PRIMARY CARE AND COMMUNITY NURSING FOR A HEALTHIER WALES
Primary Care and Community Nursing

For the purposes of this report, Primary Care Nursing refers to nurses and health care assistants employed to work in a general practice nursing (GPN) team, usually to assist in meeting the contractual requirements for GPs within NHS Wales. The focus of GPN work is on providing nursing support for people of all ages, though usually adults. Community Nursing refers to nurses employed to work within a team of community nurses, collectively known as a district nursing team. A district nurse (DN) is a registered nurse who has undertaken specific, community-focused post-registration education and leads a district nursing team. The main context of district nursing care provision is usually for adults who are unable to leave their own homes for nursing support. Community children’s nurses provide support for children in community settings, preventing unnecessary hospital admissions and facilitating early discharge.

About the Royal College of Nursing (RCN)

The RCN is the world’s largest professional organisation and trade union of nurses, representing over 435,000 nurses, midwives, health visitors, healthcare support workers and nursing students, including over 25,000 members in Wales. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care and public policy as it affects health and nursing. The RCN works locally, nationally and internationally to promote excellence in nursing practice and the interests of patients, nurses and nursing as a profession. RCN members work in all settings, including primary care, community, care homes, schools, prisons and hospitals, in both the independent sector and the NHS. Around two-thirds of our members are based in the community.

Please contact the Royal College of Nursing Wales for more information about any points raised in this report.
The Royal College of Nursing (RCN) would like to thank the following individuals for contributing to the RCN Wales Primary Care and Community Nursing Summit and to this report:

**Deborah Armstrong**  
Interim Head of Education, Professional and Clinical Practice (Nursing)  
Welsh Ambulance Services Trust  

**Thomas Barton**  
Lead Advanced Practitioner (ACT Bridgend)  
Cwm Taf Morgannwg University Health Board (UHB)  

**Hannah Bauch**  
Team Manager, District Nurses  
Aneurin Bevan UHB  

**Carole Bell**  
Director of Nursing and Quality  
Welsh Health Specialised Services Committee  

**Catherine Blakemore**  
Locality Nurse North Pembrokeshire  
Hywel Dda UHB  

**Helen Braithwaite**  
Team Leader, District Nurses  
Aneurin Bevan UHB  

**Christopher Brett**  
Nurse Assessor  
Cardiff and Vale UHB  

**Ginny Chappell**  
Lecturer in General Practice Nursing/ Primary Care Advanced Nurse Practitioner  
Swansea University/ Hywel Dda UHB  

**June Clark**  
RCN Welsh Board Member  
RCN Wales  

**Kerry Collins**  
Community Nurse  
Cardiff and Vale UHB  

**Catrin Codd**  
Operational Lead DN, Neath Port Talbot  
Swansea Bay UHB  

**Paul Crank**  
Deputy Head of Nursing for Primary Care & Localities  
Cwm Taf Morgannwg UHB  

**Lynne Cronin**  
Senior Nurse Primary Care  
Cardiff and Vale UHB  

**Nicola Darroch**  
Practice Development Nurse - Community  
Cardiff and Vale UHB  

**Anita Davies**  
Head of Nursing South Powys  
Powys Teaching Health Board (THB)  

**Catherine Davies**  
Community Nurse  
Swansea Bay UHB  

**Nicola Davis-Job**  
Interim Associate Director (Professional Practice)  
RCN Wales  

**Nadine Doyle**  
Senior Nurse, Community Nursing  
Cwm Taf Morgannwg UHB  

**Melissa Duffy**  
Community Nurse  
Cwm Taf Morgannwg UHB  

**Ceinwen Frost**  
Professional and Practice Development  
Cardiff and Vale UHB  

**Paula George**  
Community Practice and Professional Development (Pembrokeshire)  
Hywel Dda UHB  

**Nia Griffin**  
Lecturer SPDN  
Swansea University  

**Stephen Griffiths**  
Director of Nursing  
Health Education & Improvement Wales  

**Krysia Groves**  
Project manager for the workforce workstream of the Strategic Programme  
Health Education and Improvement Wales  

**Meinir Harries**  
Clinical Lead Nurse for Community, Ceredigion  
Hywel Dda UHB  

**Angela Hiscocks**  
Community Health Studies Programme Lead  
University of South Wales  

**Lorraine Joomun**  
Lecturer in Primary Care  
Cardiff University  

**Lisa King**  
Professional Lead for District Nursing  
Cwm Taf Morgannwg UHB  

**Lucy Kings**  
Clinical Lead for Primary Care Nursing  
Aneurin Bevan UHB  

**Paul Labourne**  
Nursing Officer for Primary Care, Integration and Innovation  
Welsh Government
Lynwen Law  
Senior Nurse for District Nursing  
Aneurin Bevan UHB

Polly Leett  
Senior Nurse Primary Care  
Hywel Dda UHB

Lesley Lewis  
Associate Director of Nursing, Primary and Community Care  
Aneurin Bevan UHB

Sian Lewis  
Clinical Lead Nurse for Community, Ceredigion  
Hywel Dda UHB

Amanda Liddon  
Practice Development Nurse  
Cwm Taf Morgannwg UHB

Eve Lightfoot  
District Nurse Acute Response Team  
Hywel Dda UHB

Alison Magor  
RCN Welsh Board Member & District Nurse Team Leader  
RCN Wales & Aneurin Bevan UHB

Sue Morgan  
National Director & Strategic Programme Lead for Primary Care  
NHS Wales

Teresa Neate  
Community Nurse  
Cardiff and Vale UHB

Chloe Neave  
Team Lead, Community Resource Team  
Cardiff and Vale UHB

Gina Newbury  
Lecturer: Primary Care and Public Health Nursing  
Cardiff University

Juliet Noorwood  
S.E. Wales Regional Lead Nurse, Macmillan Primary Care Cancer Framework  
Public Health Wales

