Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DIWYLLIANT, POBL A DATBLYGU SEFYDLIADOL
PEOPLE, ORGANISATIONAL DEVELOPMENT & CULTURE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 April 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Hywel Dda University Health Board (HDdUHB)Community Nursing Services Annual Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jill Paterson: Director of Primary Care, Community and Long-Term Care
SWYDDOG ADRODD: REPORTING OFFICER:	Ceri Griffiths: Community Head of Nursing Tracey Evans: Community Head of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the HDdaUHB Community Nursing Services Annual Report (Appendix 1) for 2021/2022 is to provide an opportunity to review performance over the last financial year and reflect on what has been achieved despite the many challenges during the last few years.

This report highlights the continued hard work from all the community nursing teams in HDdUHB including our community hospitals. The report reflects our community nursing vision to improve the health and well-being of our population by empowering and supporting people to live well and remain in their own communities. In addition, providing an oversight of the range of services delivered by the HDdUHB Community Nursing Service.

Cefndir / Background

Community Nursing Services are pivotal to the delivery of a whole system approach to health and social care, putting the patient at the centre and focussing on prudent health care. Despite this, community-based services are often unable to demonstrate or measure the value that services add. Community nursing is often considered to be an invisible service as it provides care, treatment and support to those most vulnerable in our communities behind closed doors. The service does not have a definitive number of beds in the same way as an acute hospital and yet it could be considered as an elastic ward which expands as priorities change.

The community nursing services are pivotal in supporting the acute sector to discharge patients back into the service and similarly supports people to remain at home thereby avoiding unnecessary and prolonged stays in hospital. The service offers acute interventions in the community setting and reduces the risk of hospital acquired infections.

HDdUHB Community Nursing Services comprises Neighbourhood District Nursing teams, Urgent and Intermediate care services including Acute Response, Community Resource Teams and Same Day Urgent Care Services, Specialist Nursing Teams and Community

Hospitals who work collaboratively to ensure the delivery of equitable, patient centred, and high-quality care based on population need.

The ambition of this annual report is to provide an overview of key aspects of the services being delivered across community settings and to promote awareness and understanding of Community Nursing services in HDdUHB.

Asesiad / Assessment

Our objectives align to the principles and strategic direction of the Healthier Mid and West Wales Strategy, our local integrated county and locality plans as well as national strategies; they include:

- Prioritising equitable and accessible person-centred care, treatment or support
- Ensuring a preventative, proactive and population health centred approach
- Delivering a system wide approach to providing high quality care closer to home
- Promoting self-care and well-being – 'help to help yourself,' encouraging an approach to care which values reablement and independence
- Delivering safe, effective and value-based health care
- Promoting ageing and dying well
- Ensuring there is a skilled, strong, flexible and sustainable workforce with clear career and development opportunities to meet the changing needs of the population
- Promoting and embedding Technology Enabled Care into all aspects of community nursing services

In line with these objectives, considerable progress has been made in developing our services such as ensuring coordination care planning - seven days a week, enabling use of technology, preventing avoidable hospital admissions and attendances, developing community services to enable patients to be 'turned around' at the front door, providing rapid crisis response utilising community services in a step up model of care and focussing on a home first approach to care supporting services to discharge patients for assessment to be done at home.

Over the last 12 months, district nursing services have implemented e-scheduling for patient calls which enables real-time visibility of the available clinical workforce capacity and patient demand, reducing duplication and ensuring safer care in the community. Work is ongoing to develop a dashboard which will provide data which demonstrates clinical activity and patient demand. New service developments have included piloting ambulatory clinics for Ear Micro Suctioning and Trial without Catheters with plans to establish these over 2022/2023.

To support our community nursing staff, we have invested in Community Practice and Professional Development Nurses in each county who work closely with teams to support training, education and development as well as facilitating peer and clinical supervision for staff. We have developed the role of the assistant practitioners to work across community nursing and community hospitals and we are committed to developing our health care support workers.

A continued focus on quality and safety has ensured that all three counties have regular scrutiny and quality, safety and experience meetings, with learning shared across services and teams. Patient experience has been prioritised and teams have been using CIVICA and the Once for Wales questionnaire; feedback is generally very positive although there are areas for improvement which will be the focus of the next 12 months.

Highlights of 2021/2022 report

- Ongoing compliance with District Nursing Interim Principles and engagement with national workstreams to move towards neighbourhood nursing models
- Engagement in quality improvement initiative including Trial without Catheter clinics, Ear Micro Suctioning clinics, and the development of ambulatory clinics
- Development of robust governance and scrutiny processes across the 3 counties
- Implementation and roll out of Patient Experience Questionnaires using CIVICA
- Overall performance metrics maintained despite significant operational challenges
- Development and implementation of 2 key roles across HDUHB and support with ongoing expansion of the community health care support worker roles across all bandings, including: A Community Senior Peer Nurse Advocate Role (1 whole time equivalent (wte) Band 8a for 12 months) and Community Practice and Professional Development Nurse (1wte Band 6 for 12 months)
- Roll out of Welsh Nursing Care Record across Community Hospitals
- Implementation of the Patient Family Liaison Offices across Community Hospitals
- Implementation of Peer Nurse Advocate training using the Advocating and Educating for Quality Improvement (A-EQUIP) model to establish and deliver restorative clinical supervision for all community nursing staff. A-EQUIP is an acronym for advocating for education and quality improvement. The A-EQUIP model is made up of four distinct functions: normative, restorative, personal action for quality improvement and education and development.

Argymhelliad / Recommendation

The People, Organisational Development and Culture Committee is asked to receive assurance from the information provided within the Hywel Dda University Health Board (HDdUHB)Community Nursing Services Annual Report 2021/22

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	To provide assurance to the Board on the implementation of the UHB's Workforce and OD Strategy, and the all Wales Health & Social Care Workforce Strategy, ensuring these are consistent with the Board's overall strategic direction and with any requirements and standards set for NHS bodies in Wales.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	NA
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included within Appendix 1
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Diwylliant, Pobl a Datblygu Sefydliadol: Parties / Committees consulted prior to People, Organisational Development & Culture Committee:	Not Applicable.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	NA
Ansawdd / Gofal Claf: Quality / Patient Care:	Patient centred approach has the potential for improved patient outcomes
Gweithlu: Workforce:	Potential positive impact on staff morale and future opportunities
Risg: Risk:	Included with Appendix 1
Cyfreithiol: Legal:	NA

Enw Da: **Reputational:**	Ineffective services can have a negative impact on the Health Board's reputation.
Gyfrinachedd: **Privacy:**	NA
Cydraddoldeb: **Equality:**	NA

Hywel Dda University Health Board
Community Nursing Services
Annual Report 2021/2022

Authors: Ceri Griffiths (Head of Nursing – Pembrokeshire)

Tracey Evans (Head of Nursing – Ceredigion)

Sarah Cameron – (Head of Nursing – Carmarthenshire)

Contents

Executive Summary

The following annual report provides an opportunity for us to look back on our performance over the last financial year and reflect on what we have achieved despite the many challenges during the last few years. This report highlights the continued hard work from all the community teams in Hywel Dda University Health Board (HDdUHB) including our community hospitals.

There is no doubt that Community nurses are an integral part of the NHS workforce providing invaluable care to people in their own homes or as close to home as possible. As we move into the endemic phase of COVID-19, it is important that we take the time to reflect on the significant impact the pandemic has had on all of us personally and professionally.

The need to rapidly implement innovative technology to manage patients during lockdown has underpinned the adaptation of clinical teams to 'new ways' of working: undertaking virtual triage, enabling collaboration with other professionals to undertake complex discharges and Multi-Disciplinary Team's with improved patient outcomes. The use of technology has undoubtedly brought some increased capacity within the workforce whilst also avoiding potentially long journeys for some patients, some of whom require ambulance transport. Communication has improved between team members during handovers, workload allocation and patient reviews. The availability of on-line training has also been beneficial. However, we must also be mindful that these developments can isolate staff who do require physical support of a team.

Despite all the challenges there is no doubt that the commitment, professionalism and dedication the community nursing teams have shown in maintaining high standards of care and keeping the person at the centre of all they do remains unprecedented. The community teams continue to demonstrate innovation, dedication, commitment, and creativity as they identify and develop solutions for managing new challenges and new ways of working going forward.

We have no doubt our community nursing teams will continue to work collaboratively with members of the wider Nursing community and multi professional team in order to identify opportunities to prevent ill health, supporting early intervention to help people manage their own health and wellbeing. This will be achievable with the development of the accelerated Clusters and the engagement of the professional collaboratives. To this end we look forward to embracing the opportunities to develop and enhance Community nursing in the coming year

Introduction and Overview

This is the annual report for Hywel Dda UHB Community Nursing Services for 2021/2022. The report will provide a summary of all adult community nursing services including Neighbourhood District Nursing teams, Urgent and Intermediate care services including Acute Response, Community Resource Teams and Same Day Urgent Care Services; Specialist Nursing Teams and Community Hospitals.

Community Services: Vision, Objectives and Values

Our community nursing vision is to improve the health and well-being of our population by empowering and supporting people to live well and remain in their own communities. Our objectives align to the principles and strategic direction of the Healthier Mid and West Wales Strategy, our local integrated county and locality plans as well as national strategies. They include:

- Prioritising equitable and accessible person-centred care, treatment or support
- Ensuring a preventative, proactive and population health centred approach
- Delivering a system wide approach to providing high quality care closer to home
- Promoting self-care and well-being – 'help to help yourself,' encouraging an approach to care, which values reablement and independence
- Delivering safe, effective and value-based health care
- Promoting ageing and dying well
- Ensuring there is a skilled, strong, flexible and sustainable workforce that has clear career and development opportunities which is equipped to meet the changing needs of the population
- Promoting and embedding Technology Enabled Care into all aspects of community nursing services

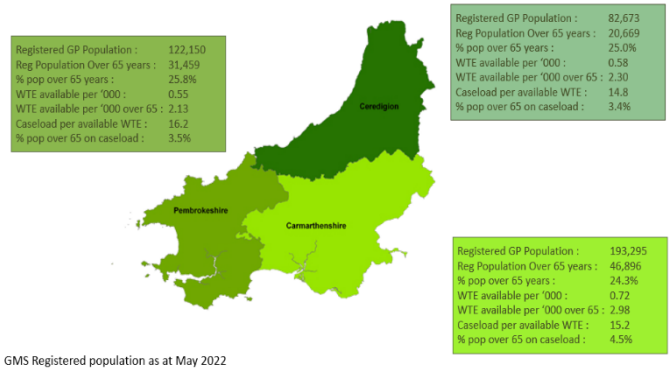
We use strong integrated partnership working with key partners including health and social care, and 3rd sector organisations to empower and support individuals to live as well as possible, ensuring safe, sustainable, accessible and kind services are available when needed. Our teams are encouraged to follow the Health Board's values which promotes a culture of learning and shared opportunity.

Community Nursing Services

Community Nursing Services are pivotal to delivering the goals for 'A Healthier Wales' (2019) – that report identified a whole system approach to health and social care while putting the patient at the centre and focussing on prudent health care. Hywel Dda UHB Community Nursing Services comprise Neighbourhood District Nursing teams, Urgent and Intermediate care services including Acute Response, Community Resource Teams and Same Day Urgent Care Services, Specialist Nursing Teams and Community Hospitals. Providing population-based health care services across the counties of Carmarthenshire, Ceredigion and Pembrokeshire in Mid and West Wales, our teams cover a large geographical area consisting of a mix of coastal, rural and urban communities.

The services support both the resident population of the Health Board and the high number of visitors who may require the expertise of the community nursing service. Our services work collaboratively to ensure the delivery of equitable, patient centred, and high-quality care based on population need.

While equity of care across our community's services is paramount, how and where individual services are delivered may differ according to local population requirements.

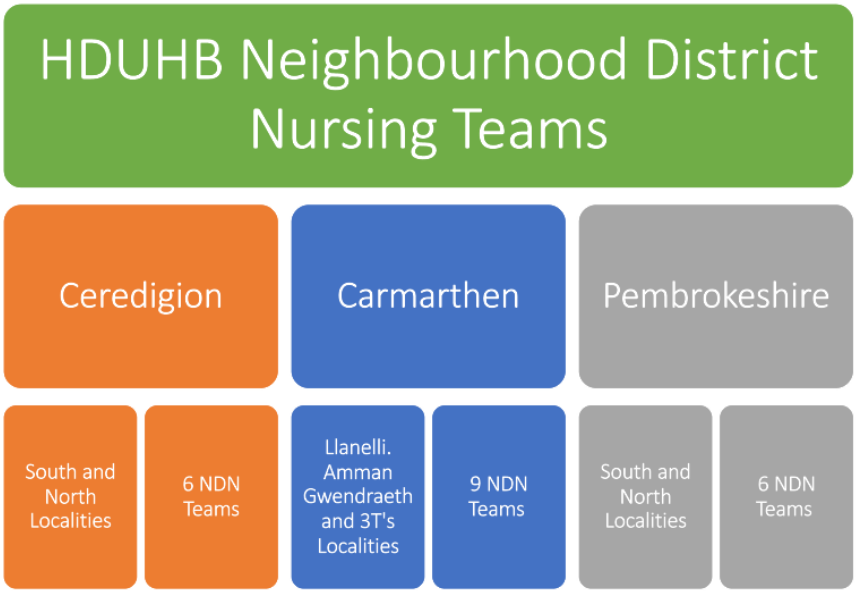


GMS Registered population as at May 2022

Core Neighbourhood District Nursing Services

Hywel Dda UHB Community and District nursing services are available for adults over 18 years of age who require care within their own homes. District Nursing teams are aligned to both clusters / localities and GP practices. There are 21 nursing teams across the Health Board.

Neighbourhood District Nursing Teams



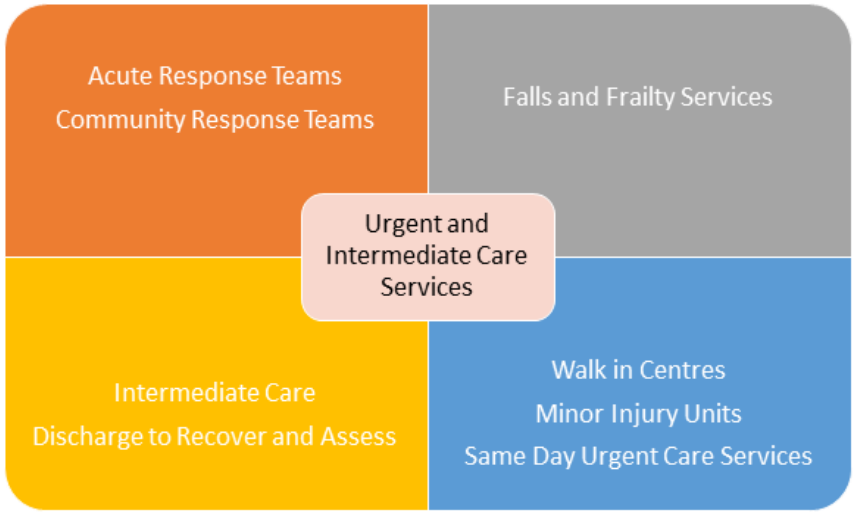
Some of the core services provided by district nursing teams include:

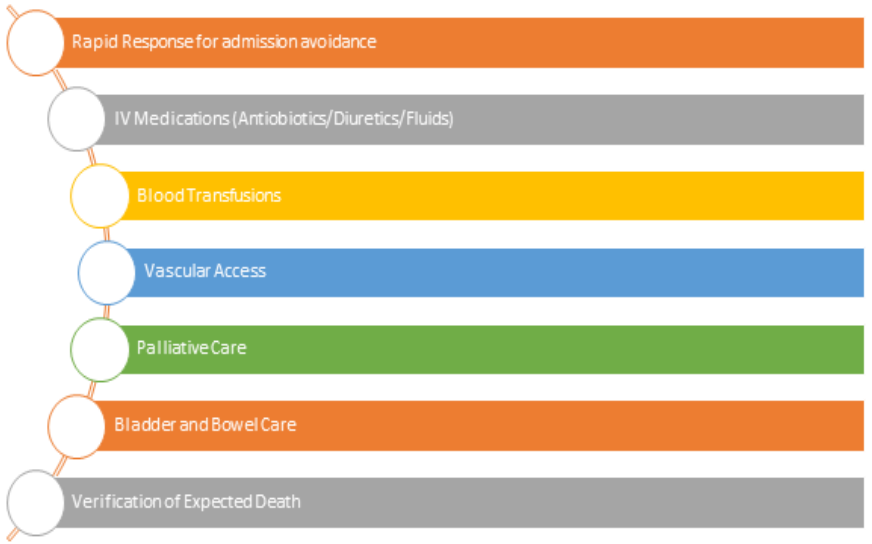
- Holistic patient centred nursing assessments
- Wound and pressure area care
- Bladder and bowel care
- Palliative and end of life care
- Medication administration
- Complex health care
- Equipment assessment and support
- Venepuncture

Urgent and Intermediate Care Teams

In line with the ambitions of the Six Goals for Urgent and Emergency Care and providing care closer to home, considerable progress has been made in developing new and innovative services across the three counties to meet key community objectives such as ensuring coordination care planning - seven days a week, enabling use of technology, preventing avoidable hospital admissions and attendances, developing community services to enable patients to be 'turned around' at the front door, providing rapid crisis response utilising community services in a step up model of care and focussing on a home first

approach to care supporting services to discharge patients for assessment to be done at home. Acute Response Services across the Health Board operate slightly differently in each locality but core service provision and access to 24/7 nursing care is provided equitably across all counties. Core activities provided by the Acute Response Teams include:





Clinical Nurse Specialists (CNS)

There are several clinical nurse specialist teams working within community settings. Progress has been made over the past 12 months in establishing Health Board wide Professional Leadership with the recruitment and appointment of Lead Nurses in a number of teams including Diabetes, Respiratory and Bladder and Bowel.

