Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
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	Cwm Taf University Health Board response to the Health, Social Care and Sport Committee inquiry into community and district nursing services.
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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.