Crystal Oldman  
Chief Executive  
Queen’s Nursing Institute

Ann Owen  
Senior Nurse  
Aneurin Bevan UHB

Donna Pace  
Lecturer Community Health Studies  
University of South Wales

Diane Powles  
Education and Lifelong Learning Adviser  
RCN Wales

Carol Preece  
Senior Nurse  
Cardiff and Vale UHB

Ruth Richardson  
Lead Nurse for Children and Young People  
Powys THB

Rhys Roberts  
Senior Nurse - District Nursing  
Cwm Taf Morgannwg UHB

Kate Roberts  
District Nurse Team Leader  
Cardiff and Vale UHB

Katrina Rowlands  
Assistant Director of Nursing  
Powys THB

Cathryn Smith  
Lecturer: Primary Care and Public Health Nursing  
Cardiff University

Andrea Surridge  
Programme Director - BS/MSc Specialist Practice District Nursing  
Swansea University

Sue Thomas  
Primary Care, Community & Independent Sector Adviser  
RCN Wales

Sian Thomas  
Consultant Nurse Community Child Health  
Aneurin Bevan UHB

Michelle Treasure  
Professional and Practice Development Nurse, Primary Care Team  
Cardiff and Vale UHB

Kate Wakeling  
Senior Practice Nurse  
Cwm Taf Morgannwg UHB

Jo Webber  
Head of Nursing - Community Division  
Aneurin Bevan UHB

Shirley Willis  
Lecturer: Primary Care and Public Health Nursing  
Cardiff University

Fiona Wood  
Senior Nurse, Community Resource Team  
Cwm Taf Morgannwg UHB
Executive Summary

<table>
<thead>
<tr>
<th>PRIMARY CARE AND COMMUNITY NURSES COMMIT TO ...</th>
<th>SUPPORTIVE REQUIREMENTS TO ACHIEVE THE COMMITMENTS INCLUDE ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the health and care needs of local populations and individuals, based on available information, data and evidence.</td>
<td>Recognition of the need for time and resources (including connected IT systems) to undertake meaningful, focused health and care needs assessments.</td>
</tr>
<tr>
<td>Undertake individualised, holistic assessment of biological, psychological, sociological, cultural and spiritual needs, starting with the question ‘what matters to you?’</td>
<td>Recognition of the need for time and resources to undertake meaningful, individualised holistic assessments that result in collaborative care plans.</td>
</tr>
<tr>
<td>Understand the elements of quality and safety outcomes and what matters for patients and their care, through the generation, retrieval and use of research and an evidence base.</td>
<td>Focused support and resources for primary care and community nurses to generate empirical research, relating to quality and safety outcomes and what matters to patients.</td>
</tr>
<tr>
<td>Take time to work with individuals and families to understand a person's wishes and capacity for independence.</td>
<td>Recognition of the need for time and resources to undertake meaningful, assessments of a person's wishes and capacity for independence.</td>
</tr>
<tr>
<td>Take time to agree a plan of care that fosters independence, whilst supporting expressed needs.</td>
<td>Recognition of the need for time to agree and support a plan of care that fosters independence.</td>
</tr>
<tr>
<td>Review the effect of nursing care on the person's activity and independence.</td>
<td>Focused support and resources for primary care and community nurses to generate empirical research, relating to the effects of nursing care on a person's activity and independence.</td>
</tr>
<tr>
<td>Use knowledge and skills to maximise opportunities for illness prevention interventions with individual or groups of people.</td>
<td>Recognition of the need for time to maximise opportunities for illness prevention interventions with individuals.</td>
</tr>
<tr>
<td>Use recognised frameworks, such as Making Every Contact Count (MECC), Motivational Interviewing (MI) or other contemporary aids, to support people with change in a relevant and effective way.</td>
<td>Support and resources for all primary care and community nurses to learn about and be able to use recognised frameworks that help people to make health-related lifestyle or other changes.</td>
</tr>
<tr>
<td>Ensure that local, community-based resources and assets are used to their best, for the benefit of every citizen's holistic needs.</td>
<td>Focused resources to enable primary care and community nurses to access directories of information, such as DEWIS, as routine part of their clinical activities.</td>
</tr>
<tr>
<td>Work collaboratively alongside and/or co-ordinate a broad range of health and care professionals, to improve people’s access to individualised support.</td>
<td>Facilitate environments that are conducive to collaborative team working, including shared IT systems, co-located working premises or other means of instant communication.</td>
</tr>
<tr>
<td>PRIMARY CARE AND COMMUNITY NURSES COMMIT TO …</td>
<td>SUPPORTIVE REQUIREMENTS TO ACHIEVE THE COMMITMENTS INCLUDE …</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Ensure that people do not experience avoidable physical, psychological or other harm or distress, by seeking to understand their perceptions and perspectives of their health-related circumstances.</td>
<td>Education in clinical triage and care navigation, to ensure safe and effective signposting at first point of contact to the most appropriate health and care support.</td>
</tr>
<tr>
<td>Ensure development of well-balanced primary care and community nursing teams, so that people can receive safe and competent care from staff at all clinical skill levels, from 3 to 8. Contribute expertise to and support the development of career pathways for primary care and community nursing teams, to enable equal health outcomes for people receiving care from a consistently well-educated skill mix, with standardised job descriptions.</td>
<td>Focused, specific education and career framework for primary care nursing teams, as committed by the Cabinet Secretary for Health and Social Services in Wales.</td>
</tr>
<tr>
<td>Ensure at least one nurse independent prescriber within each primary care and community nursing team within Wales</td>
<td>Focused planning, funding and educational support for developing a minimum of one nurse independent prescriber within all primary care and community nursing teams across Wales.</td>
</tr>
<tr>
<td>Provide sensitive, individualised, nursing care for people, assisting their wishes for a preferred place of death.</td>
<td>• Co-ordinated education in psychological approaches to supporting health, well-being and decision making. • Co-ordinated education for end of life care and verification of death.</td>
</tr>
<tr>
<td>Lead, contribute to and support the development of ‘gold standard’ best practice for all areas of primary care and community nursing.</td>
<td>Health and care systems continuity to ensure consistent, joined-up approaches.</td>
</tr>
<tr>
<td>Use the experiences and learning from pilots and new initiatives in primary care and community nursing, to shape teams that help people receive safe and relevant community-based care, where hospital would otherwise be the only available option.</td>
<td>Focused support and resources for primary care and community nurses to generate evaluations of the impact of nursing practice; including the use of frameworks such as Time Spent at Home, Economic Analysis, Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs).</td>
</tr>
<tr>
<td>Continue to shape, lead and provide individualised and population-based, evidence-led, evaluated, efficient and sensitive nursing care to meet the contemporary needs of patients and the community-focused NHS in Wales</td>
<td>• A Welsh Clinical Leadership Training Fellowship scheme, to develop high quality clinical leaders in primary care and community nursing. • Focused development of primary care clinical leadership roles, to ensure increased numbers of nurses with the knowledge, skills and experience for Primary Care Cluster Lead roles. • Recruitment of one Nurse Consultant in Primary and Community Care within each Primary Care Cluster in Wales.</td>
</tr>
</tbody>
</table>
This report sets out the RCN’s and expert clinicians’ views on Primary Care and Community Nursing in Wales.

