we have a clear picture of the district nursing/community nursing workforce in Wales?

The DN service operates on a Health Board-wide footprint under one Service Specification. The service provides short, medium and long-term interventions for patients who need nursing services and health care at home.

The District Nurse undertakes the care Coordinator role for the majority of patients being cared for within the home setting. There is collaborative working for short-term interventions from separate community nursing services such as Acute Clinical teams and support from Disease specific specialist professionals from both community and secondary care depending on the clinical need.

The quarterly submissions for the DN CNO Principles is providing a clear picture of the DN workforce. The pilot phase of an Escalation Process for District Nursing is also helping to clarify workforce resources. Community Nursing services not covered by and separate to the DN Principles are not so clearly defined; these nursing groups include Acute Clinical Teams, Wound Care teams and Continence Services.

Do we have a clear picture on the level of need for community nursing services (including future need)?

The Three Year Network Cluster Plans and Primary Care IMTPs incorporate an assessment and planning mechanism to determine needs at a Cluster and Health Board Level, the assessment and needs presented in each of the plans are not specific enough to identify the key areas where Community Nursing services can be deployed and redesigned to meet those needs.

Do we have the evidence base to support effective workforce planning?

For the District Nursing Workforce, a clear understanding of the workforce is emerging through the CNO Principles. The service is using the workforce information to understand the deficits and to begin planning to redesign and shape district nursing workforce in order to comply with the Eight Principles.

There are numerous capacity and demand tools that have been implemented; however, there is a paucity of evidence around the validity of tools and the

effectiveness by which they match workforce to workload. The All Wales District Nurse Workload and Workforce Group is supporting ongoing collaborative testing of acuity tools.

ABM has utilised skill mix where appropriate to match workload and workforce as well as implementing efficient mobilised IT systems that deliver efficiency benefits in terms of time.

Ongoing issues with the training and retention of Advanced Nurse Practitioners due to sustainability of Primary Care, once qualified ANPs are leaving the community workforce to take up employment with General Practice and acute hospital settings due to attainability of higher grades.

Ongoing issues with the ability to support the required numbers of DN SPQ students due to inability to backfill permanently, despite funding from WEDS. There are lost opportunities in not being able to support direct entrants to the SPQ as this would decrease internal pressures and expand the talent pool into community nursing from the acute settings.

There are opportunities to expand and development the nursing workforce and skill mix with the development of a Band 4 HCSW role.

Available resources have traditionally driven workforce planning. The Three Year Network Cluster Plans that incorporate a public health approach to population assessment now present the opportunity for future workforce planning to be based on local and regional population needs.

There are opportunities within the new pre-registration nurse training to ensure newly qualified nurses can take up post in community services upon qualifying with the necessary skills for community practice; e.g. supplementary prescribing.

Whether there is clear strategy, at national and local levels, about the future direction for district nurse-led community nursing services.

The Community Nursing Strategy for Wales 2009 started to articulate the direction required for community nursing services, this has been superseded by a Health Board Nursing and Midwifery Strategy 2017. This high-level strategy has little specific direction for the Community Nursing workforce as a whole.

The CNO Principles have clear direction for district nursing in that the service should be aligned with the Clusters. The Cluster plans have started to incorporate nursing requirements. However, Community Nursing representatives need to become integral to the needs assessment and planning mechanisms for each neighbourhood cluster to ensure all opportunities to engage and direct the DN workforce are supported.

How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in A Healthier Wales.

It is widely acknowledged that community nursing is a fundamental aspect of the primary care team and is key to supporting the implementation of the key themes of the Quadruple Aim in a Healthier Wales.

- Improved population health and wellbeing
- Better quality and more accessible health and social care services
- Higher value health and social care
- A motivated and sustainable health and social care workforce.

The skill sets to deliver on the agenda of keeping people out of hospital during acute illness and supporting them to return home early after illness are wider than traditional community nursing training courses such as the DN SPQ. In an attempt to address deficits in the workforce, varying specialist nursing roles have developed e.g. Chronic Condition Nurses and Advanced Nurse Practitioners.

This has led to a disintegration and fragmentation of community nursing services and the development of hyper-specialist roles that can, on occasions result in multiple nursing teams caring for patients or condition specific nursing leading to confusion for patients and key stakeholders. The multiple teams also compete against once other for scarce resources in an already stretched pool of specialist staff.

The new registrant programme will future proof the workforce as nurses will qualify with advanced skills and will be ready to work in a generalist Community Nursing role on qualifying. What is required in terms of further or specialist training can be aligned to local cluster plans and Health Board IMTPs and directed/supported in terms of local population needs assessment.

How effectively Community Nursing teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services, and the voluntary sector) to deliver seamless, person-centred care. Integration, IT systems, co-location, mobilisation, loss of relationships

With the ICF investment, teams of Local Authority and Health staff became co located and function in an integrated management structure. The advantages of delivering on the “what matters to me” objective were obvious as patient focussed outcomes were able to be agreed

However, the integration of the Public Sector Services has come at a cost and that was the loss of synergy with the Primary Care Sector and the deterioration of previously strong professional relationships.

The community nursing service is a clinical facing professional nursing service and the CNO Principles and Cluster Plans provide new opportunities to refocus the professional working relationships with Cluster teams in their broadest sense.

WCCIS will give opportunities for an integrated health and social care system, however, the system has limited interface with the GP systems. GPs are responsible for 85% of patient referrals for the DN service, thus further work is required to bring the two clinical facing professional services together.

The recent mobilisation of the Community Nursing workforce gives rise to exciting opportunities for community nursing staff to remotely access the GP patient record that will support improved communication and partnership working for the local population.

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HSCS(5) CDN15
Ymateb gan Gyngor Deoniaid Iechyd Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Council of Deans of Health Wale

Cyngor Dioniaid Iechyd Cymru/The Council of Deans of Health Wales welcomes the opportunity to contribute to this consultation. The Council of Deans of Health represents the 84 UK university faculties engaged in education and research for nursing, midwifery and the allied health professions. Our seven member institutions in Wales work together with policy makers to help shape the education and research of the future healthcare workforce in Wales.

1. Whether we have a clear picture of the district nursing and community nursing workforce in Wales, and the level of need for community nursing services (including future need). Do we have the evidence base to support effective workforce planning?

The Interim District Nurse Guiding Staffing Principles help to inform district nurse workforce numbers. Health boards across Wales are working towards realigning staff numbers and skills mix to meet these principles. Prospective staffing plans are completed annually by health board matrons, reporting to senior management, thereby providing direction on future workforce planning. This is fed into education commissioning, which means higher education institutions (HEIs) can respond effectively to ensure they work to develop the district nurse workforce and align with current Welsh Government directives, such as 'A Healthier Wales'.

Across some regions, district nursing managers are reiterating to our members the challenge of balancing complex care needs in the community with opportunities for staff development. This is particularly difficult due to current staffing vacancies and because some experienced level 6 and 7 district nurses are opting for early retirement. Educationalists are further affected by variation in the level of service from community nursing teams. In some areas there is a 24-hour community nursing service and in others the service concludes at 22.00. Educationalists must plan accordingly in their schedules, and this can limit placement capacity in these primary care services. We would recommend nursing students timetables are taken into consideration, so they do not have to cover night shifts in their placements.

The All Wales District Nursing Forum is currently carrying out work to develop levels of care for district nursing in Wales as outlined in the Nurse Staffing Levels (Wales) Act. A range of models are being trialed across different health boards. For

example, one health board has developed an escalation tool, which scrutinises a variety of factors (such as acuity, complexity, and workload) to rate the status of certain cases.