Heart Failure services plan to appoint a 3-County lead nurse in 2022 and Palliative Care services are awaiting the outcome of the formal service review but are likely to see similar recommendations.

The value of a three-County professional lead will be seen in improving the consistency and equity of specialist services across the Health Board for patients and staff.

Some CNS services which work across community settings but not within community teams include Parkinsons, Epilepsy and MS nurses who work collaboratively with core community services.

Bladder and Bowel Advisory Service (BABAS) update

As services begin to emerge from the COVID-19 pandemic BABAS has used opportunities to transform pelvic floor and continence services.

The term ‘pelvic health disorder’ is used as a catch-all for a number of conditions that primarily affect the bladder, lower bowel (anus and rectum) and vagina, and whose cause (at least in part) derives from a loss of support by the sheet of muscles that forms the pelvic floor itself.

It is recognised that people living with pelvic floor disorders face barriers to attending in-person appointments, particularly in relation to travelling. In HDdUHB patients are offered a choice of telemedicine and in-person consultations based on patient and clinician needs, such as for physical examination.

Many pelvic floor problems can be managed in the community and patients are encouraged to present for treatment and to self-refer if possible. It is essential that when problems are more complex these patients are not delayed in reaching expertise that can better deal with their condition and help them to return to normal life. Most pelvic floor problems can be fixed if patients are able to follow the right care pathway and reach the most appropriate person to care for their condition.

During 2021/2022 BABAS has contributed to the development of the new HDdUHB Pelvic Health Pathway working with the wider team to develop patient services with key achievements noted below.

I.T. and Transformation Team	Health Board 'Pelvic Health' website that provides adequate signposting, accessible information, support and services. Launched in December 2022
Patients Know Best	'Patients Know Best' (PKB) From the start, patients will be able to access appointment letters, see appointment details and access online information and resources about their care.
Value Based Healthcare	Patient-reported experience measures (PREMS) Online questionnaires will be sent to the patient to allow accurate personal histories to be collected in advance, making clinics more efficient.
HDD Communication Hub	BABAS is working towards a single point of access for all patients across the Health Board.
Trial without Catheter Project (TWOC)	In 2021 BABAS and Urology developed a new 'hybrid' process for TWOC in the community. The project was supported through the quality improvement programme. Following the success of the initial trial the project went on to the Dragons Heart Spread and Scale programme and is now awaiting funding for 'roll out' across the Health Board.
Pelvic Health Education Event – July 2022	In collaboration with the wider pelvic health team BABAS held an education event at the Botanical Gardens for all Advanced Nurse Practitioners (ANPs)/Practice Nurses in Primary Care. Topics included Endometriosis, Menopause, Bladder and Bowel Dysfunction.
Multi Disciplinary Team (MDT)Working	The BABAS team now attend a monthly urogynaecology MDT enabling the service to make the most of expertise and availability. NICE guidelines recommend both local and regional MDTs, with local meetings reviewing treatments for primary stress urinary incontinence, overactive bladder or primary prolapse, and regional meetings to cover multi-compartmental prolapse and mesh-related problems. In HDdUHB virtual multidisciplinary team (MDT) meetings have increased attendance, allowing participants to join from different sites.

Heart Failure Update

Heart failure (HF) CNSs across the three counties have been closely involved in the Heart Failure Pathway Transformation Project aimed at optimising value in heart failure care.

Focussed on integrated pathways, the project has secured funding for several key roles and service developments including:

- Development of a one stop HF diagnostic clinic
- Recruitment of advance practitioners and additional CNSs & HCSWs to deliver services
- Development of IV Diuretic / In patient CNS nurse roles
- Development of a Step Up and Step model of care
- Delivery of a seamless responsive and proactive service
- Ensuring the majority of patients are managed within primary care settings
- Enabling HF CNS to manage the most complex patients in the community
- Remote monitoring of patients has been commenced across the three counties currently numbers being monitored are
    - Ceredigion – 65
    - Pembrokeshire – 34
    - Carmarthenshire - 133

Respiratory Update

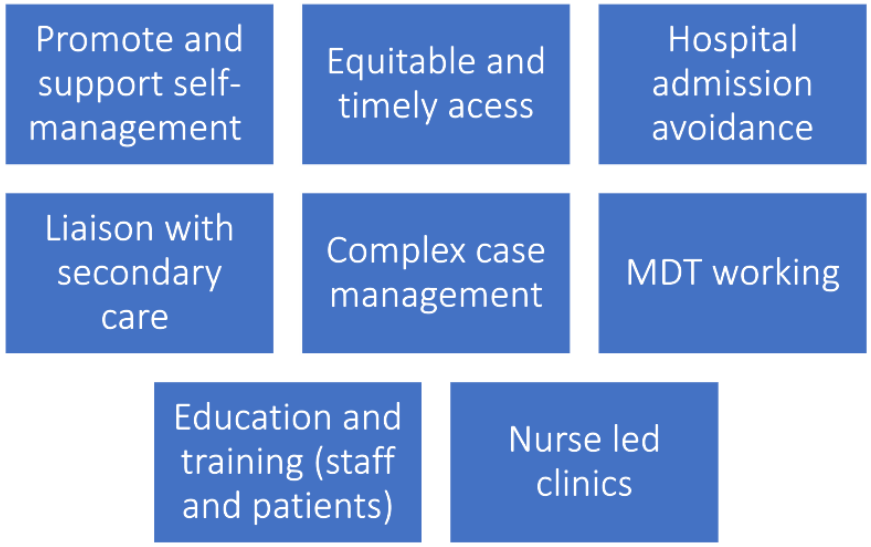
- Lead Nurse appointed across three counties
- Successful recruitment into a Pembrokeshire Respiratory CNS Post
- Home Oxygen Nurse Specialists roles have been amalgamated into Community Respiratory Nurses across the three counties
- The service is centrally managed but CNS's work closely with local teams and services
- Supported primary care to improve diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and asthma by using spirometry on a mobile respiratory hub at local sites across the three counties;563 appointments were offered during May-October 2022.
- Remote patient monitoring is being used to support patients to stay at home. Patients with respiratory conditions currently number 127

- Development of a Health Care Support Worker (HCSW) role in Respiratory conditions trialled in Pembrokeshire community services and to be rolled out to Carmarthenshire community services.

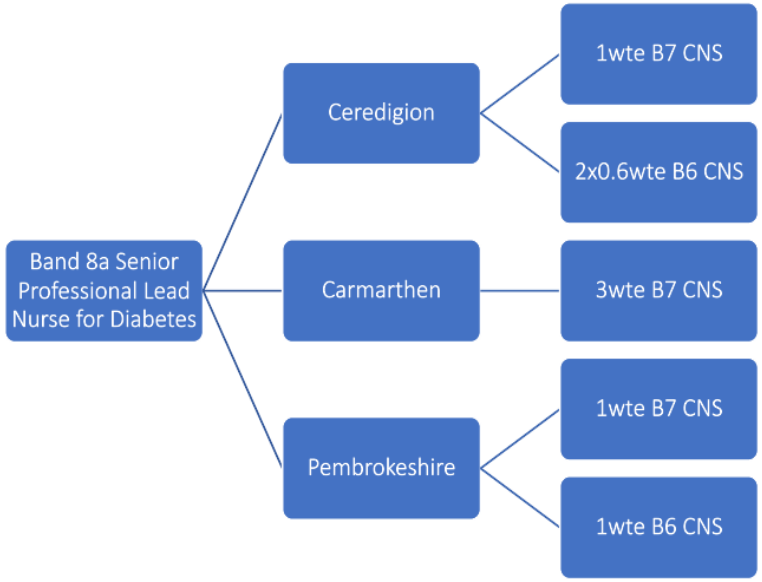
Diabetes Community Service Update

The delivery of care to patients with diabetes varies across the three counties, however since the appointment of a Senior CNS professional lead in diabetes across Hywel Dda (secondary, community and primary care) community diabetes specialist nurses (CDSN) teams have begun reviewing working practices and delivery of care so services will be equitable and consistent across the organisation.

Key aims of the service



Team Members



Achievements and recommendations

Achievements for 2022	Recommendations for 2023
• Successful recruitment for lead senior diabetes nurses to lead the development of HDdUHB diabetes nursing teams across three counties, acute, secondary and primary care • Successful recruitment and development of CNS for Pembrokeshire team • Joint working on policy for insulin delegation to HCSWs • Implementation of Welsh Information Solution for Diabetes Management (WISDM) accessed via Welsh Clinical Portal (WCP) across the Health Board • New referral criteria for community diabetes nursing service across three counties agreed. • Development of a communications hub single point of access to diabetes teams. • Professional team meetings with community DSNs across HDdUHB established (3-4 monthly). • Professional team meetings with all diabetes nurses (secondary and community) in HDdUHB established (4-6 monthly). • Development and implementation of a diabetes induction programme for new staff and TREND-UK diabetes competency package for diabetes nurses	• Encourage diabetes nurses to undertake MSc Diabetes Nursing and undertake Non-Medical Prescribing qualification • Achieve the minimum recommendation for administrative support to teams, (15hrs per team) so they can focus on clinical specialist work • Continue to encourage and offer personal and professional staff development and opportunities • Maintain compliance with performance metrics and develop patient-reported outcome measures (PROMS) and PREMs with Value Based Healthcare (VBHC) Team • Support and encourage developments and investment in IT and Technology Enabled Care • Maintain consistency and standardisation of management and address all Quality and Assurance issues across the three Counties diabetes Nursing Services. • Work with finance and county directors to move from short term funding initiatives to more sustainable and long-term funding for recruitment and development of new initiatives and opportunities • Establish consistent approaches to data collection and service metrics across all CDSN services to enable benchmarking and support service development and investment. • Introduce communications contact centre for all community diabetes services hub for referral and assessment • Review medication /prescription process for district nurses and insulin • Develop HDdUHB pathways, guidelines and diabetes community care policy • Increase self-management education programmes ie introduce ‘Xpert Insulin Programme’ • Review of service to look at different ways of working i.e. HCSW and administrators to enable clinicians to focus on more complex patients

Specialist Palliative Care Update

The Palliative Care Clinical Nurse Specialists work as part of the wider multi-disciplinary Specialist Palliative Care Team (SPCT) across both acute and community. In Carmarthenshire, there is also a seven bed specialist inpatient palliative care unit which accepts referrals from across the three Counties.

Each county operates Palliative and End of Life (EOL) Care services configured to their individual geography, population need and assets however recently a regional approach, through the West Wales Care Partnership (WWCP) outlining standards and principles has been agreed which seek to align all three Counties to meet outcomes equitably. Taking this work forward, Hywel Dda University Health Board (HDdUHB) Palliative & End of Life Care (EoLC) Strategy development programme commissioned Attain, an independent health advisory service, to develop a formal Health Board Palliative Care Strategy. There was good engagement from all three counties and work has progressed well on finalising the strategy.

Key recommendations from the review include:

- Development of a Triumvirate Team consisting of a Clinical Lead, Service Delivery Manager and Lead Nurse to provide the operational, managerial and strategic direction for delivering the Palliative and End of Life Care Strategy.
- Development of a three county Service Specification
- Development of standardised criteria for Specialist Palliative Care Input and referral criteria
- Standardisation of referral processes

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Highlights from Ceredigion Specialist Palliative Care Team

Activity

- 434 new referrals
- 78 patients active on caseload
- 571 face to face contacts Bronglais Hospital
- 752 face-to-face contacts in patients own home
- 14 face to face contacts in Care Homes
- 19 face to face contacts in Tregaron Community Hospital
- 14,933 phone calls made
- 20 GP Palliative Care Register meetings attended
- 68% of patients known to SPCT died in the community
- 51% new referrals from Bronglais Hospital
- 52 Multi-disciplinary Team Meetings

Service Highlights

- Virtual Reality in End-of-Life care – a 2-year Macmillan funded project
- Appointment of Speciality Doctor in Palliative Medicine
- Appointment of Improvement Specialist Nurse
- Supportive Care UK – Consultant cover
- Appointment of Occupational Therapist
- Appointment of Bank Art Psychotherapist
- 3 Paramedic Students on placement
- EOL Companion Volunteer project story featured in Helpforce report
- A Christmas Wedding – CNS marrying Paramedic. Featured on S4C's Priodas Pum Mul

Feedback

Team Learning / Development

- Attended St Christopher's Hospice Webinar regarding the Lantern Model of Nursing dedicated to palliative and end of life care.
- Attended online CPD for Palliative Care Professionals: Ethical issues around nutrition in advanced disease.
- Online CPD for Palliative Cre Professionals 'End of life and bereavement experiences during COVID19, national survey of bereaved people' - Dr Emily Harrop
- Attended online All Wales Care Decisions Guidance for Last Days of Life update and workshop
- Contributed to the development of an All Wales competency framework for nurses completing DNACPR (section 5)
- Arranged and contributed to Advance Future Care Planning - Hywel Dda UHB Workshop with Channel 3 OBC Project for electronic solution All Wales.
- Pilot site for Care Decisions Guidance Partnership Leaflet.
- Attended Challenge Panel for Professionals on Macmillan's position and Unique Selling Point for palliative and end of life care
- Completed and evaluated the Companion Volunteer project (Marie Curie and Helpforce)

Community Hospitals

Hywel Dda UHB has four community hospitals across the three counties, two in Carmarthenshire, one in Ceredigion and two in Pembrokeshire.

Pembrokeshire Community Hospital includes Sunderland Ward based in South Pembrokeshire Hospital. This includes 35 inpatient Health beds and five inpatient Social Care beds. The Health Board also commission nine inpatient Health beds on Tenby Cottage ward in Park House Court in Tenby with potential to surge to 10 when required. The Ward provides inpatient beds for patients being transferred from both acute hospital sites and community-based settings. Patients may be referred for repatriation and ongoing rehabilitation and reablement, recovery following acute admission, complex discharge planning and end of life / palliative care.

Carmarthenshire Community Hospitals include Amman Valley Hospital which is a 28 bed unit, which serves the community of the Amman and Gwendraeth localities, and Llandovery Community Hospital which is a 15 bed unit which serves the surrounding areas of Llandovery. Both hospitals provide rehabilitation, step up and step-down beds as well as providing palliative care resources. Llandovery also has a minor injuries unit but this has remained closed during the period of COVID-19 due to Infection, Prevention and Control and Health and Safety advice.

Ceredigion Community Hospital is Tregaron Hospital, which is a 15 bed unit serving the population of Ceredigion. The beds in this Intermediate Care of the Elderly, Rehabilitation and Palliative Care Unit are intended for those patients who require comprehensive multi-disciplinary geriatric assessment, medical diagnosis/management, maintenance rehabilitation and organisation of discharge. Intense therapy provision is not available in Tregaron as there is not a seven day physiotherapy service available, however the beds are used flexibly in order to respond to needs, provided those needs can be safely and effectively met within the clinical and environmental resources available.