The report highlights the Primary Care and Community Nursing response to A Healthier Wales (2018) and the Strategic Programme for Primary Care and Community (2018). It defines the Primary Care and Community Nursing contribution needed to meet the transformational aims of Care Closer to Home in Wales. The report is the result of wide consultation with primary care and community nurses and managers across Wales; with the aim to guide and assist stakeholders concerned with the provision and support of health and care within Wales.

Realising the ambitions set out in this report requires strategic partnership working, to support the pledges made by primary care and community nurses in Wales. We look forward to working on and delivering these commitments with people receiving support from primary care and community nurses, Welsh Government, NHS Wales Health Boards, Health Education and Improvement Wales, Education providers and all stakeholders.

In meeting health and well-being needs with and for the people of Wales, Primary Care and Community Nurses commit to:

1. Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.
2. Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of care.
3. Consider the whole person and their biological, psychological, social, cultural or spiritual needs.
4. Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.
5. Empower people to achieve, maintain or recover independence.
6. Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences.
7. When death is inevitable, help to maintain the best possible quality of life until its end.

The commitments to deliver safe, effective primary care and community nursing support are underpinned by six, defining principles of nursing, as outlined by RCN (2014):

1. The purpose of primary care and community nursing is to promote health, healing, growth and development, and prevent disease, illness, injury, and disability. When people become ill or disabled, the purpose of primary care and community nursing is to minimise distress and suffering, to enable people to understand and cope with their disease or disability, its treatment and its consequences. When death is inevitable, the purpose of primary care and community nursing is to maintain the best possible quality of life until its end.
2. Primary care and community nursing interventions are concerned with empowering people and helping them to achieve, maintain or recover independence. Nursing includes the identification of nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support. In addition to direct patient care, primary care and community nursing practice includes management, teaching, quality improvement and research.
3. The specific domain of primary care and community nursing is people’s unique responses to and experience of health, illness, frailty, disability and health-related life events in whatever environment or circumstances they find themselves. People’s responses may be biological, psychological, social, cultural or spiritual and are often a
combination of all of these. The term people includes individuals of all ages, families and communities, throughout the entire life span.

4. The focus of primary care and community nursing is the whole person and the human response, rather than a particular aspect of the person or a particular pathological condition.

5. Primary care and community nursing is based on ethical values which respect the dignity, autonomy and uniqueness of human beings, the privileged nurse-patient relationship, and the acceptance of personal accountability for decisions and actions. These values are expressed in written codes of ethics, and supported by a system of professional regulation.

6. Primary care and community nurses work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team. Where appropriate they lead a team, prescribing, delegating and supervising the work of others; at other times they will participate under the leadership of others. At all times, however, they remain personally and professionally accountable for their own decisions and actions.

(Adapted from Defining Nursing; RCN, 2014)

Primary health care provides the first point of contact and main point of continuing care for patients within the health and care system. Primary health care practitioners coordinate specialist care for patients who have multiple biological, psychological and social concerns. Patients commonly receive primary care from professionals like family doctors, practice nurses or district and community nurses. In NHS Wales the main source of primary health care is through general practice (SB 25/2016. Stats Wales, 2016).

The Welsh Government’s Vision for “A Healthier Wales” has brought primary care and community health and care services closer into focus, whilst the Strategic Programme for Primary Care and Community details the ways in which the aspirations of A Healthier Wales and Care Closer to Home will be achieved.

A Healthier Wales (2018) notes the following aspirations:

- Everyone in Wales should have longer healthier and happier lives, able to remain active and independent, in their own homes, for as long as possible.
- There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives.
- There will be a ‘wellness’ system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.
- This whole system approach will be equitable. Services and support will deliver the same high quality of care, and achieve more equal health outcomes, for everyone in Wales.
- It will improve the physical and mental well-being of all, throughout their lives, from birth to a dignified end.
- When people need support, care or treatment, they will be able to access a range of services which are made seamless, and delivered as close to home as possible.
- Services will be designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.
- People will only go to a general hospital when that is essential.
- The shift in resources to the community will mean that when hospital-based care is needed, it can be accessed more quickly.
The Wellbeing of Future Generations (Wales) Act 2015 outlines the five ways of working including Long term, Prevention, Integration, Collaboration, and Involvement; demonstrating close alignment to the aspirations of A Healthier Wales.

The Strategic Programme for Primary Care in Wales places the actions and activities for health services in Wales within a structured framework. Six Key Work Streams include:

1. Prevention and wellbeing
2. The 24/7 Model
3. Data & Digital Technology
4. Workforce & Organisational Development
5. Communication, Engagement
6. Transformation Programme and the Vision for Clusters

Prudent Healthcare (2016) principles guide the development of health and care services in Wales, by aiming to:

- Do only what is needed, no more, no less and do no harm
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

There is clear alignment of nursing skills, expertise and contribution to the overarching policy context within Wales.