Regarding the education of the community and district nurse workforce, there has been a move towards all community nurses with a band 6 position needing the District Nursing Specialist Practice Qualification (SPQ) in order to undertake a caseload. Early indications using the interim principles have highlighted a need to realign the skills mix to better meet the needs of service users in the community and for more investment in leadership within the SPQ. As a result of engagement with health boards, at least one member has developed and validated a level 7 module specifically for newly qualified district nursing SPQ practitioners in combination with allied health professional roles working in the community.

2. Whether there is clear strategy, at national and local levels, about the future direction for district nurse-led community nursing services. How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in A Healthier Wales.

3. How effectively community nursing teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services and the voluntary sector) to deliver seamless, person-centred care.

The Nurse Staffing Levels (Wales) Act, the Welsh Levels of Care and patient and service user demand all inform strategy on the future direction of district nursing services. Some health boards have been involved with piloting the neighbourhood nurse module (Buurtzorg model) that was initiated by the Welsh Government in 2018. In this model, discrete teams of SPQ qualified district nurses lead and deliver all care provision within a specific geographical location. The ongoing work of the Welsh Community Care Information System (WCCIS) is another area where district nurses are leading work. This is an innovative digital system to help health and social care professionals work more collaboratively. Several health boards have been involved in this work, with early implementation sites looking to roll out a totally paperless system soon.

A central focus of current strategy is the development of cluster hubs to meet the needs of the population in certain localities. District nursing is well represented in cluster meetings and the development of this new way of working within primary care. Most district nursing teams are working towards the implementation of the single point of contact service. This will allow all contacts to the district nursing service (including patients, carers, GP practice staff and others) to be directed through a single contact point where each call is triaged by a district nurse and administrative staff to filter and pass on calls to the required professional.

For more information contact: xxxx, Policy Officer, Council of Deans of Health,

Cynulliad Cenedlaethol Cymru Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal HSCS(5) CDN16 Ymateb gan Bwrdd Cyngor Iechyd Cymuned	National Assembly for Wales Health, Social Care and Sport Committee Inquiry into Community and District Nursing services Evidence from Board of Community Health Councils

CHCs are the independent watch-dog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

CHCs seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it.

CHCs maintain a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through enquiries, our Complaints Advocacy Service, visiting activities and through public and Patient surveys. Each of the 7 CHCs in Wales represents the "Patient voice" within their respective geographical areas.

CHCs routinely monitor the performance of NHS services in their area as well as respond to service developments and changes.

District & community nursing is an integral and vital part of primary care provision and cannot be looked at in isolation from other parts of the primary care multi-disciplinary team.

The Kings Fund Report "Reimagining Community Services"[1] takes a holistic look at these issues. The report contains practical and useful suggestions for new ways of working and involving patients in their own care through co-production.

Local Health Boards across Wales are struggling with the difficulty of recruiting GPs and skilled nurses. CHCs receive proposals to develop or change primary care services increasingly regularly, including proposals to close branch surgeries or limit the numbers of registered patients in a practice. The implications for primary care are significant.

It is timely that the Health, Social Care & Sport Committee is reviewing the District Nursing service and considering its future contribution to the delivery of healthcare in community settings.

[1] Reimagining Community Services – Kings Fund - January 2018 - https://www.kingsfund.org.uk/sites/default/files/201801/Reimagining_community_services_summary_0.pdf

The consultation paper highlights the shortfall in knowledge in relation to the real contribution of district nurses and their teams to the NHS in Wales. In the overview to the consultation brief, the term an "*invisible*" service is used; if the best use of the service is to be made in the future then health boards need to develop a much clear focus and understanding of the role and contribution of these services within local health systems.

Qualified district nurses are skilled professionals functioning at a high level in the community setting and together with their team members they have always worked with a range of professionals and agencies both within primary care and secondary services as well as the voluntary sector.

With the increasing range of professionals (*such as advanced paramedics, physiotherapists*) now working in the community and primary care settings, district nursing teams will need to adapt their working activities to ensure that they work effectively with these new services and use their individual skills to the best advantage for patients and their families.

In the last paragraph of the overview document, comment is made on the lack of information around the work of children's nurses in the community. We think there is real benefit in the inquiry focusing on this aspect of community nursing as increasingly paediatric care is being provided in community settings.

The Queen's Nursing Institute (QNI) District Nurse Education Reports contain useful information on enrolment for the District Nurse qualification. In recent years enrolment levels across the UK has been steadily falling. The QNI warns that, given the numbers who retire from the service annually, "*this will represent a major challenge to current and future recruitment efforts to district nursing teams*".

The most recent QNI report notes that 40 of the 44 universities in the

UK approved by the Nursing and Midwifery Council (NMC) to offer the District Nurse Specialist Practice Qualification (DNSPQ) had "*major concerns about future funding and viability of district nurse programmes*".

So while there is a drive to move care into the community, there is a clear risk of fewer district nurses. This is particularly concerning at a time when NHS Wales has an ambition of having care closer to home, rather than in hospital settings. It will be extremely difficult to achieve this unless there are sufficient qualified nurses to manage it.

CHC's are hearing of many innovative schemes to deal with the current GP recruitment crisis through the introduction of multidisciplinary teams. These often include specialist district and community nurses who may be just as scarce a resource as GPs in the very near future.

This is not a problem that can be solved by any individual LHB and we want to see the NHS in Wales and the Welsh Government continuing to look at new ways of

increasing the numbers of nurses in training and at ways of making a career in nursing more accessible to young people.

Monitoring Community Nursing Services

Traditionally the CHC movement has focused primarily on visits to hospitals (*Community and District General Hospitals*), health centres and primary care and it is important that such visits remain a key aspect of CHC work.

However, a substantial and increasing amount of care is provided by community health services. CHCs are responding to this shift by continuing to look at the best ways of hearing directly from people about their views and experiences of NHS services delivered in the community.

CHC's in some parts of Wales have carried out surveys in their local communities to hear from people about their experience of the District Nursing Service. It is clear from the responses that this service is highly valued and respected by patients and carers overall.

Contact details

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Ymatebion i'r Ymgynghoriad yn y Gymraeg

Consultation Responses in the Welsh Language

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal
HSCS(5) CDN06
Ymateb gan Addysg a Gwella Iechyd Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Health, Education and Improvement Wales

1. CYFLWYNIAD

Mae Addysg a Gwella Iechyd Cymru yn croesawu'r cyfle i roi tystiolaeth i ymchwiliad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yn ymwneud â *'gweithgarwch timau nyrsio cymuned dan arweiniad nyrsys ardal ac ansawdd gofal nyrsio a roddir i bobl yn eu cartrefi eu hunain'*.

Cafodd Addysg a Gwella Iechyd (HEIW) ei sefydlu fel Awdurdod Iechyd Arbennig ar 1 Hydref 2018, gan ddod â Deoniaeth Cymru, Canolfan Addysg Broffesiynol Fferylliaeth Cymru a Gwasanaeth Gweithlu a Datblygu Addysg y GIG at ei gilydd.

Mae HEIW yn gweithio ochr yn ochr â Byrddau Iechyd ac Ymddiriedolaethau, ac mae ganddo rôl arweiniol o ran addysgu, hyfforddi, datblygu a llunio'r gweithlu gofal iechyd yng Nghymru, er mwyn sicrhau gofal o ansawdd uchel i bobl Cymru.