New Roles and Service Developments in community hospitals

Family Liaison Officers (FLO)

The FLO role was initially developed to enable patients and families to stay connected during times of lockdown and limited visiting through COVID-19. The roles have been very successful and positively received with all community hospitals keen to ensure that there is funding to support the substantive recruitment of these roles moving forward.

Welsh Nursing Care Record (WNCR)

In April 2021 Sunderland Ward (Pembrokeshire) was the first ward in Wales to implement the WNCR. The transition from paper inpatient assessments to digital records was a challenge for teams but one which, with the support of the Informatics team, was embraced. The WNCR has since been successfully rolled out across all community hospitals and is now being successfully utilised across the Health Board.

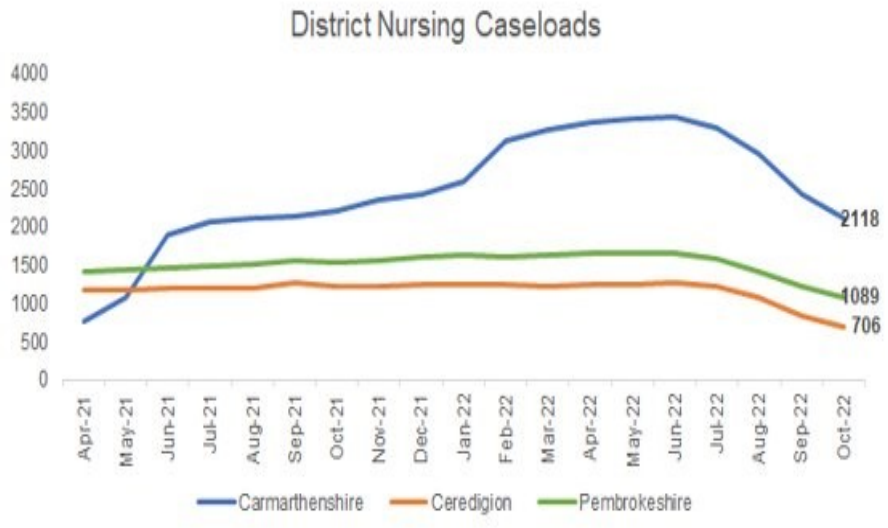
Service activity

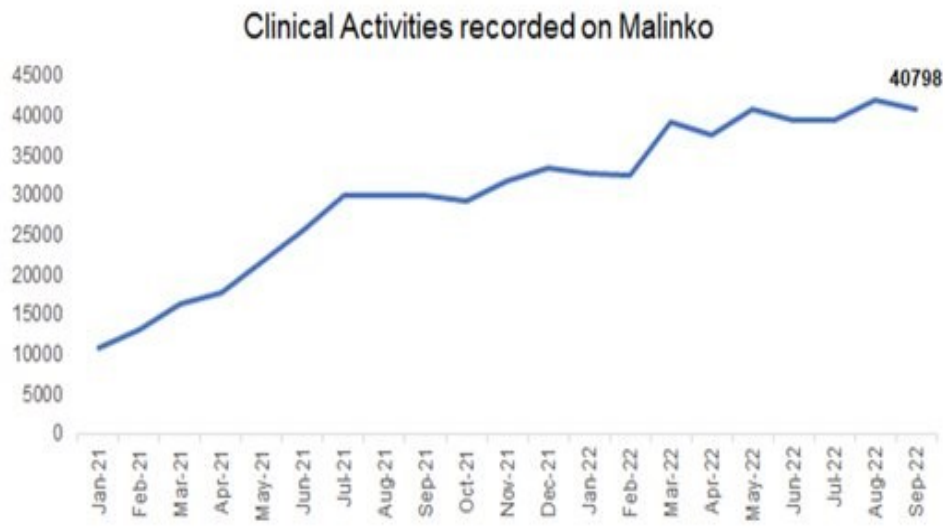
District Nursing

Over the last 12 months, district nursing services across the three counties have been working to roll out CIVICA scheduling, an e-scheduling system which enables real-time visibility of the available clinical workforce capacity and patient demand, reducing duplication and ensuring safer care in the community. A key challenge has been the ability to access data and develop dashboards demonstrating both clinical activity and patient demand.

Activity data for 2021-2022 have been collated from Malinko however it is important to note that services went 'live' at different stages over the 12 month period and that there have been significant challenges in accessing the data in a consistent and accurate format. However, on review, the data provided demonstrates trends in activity and demand which correlates with previous data collection.

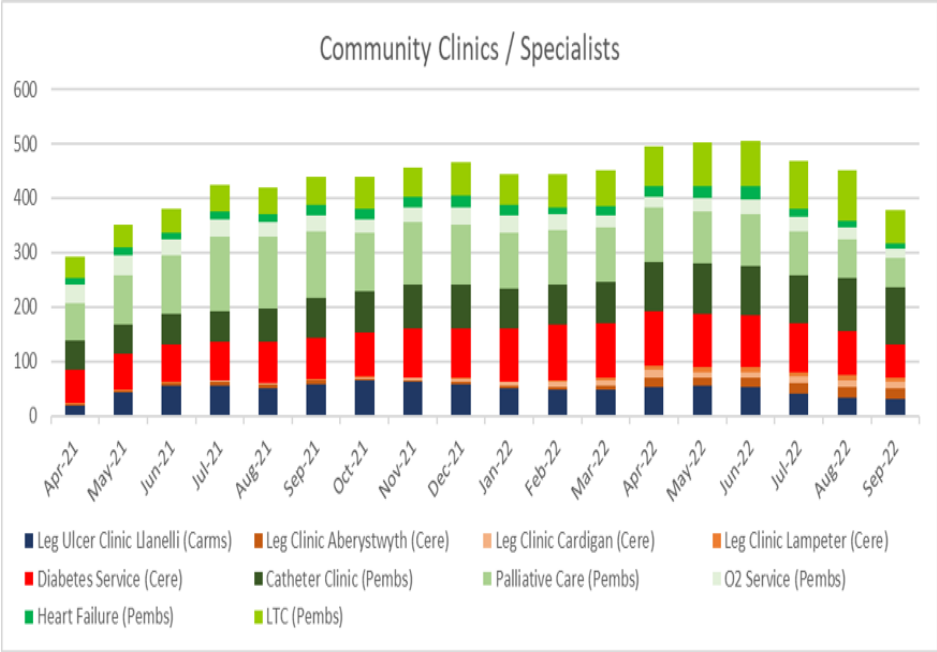
On average district nursing (DN) teams alone have a caseload of 4000 patients at any one time providing around 30,000 contacts per month. Clinical activities recorded per month for all community teams on Malinko, range on average from 30,000 to 40,000 however some patients will have multiple interventions recorded per visit. Teams included are DN teams, Acute Response Teams (ART) teams, Intermediate Care teams and specialist services.

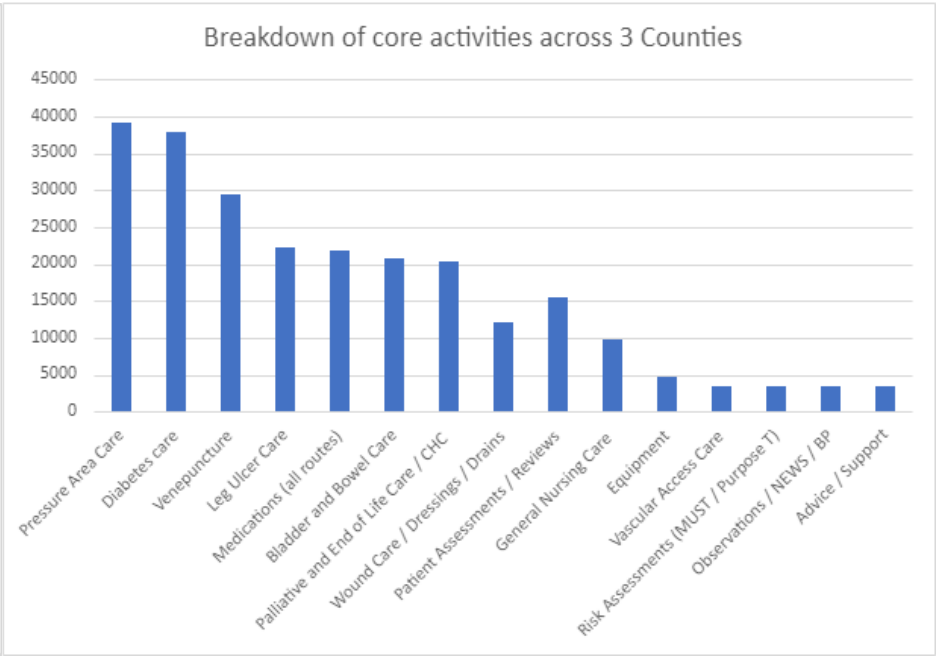




While each service captures activity and data, historically the lack of a standardised IT system has limited our ability to provide any comparisons or benchmarking across each county. With the planned introduction of e-scheduling across specialist services the ambition will be to provide detailed and consistent data from all Community CNS Services for 2022/2023.

However, while some data is available as shown below there is a lack of consistency across each county as not all Community Clinic and Community Specialist Information is captured in the same place or in a consistent way – further work is needed to align information from CIVICA scheduling and Welsh Patient Administrative System (WPAS). The data below is a snapshot of activity taken from CIVICA scheduling and indicates the caseload over time and not the activity.

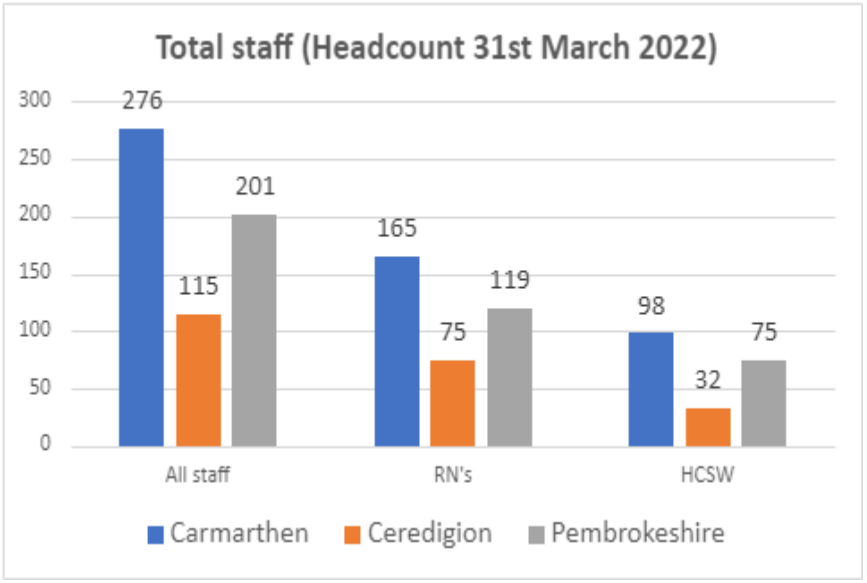


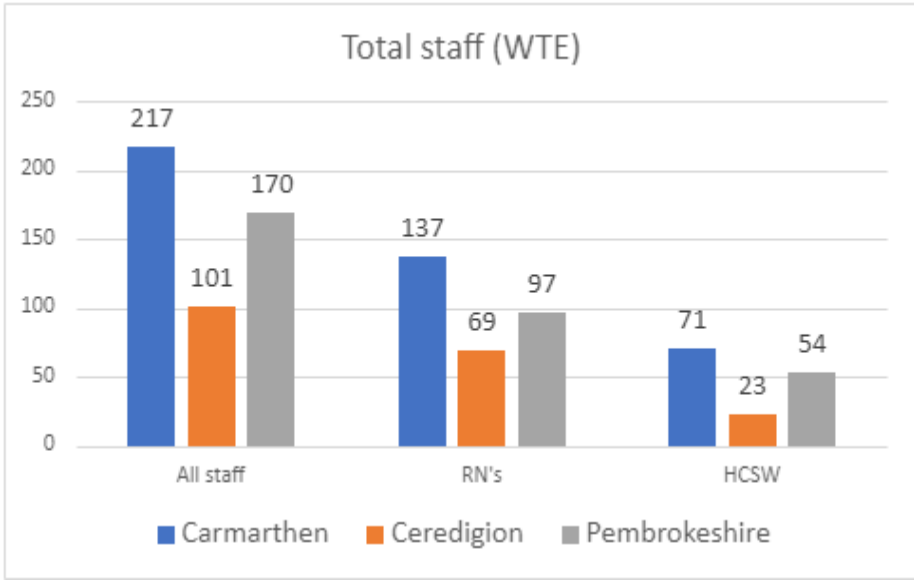


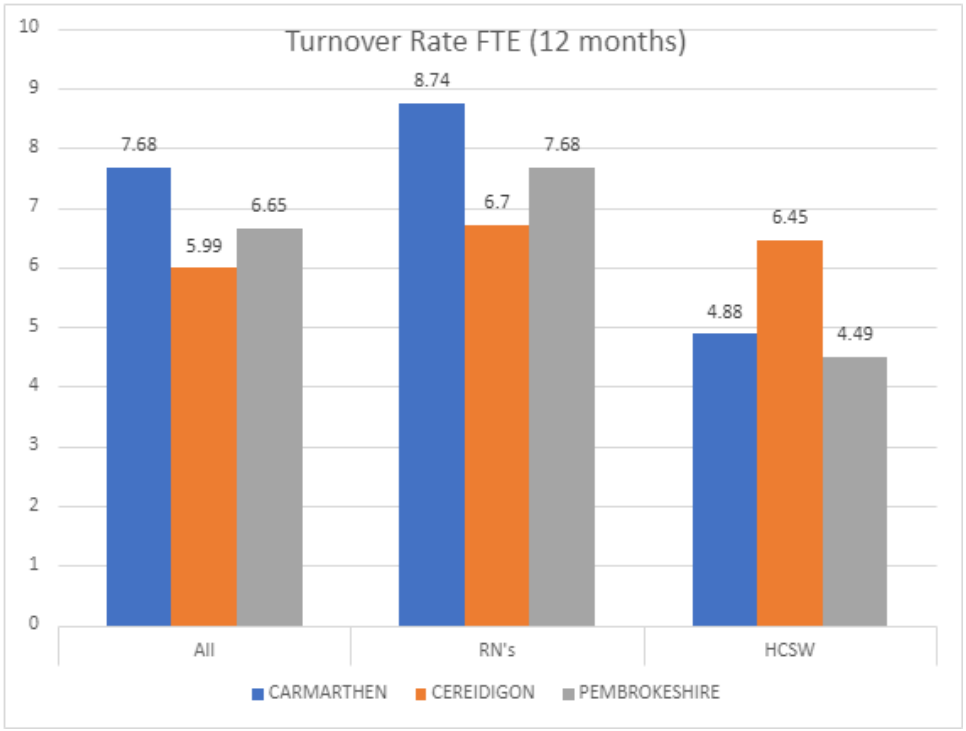
Workforce

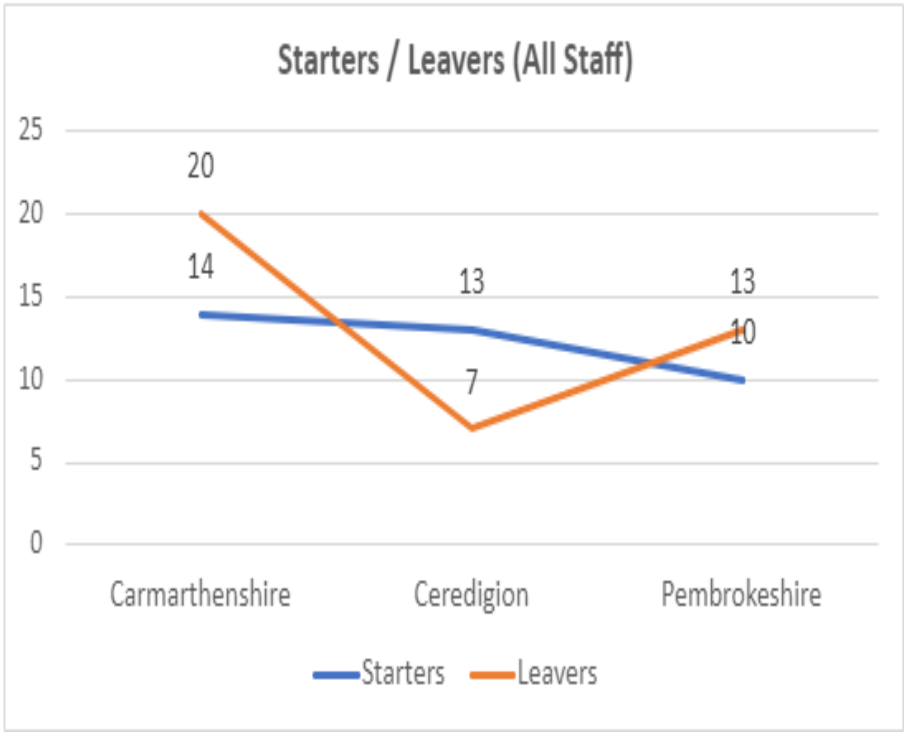
Staffing

There are over 590 community nursing staff employed across Carmarthenshire, Pembrokeshire and Ceredigion (as of March 2022) with 61% of staff registered nurses. The overall headcount for registered and unregistered staff is consistent across counties with an average annual turnover across the three counties of 6.77%. Historically vacancies were filled although there are increasing reports of some community vacancies now remaining unfilled despite recruitment campaigns to raise awareness of community working.