Primary care and community nurses welcome the continued move towards integrated, collaborative working with colleagues from multiple agencies and professional groups, in order to support health and well-being for people of Wales. They recognise the crucial roles played by primary care and community nurses in improving outcomes for the people of Wales, whilst achieving the contemporary aims for health and care in Wales, on a 24 hour basis, both ‘in’ and ‘out of hours’.

Nursing is defined as “the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death” (RCN, 2014). Nowhere is this definition more comprehensively relevant than in primary care and community settings.
The primary care and community nursing workforce in Wales

RCN Wales has previously recorded its concerns about the lack of accurate and robust data on the primary care and community nursing workforce (RCN Wales, 2018), which Welsh Government has made efforts to address. However, there are still difficulties in accessing reliable information about this workforce.

The Welsh Government’s Statistical First Release (SFR 21/2019) identifies that 42% of all directly employed Wales NHS staff are nurses, health visitors or midwives, illustrating the necessity of addressing the nursing contribution to A Healthier Wales.

The SFR 21/2019 does not include practice nurses who are employed by the 462 independent contractor GP surgeries in Wales (Statistical Bulletin: SB 25/2016). Nursing roles are increasing within general practice, due to difficulties recruiting and retaining GPs; therefore it is sensible to assume there to be at least one nurse in post per practice, but usually a team comprising health care assistants (HCAs), general practice nurses (GPNs) and advanced nurse practitioners (ANPs).

The SFR 21/2019 identifies 581 District Nurses within Wales. However, the CNO for Wales’ Interim District Nursing Principles (2017) outlines the requirement that each district nursing team should have a staffing complement of no greater than 15 staff/12 WTE. This team will usually comprise two District Nurses with an NMC recordable qualification (SPQ) plus a team of approximately 10 Community Nurses.

The RCN recommends that for an average-sized district with a child population of 50,000, a minimum of 20 whole-time equivalent community children’s nurses are required to provide a holistic community children’s nursing service, in addition to any individual child requiring specific continuing care investment. In the average CCN team the minimum ratio of registered nurse to unregistered staff should not fall below 70:30 percent, with a minimum of 25 per cent of the registered nurse component being CCNs who have completed a recognisable community education and development programme (RCN, 2013). A review undertaken in 2017 suggests that in Wales we have approximately half of the recommended numbers, which includes supporting children with continuing care needs.

Methods

RCN Wales presents this report, which outlines many conversations between expert practitioners and organisations concerned with providing primary care and community nursing support to the people of Wales. The all-Wales District Nursing Forum and all-Wales Primary Care Nurses Forum have addressed the contribution of primary care, district and community nurses to A Healthier Wales and The Strategic Programme for Primary Care in Wales. Their collective views are represented here.

An RCN Wales’ Primary Care and Community Nursing Summit was held in June 2019, the aims of which were to:
1. Facilitate professional discussion about the current and future contribution of primary care and community nurses to meeting the agenda for A Healthier Wales and The Strategic Programme for Primary Care in Wales.
2. Provide support and assistance for Welsh Government, Health Education and Improvement Wales (HEIW) and other stakeholders in developing the programme to meet the Strategic Programme for Primary Care in Wales.
The Primary Care and Community Nursing commitments

Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.

Community and district nurses strongly identify themselves as “specialist generalists”. This has been a common theme in discussions during the process of formulating this report. This theme is supported by Barrett, Latham & Levermore (2007) who proposed that district nurses offer a generalist nursing model of care for patients with multiple health problems and social needs by taking a holistic view of the patient and their personal circumstances.

Generalism is defined by Brindle (2011) as a commitment to continuity of care combined with an ability to manage different forms of care and support. Further, “the generalist sees health and ill-health in the context of people’s wider lives, recognising and accepting wide variation in the way those lives are lived, and in the context of the whole person” (Brindle, 2011 p.4). The UK Royal College of General Practitioners (RCGP) (2012) offer their definition of generalism as seeing the person as a whole and in the context of his or her family and wider social environment; working with the widest range of patients and conditions; addressing continuity of people’s care across many disease episodes and over time and coordinating care across health and social care organisations.

The RCGP and the Health Foundation (2011) draw attention to the importance of defining modern generalism, so that public expectations, professional interfaces and future developments can be clarified and planned for. Reeve (2010b) outlines a suggested model for working with patients, based on an exploratory approach which illuminates the interpretive skills inherent in the generalist role of a general practitioner. Reeve argues that such skills define a unique and intellectual discipline.

Due to district nurses’ close working with patients and their families within the home, this means that they are the experts in assessing the breadth of factors that might influence a patient at any given time. The results of conversations reported here demonstrate this to be the case for district nurses in Wales.

In their role as first point of contact for people, practice nurses have said that they are often ‘gatekeepers’ to accessing health care beyond general practice. This has been a title previously attributed to GPs. However, with expanding role of the GPN and the general practice-based Advanced Nurse Practitioner (GPANP), increasingly they are the first point of contact for the patient. As such, GPNs and GPANPs now undertake onward referrals, including as care co-ordinators and for specialist assessment from other colleagues. This illustrates a new understanding of first point of contact and ‘gatekeeping’. With this recognition comes the need for contemporary approaches to education and support, for nurses to undertake roles safely and appropriately.

Nurses working within the Urgent Primary Care OOH service are also generalists and can be described as “gate keepers” to accessing health when GP surgeries are closed. Triaging skills, minor illness skills and the role of the ANP are all incorporated in to the multi-disciplinary approach to patient care.

This report makes the case for recognition of the generalist primary care and community nursing roles and the subsequent need for investment in education and developmental support.

When reviewing a patient’s need for the annual influenza vaccine, the GPN will discuss whether other family members will need to offered the influenza vaccination. For example, where a patient is immunosuppressed through medical intervention, other family members will need to ensure they do not contract influenza that may put the individual at risk of infection.
Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of care

One of the recurring themes has been of care co-ordination by all primary care and community nurses; either following referral to District Nursing teams or directly to General Practice Nursing teams.