2. GWYBODAETH ALLWEDDOL

2.1 Siâp a maint y gweithlu

Mae'r gweithlu nyrsio cymuned (nyrsys cofrestredig) wedi tyfu'n sylweddol dros y degawd diwethaf:

Mae'r gweithlu nyrsio cymuned cyffredinol (nyrsys cofrestredig ar draws oedolion, seiciatreg ac anableddau dysgu) wedi cynyddu 37% ers 2009 o 3,402 wte i 4,655 wte yn 2018

Mae nifer y nyrsys cofrestredig sy'n gweithio yn y gymuned (oedolion) wedi cynyddu 48% ers 2009 o 2,090 wte i 3,084 yn 2018.

Mae nifer y nyrsys cofrestredig sydd â chymhwyster SPQ cofnodadwy wedi lleihau 17% ers 2009 o 690 wte i 590 wte yn 2018

Mae 46% o'r gweithlu nyrsio cymuned yn 50 oed a throsodd

2.2 Gofynion addysg

Cytunodd GIG Cymru a Llywodraeth Cymru yn 2008 nad y Cymhwyster Ymarfer Arbenigol (SPQ), fyddai'r unig gymhwyster a fyddai'n cael ei gydnabod er mwyn dangos bod unigolyn yn gallu cyflawni rôl nyrsio cymuned ar fand 6/7. Gall nyrsys cofrestredig heb SPQ weithio i'r un lefel â Nyrs Ardal a gallant arwain tîm nyrsio cymuned ond ni allant alw eu hunain yn Nyrs Ardal.

2.3 Darpariaeth addysg

Mae HEIW yn cynnig cyllid ar gyfer yr addysg ôl-radd ganlynol:

- Addysg Ymarfer Uwch/Estynedig ar swm o £1.25 miliwn, o'r swm hwn, caiff £750K ei dargedu at addysgu staff yn yr amgylcheddau gofal sylfaenol/cymunedol/ymarfer cyffredinol
- Addysg am ragnodi anfeddygol gyda chost o £300,000, mae'r gyllideb hon yn caniatáu i HEIW gomisiynu rhyw 230 o raglenni o brifysgolion o bob rhan o Gymru
- Addysgu Nyrsio Ymarfer Arbenigol a Nyrsys Iechyd Cyhoeddus Cymunedol - £4.3 miliwn

Yn ogystal â'r uchod, mae Llywodraeth Cymru wedi ymrwymo i fuddsoddi £2 filiwn bob blwyddyn dros 2018/19 a 2019/20 i gefnogi cynllun peilot Nyrsio Ardal mewn cymdogaethau. Mae £1.4 miliwn o'r cyllid hwn wedi'i ddyrannu i HEIW er mwyn cefnogi'r rhaglenni addysg a hyfforddiant sydd eu hangen i danategu'r cynllun peilot ac i gefnogi rhyddhau nyrsys i hyfforddi fel nyrsys ardal neu gyfwerth.

3. MATERION PENODOL A NODWYD GAN YR YMCHWILIAD

3.1 P'un a oes gennym ddarlun clir o'r gweithlu nyrsio ardal a nyrsio cymuned yng Nghymru, a lefel yr angen am wasanaethau nyrsio cymuned (gan gynnwys yr angen yn y dyfodol). P'un a oes gennym y sail tystiolaeth i ategu at gynllunio'r gweithlu yn effeithiol.

Ymateb

Mae'n ofynnol i'r holl fyrddau iechyd ac ymddiriedolaethau lunio cynllun gweithlu (IMTP) bob blwyddyn, sy'n cynnwys cwblhau templed comisiynu addysg. Mae'r templed hwn yn mynegi'n glir niferoedd lleoedd hyfforddiant y bydd eu hangen ar y sefydliad, yn ei dyb ef, er mwyn cynnal y gweithlu yn y dyfodol. Mae'r data hwn yn llywio'r broses gomisiynu.

Buddsoddir mewn addysg bob blwyddyn er mwyn sicrhau bod cyflenwad o nyrsys cofrestredig ar gael i weithio mewn timau cymuned. Fel y nodir uchod, mae HEIW yn comisiynu Cymwysterau Ymarfer Arbennig a Graddau Iechyd Cymuned o brifysgolion yng Nghymru. Yn ogystal, mae HEIW yn comisiynu addysg fodiwlaidd

i ategu at ennill y wybodaeth a'r sgiliau priodol i wella cymysgedd sgiliau timau nyrsio cymuned, sy'n gallu ategu at ddatblygu gwasanaethau newydd.

3.2 P'un a oes strategaeth glir, ar lefelau cenedlaethol a lleol, am gyfeiriad gwasanaethau nyrsio cymunedol dan arweiniad nyrsys ardal. Pa mor dda y mae hon wedi'i halinio â datblygu'r model clwstwr gofal sylfaenol er enghraifft, ac â gweledigaeth gwasanaethau iechyd a gofal a amlinellir yn ymateb Cymru Iachach.

Ymateb

Mae Llywodraeth Cymru wedi comisiynu cynllun peilot Nyrsio Ardal Cymdogaethau: gyda'r nod o hyfforddi 80 o Nyrsys Ardal ychwanegol yn ystod y cyfnod 2018-20.

Yn 2018, cafodd Cymru Iachach: ein Cynllun ar gyfer Iechyd a Gofal Cymdeithasol ei gyhoeddi; roedd yn disodli'r Cynllun Gweithredu ar gyfer y Gweithlu Gofal Sylfaenol blaenorol a chafodd y prif feysydd ffocws i'w datblygu ymhellach eu blaenoriaethu a'u hamlinellu yn *Rhaglen Strategol Gofal Sylfaenol (Tachwedd 2018).* Fel rhan o'r trosolwg strategol hwn, caiff gofal sylfaenol ei ddiffinio fel ..."y gwasanaethau hynny sy'n cynnig pwynt cyntaf gofal, ddydd neu nos... Mae'n ymwneud â chydlynu mynediad ar gyfer pobl at yr ystod eang o wasanaethau yn y gymuned leol er mwyn helpu i ddiwallu eu hanghenion iechyd a lles....gan gynnwys ystod eang o staff, fel nyrsys cymuned ac ardal, bydwragedd..."

3. 3 Pa mor effeithiol y mae timau nyrsio cymuned yn gallu gweithio gydag ystod o weithwyr proffesiynol ac asiantaethau (gan gynnwys gwasanaethau gofal sylfaenol ac eilaidd, gwasanaethau gofal cymdeithasol, a'r sector gwirfoddol) i gynnig gofal di-dor sy'n canolbwyntio ar unigolion.

Ymateb

Mae HEIW yn comisiynu addysg ôl-radd ar gyfer ystod eang o glinigwyr, sy'n cynnwys cyllideb wedi'i chlustnodi ar gyfer staff sy'n gweithio yn y gymuned ac mewn lleoliadau gofal sylfaenol.

Mae'r cyllid hwn yn helpu nyrsys a gweithwyr proffesiynol eraill i fanteisio ar addysg er mwyn datblygu gwybodaeth a sgiliau uwch neu estynedig sy'n gallu cefnogi a gwella'r gwasanaethau a gynigir gan wasanaethau nyrsio cymunedol. Fwyfwy, caiff yr addysg hon ei chynnig fel rhan o raglenni hyfforddiant amlbroffesiynol / rhyngddisgyblaethol.