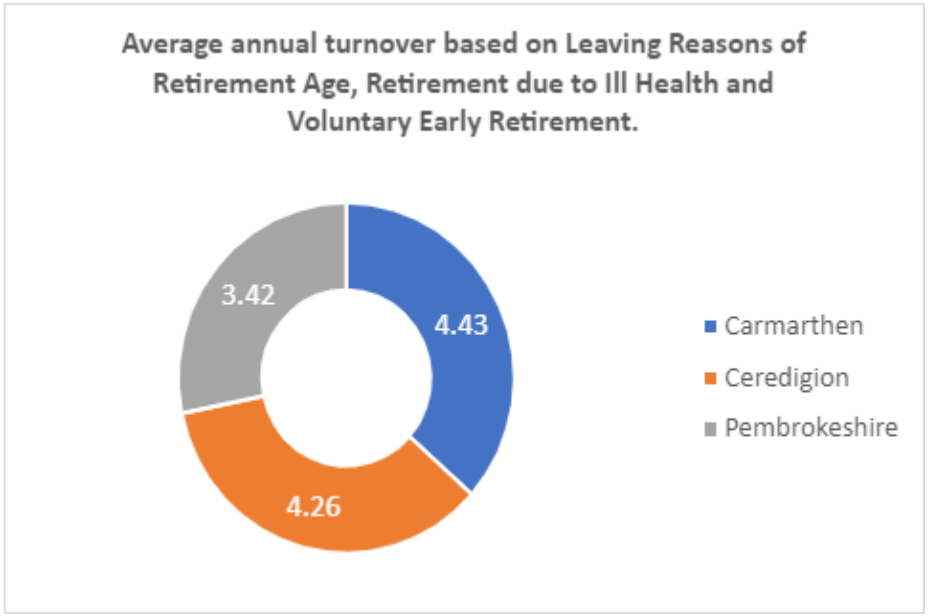

Total staff (Headcount 31st March 2022)
300
250
200
150
100
50
0
276
115
201
165
75
119
98
32
75
All staff
RN's
HCSW
Carmarthen
Ceredigion
Pembrokeshire

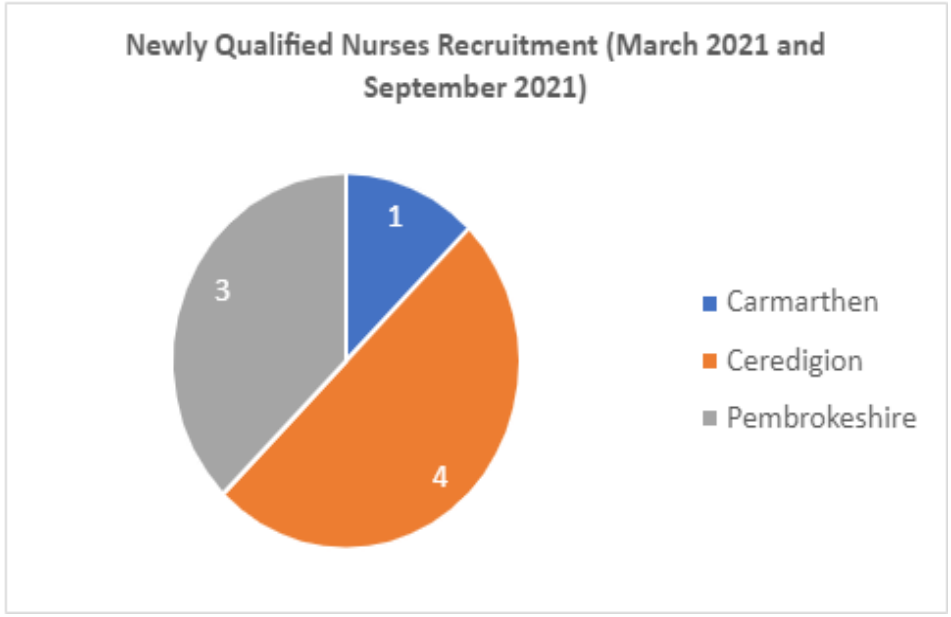

Total staff (WTE)
250
200
150
100
50
0
217
101
170
137
69
97
71
23
54
All staff
RN's
HCSW
Carmarthen
Ceredigion
Pembrokeshire



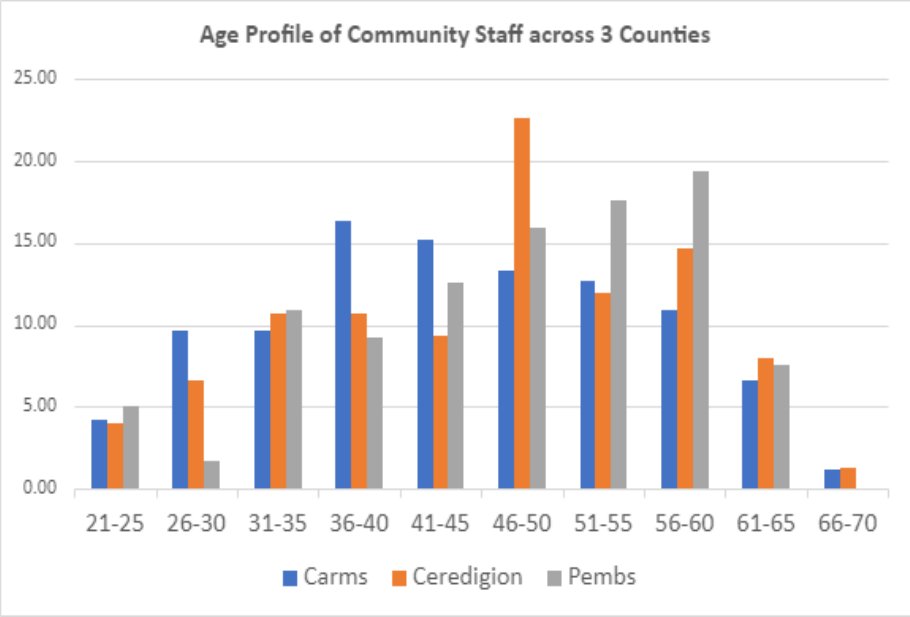


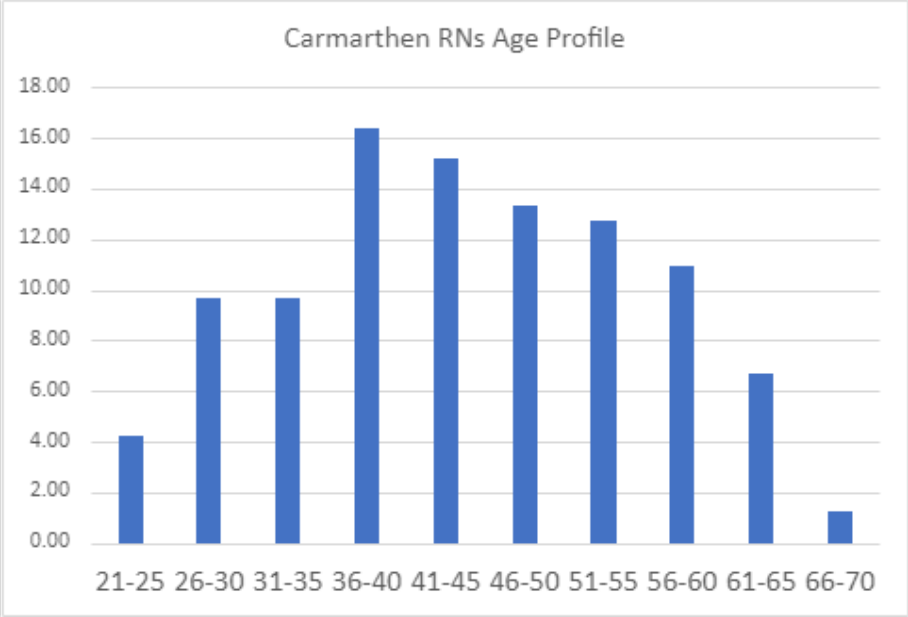
Annual turnover across the three counties for retirement reasons (including leaving reasons of retirement age, retirement due to ill health and voluntary early retirement) was 3.86%. Ongoing progress is being made in the recruitment of newly qualified nurses into community nursing teams.

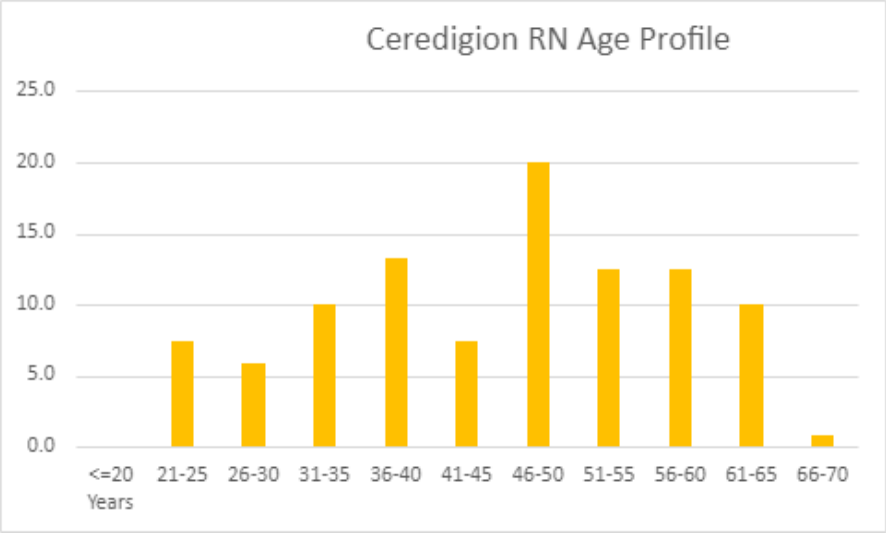


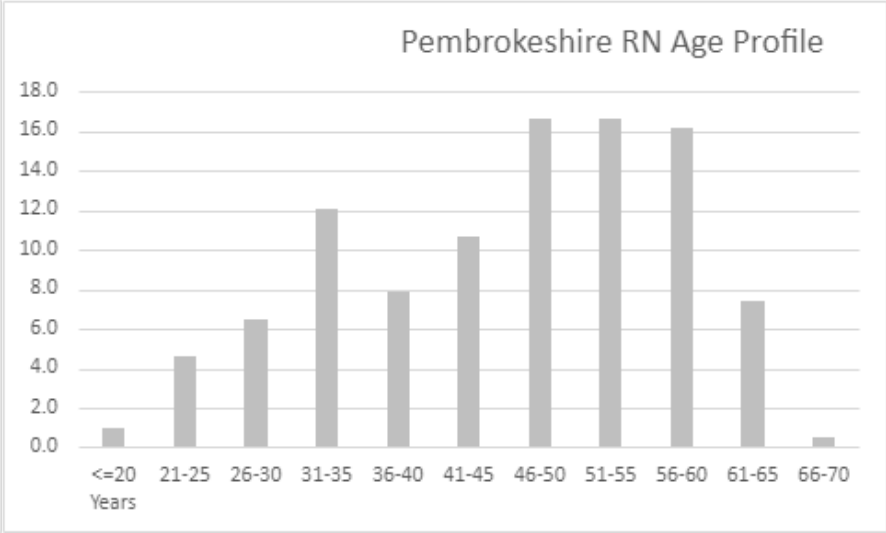


The age profile of all community nursing staff shows a high proportion of the workforce is aged 46 and over, particularly in Ceredigion and Pembrokeshire.


Age Profile of Community Staff across 3 Counties
25.00
20.00
15.00
10.00
5.00
0.00
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
Carms
Ceredigion
Pembs


Carmarthen RNs Age Profile
18.00
16.00
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70





Staff Professional and Practice Development

The Health Board now employs three Community Professional and Practice Development Nurses (PPDN's) to cover each county. Working closely as a team, the focus has been on standardising quality of care, education and development opportunities, and governance processes across the three counties, sharing and promoting best practice.

Some of the key areas of success in the last 12 months include:

- The PPDNs have supported education and training in numerous ways. They have contributed to an improvement in mandatory training compliance for staff across all community teams by delivering or cascading training including Basic Life Support, Intermediate Life Support and Moving and Handling training, ensuring care is safe and in accordance with policies and guidelines.
- They have supported practice development through implementation of a new pressure damage risk assessment tool, delivering training in pressure damage grading and reporting, and contributed to the development of, and promoted the use of a lymphoedema pathway to improve the quality of

care delivered. They have facilitated the professional development of District Nurses, supporting SPQ students as Practice Assessors, and providing clinical supervision and training for leaders to support the management of staff and caseloads.

- They have created and utilised a documentation audit, alongside delivering training and support, to demonstrate an improvement in record keeping.
- They have worked closely with workforce and development teams on the development of an All Wales Job Description, scope of practice and core competencies for the Assistant Practitioner in Community, providing recruitment and development support to teams and individual staff members.
- They have provided clinical supervision to staff across the community, including newly registered nurses, as part of the Health Board's preceptorship programme, and also offer development discussions, identifying and signposting to training and education opportunities. All PPDNs have recently undertaken the Professional Nurse Advocate qualification, enabling them to support the professional, educational and emotional development of staff through the provision of restorative clinical supervision.
- They have delivered a large programme of training to prepare staff for the implementation of Welsh Levels of Care, with 217 staff across the three counties receiving training.
- Currently they are working with primary care colleagues on the piloting and evaluation of a community news tool and escalation algorithm.
- The team has developed a three county Community SharePoint Site which will provide information and details of how to access community services as well as advice and training resources for staff.

Neighbourhood District Nursing Project

District Nursing Services across Hywel Dda UHB have received funding from Welsh Government (WG) to build on recommendations which arose from the Neighbourhood District Nursing Pilots in Wales, specifically, the need for health boards to develop a Neighbourhood District Nursing workforce with the range of skills and opportunities for career progression required to meet the needs of the local population.

The funding will be used to support the development and implementation of two key roles across HDdUHB and support with ongoing expansion of the community Health Care Support Worker roles across all bandings. These roles are highlighted below and will be rolled out over 2022/2023.