A care co-ordinator is defined by Hickam et al (2013 p.3) as “an agent of the patient, taking a “whole person” rather than a solely clinical or disease focused approach to care, and serving as a bridge between the patient, the practice team, the health system, and community resources”.

Summit participants identified the co-ordinating role of primary care and community nurses from the point of request for support. There was recognition of the skills attributed to primary care and community nurses, resulting in a broad range of referrals, including patient discharge from hospital. The concept of a “ward without walls” has been previously documented (QNI, 2006; Haycock-Stuart et al, 2008). However, this reflects the reality of primary care and community nurses’ expertise as co-ordinators of care on behalf of patients who they meet and support. Care co-ordination includes managing the complex needs of a patient, by working with all personnel relating to health, social care, carers and voluntary agencies.

In identifying and addressing personal care needs, district nurses work closely with colleagues from partner organisations such as local authority, social services and third sector, to collaborate, co-ordinate and signpost to suitable support and resources. This aspect of the district nursing role is a long-valued contribution to ensuring people’s health and well-being within the home, especially following an early discharge from hospital.

District nurses describe their continued experiences of receiving requests to undertake home visits for discharged patients who are discovered to be unsafe for an often complex range of bio-psycho-social reasons. Whilst it is understood that decisions are made to discharge such patients to enable hospital flow, it must be understood that district nurses require the recognition, support and resources to co-ordinate services that avert crisis and re-establish safety in home-based health and well-being for individuals.

Primary care and community nursing services are very well suited to ‘place-based’ care approach, where local services are connected to enable people to receive care close to their home and community. This is the historical way of working. However, investment in further developing these services would result in increased opportunities to improve patient care at home.

District nurses and community children’s nurses are a key link between adult and children’s health and social services and have an important role to play in co-ordination of services between partner health and care agencies commonly engaged in responding to assessed patient need. Such nurses are the ideal care co-ordinators for individuals’ bio-psycho-social needs within the community context of care within Wales.

EXAMPLE CASE STUDY

The community children’s nurse supports the outreach oncology service to provide shared care for children with a cancer diagnosis. The CCN will see the child and family weekly to manage the central line and take bloods, linking with the tertiary centre and specialist nurses as required. For children with a diagnosis of acute lymphoblastic leukaemia, this is a long journey over a 3-4 year period and the CCNs build a strong relationship with families.

Practice nurses use prudent healthcare principles in signposting people to the most relevant professional to support their needs. This is frequently to agencies and resources such as X-pert (diabetes), Expert Patient Programme (EPP), podiatry, sexual health, pulmonary rehabilitation, cardiac rehabilitation, community resource teams, frailty services, acute response teams, ‘social prescribers’, ‘community connectors’ and many more.

Within the Urgent Primary Care Out of Hours (OOH) arena nurses work within a multi-disciplinary team; triaging patients, providing self-care advice, undertaking a face to face consultation in a primary care centre,
undertaking a home visit, or referring and signposting to the most relevant health care professional to support their needs, including pharmacist, optician or specialist secondary care.

- As part of a Chronic Obstructive Pulmonary Disease (COPD) review, Cardiff and Vale-based GPNs assess a patient’s breathlessness score and, based on this, co-ordinate support from the local pulmonary rehabilitation course. This is a 6 week course where the patient is supported by physiotherapists, occupational therapists, smoking cessation counsellors and nutritionists to improve health and wellbeing.

- In recognition that it can be a daunting experience to receive a diagnosis of Type 2 diabetes, practice nurses co-ordinate support from the X-pert programme. This is a 6 week programme, run by community dieticians, designed to give individuals the knowledge and understanding of diabetes and how to manage their own health. In the Cardiff and Vale areas this is now being rolled out to include translators for the hard to reach ethnic communities and also offered as evening meetings to allow easier access for the working population to meet their needs.

- Practice nurses within the Cardiff and Vale South East Cluster co-ordinate support for people who are isolated, by introducing them to local ‘gardening groups’.

District nurses have been instrumental in developing a community-based virtual ward/MDT weekly meeting within Newport. One example of how the virtual ward has supported the needs of an individual patient: A district nurse was concerned about the person’s deteriorating health and well-being and believed the collective resource of the virtual ward would help avert a crisis. In addition to bio-medical difficulties, there appeared to be untreated psychological challenges, social isolation, poor housing, no food in the fridge, and general vulnerabilities affecting the person’s ability to make choices. The virtual ward/MDT discussion focused on the person’s reduced participation in self-care and suggested treatments, which was leading to worries about his ability to remain safely at home.

Following a collaborative, complex medical, nursing and social assessment, the primary aim was to improve the individual's medical and psychological health and well-being, alongside improvements in the person's home environment. The MDT worked together to develop ideas and care plan, including self-volunteered, pharmacist-led medication review and support from the Older Person's Pathway personnel. The single virtual ward/MDT discussion resulted in the person’s active re-involvement with a jointly agreed care plan to support his medical and psychological health problems, along with actively making use of furniture and equipment to help with mobility difficulties. With improved mood, the individual also felt able to receive neighbour’s help and company.
Consider the whole person and their biological, psychological, social, cultural or spiritual needs.

District and community nurses are the health professional group that spends most time with patients and their families, communities and social networks. They are therefore well placed to understand the context of care for each individual, whilst adopting a holistic, bio-psycho-social model of care, not purely a biological/medical model.

District and community nurses emphasised their expertise in holistic assessment of patient. Nurses of all levels asserted their role in meeting a person’s complex needs through a holistic approach to that person’s life and circumstances. Having a close relationship with patients, their families and carers was valued as integral to supporting the person’s ability to remain safely at home. Primary care and community nurses reported their role as negotiator and mediator for patients, families and the dynamics related to family lives, often by using skilled communication to assist important and sensitive conversations about health and care decisions.

Practice nurses focus on family connections during contacts with patients, leading to consideration of holistic needs. For example, considering the impact of family health and well-being on a person’s life and circumstances, such as asthma or immunosuppression medication.