GWYBODAETH YCHWANEGOL

4.1 Cyrsiau Nyrsio Cymuned Arbenigol

Yn ystod y 1990au, datblygodd y Cyngor Nyrsio a Bydwreigiaeth (NMC) safonau'n ymwneud ag addysgu nyrsys cymuned. Mae'r Cymwysterau Ymarfer Arbenigol (SPQ) hyn yn gofnodadwy â'r NMC ond nid cymwysterau cofrestradwy ydynt. Yn

ddiweddar, mae'r NMC wedi cyhoeddi y caiff adolygiad o addysg ymarfer arbenigol ei gynnal o fewn y ddwy flynedd nesaf.

Y cyrsiau addysgu nyrsio cymuned arbenigol y mae HEIW yn eu comisiynu ac yn eu hariannu ar lwybr rhan-amser neu fodiwlaidd, yw'r rheiny sy'n arwain naill ai:

- at Gymhwyster Ymarfer Arbenigol (SPQ) sy'n gofnodadwy yn y NMC neu
- Gradd BSc/PG Dip mewn Astudiaethau Iechyd y Gymuned.

Gellir dilyn cyrsiau addysg nyrsio cymuned mewn nifer o feysydd arbenigol. Mae'r rhain yn cynnwys:

- Nyrsio Ymarfer Cyffredinol (ar gyfer y rheiny sy'n gweithio mewn meddygfa lle mai'r meddyg teulu yw'r cyflogwr neu'r rheiny a gyflogir gan Sefydliad yn y GIG), a
- Nyrsio Ardal; Nyrsio Paediatrig yn y Gymuned; Nyrsio Anableddau Dysgu yn y Gymuned.

Mae dau lwybr i gyflawni dyfarniadau'r SPQ/Astudiaethau Iechyd Cymuned:

- Y llwybr rhan-amser a gwblheir fel arfer dros gyfnod o ddwy flynedd.

Neu

- Y llwybr modiwlaidd, sy'n caniatáu i fyfyrwyr ymgymryd ag un neu fwy o fodiwlau a addysgir sy'n fwy penodol dros gyfnod amhendant. Mae myfyrwyr sy'n dilyn y llwybr modiwlaidd yn cwblhau *Hanfodion Ymarfer Cymunedol*, fel eu modiwl cyntaf. Ar ôl cwblhau'r modiwl hwn, gall myfyrwyr ddewis p'un ai i gwblhau modiwl arall neu fodiwlau eraill neu i ymadael â'r rhaglen.

Er bod y SPQ yn statws cydnabyddedig, fel y'i nodir gan y NMC a'r proffesiwn, yn ei hanfod, gorchwyl y cyflogwr yw penderfynu a chytuno gyda'u staff pa sgiliau a gwybodaeth sydd eu hangen er mwyn cyflawni eu rôl yn effeithiol.

Mae'r tabl isod yn nodi nifer y lleoedd a gomisiynir ar gyfer nyrsio ardal/cymunedol a'r niferoedd sy'n manteisio ar y lleoedd hyn ar draws Cymru

NYRSIO ARDAL/CYMUNEDOL				
	Modiwlau rhan-amser a gomisiynir	Niferoedd sy'n dilyn modiwlau'n rhan-amser	Modiwlau a gomisiynir	Niferoedd sy'n dilyn modiwlau
2018.19	80	Dim manylion ar gael eto	123	Dim manylion ar gael eto
2017.18	80	61	123	128
2016.17	41	39	123	88
2015.16	41	41	123	84

4.2 Datblygu Gweithwyr Cefnogi Gofal Iechyd (HCSW) Gofal Sylfaenol

Mae datblygu gweithlu cefnogi hyblyg a chynaliadwy'n gofyn am fynediad at yr addysg, y sgiliau a'r hyfforddiant angenrheidiol. Gan ddefnyddio sgiliau a thalentau Gweithwyr Cefnogi Gofal Iechyd sy'n bodoli eisoes ac sydd heb gofrestru a chan gynnig cyfleoedd datblygu, yn enwedig i fodloni gofynion gwasanaeth newydd, mae'n elfen allweddol o ran sicrhau gweithlu'r dyfodol.

Mae tystysgrif a rhaglen diploma Lefel 3 safonedig o hyfforddiant achrededig ar gyfer HCSWs gofal sylfaenol yng Nghymru wedi'u datblygu. Mae'r rhaglen yn caniatáu dilyniant gyrfa; yn hwyluso cymysgedd sgiliau; yn ategu at ddarpariaeth gwasanaeth yn y dyfodol; ac yn alinio â:

- Fframwaith Sgiliau a Datblygu Gyrfa GIG Cymru
- Fframwaith Cymwyseddau Cynorthwywyr Gofal Iechyd Ymarferwyr Coleg Brenhinol yr Ymarferwyr Cyffredinol

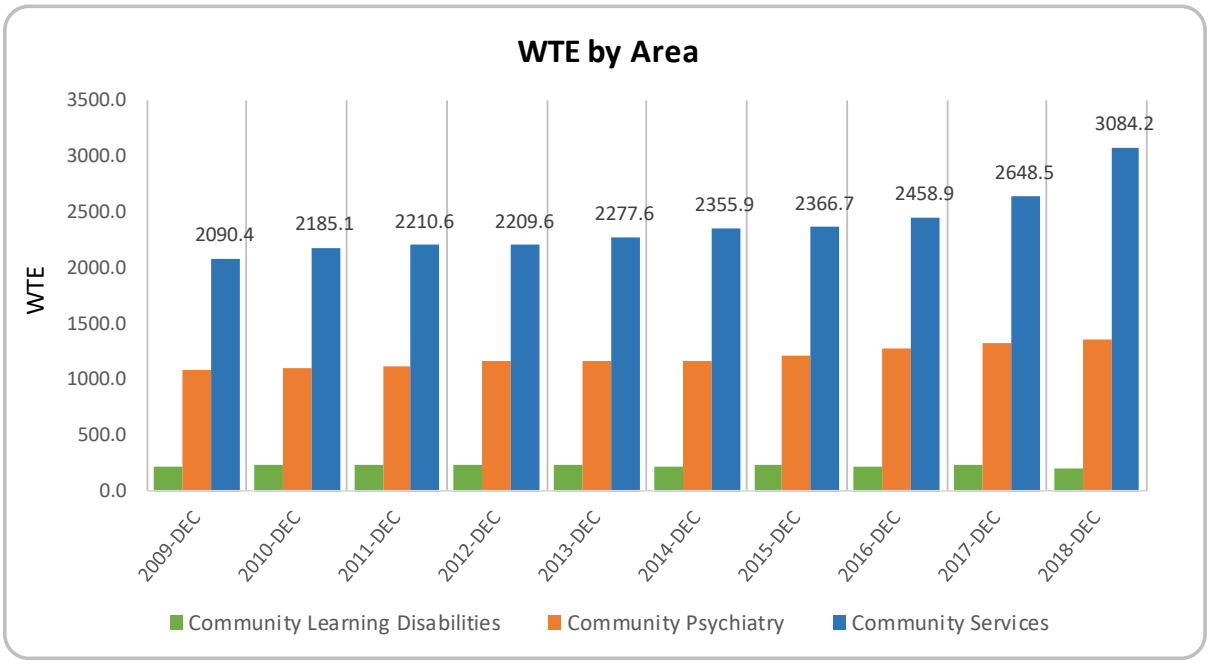
Mae gwaith ar y gweill i ehangu cyfleoedd i ddatblygu rôl HCSWs ym maes gofal sylfaenol, gyda mynediad at unedau dysgu eang sy'n adlewyrchu modelau darpariaeth gwasanaeth newydd ac sy'n dod i'r amlwg e.e. HCSWs i gefnogi uwch ffisiotherapyddion ymarfer; hyfforddi staff derbyn a llywio.