- A Community Senior Peer Nurse Advocate Role (one whole time equivalent (wte) B8a for 12 months)
- A Community Practice and Professional Development Nurse (one wte B6 for 12 months)
- Community Health Care Support Workers and Assistant Practitioners (funding for five years)

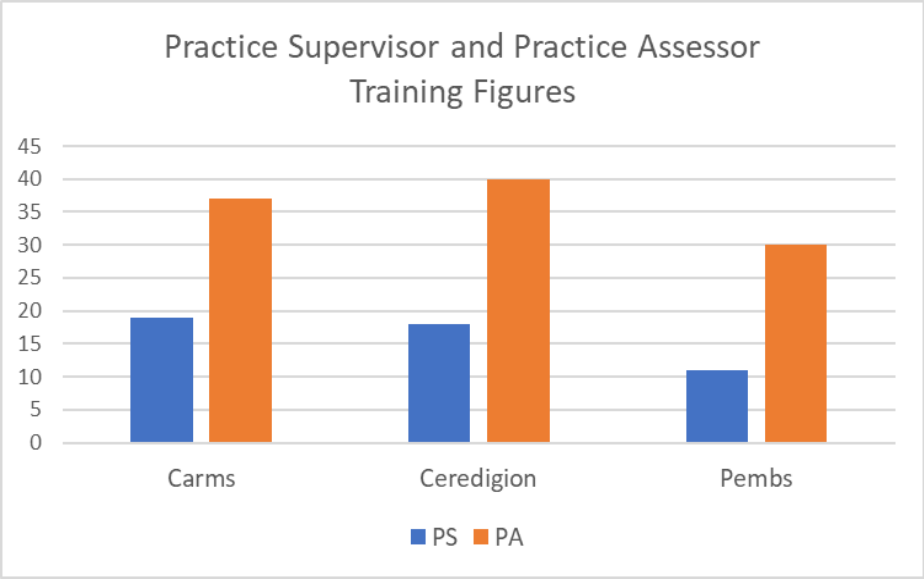
Peer Nurse Advocate Training

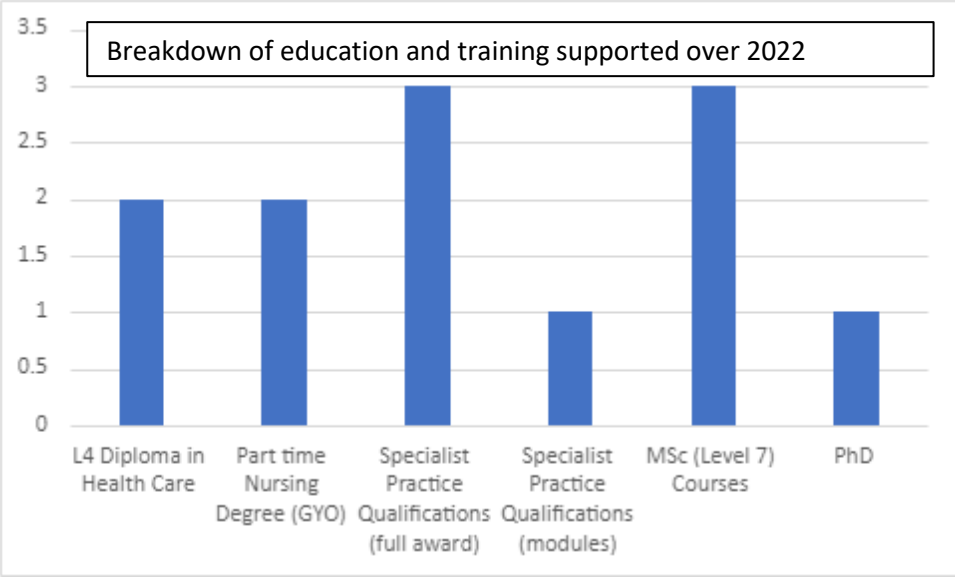
Peer Nurse Advocate training courses are being provided remotely by Canterbury Christ Church University and funding from WG was utilised for 18 training places with 10 staff committed to undertaking the training in April and May 2022. Full details of this pilot will be provided in a formal evaluation in 2023 but feedback to date from nurses who have undertaken the training has been very positive.

Higher Education Awards and Modules

All community staff across the three counties continue to be supported and encouraged to undertake personal and professional development opportunities.

The table below shows the numbers of staff who have successfully applied and commenced training in 2021-2022 alongside compliance with practice supervisor and practice assessor training is also monitored on a monthly basis and current training figures are shown below.



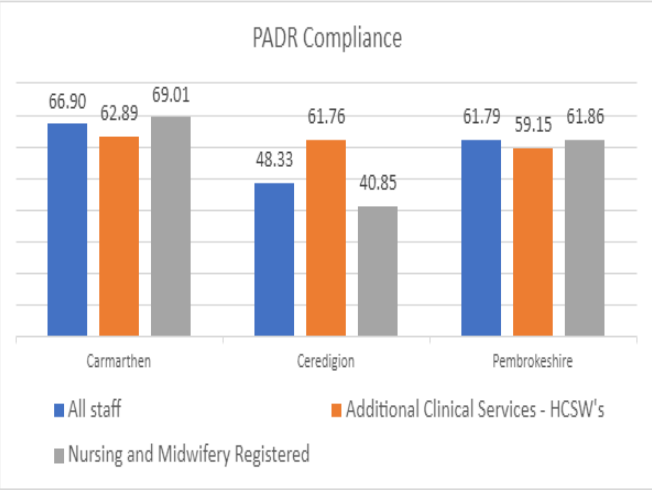


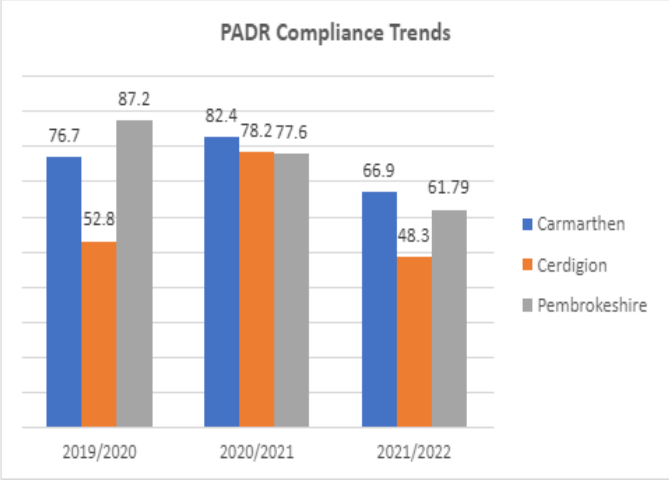
Performance

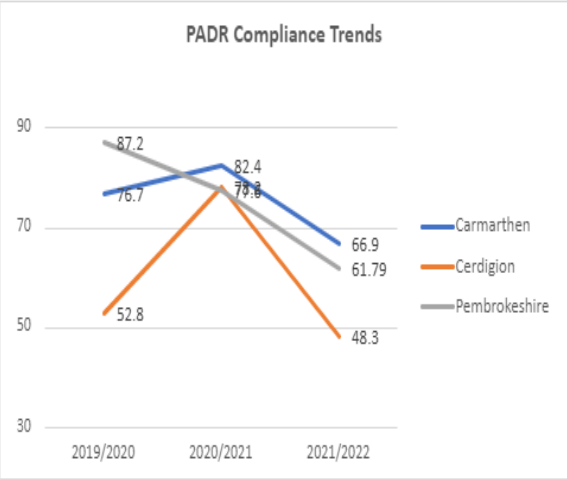
Community nursing services across the three counties have developed informatics dashboards to monitor performance, impact on population health and to ensure national and local targets are achieved in order to inform future service improvements. Patient experience and satisfaction is also a valuable outcome measure to be included in performance monitoring along with national Electronic Staff Record (ESR) systems.

Performance Appraisal and Development Review (PADR)

The PADR compliance for the three Counties in 2021/2022 is shown across all staff groups. Trend analysis highlights the decrease noted across the three counties in 2021/2022.

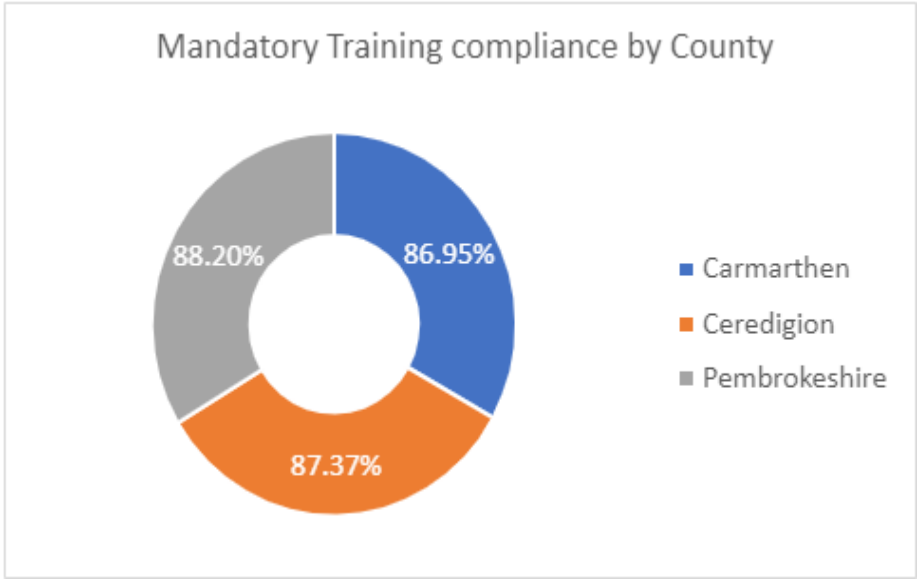


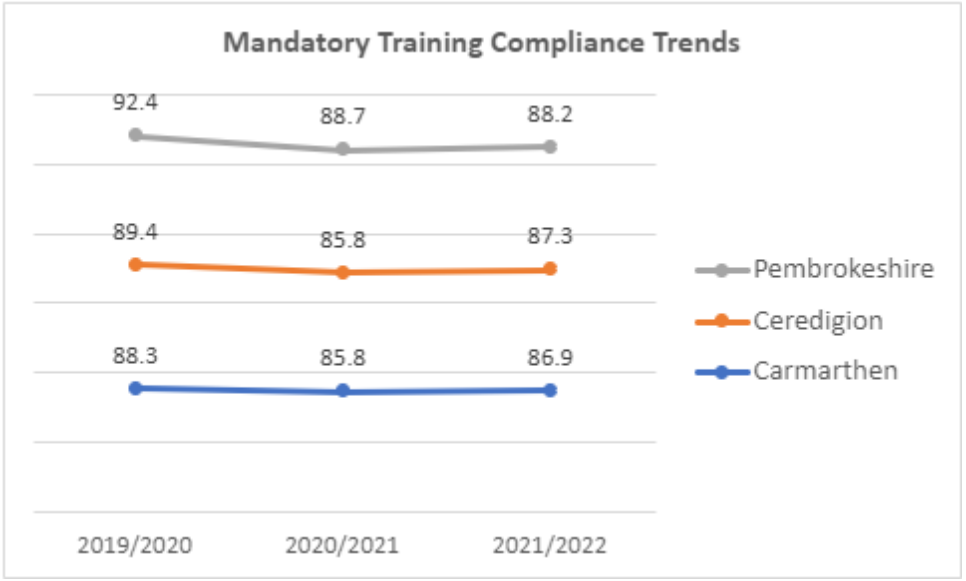




Mandatory Training

The figures below are based on the 12 Core Skills Training Framework (CSTF) Mandatory Training areas including: Equality, Diversity & Human Resources (HR); Fire Safety; Health, Safety & Welfare; Infection Prevention & Control, Information Governance; Moving & Handling; Resuscitation; Safeguarding Adults and Children; Violence & Aggression; Dementia Awareness and Violence against Women, domestic abuse and sexual violence (VAWDASV).





Overall, despite the significant challenges faced by teams, community nursing services worked hard to maintain good levels of compliance with mandatory training. Slight decreases are noted in Ceredigion and Pembrokeshire with a slight improvement noted in Carmarthen when compared to 2020/2021, however overall compliance remains above 85%.

Sickness

Across all the counties, anxiety, stress and depression was by far the most common reason for absence, accounting for on average 28% of all sickness with over 3665 days lost, however, this is an improvement on 2020/2021 when anxiety and stress accounted for almost 40% of all sickness with 4330 days lost.

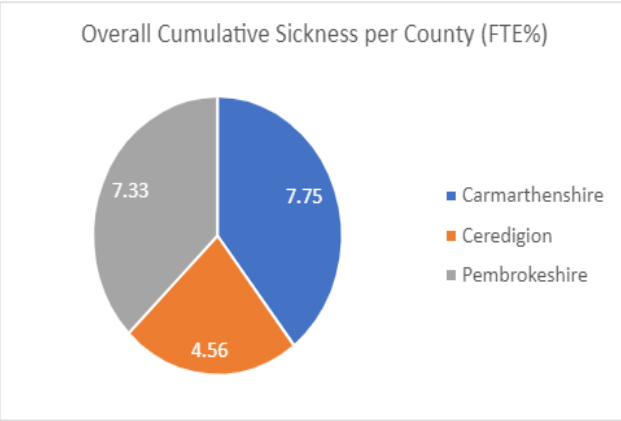
Carmarthen (all staff)	FTE Days Lost	%	Ceredigion (all staff)	FTE Days Lost	%	Pembrokeshire (all staff)	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	1,806.52	29.5	S10 Anxiety/stress/depression/other psychiatric illnesses	375.60	22.4	S10 Anxiety/stress/depression/other psychiatric illnesses	1,484.35	32.6
S12 Other musculoskeletal problems	921.63	15.1	S28 Injury, fracture	325.00	19.4	S27 Infectious diseases	740.37	16.3
S27 Infectious diseases	709.30	11.6	S16 Headache / migraine	276.55	16.5	S11 Back Problems	460.48	10.1

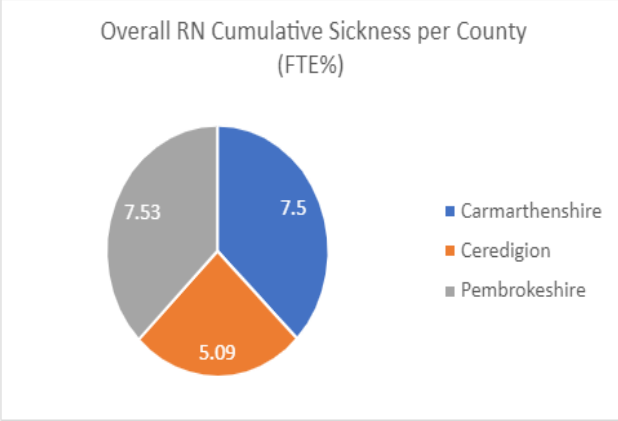
When overall sickness is compared by staff groups, there is no difference in the main reason for sickness which remains Anxiety/Stress. In HCSWs the second most common reason for absence is seen as musculoskeletal/Injury/back problems whilst for registered nurses it was infectious diseases which can be explained by the ongoing COVID-19 challenges faced.

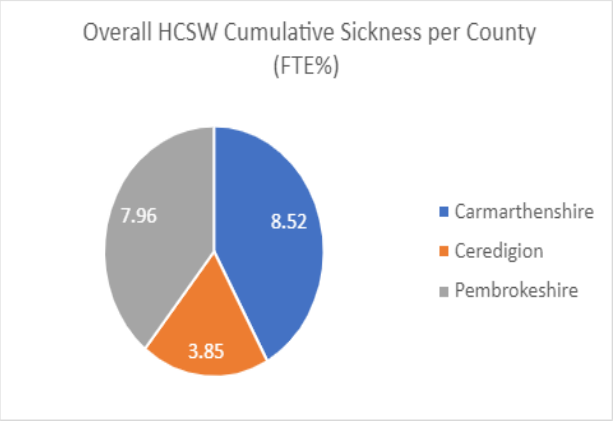
RNs	FTE Days Lost	%	RNs	FTE Days Lost	%	RNs	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	1,241.75	33.2	S10 Anxiety/stress/depression/other psychiatric illnesses	286.60	22.4	S10 Anxiety/stress/depression/other psychiatric illnesses	940.55	35.2
S27 Infectious diseases	478.35	12.8	S16 Headache / migraine	275.88	21.6	S27 Infectious diseases	614.44	23.0
S12 Other musculoskeletal problems	449.68	12.0	S28 Injury, fracture	232.00	18.2	S12 Other musculoskeletal problems	235.60	8.8

HCSW	FTE Days Lost	%	HCSW	FTE Days Lost	%	HCSW	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	564.77	25.9	S10 Anxiety/stress/depression/other psychiatric illnesses	89.00	28.2	S10 Anxiety/stress/depression/other psychiatric illnesses	423.12	27.1
S12 Other musculoskeletal problems	377.55	17.3	S28 Injury, fracture	53.00	16.8	S11 Back Problems	224.04	14.4
S15 Chest & respiratory problems	235.97	10.8	S27 Infectious diseases	52.00	16.5	S16 Headache / migraine	212.13	13.6

The breakdown of sickness/absence per county and staff groups is shown below. Overall, sickness appears consistently lower in Ceredigion across both registered nurses (RNs) and HCSW's and a review of possible reasons or lessons to be shared will be considered.