This fits with the modern vernacular of “what matters” to the person requiring support. It is an excellent illustration of the existing skills and approach being undertaken by primary care and community nurses, whilst at the same time addressing a contemporary way of thinking about health and care support for the people of Wales. Primary care and community nurses already practice with this framework in mind and are well placed to continue to do so. However, it would be erroneous not to give adequate recognition and resources that are required to do this properly, including adequate time and educational support.

Community children’s nursing services are the bedrock of the pathways of care for all children requiring out of hospital nursing support, these can be divided into four groups:

- Children with acute and short-term conditions;
- Children with long-term conditions;
- Children with disabilities and complex conditions, including those requiring continuing care and neonates; and
- Children with life-limiting and life-threatening illness, including those requiring palliative and end-of-life care.

The community children’s nurse has a pivotal role in the discharge management of children with complex medical and nursing needs. For example a term baby who following significant birth trauma is assessed as needing naso-gastric feeding, oxygen and suction. The CCN will attend discharge planning meetings, initiate any continuing care assessments, link with social services and support training needs for the parent. On discharge the CCN will visit as frequently as required to ensure the child’s needs are being met and that the parents are supported. This is all against the background of supporting the grieving process for parents who are having to come to terms with the reality of supporting a child with significant needs.

EXAMPLE CASE STUDY

Using the Care Aims (Malcomess, 2005) approach to “reasoning, decision making, risk management and reflective practice”, district nurses in Newport have reported improved confidence and effectiveness to work with individual patients towards self-management where possible. Use of the Care Aims framework helps to facilitate conversations about what is important to individual patients and their families/carers, in ways that have not been previously explored.

District nurses report that this helps to identify patients’ and families’ expectations of, involvement in and satisfaction with care and support, where previous reliance on professional support would have been assumed or accepted. Introduction to this new way of working has been described as “the best thing I ever learnt in all my nursing career”, and has helped increase the knowledge and skills to work differently with people in their own homes. This is a working illustration of the contemporary community nursing realisation of Prudent Healthcare in achieving health and wellbeing with the public and patients as equal partners.
Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.

Primary care and community nurses help people manage their acute and long term conditions, including cancer, asthma, diabetes, chronic obstructive pulmonary disease, leg ulcers and mental health problems. Such co-morbidities are known to be associated with poorer health outcomes and greater health care costs as well as more complex management or care (Valderas, 2009). Through these interactions with patients, practice nurses provide large aspects of the GMS contract for general practice.

The range of practice nursing involvement in long term conditions management varies, from condition review, help with device technique, self-management plans, medicines commencement, optimisation and adjustment, education for people’s own home medicines management such as ‘rescue packs’ for COPD. Children with long term conditions are often supported by a clinical nurse specialist (such as for diabetes, respiratory, epilepsy, endocrine and continence) along with a community children’s’ nurse in the home or community setting.

- **Specialist diabetes nurses** work with practice nurses, to help provide specialist care for people with diabetes who would previously have been required to attend hospital for insulin therapy. This means that people do not need to travel to and wait at a busy hospital out-patients clinic to receive specialist care. It also means that people can benefit from a blend of specialist and generalist approaches to their health and well-being, in the context of their lives, family and community.

- **Practice nurses** liaise with the local wound healing service for specialist assessment and care planning of complex wounds, before the individual returns to general practice-based support and care. This shared learning with TVNs means that practice nurses maintain an individualised complex wound care plan, with increased confidence and competence, whilst ensuring continuity of care across the Multi-Disciplinary Team (MDT).
A Cochrane review (Laurant et al, 2018) reported that “for chronic (long term) conditions, trained nurses, such as nurse practitioners, practice nurses, and registered nurses, probably provide equal or possibly even better quality of care compared to primary care doctors, and probably achieve equal or better health outcomes for patients”.

This need not be limited to surgery-based contact. For example, increasing numbers of practice nurses are supporting people with long term conditions who are unable to attend the surgery, by visiting them. This ensures equity of service provision to people who are housebound, are not receiving district nursing services, and who would otherwise fall through a gap in existing service provision.

Table 2 illustrates how achievement of the 2 core areas of the GMS contract (essential services and the Quality and Outcomes Framework (QOF) is dependent on the contribution of nurses working in general practice.

<table>
<thead>
<tr>
<th>Essential services provided by general practice (GMS)</th>
<th>Example of GPN role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of patients who are ill or believe themselves to be ill with conditions from which recovery is generally expected</td>
<td>GPN- led minor illness and minor injury services, especially independent nurse prescriber and ANP</td>
</tr>
<tr>
<td>Management of chronic disease</td>
<td>GPN led service, especially independent nurse prescriber</td>
</tr>
<tr>
<td>Screening services</td>
<td>GPN-led service for cervical cytology, GPN-assisted for national screening services of bowel and breast cancer, diabetic retinopathy, aortic aneurysm</td>
</tr>
<tr>
<td>Vaccinations &amp; immunisations</td>
<td>GPN led services for national immunisation programmes (tier 1 target), including influenza, shingles, pneumococcal, meningitis, pertussis in pregnancy, and the childhood vaccination schedule. Also includes travel immunisation for hepatitis A, DTP and Typhoid</td>
</tr>
<tr>
<td>Child health surveillance</td>
<td>GPN signposts to PHCT</td>
</tr>
<tr>
<td>Contraceptive services</td>
<td>GPN assisted and/or led e.g. IUCD fitting, Nexplanon fitting and removal, Depo-Provera, oral contraception, especially independent nurse prescriber</td>
</tr>
<tr>
<td>Minor surgery services</td>
<td>GPN team assisted</td>
</tr>
</tbody>
</table>

The domains of QoF/QAIF include:

- Clinical - this domain has indicators across different clinical areas e.g. CHD, heart failure, asthma, COPD and hypertension. Usually GPN led |

Children with long term conditions are often managed by a clinical nurse specialist along with the CCN in the community setting.