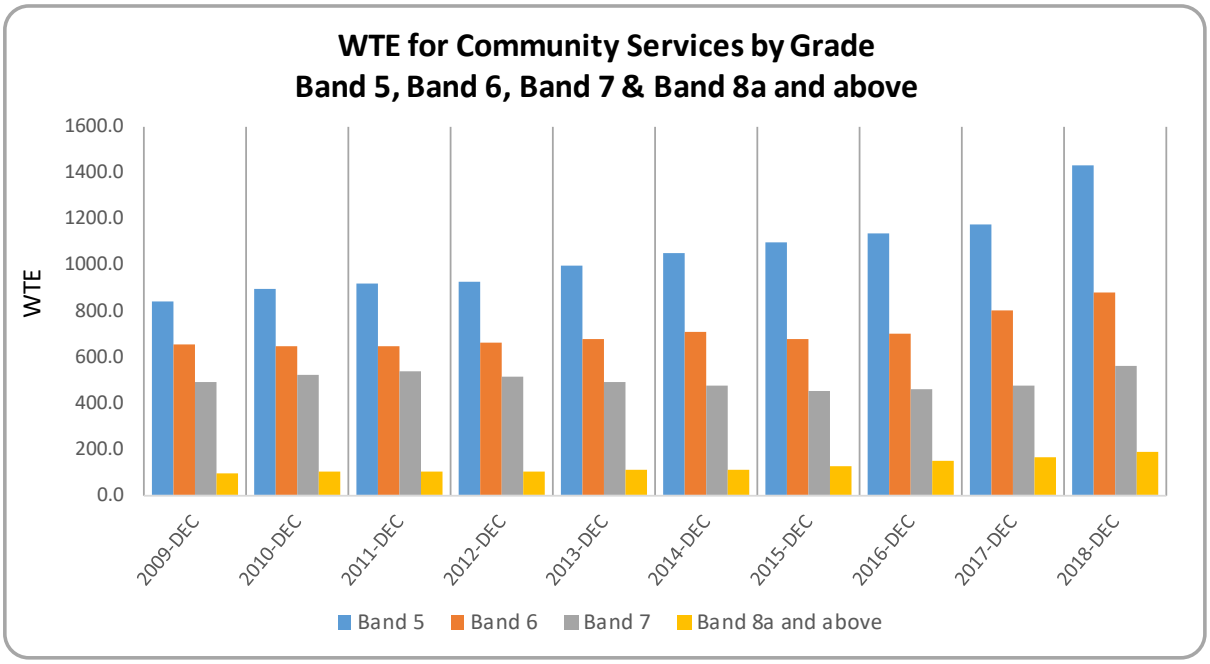
4.3 Gwybodaeth am y Gweithlu

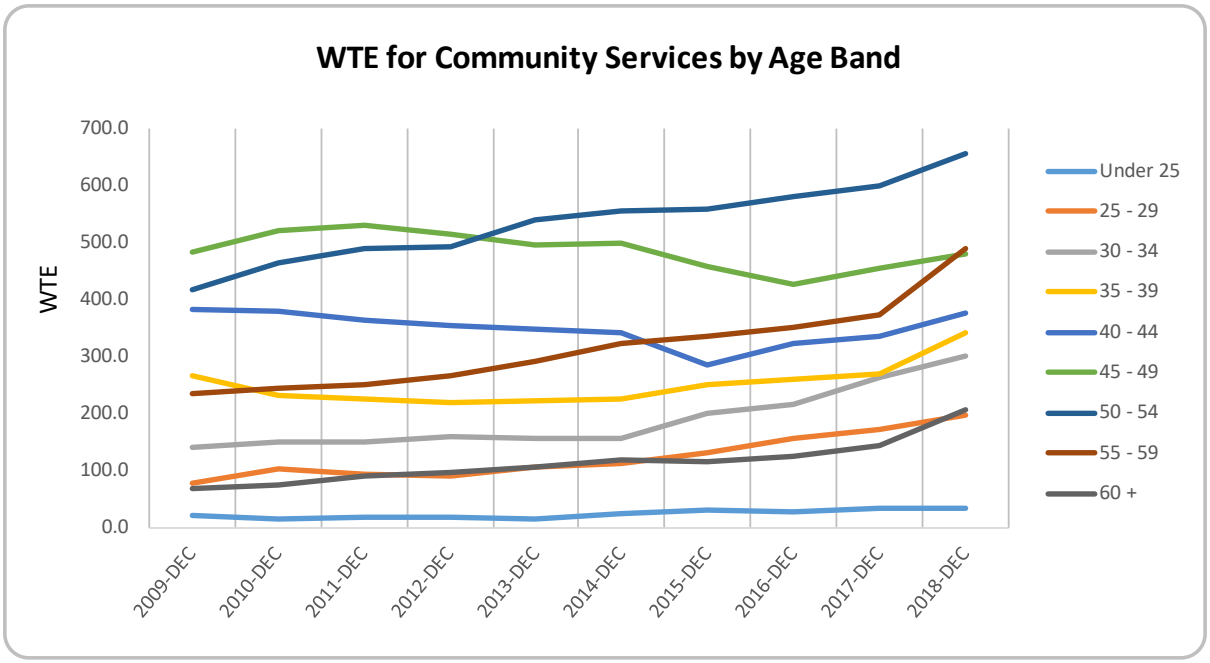
Daw'r wybodaeth yn yr adran hon o Warws Data ESR yn seiliedig ar y staff sydd yn eu swyddi ar Ragfyr 2009 - 2018.

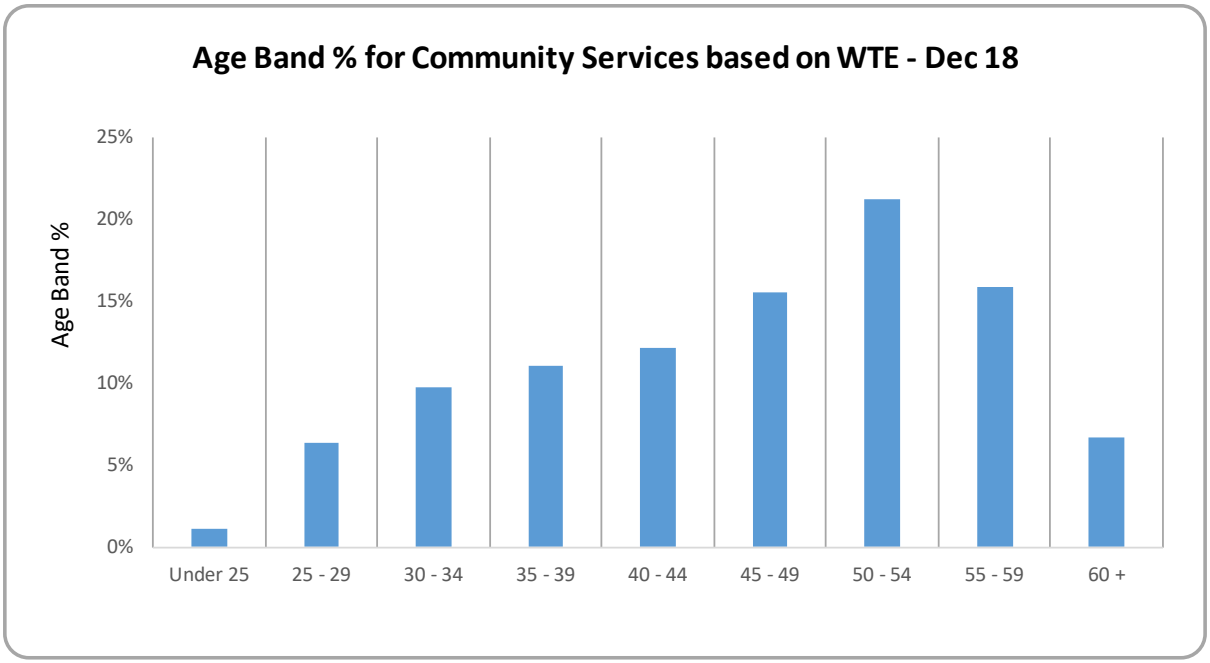
Pwyntiau allweddol:

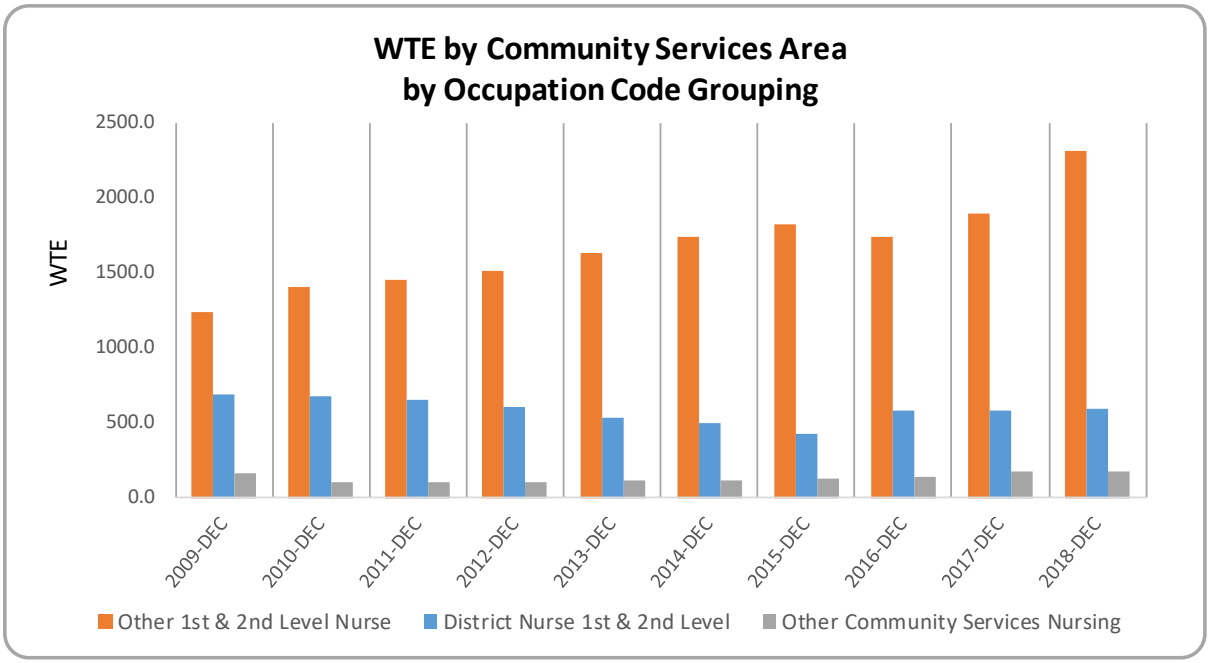
Mae'r tabl isod yn dangos newidiadau i'r gweithlu dros y cyfnod hwn.






WTE for Community Services by Age Band
WTE
700.0
600.0
500.0
400.0
300.0
200.0
100.0
0.0
2009-DEC
2010-DEC
2011-DEC
2012-DEC
2013-DEC
2014-DEC
2015-DEC
2016-DEC
2017-DEC
2018-DEC
Under 25
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 +


Age Band % for Community Services based on WTE - Dec 18
Age Band %
25%
20%
15%
10%
5%
0%
Under 25
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 +


WTE by Community Services Area
by Occupation Code Grouping
WTE
2500.0
2000.0
1500.0
1000.0
500.0
0.0
2009-DEC
2010-DEC
2011-DEC
2012-DEC
2013-DEC
2014-DEC
2015-DEC
2016-DEC
2017-DEC
2018-DEC
Other 1st & 2nd Level Nurse
District Nurse 1st & 2nd Level
Other Community Services Nursing

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal
HSCS(5) CDN09
Ymateb gan British Lung Foundation

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from British Lung Foundation

1. O safbwynt trin cyflyrau anadlu, mae hyn wedi gwella yng Nghymru ers y Cynllun Cyflawni cyntaf ar gyfer Iechyd Anadlol yn 2014. Er hynny, yn ôl Adroddiad gan Arsyllfa Iechyd Cyhoeddus Cymru (2018), sef *Iechyd a'i Benderfynyddion yng Nghymru*, gwelwyd bod clefyd anadlu yn dal i roi baich enfawr ar Gymru.

2. Mae 8% o boblogaeth Cymru, sef cyfran uwch na chyfartaledd y DU, yn byw efo cyflwr anadlu. Mae hyn yn cyfrannu at ryw 16% o'r holl farwolaethau yng Nghymru.

3. Mae 70,000 o bobl yn byw efo clefyd rhwystrol cronig yr ysgyfaint *(COPD)*, ac mae 250,000 o bobl yn byw efo asthma – plant yw bron i 60,000 o'r rhain.

4. Mae unigolion sy'n byw yn y cymunedau mwyaf difreintiedig ddwywaith yn fwy tebygol o ddweud fod ganddynt salwch anadlu (11% yn yr ardaloedd mwyaf difreintiedig, o gymharu â 6% yn yr ardaloedd lleiaf difreintiedig).

5. Roedd cyflwr anadlu cronig yn cyfrannu at fwy na 16,000 o flynyddoedd yn byw efo anabledd, bron i 31,500 o flynyddoedd o fywyd a gollwyd, a bron i 48,000 o flynyddoedd o fywyd wedi'u haddasu gan anabledd yng Nghymru, yn 2016.

6. Yn ôl rhagamcanion, gallai'r clefydau hynny sy'n rhai cronig, ac yn cyfyngu ar fywyd, godi mwy nag 20% erbyn 2035.

7. Ymweliadau â meddyg teulu a Derbyniadau i'r Ysbyty

7.1. Mae derbyniadau i'r ysbyty, wedi'u hachosi gan gyflyrau anadlu, wedi codi 27% dros y pum mlynedd diwethaf.

7.2. Mae derbyniadau brys wedi codi 28% dros yr un cyfnod amser.

7.3. Mae nifer yr ail dderbyniadau o fewn 30 diwrnod o adael yr ysbyty, o achos cyflyrau anadlu, wedi codi 35% yn y pum mlynedd diwethaf. Mae hyn yn codi i 55% ar gyfer cleifion niwmonia.