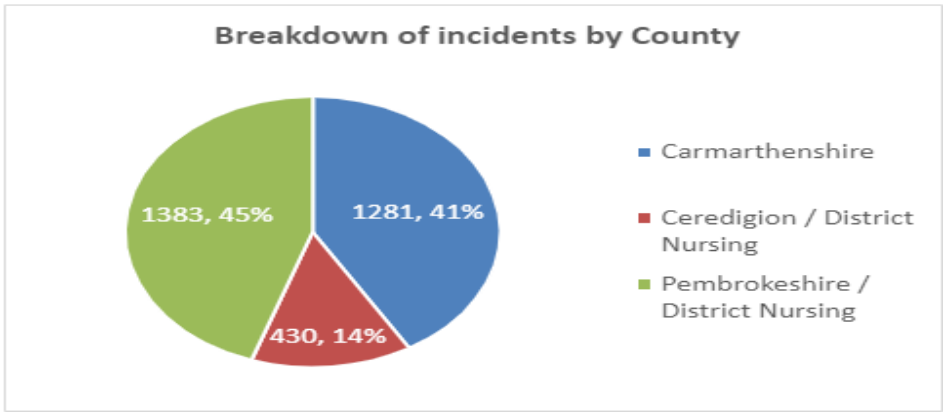


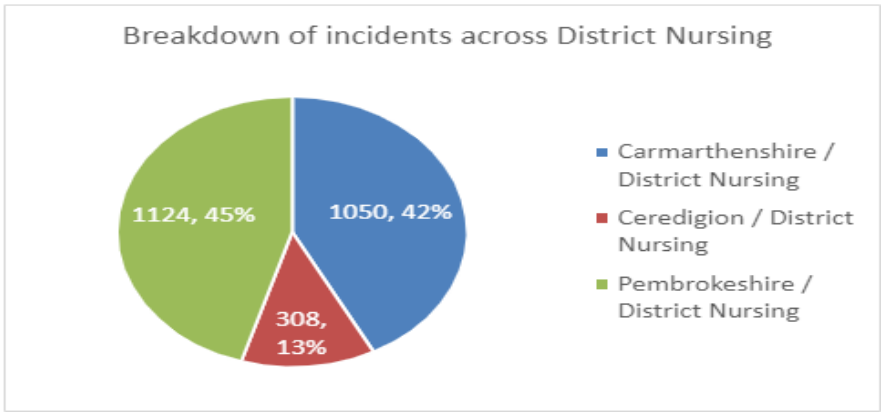


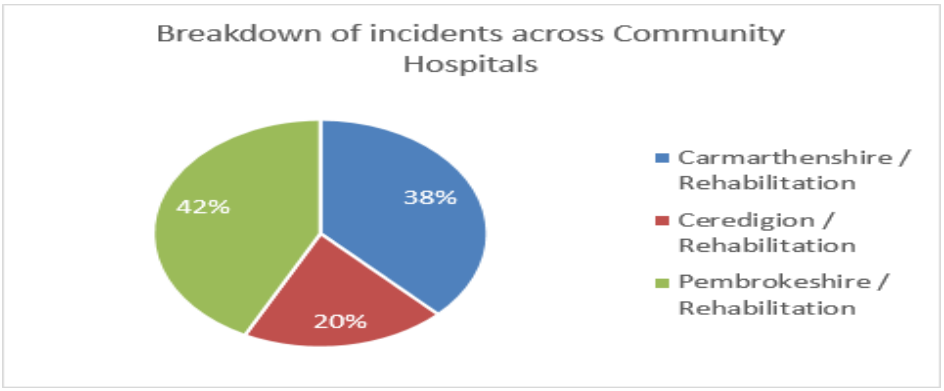
Quality, Safety and Patient Experience

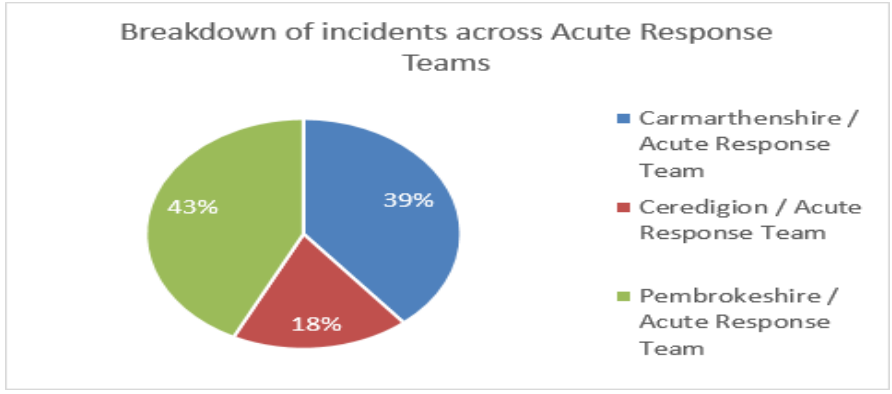
Patient Safety Incidents

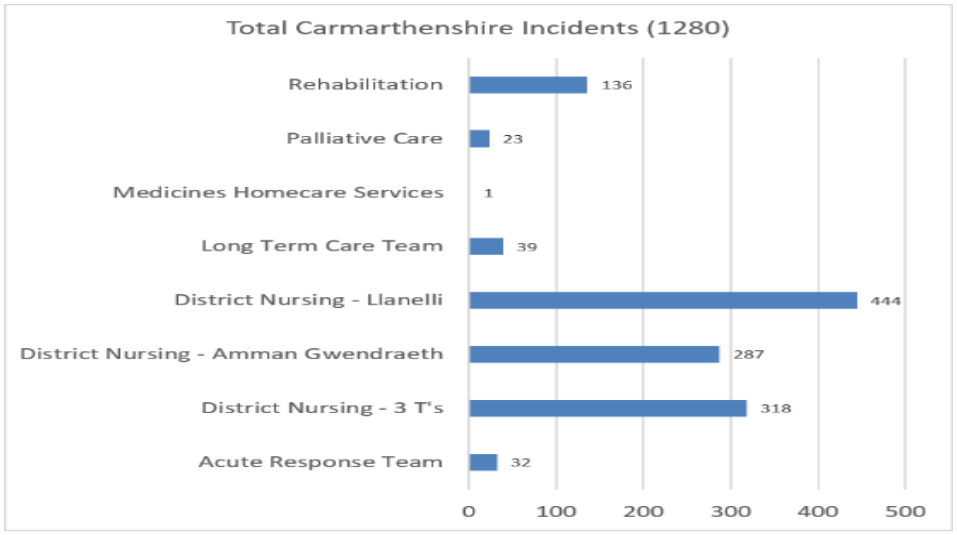
A total of 3094 incidents were reported across the three counties community nursing teams and community hospitals between April 2021 and March 2023. Pembrokeshire had the highest number of reported incidents, accounting for 45% of all incidents across the three counties, Carmarthen having 41%. Ceredigion had the lowest number of incidents with 14% of the overall total. District nursing teams accounted for the majority of all reported incidents, (n=2484, 80%), while 362 incidents (12%) were reported by community hospitals. The remaining incidents were across Acute Response Teams, Palliative Care, Bladder and Bowel, Minor Injury Units. Of the total incidents 106 were reported for the Long Term Care Team which are not investigated by County Teams.

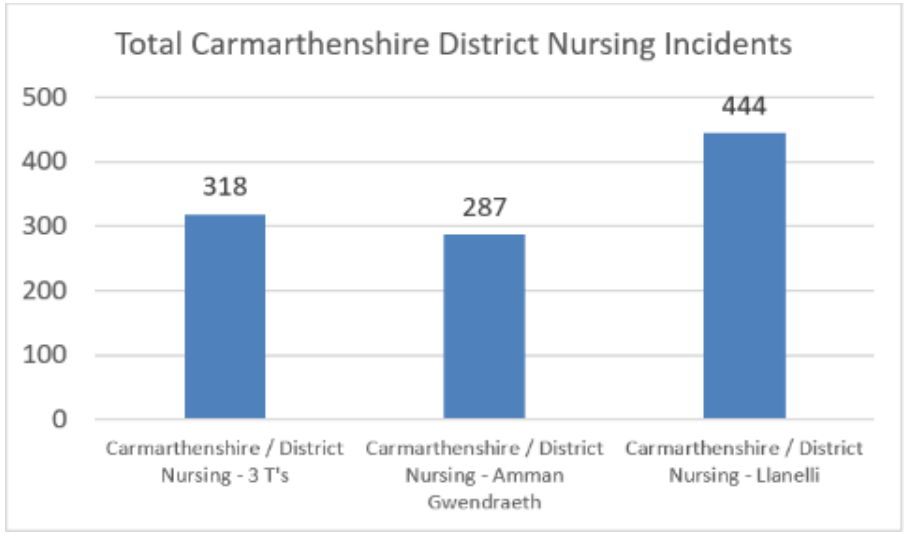

Breakdown of incidents by County
1281, 41%
430, 14%
1383, 45%
Carmarthenshire
Ceredigion / District Nursing
Pembrokeshire / District Nursing

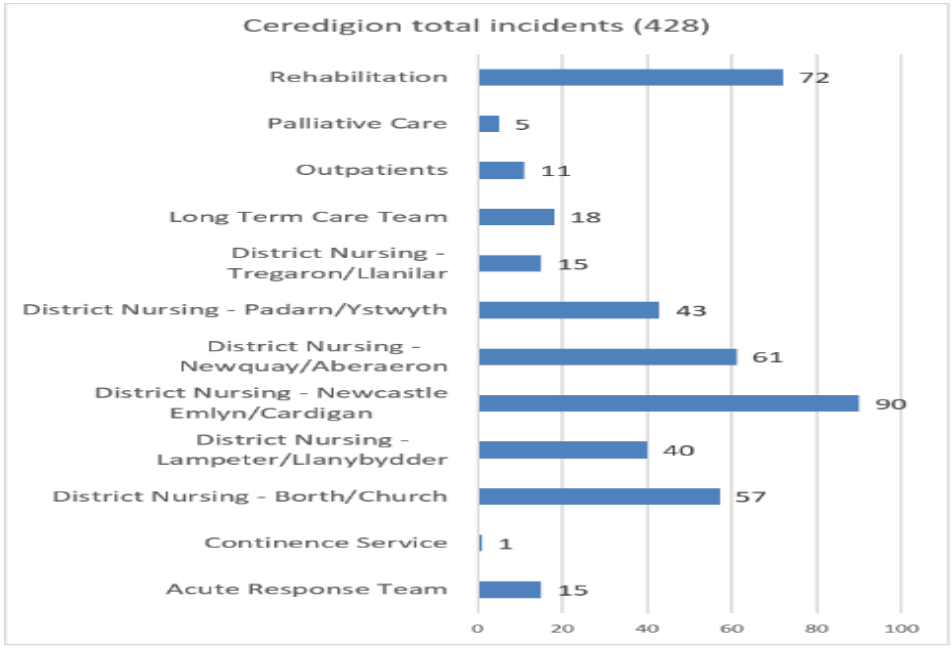

Breakdown of incidents across District Nursing
1050, 42%
308, 13%
1124, 45%
Carmarthenshire / District Nursing
Ceredigion / District Nursing
Pembrokeshire / District Nursing

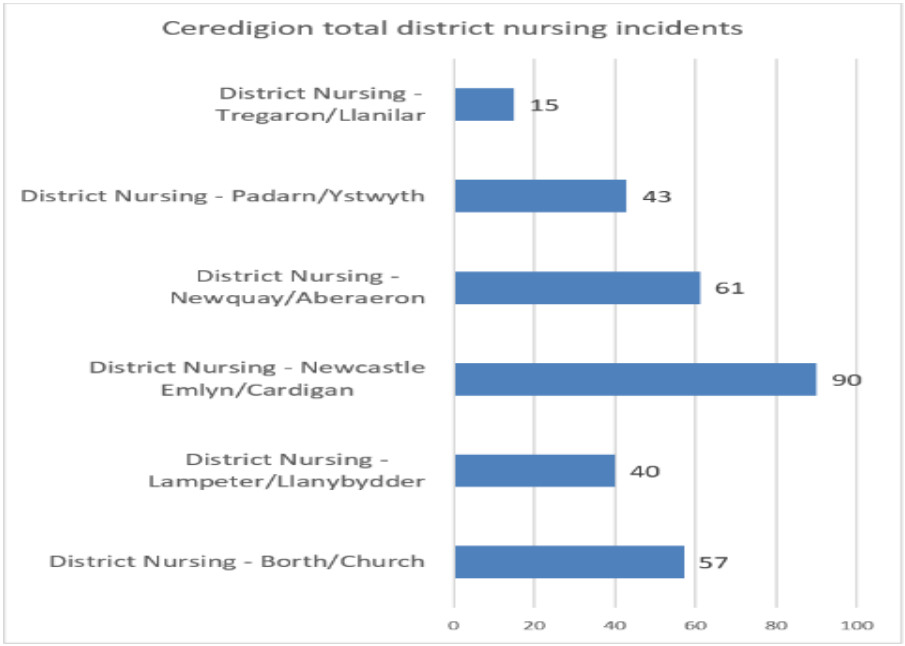

Breakdown of incidents across Community Hospitals
38%
20%
42%
Carmarthenshire / Rehabilitation
Ceredigion / Rehabilitation
Pembrokeshire / Rehabilitation


Breakdown of incidents across Acute Response Teams
39%
18%
43%
Carmarthenshire / Acute Response Team
Ceredigion / Acute Response Team
Pembrokeshire / Acute Response Team

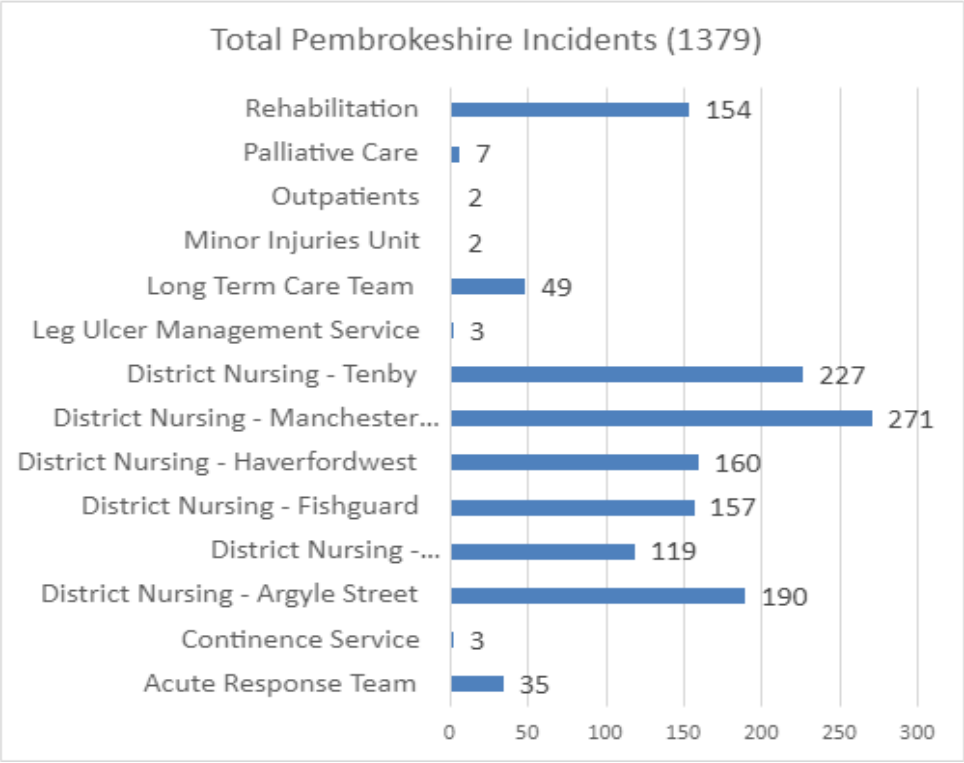

Total Carmarthenshire Incidents (1280)
Rehabilitation
136
Palliative Care
23
Medicines Homecare Services
1
Long Term Care Team
39
District Nursing - Llanelli
444
District Nursing - Amman Gwendraeth
287
District Nursing - 3 T's
318
Acute Response Team
32
0
100
200
300
400
500