Children and young people with long term conditions want to live as normal a life as possible; however, they often experience frequent disruption to their everyday lives, especially absence from school for hospital appointments or due to an exacerbation of their condition. Person centred healthcare helps children and young people to meet their wider aims and needs. For example, by having access to a community children’s nurse in collaboration with the school nursing team, a child can have an individual health plan. This enables them to learn how to manage their illness and its treatment, to recognise early signs.
GPNs provide an extensive range of contraceptive services for women, through general practice.

Population data showed a high incidence of unplanned teenage pregnancies within a GP practice. To broaden the range of choice options for long-term contraception, the GPNs undertook accredited training to be able to offer fitting and removal of IUDs/IUS and Nexplanon devices. GPNs now offer weekly practice-based appointments and have successfully met patients’ needs, resulting in reduced demand on midwifery services. More importantly, this practice-based initiative has offered improved choice and easily accessible contraceptive services.

GPNs are the most usual health professionals to perform community-based spirometry as the diagnostic test for COPD. GPNs are usually responsible for interpreting spirometry results and then conveying the results to people about this long term, irreversible condition. From the start of the patient’s journey GPNs co-ordinate and facilitate; diagnosis; medicines management; inhaler device selection; referral to secondary care and pulmonary rehabilitation; smoking cessation support; personal and emotional support; recognising deterioration in lung health; arranging third sector services; and having end of life care discussions with people and their families.

This locally accessible service is not delivered as flexibly in secondary care settings and it is essential that these patients are supported in their own community for as long as possible. People with COPD have poorer outcomes following hospital admissions, therefore enabling seamless, local, holistic care in the community helps patients to live healthier lives, at home, for as long as possible.

GPNs undertake shared-care annual review for people living with Rheumatoid Arthritis. This includes; undertaking Disease Activity Scores and Osteoporosis scoring; reviewing and discussing management of prescribed medication; ensuring DMARD blood levels are monitored at recommended intervals; referring for DEXA scan where appropriate; offering health promotion advice about reducing risk of cardiovascular disorders.

Recognising that 30% of presentations in GP are for mental health concerns, a new service is being introduced into all Cardiff and Vale UHB GP practices, so that patients will have access to mental health nurses for a range of concerns from insomnia to bereavement support. Patients are able to access the mental health nurses as a self-selected first point of contact, rather than seeing a GP first. This is helping to improve options for access to appropriate members of the primary care team.

Nurses are a key resource used within the Urgent Primary Care OOH service. They work as part of a multi-disciplinary team providing care for patients with urgent health care needs that cannot wait until their own GP practice re-opens. Over recent years the Urgent Primacy Care OOH Service has moved from a GP only workforce to a more multi-disciplinary team approach. Recent capacity and demand exercises have shown that a more sustainable 60:40 model (60% MDT, 40% GP’s) is what the OOH services need to move towards within their workforce plans.
Out of Hours (OOH) Triage Practitioner:
These nurses or paramedics are trained to a minimum of BSc (degree) level and usually have a background of working in one or more of the following areas of care: general practice, community, Welsh ambulance service or A+E. They undertake telephone triage using decision making templates that aid the safe triage of patients via a telephone consultation. They are able to provide self-care advice, refer to alternative services (including ambulance, A+E, own GP) or direct patients to the primary care centres for a clinical consultation that will be undertaken by a GP, Clinical Practitioner or Minor Illness Practitioner. They can work alone but are supported within the OOH service by the Clinical Practitioners or GP’s. All of these practitioners triage patients who are 3 years and over.

Out of Hours (OOH) Minor Illness Practitioner: These nurses or paramedics are trained to a minimum of BSc (degree) level and have completed an additional diploma qualification in Minor Illness. They are able to undertake consultations for patients presenting with minor illness only. They can work alone but are supported within the OOH service by the Clinical Practitioners or GP’s. All of these practitioners see patients 5 years and over. Some of the nurses are qualified as Independent Prescribers (IPs), enabling them to generate and sign prescriptions; whilst those who are not IPs utilise PGDs to enable them to dispense from the OOH pharmacy.

Out of Hours (OOH) Clinical Practitioner: These nurses or paramedics are trained to MSc (Masters) level and are either an Advanced Nurse Practitioner or an Advanced Paramedic Practitioner. They can undertake autonomous consultations and are able to assess, diagnose, treat/prescribe and refer on to other health care professionals as and when needed. They have admission rights, which allows them to refer in to the secondary care system, including medicine, surgery, ENT, children's assessment unit (above 5yrs of age), and A+E. If support is required they may call upon one of their OOH GP colleagues. All of these practitioners see patients 5 years and over. Some of the nurses are qualified as Independent Prescribers enabling them to generate and sign prescriptions while the paramedics are currently utilising PGDs to enable them to dispense from the OOH pharmacy.
Using a biopsychosocial understanding of health, **complex conditions** refers to the presence of multiple health disorders or the interaction between two or more health disorders. **Complex need is defined** as relating to patients whose requirements are multifactorial, overlapping and which vary in their presentation for person to person. Contributory factors are biological, psychological or sociological in nature; including long-term (chronic) conditions, co-morbidities, increasing age, frailty, psychological or mental health related, and social or family circumstances. A person with complex need may require the support of both health and social services.

Along with the primary care shift and demographic changes of age and disease profile, it is stated that patients now need care for complex conditions at home (Queen’s Nursing Institute, 2011) or that patients at home have greater need for more complex care (Coleman, 2003; King’s Fund, 2012a; Department of Health, 2013). Thus, community-based patients are increasingly likely to have complex needs (Kings Fund, 2012b).

The increasing multiplicity and complexity of community-based patients’ needs has been described as a “care quake” (Department of Health, 2010) and primary care and community nurses are a central position to meet such needs. In addition, the environment of contemporary health and social care is complex, which requires knowledge, skills and confidence to negotiate for the benefit of patients and families.

Primary care and community nurses report the need to maintain a broad, diverse set of skills to deliver expert clinical care and reduce avoidable hospital admissions. An increasing assortment and sophistication of medical equipment is being used within the home. which district and community nurses need to be familiar with and practised at using. This expertise enables complex patients to stay at home or be discharged from hospital earlier than would have previously been possible.