7.4. Mae'r gost i'r GIG, fesul derbyniad, yn amrywio rhwng £1,900 a £5,000 y claf, pob tro.

7.5 Yn y tabl, gwelwn gynnydd yn nifer y derbyniadau brys, fesul Bwrdd Iechyd Lleol, rhwng 2012/13 a 2017/18.

Bwrdd Iechyd Lleol	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
ABM	8,215	7,652	8,461	8,964	10,124	10,100
Aneurin Bevan	9,214	9,636	10,365	11,657	11,742	11,143
Betsi	10,939	10,022	11,341	11,952	12,290	13,443
Caerdydd a'r Fro	6,437	6,921	6,985	8,013	8,162	8,189
Cwm Taf	5,764	6,041	6,256	6,617	6,946	7,225
Hywel Dda	5,657	5,199	5,720	6,053	6,512	5,994
Powys	1,617	1,634	1,794	1,915	2,018	2,180
Cyfanswm	47,843	47,105	50,922	55,171	57,794	58,274

8. Felly, mae angen gweld mwy o fuddsoddi mewn mentrau fel nad oes cymaint o risg i gleifion orfod mynd i'r ysbyty, lle nad yw hynny'n angenrheidiol, a lle y gellir osgoi hynny.

9. Byddai nyrsio cymunedol yn sicrhau bod cymorth, cyngor a gofal yn y gymuned wrth law i fwy o gleifion, a byddai hyn yn lleihau'r angen i fynd i'r ysbyty.

10. Mae hefyd yn cyfrannu at wella hunanreoli a hunangyfeirio, pan fo angen, at wasanaethau mwy hygyrch yn y gymuned. Fel y nodwyd uchod, gyda chlefydau anadlu yn amlycach mewn cymunedau mwy difreintiedig, byddai'r cymunedau hynny yn elwa o gael gwasanaethau yn lleol, yn hytrach nag ysbytai cyffredinol dosbarth.

11. Drwy roi gwybodaeth i gleifion, gallant adnabod yr arwyddion pan fydd eu cyflwr ar fin gwaethygu, a defnyddio gwrthfiotigau neu corticosteroidau yn fuan, neu'r ddau. Bydd hyn yn lleihau'r angen i bobl sy'n byw efo clefyd rhwystrol cronig yr ysgyfaint, neu gyflyrau eraill, fynd at eu meddyg teulu am ofal.

12. Integreiddio a Chyfeirio

13. Rhaglen Adsefydlu i Gleifion yr Ysgyfaint

14. Dyma raglen ymarfer corff ac addysg sy'n cael ei chynnal gan y GIG, yn benodol i bobl sydd â chyflwr ar eu hysgyfaint. Fel arfer, caiff y rhaglen ei chynnig i bobl sydd wedi cael diagnosis o glefyd rhwystrol cronig yr ysgyfaint. Er hynny, mae tystiolaeth gynyddol fod y rhaglen yn gost effeithiol ar gyfer cyflyrau anadlu cronig eraill, fel clefyd interstitaidd yr ysgyfaint *(ILD),* bronciectasis ac asthma cronig.

15. Mae rhaglenni adsefydlu 'safon aur' yn rhoi cleifion mewn cysylltiad â llu o broffesiynau, ac yn golygu gwneud ymarfer corff a dysgu. Daw cleifion i gysylltiad â gweithwyr proffesiynol y Cynllun Cenedlaethol i Atgyfeirio Cleifion i Wneud Ymarfer Corff *(NERS).* Mae hyn yn cynnwys dysgu am sut i ofalu am eich hun, cyngor ar ddiet, therapi galwedigaethol, cefnogaeth seicolegol a chymdeithasol.

- Bydd yr ystod o gymorth yn cael ei ddarparu gan dîm, gan gynnwys:
- Therapyddion Galwedigaethol
- Nyrsys Anadlu Arbenigol
- Dietegydd
- Fferyllydd
- Seicolegydd

16. Yn anffodus, nid yw gwasanaethau ymarfer corff priodol fel hyn ar gael i bawb. Yn wir, dim ond 1 ym mhob 10 o bobl sydd â chyflwr anadlu cronig sy'n dilyn rhaglen adsefydlu yng Nghymru. Mae cyfraddau cyfeirio hefyd yn amrywio'n fawr rhwng byrddau iechyd lleol a meddygon teulu.

17. Byddai nyrsio cymunedol yn helpu drwy wella'r broses gyfeirio at fentrau fel y Rhaglen Adsefydlu a'r Cynllun Atgyfeirio, a'r ymwybyddiaeth ohonynt. Mae manteision hirdymor o ran hunanreoli, teimlo'n ynysig ac yn unig, ac arafu pa mor gyflym mae'r cyflwr yn gwaethygu.

18. Cyfeirio at wasanaethau rhoi'r gorau i ysmygu

19. Mae ysmygu yn achosi dros 80% o achosion o glefyd rhwystrol cronig yr ysgyfaint a chanser yr ysgyfaint, ac yn achosi neu'n gwaethygu pob cyflwr anadlu arall. Er hynny, ni lwyddodd yr un Bwrdd Iechyd i gyflawni targed perfformiad arwyddocaol; sef, bod 5% o ysmygwyr yn cael eu trin gan wasanaeth arbenigol.

20. Rydym am weld gwelliant yn y modd y caiff pobl sydd â chyflwr ar eu hysgyfaint eu cyfeirio at wasanaethau rhoi'r gorau i ysmygu. Mae'n bwysig rhoi'r gorau i ysmygu oherwydd mae'n gwella symptomau clefyd rhwystrol cronig yr ysgyfaint, ac yn arafu pa mor gyflym mae'r cyflwr yn gwaethygu. Gall rhoi'r gorau i ymysgu yn 30 oed ychwanegu 10 mlynedd at ddisgwyliad oes. Gall rhoi'r gorau iddi yn 60 oed ychwanegu tair blynedd arall at ddisgwyliad oes.

21. Drwy wella mynediad at wasanaethau yn y gymuned, ar ffurf cymorth nyrsio cymunedol, gall hyn helpu i wella nifer y cleifion â chyflwr anadlu sy'n dilyn y rhaglen 'Helpa fi i roi'r gorau iddi', a gwella cyfradd yr ymdrechion llwyddiannus i roi'r gorau iddi.

22. Gwella'r nifer sy'n cymryd y brechiad ffliw

23. Mae pobl sydd â chlefyd rhwystrol cronig yr ysgyfaint, a chlefydau anadlu cronig eraill, yn fwy tebygol o gael cymhlethdodau difrifol sy'n gysylltiedig â ffliw.

24. Gall brechiadau leihau nifer y pyliau drwg a gaiff pobl sydd â chlefyd rhwystrol cronig yr ysgyfaint, a pha mor ddifrifol ydynt. O ganlyniad, gall hyn leihau'r siawns o orfod mynd i'r ysbyty.

25. Er hynny, dim ond 46.9% o'r rheiny oedd yn chwe mis i 64 oed, mewn unrhyw grŵp risg clinigol, gymerodd y brechiad ffliw yn ystod y tymor ffliw yn 2016/17 yng Nghymru, o gymharu â tharged o 75%. I bobl â chlefyd anadlu cronig, 46.5% ohonynt a gymerodd y brechiad, canran sydd wedi bod yn statig ers y pum mlynedd diwethaf.

26. Yng Ngaeaf 2017/18, yng Nghymru yr oedd y nifer uchaf o farwolaethau dros y Gaeaf yn unrhyw le yn y DU. Roedd y ffigwr yn 32.8% yn fwy – yn uwch nag yn unrhyw le arall yn y DU.