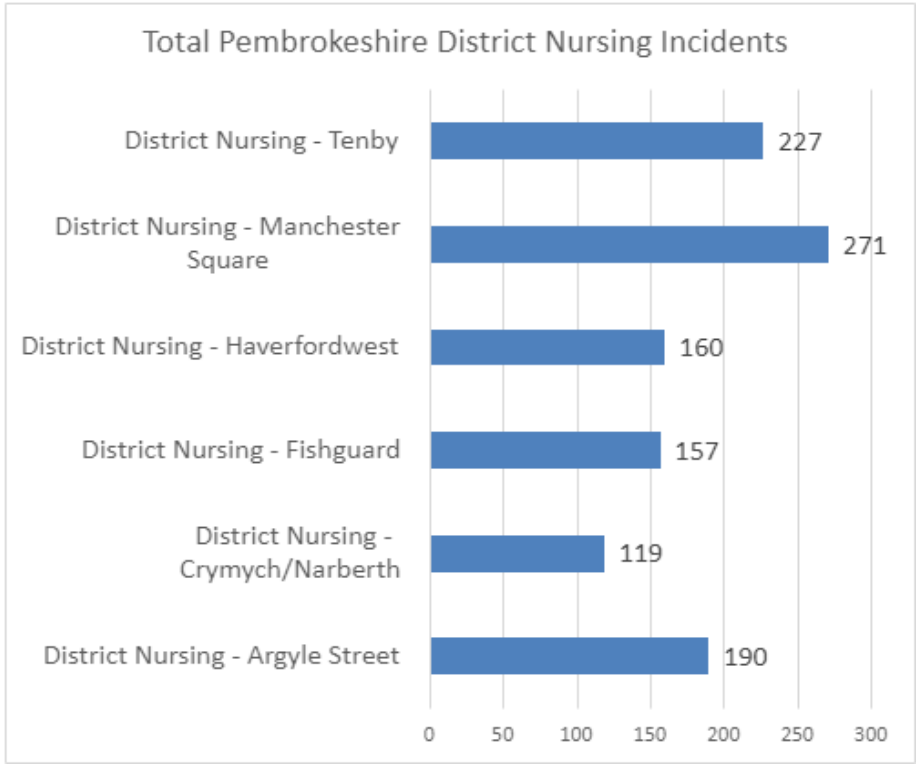

Total Carmarthenshire District Nursing Incidents
500
400
300
200
100
0
318
287
444
Carmarthenshire / District Nursing - 3 T's
Carmarthenshire / District Nursing - Amman Gwendraeth
Carmarthenshire / District Nursing - Llanelli


Ceredigion total incidents (428)
Rehabilitation
72
Palliative Care
5
Outpatients
11
Long Term Care Team
18
District Nursing - Tregaron/Llanilar
15
District Nursing - Padarn/Ystwyth
43
District Nursing - Newquay/Aberaeron
61
District Nursing - Newcastle Emlyn/Cardigan
90
District Nursing - Lampeter/Llanybydder
40
District Nursing - Borth/Church
57
Continence Service
1
Acute Response Team
15
0
20
40
60
80
100


Ceredigion total district nursing incidents
District Nursing - Tregaron/Llanilar
15
District Nursing - Padarn/Ystwyth
43
District Nursing - Newquay/Aberaeron
61
District Nursing - Newcastle Emlyn/Cardigan
90
District Nursing - Lampeter/Llanybydder
40
District Nursing - Borth/Church
57
0
20
40
60
80
100

Pembrokeshire Incidents



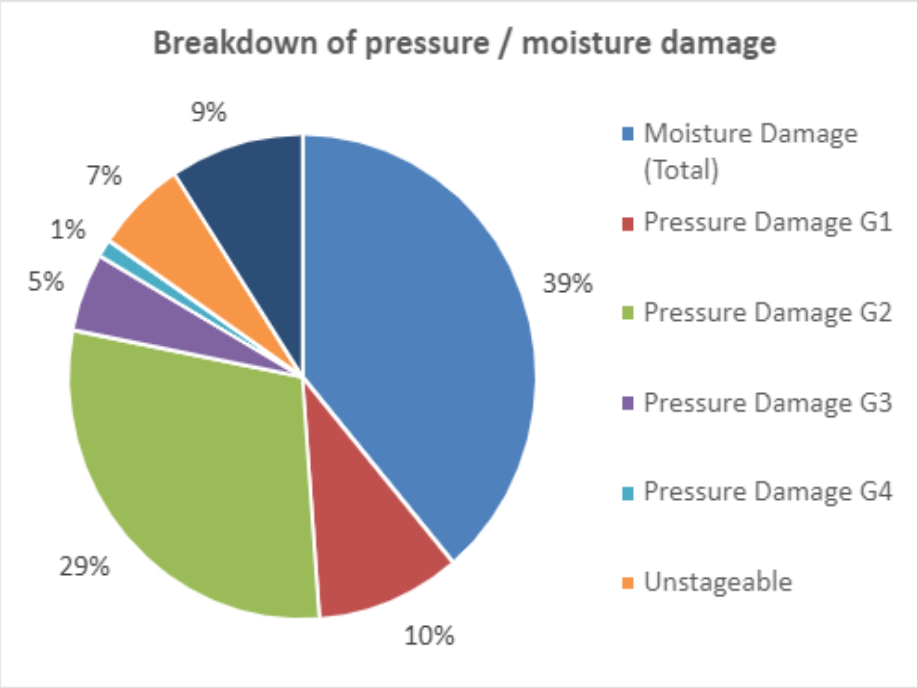


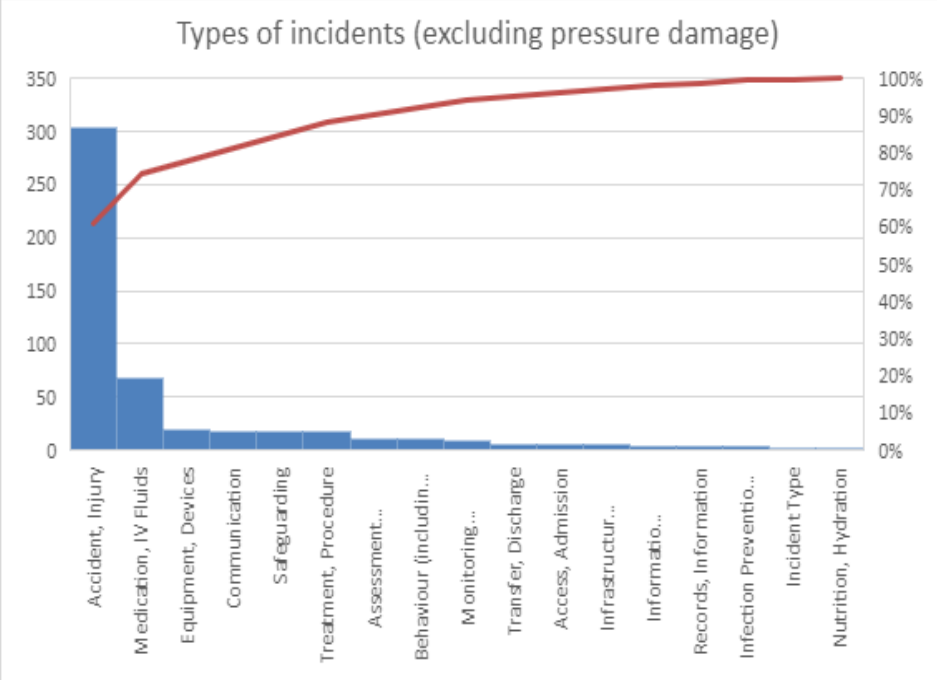
Types of incidents

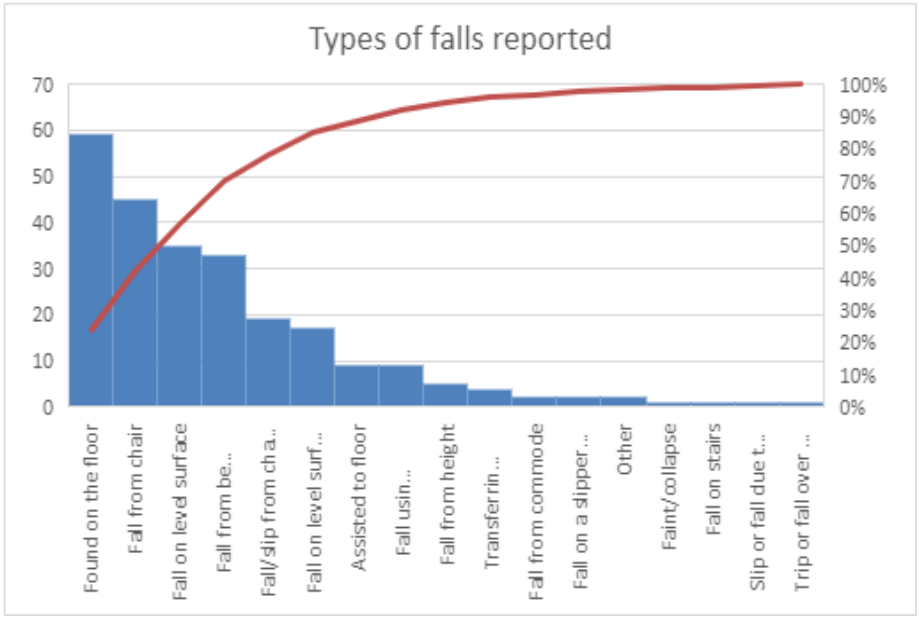
Of all incidents, 2594 (84% of incidents were related to moisture and pressure damage with the breakdown of categories shown below.

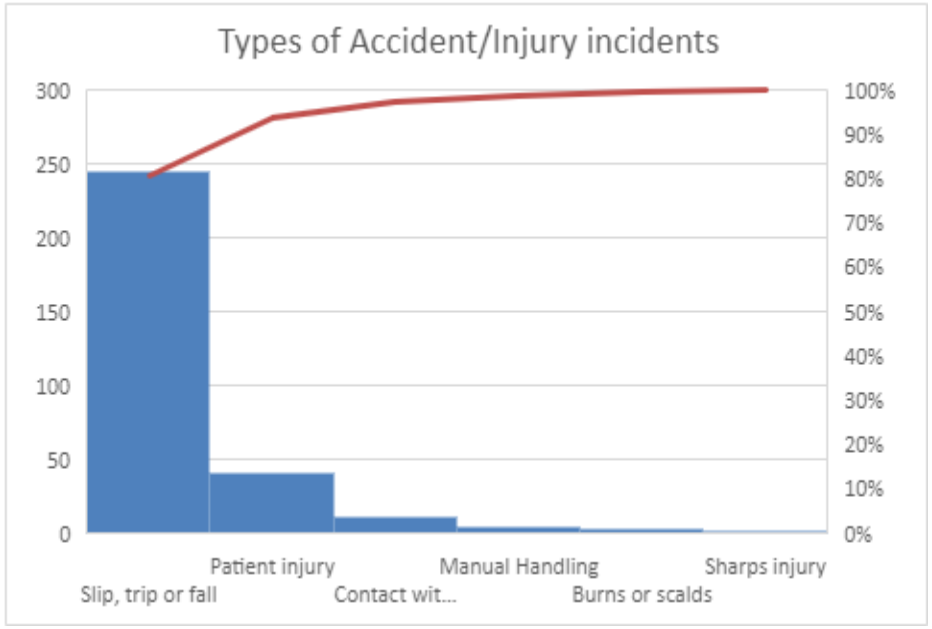
There were 568 incidents related to G3 and above pressure damage (including suspected deep tissue injury incidents) equating to 22% of all pressure and moisture damage incidents reported. Moisture damage and G1 reported incidents account for 49% of incidents and G2 reported pressure damage for 29% of incidents. Of these, 372 incidents are closed and 196 incidents (35%) remain under investigation or awaiting scrutiny and closure.

In terms of those closed, 82% state that following investigation the pressure damage was deemed unavoidable. It is not possible to determine the overall number which was unavoidable as 196 incidents remain under investigation or awaiting scrutiny and closure. A breakdown of other types of incidents is shown below. Of the remaining 500 incidents, 304 were classified as accident or injury and of these 245 incidents related to slips, trips and falls with the remaining incident categories.

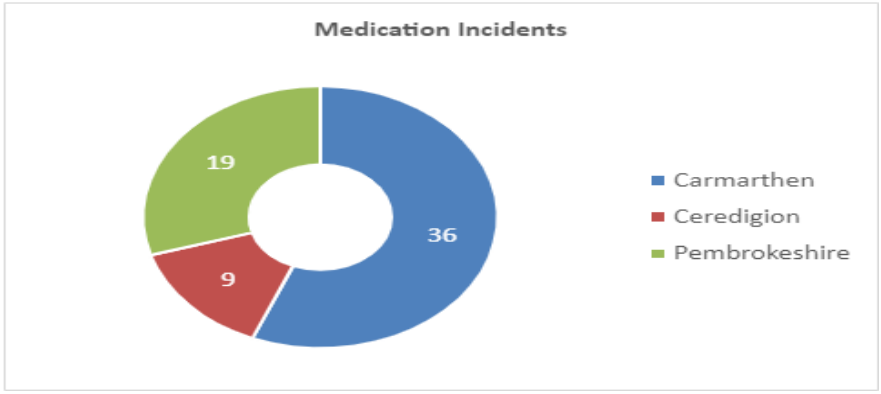


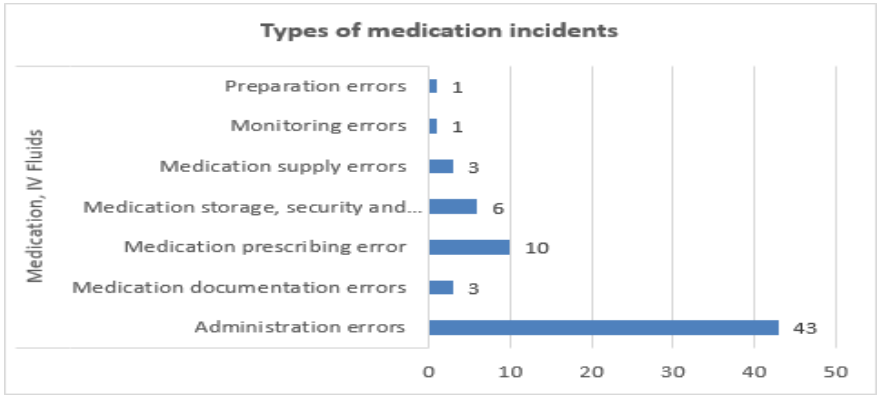


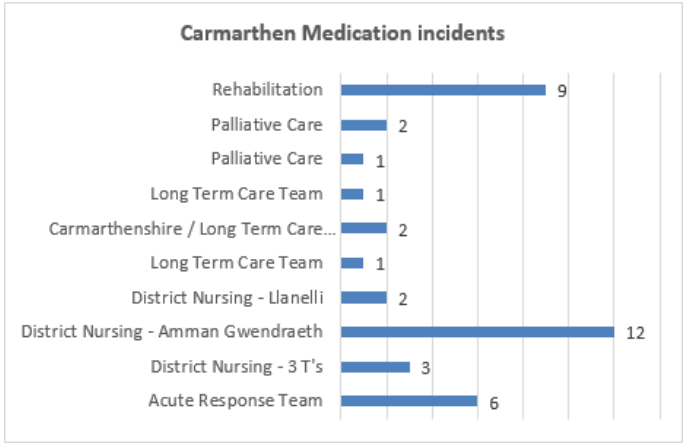


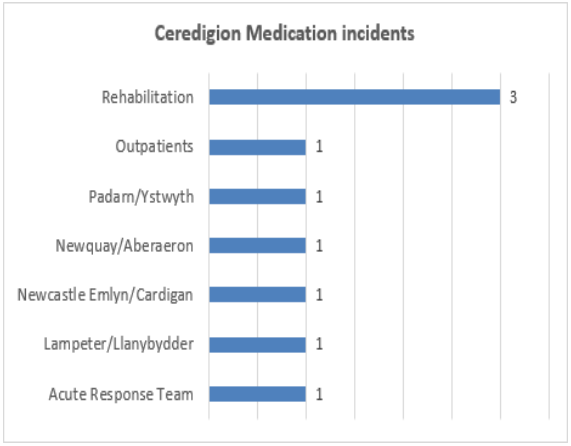


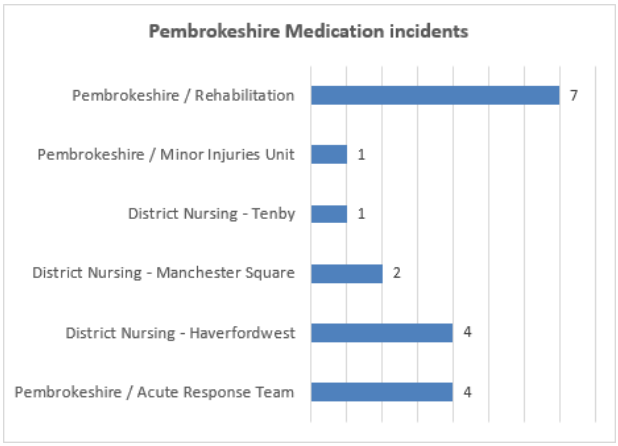
Medication incidents account for 2% of all reported incidents and of these 28% occurred within the community hospital setting;43 (64%) were administration errors with prescribing errors accounting for 15%.