27. O'r marwolaethau hyn, cyflyrau anadlu oedd prif achos y farwolaeth, gyda bron i 17,500 o farwolaethau ar draws y DU. Mae hyn 84.9% yn fwy o farwolaethau ym misoedd y Gaeaf, o gymharu â'r misoedd eraill yn 2017

hyd at 2018. Mae'n debyg bod hyn yn gysylltiedig â'r ffaith bod ffliw yn fwy cyffredin yn ystod y cyfnod.

28. Roedd nifer y marwolaethau ychwanegol yng Ngaeaf 2017 i 2018 yr uchaf sydd ar gofnod ers Gaeaf 1975 i 1976.

29. O safbwynt y bobl hynny sydd wedi cael diagnosis o glefyd anadlu, rydym am weld mwy ohonynt yn cael brechiad ffliw pob blwyddyn, a hynny er mwyn lleihau'r risg iddynt gael gymhlethdodau yn sgil cael ffliw a gorfod mynd i'r ysbyty.

30. Byddai nyrsio cymunedol, a fyddai'n gwella hunanreoli a hunangyfeirio, yn helpu i wella'r nifer sy'n dewis cymryd y brechiad ffliw ymysg y grwpiau risg.

Am y British Lung Foundation

Y BLF yw'r unig elusen yn y DU sy'n gofalu am ysgyfaint y genedl. Rydym ni'n cynnig gobaith, cymorth a llais. Mae ein gwaith ymchwil yn dod o hyd i ffyrdd newydd o drin a gwella. Rydym yn helpu pobl sy'n cael trafferth anadlu i gymryd rheolaeth ar eu bywyd. Gyda'n gilydd, rydym yn ymgyrchu dros wella iechyd yr ysgyfaint. Gyda'ch cymorth chi, fe ofalwn ni y bydd pawb, un diwrnod, yn anadlu aer glân efo ysgyfaint iach.

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad I wasanaethau Nyrsio Cymunedol a Nyrsio Adal
HSCS(5) CDN12
Ymateb gan Gomisiynydd Pobl Hŷn Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Community and District Nursing services

Evidence from Older People's Commissioner for Wales

Diolch ichi am y cyfle i ymateb i ymgynghoriad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon ynglYn å'r gwasanaethau nyrsio cymunedol a nyrsio ardal yng Nghymru.

Mae'r gwasanaethau nyrsio cymunedol a nyrsio ardal yn chwarae rhan hollbwysig i warchod annibyniaeth unigolion a gofalu am eu hiechyd (gan gynnwys rheoli cyflyrau hirdymor a salwch aciwt) y tu allan i'r ysbytyi.

Dros y blynyddoedd diwethaf bu ymdrechion yn mynd rhagddynt i gyflenwi mwy o ofal, a gofal cynyddol gymhleth i unigolion y tu allan i'r ysbyty ac yn y gymuned. Er bod llawer o bobl h9n yn croesau hyn, gan nad ydynt o bosibl eisiau aros yn ddiangen yn yr ysbyty na theithio i apwyntiad ysbyty, mae'n dwyn yn ei sgil lawer o heriau ac yn rhoi mwy o bwyslais ar sicrhau bod gennym weithlu sy'n briodol o ran maint, ansawdd a chefnogaeth.

Rwy'n ymwybodol, O'r gefnogaeth gwaith achosion a ddarperir gan fy swyddfa a drwy gyfarfodydd phobl hYn, faint y mae pobl hYn yn gwerthfawrogi'r gwasanaethau nyrsio cymunedol a nyrsio ardal.

Fodd bynnag, mae nifer fechan o bobl hYn wedi cysylltu å'm swyddfa yn mynegi'r anawsterau a gawsant yn cysylltu å'u gwasanaethau nyrsio cymunedol a nyrsio ardal. Er enghraifft, mae unigolion wedi bod eisiau newid/ail-drefnu apwyntiadau, codi pryderon am eu cyflwr neu geisio cyngor ar driniaethau, ond maent wedi methu'n län chysylltu ä'u nyrs.

Oherwydd natur eu rolau, rwy'n deall mai ychydig o amser y mae nyrsys cymunedol a nyrsys ardal yn ei dreulio yn y swyddfa — ac eto'r rhif cysylltu a roddwyd i bobl h9n oedd system peiriant ateb yn y swyddfa. Roedd hyn nid yn unig yn achosi straen a gofid, ond roedd hefyd yn creu'r risg y bydd angen i'r unigolion hyn ddefnyddio gwasanaethau gofal heb eu trefnu O'r herwydd.

Gallai person hYn sy'n dibynnu ar y gwasanaethau hyn fod mewn sefyllfa fregus iawn, er enghraifft, oherwydd anawsterau symud neu anghenion gofal a chefnogaeth sydd ganddynt eisoes. Ac ystyried natur fregus y bobl hyn, a'r gofal cynyddol gymhleth sy'n cael ei ddarparu drwy'r gwasanaethau nyrsio cymunedol a nyrsio ardal, mae'n bwysig sefydlu dull effeithiol o gysylltu a chyfathrebu rhwng nyrsys a phobl h9n ar draws Cymru.

Mae nifer fechan o bobl hYn hefyd wedi mynegi eu pryderon wrthyf ynglYn ag anghytundeb rhyngddynt a'r gwasanaethau nyrsio cymunedol a nyrsio ardal pan

fo'r gwasanaethau'n cael eu tynnu oddi arnynt/oddi ar eu hanwyliaid. Er enghraifft, pan ddywed y gwasanaeth bod unigolyn yn ddigon da neu'n ddigon abl i beidio å chael gwasanaethau nyrsio cymunedol a nyrsio ardal mwyach a theithio at eu meddyg teulu am apwyntiadau arferol, ond bo'r unigolion/ eu teulu'n teimlo eu bod yn dal angen y gwasanaethau hyn.

Mae'r gwasanaethau hyn yn rhan hanfodol a gwerthfawr iawn O'r broses o gyflwyno gofal iechyd yn ein cymunedau, i rai O'n pobl hYn fwyaf i agored i niwed. Fodd bynnag, rwy'n bryderus y gallai pwysau ychwanegol fod yn cael ei roi ar y gwasanaethau nyrsio cymunedol a nyrsio ardal wrth i nifer gynyddol o wasanaethau iechyd cymhleth gael eu symud allan O'r ysbytai ac i'r gymuned.

Rwy'n ymwybodol bod 1000 0 Fywydau yn gwneud gwaith ar sefydlu'r dystiolaeth a'r dull gweithredu sydd eu hangen i ymestyn Deddf Lefelau Staff Nyrsio (Cymru) 2016 i nyrsio ardal. Hefyd, mae angen trefniadau I fonitro'n barhaus ansawdd y gwasanaethau hyn, ynghyd chanlyniadau cleifion, niferoedd yn y gweithlu a llesiant staff i sicrhau eu bod yn cael digon o adnoddau a bod cleifion yn cael gofal o ansawdd uchel yn eu cartref a'u cymuned wrth i natur a chymhlethdod y gofal hwn newid dros amser.

Rwy'n gobeithio bod y sylwadau hyn o gymorth. Os gallaf fod o unrhyw gymorth pellach, mae croeso ichi gysylltu xxxx fy Arweinydd lechyd a Gofal, ar xxxx neu drwy e-bostio xxxx

Helena Herklots

Comisiynydd Pobl Hŷn Cymru