Medication Incidents
19
36
9
Carmarthen
Ceredigion
Pembrokeshire

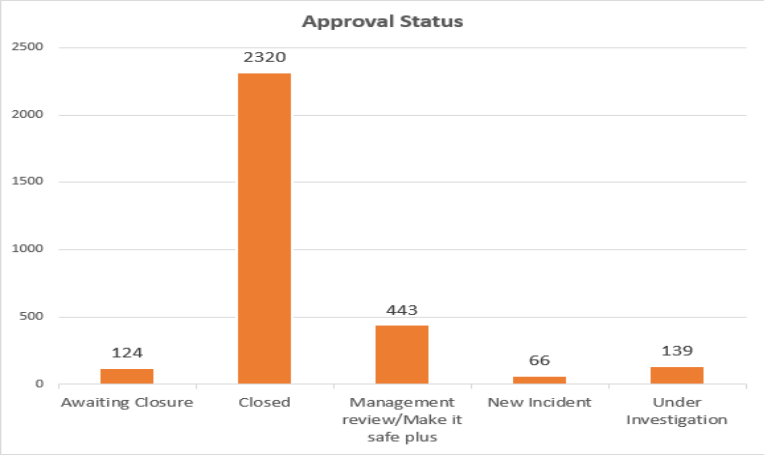

Types of medication incidents
Medication, IV Fluids
Preparation errors 1
Monitoring errors 1
Medication supply errors 3
Medication storage, security and... 6
Medication prescribing error 10
Medication documentation errors 3
Administration errors 43
0 10 20 30 40 50


Carmarthen Medication incidents
Rehabilitation 9
Palliative Care 2
Palliative Care 1
Long Term Care Team 1
Carmarthenshire / Long Term Care... 2
Long Term Care Team 1
District Nursing - Llanelli 2
District Nursing - Amman Gwendraeth 12
District Nursing - 3 T's 3
Acute Response Team 6

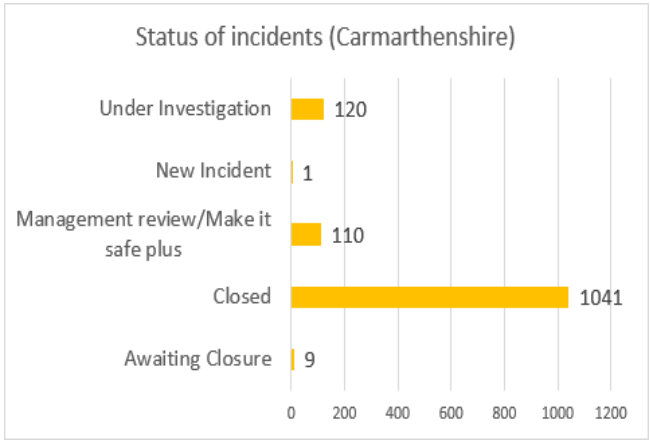

Ceredigion Medication incidents
Rehabilitation 3
Outpatients 1
Padarn/Ystwyth 1
Newquay/Aberaeron 1
Newcastle Emlyn/Cardigan 1
Lampeter/Llanybydder 1
Acute Response Team 1

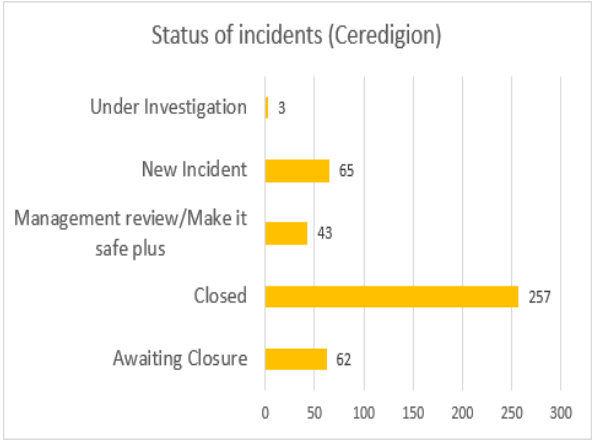

Pembrokeshire Medication incidents
Pembrokeshire / Rehabilitation 7
Pembrokeshire / Minor Injuries Unit 1
District Nursing - Tenby 1
District Nursing - Manchester Square 2
District Nursing - Haverfordwest 4
Pembrokeshire / Acute Response Team 4

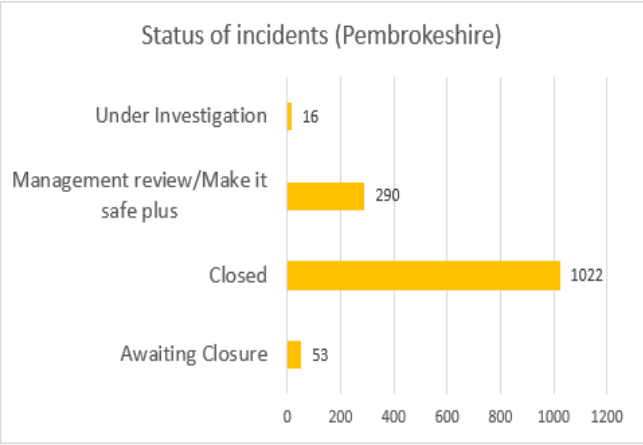
Approval status



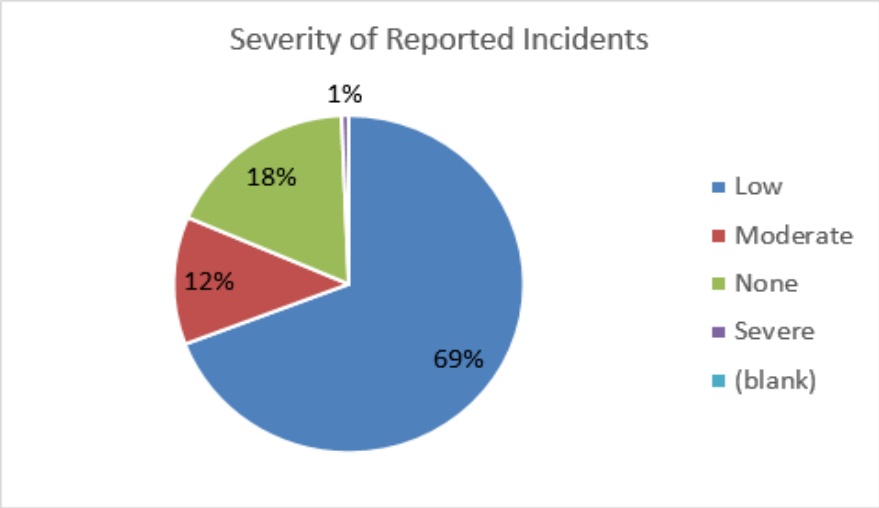
The approval status of all reported incidents between April 2021 and March 2022 can be seen below. 75% of all incidents have been closed following investigation, 4% are awaiting closure with 648 (21%) incidents still under investigation as of August 2022. In Pembrokeshire 22% of incidents remain outstanding for investigation, 18% of Carmarthenshire incidents are outstanding and in Ceredigion 26% of incidents are still under or awaiting investigation. This excludes those incidents awaiting closure.

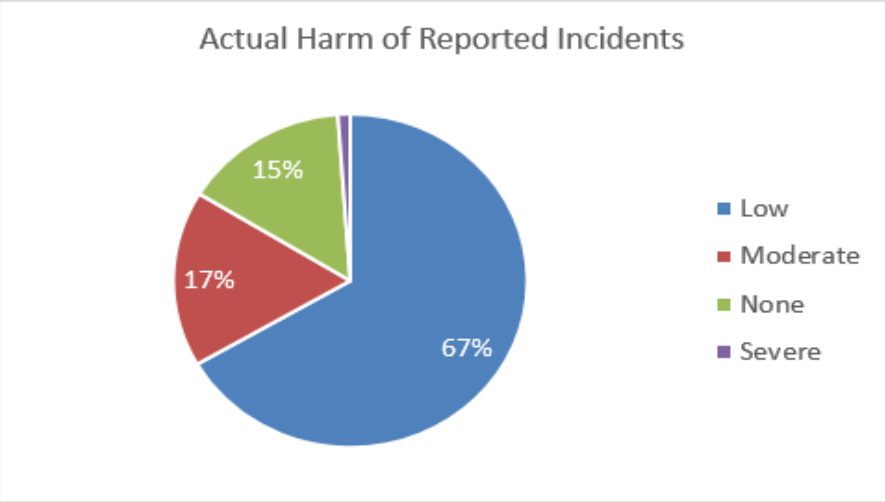






The severity of all reported incidents shows that the majority of incidents are low severity (69%) with only 1% of all incidents initially reported as severe. There is little change following investigation suggesting that reporting of incidents is accurate and appropriate.





Scrutiny meetings are well established in each county where themes and learning are identified and shared. Each county also has a monthly Quality, Safety and Experience meeting where any concerns are escalated. '7 Minute' briefings have been adopted to share learning and action plans are developed where improvements have been recommended. The most common issues identified from scrutiny relate to documentation and record keeping, such as risk assessments not being updated or completed in a timely manner, inconsistency with wound care charts, inconsistent use of non-concordance documentation and lack of care planning.

Some key areas of work around management of wound care and pressure damage include:

- Rollout out of the Lymphedema Pathway
- Pilot of Skin Bundle Document
- In-house training

Safeguarding

Safeguarding reports 2021 - 22	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Annual Totals
Community Services - Carmarthen	0	0	0	1	3	0	0	0	0	4	2	3	13
Community Services - Ceredigion	0	0	0	0	0	0	0	1	1	1	0	0	3
Community Services – Pembrokeshire	1	2	1	1	0	1	2	1	0	0	0	1	10
Monthly Total	1	2	1	2	3	1	2	2	1	5	2	4	26

Themes	**Learning**
Medications Sharps left unattended and incorrect disposal of waste	Sharps investigation checklist now implemented; Sharps incidents discussed in scrutiny and learning shared with all staff
Standards of Care Hygiene needs not being met appropriately. Delays in care provision.	All care being given but breakdown in communication between family and staff, improving communication and involvement of family with care plans
Falls	Appropriate use of bed rails assessments – training provided Lack of timely enhanced patient supervision (EPS) assessments or lack of available staff to provide EPS
Pressure Damage	Training provided on documentation. Datix reporting and investigating workshops held.

Pressure damage as result of incorrect or poor documentation, missing wound care charts and care plans, delays in reporting of Datix	Shared learning from events, 7 minute briefings, and Scrutiny meetings held, documentation audits implemented.

Initiatives and Developments 2021-2023

A Health Board wide Community Ambulatory Clinic Model is to be developed based on the successful outcomes of both the Ear Micro Suctioning and Trial without Catheter pilots in 2021. An overarching clinic model and service specification is being developed to embed community clinics across the three counties for a range of services including; Leg Ulcer Clinics, Catheter Clinics, Wound Care Clinics, Phlebotomy Clinics, One Stop Diagnostic Heart Failure Clinics, Ear Micro Suctioning clinics, Trial without Catheters alongside existing speciality clinics.

Patient Experience

For 2021/2022, Pembrokeshire community nursing services have been working with the Patient Support Services to pilot the Once for Wales Patient Experience Survey through CIVICA. The pilot has been successful and there are plans to formally roll out the use of the CIVICA questionnaire in 2022/2023 across Carmarthen and Ceredigion. Feedback and comments are noted below, overall feedback is very positive with some core themes identified for improvement shown below.

Positive comments generally related to excellent care, expectations nursing staff being caring, kind and helpful.

It was suggested that there could be improvements to managing patient providing planned /timed calls, improving continuity of staff, ensuring skill mix of staff is sufficient and how staff challenge referrals felt to be unsuitable.

Recommendations for 2021/2022

2021/2022 Recommendations	Outcomes
Participate in the proposed Health Board reviews planned for a number of specialist services including Tissue Viability, Respiratory, Diabetes and Cardiology	Community Head of Nursing and Clinical Lead Nurses continue to work with and support specialist reviews and have welcomed the development of a Health Board wide lead nurse role for specialist services
Establish a consistent Once for Wales approach to Patient Experience Feedback, utilising CIVICA.	District Nursing Teams across the three counties are now able to access the Patient Experience questionnaire through CIVICA.
Establish consistent approaches to data collection and service metrics across all community nursing teams and services, this will enable benchmarking and support service development and investment.	The implementation of Malinko and the challenges with accessing data has limited the progress able to be made during this year. Work is ongoing to identify clear metrics and outcomes which can be accessed through existing systems such as Malinko for data collection and benchmarking.
Ensure that there is strong professional leadership and representation at local, cluster, Health Board and national level.	Work has progressed with the Accelerated Cluster Development and Professional Collaborative. There is strong and consistent Professional leadership across local and national levels.

Upscale and roll out local initiatives and pilots to provide consistent and equitable care provision	Pilots undertaken in the last 12 months include: • Trial without Catheter • Ear Micro suctioning
Continue to encourage and offer personal and professional staff development and opportunities	The role of the Community Practice and Professional Development Nurse has been established across all three counties and the team continue to support all staff with both personal and professional development opportunities.
Maintain consistency and standardisation of management and address all Quality and Assurance issues across the three Counties Community Nursing Services.	All three counties have established monthly Quality, Safety and Experience Meetings and Monthly Scrutiny meetings.
Ensure staff are supported and have awareness and access to any support for psychological wellbeing	All staff aware of staff psychological and wellbeing services and able to access Occupational Health and Psychological services as required. Engagement with Organisational Development and Relationship managers to also support teams and individuals.
Ensure good compliance with the CNO District Nursing Interim Staffing Principles: ✓ **Achieve the minimum recommendation for administrative support to teams, (15 hours per team)** ✓ **All Teams to have dedicated Band 7 DN Team Leaders** ✓ **Recommended staffing levels / size of teams are achieved**	HDdUHB Community Services continue to report consistent progress and compliance against the Interim DN Staffing Principles. A key area for ongoing improvement remains administrative support for all DN teams, particularly given the additional administrative requirements of CIVICA scheduling Current bi-annual reporting of the Interim Principles has been suspended and not currently required by WG.

2022 / 2023 Recommendations
Update DN Service Specification for 2022 **Participate in Accelerated Cluster Developments** **Establish Professional Collaboratives** **Continue to participate in DN Workstream for Nurse Staffing Act** ➢ **Introduce DN Welsh Levels of Care (WLoC) Acuity and Dependency Tool** ➢ **Participate in Quality Audits and Professional Judgement Workbook pilots** **Implementation of Ambulatory Community Clinic Models across three counties** **Increase capacity for enhanced bridging, home based care and proactive care management** **Ongoing development of urgent and intermediate care services across three counties** ➢ **Development of Same Day Urgent Care (SDUC) in Ceredigion** ➢ **Development of Virtual Wards** ➢ **Expansion of homebased and bridging care services** **Pilot Admiral Inpatient CNS for Sunderland Ward, South Pembrokeshire Hospital with learning to be shared for further development of roles across other community hospitals** **Establish Neighbourhood District Nursing Model of working** ➢ **Offer access to the Advocating for Education and Quality Improvement (A-Equip) model of Restorative Supervision to community nurses** ➢ **Development of HCSW and Assistant Practitioner (AP) roles through Welsh Government funding** ➢ **Embed the role of the Professional Nurse Advocate across community nursing**