Recognition of sepsis is made through use of the community-based NEWS assessment, which means that early identification can be made of individuals exhibiting clinical signs of sepsis.

**District and community nurses excel at holistic assessment, tackling this through juggling the interlinking elements at play for an individual patient.** Reported by the district and community nurses in Wales as being complex, the policy-driven shift of health services away from hospital towards community care settings, changing health needs within the community-based patient population and the Welsh Government’s aim to “enable nurses to assess the severity of patients’ conditions, whether they are likely to deteriorate, and what their ongoing needs will be”, a research study within Wales investigated district nursing assessment for community-based patients with complex needs.
It is more important than ever to recognise, acknowledge, understand and support the educational requirements of primary care and community nurses who support people 24 hours a day, 7 days a week, so that prudent healthcare principles can be applied to ensure patients’ holistic and complex needs are addressed safely and by the person best placed to support continuity and expertise.

**EXAMPLE CASE STUDY**

An RCBC-funded PhD study aimed to develop and validate an instrument to identify and measure complex need for community-based patients. The investigation addressed district nursing assessment for community-based patients with complex needs and the Welsh Government’s aim to “enable nurses to assess the severity of patients’ conditions, whether they are likely to deteriorate, and what their ongoing needs will be”.

The development of the Patient Complexity Instrument (PCI) involved widespread stakeholder participation and continuous consultation. Through gaining all-Wales agreement from a diverse range of perspectives, the instrument’s items targeted the areas that district nursing clinicians, managers and strategic planners regard as crucial components of complexity for community-based patients. The PCI was tested in practice by district nurses, during assessments of community-based patients’ needs. Validity and reliability of the instrument was established in its applied context.

The results demonstrate the issues, identified by district nurses, associated with complex care in the community, including: patient engagement, social contact, clinical need, family and care givers, resources and safety, which may predispose an adult patient to increased complexity of need.
When death is inevitable, help to maintain the best possible quality of life until its end.

With an increasingly ageing population, myriad long-term conditions, better treatments to manage symptoms and prolong life and an increased focus on community-based care for people living with long-term and/or life-limiting conditions, there is a growing need to provide well-planned, un-interrupted community and home-based palliative and end of life care for people, including children.

The Queen’s Nursing Institute (QNI) defines palliative care as the “active holistic care of patients with advanced progressive illness. Symptom management, and the provision of psychological, social and spiritual support is paramount. The key goal of palliative care is the achievement of best quality of life for patients and their families”.

Key issues for primary care and community nursing include; provision of support for patients with life-limiting conditions other than cancer, advanced care planning to determine people’s needs and preferences, enhanced carer support and self-care, high quality 24 hour clinical management and service provision, achievement of gold standard expectations and good communication across health, care and third sector boundaries.

Primary care and community nursing teams deliver excellent palliative care for patients at the end of life and enable patients to die well where they choose, when supported by open and easy access to timely specialist support and expertise. District Nursing teams are central to supporting patients’, families’ and carers’ needs for palliative care within the community, where approximately 40% of district nursing time is spent in this way.

In recognition of the importance of the nursing role in supporting people’s needs for palliative and end of life care, RCN (2015) recommends that nurses are enabled to:

- treat people compassionately
- listen to people
- communicate clearly and sensitively
- identify and meet the communication needs of each individual
- acknowledge pain and distress and take action
- recognise when someone may be entering the last few days and hours of life
- involve people in decisions about their care and respect their wishes
- keep the person who is reaching the end of their life and those important to them up to date with any changes in condition
- document a summary of conversations and decisions
- seek further advice if needed
- look after themselves and their colleagues and seek support if needed

GPNs are involved in end of care matters on behalf of patients, their families and carers. For example, through their ongoing knowledge of patients and their families, simply removing patients from practice-based invitations for appointments has alleviated distress.
District and community nurses help people to stay at home, to receive care in their preferred place and wherever their home is situated, including in a care home.

Heart Failure specialist nurse are working with GPNs in practice to update GPNs’ knowledge of heart failure. This has resulted in GPNs being more confident and competent to support individuals with key aspects of heart failure care, including: medication usage and efficacy, maintaining a healthy blood pressure, lifestyle choices. It is also enabling individuals to discuss aspects of their care planning, including end of life care.

To improve the care journey for people living in local care homes, district nurses within Newport have worked with care home colleagues to undertake advanced care planning with residents and their families. This initiative aims to ensure that residents’ wishes are met, as a result of facilitated discussions between an individual resident, their families, carers and all staff who come into contact with the resident during their day and nights.

Working in this way has increased the confidence of care home staff to provide the support and care during any period when care needs change, for example when health deteriorates temporarily or longer term. It enables district nurses and care home staff to work as a co-ordinated team to provide the holistic care needed by an individual, as conversations have already been shared and plans made for anticipated eventualities. Such discussion enables planned care within the person’s own home, instead of resorting to unplanned admissions if and when deterioration occurs.

To further enhance the care experience, district nurses have also completed training in verification of death, so that continuity of care and support is maintained for residents and families when death occurs.

Community Children’s Nurses are actively involved in supporting the palliative care and end of life care needs of children.

A large proportion for the CCN caseload is children and young people with life-shortening conditions and who are classed as requiring palliative care. The CCN is responsible for providing healthcare within a partnership approach, working closely with other health professionals and Children’s Disability Services in the Local Authority; acting as the key worker where appropriate. This approach has resulted in a move away from the medical model of care towards person centred approaches with the focus on the child’s voice and co-produced plans. The child’s journey through levels of care needs is monitored and the CCN has a joint role with the social worker in ensuring that support services are identified and increasing need is identified early with the move into continuing care and/ or end of life care made appropriately. The CCN provides direct end of life care liaising with the paediatric palliative care clinical nurse specialists and the Children’s Hospice to support families for the end of life phase.
Challenges for the development of primary care and community nursing in Wales

The workshop identified the challenges of delivering current and anticipated increased levels of care and support without the workforce numbers required. Recruitment and retention were identified as the biggest challenges for primary care and community nursing.

Primary care and community nursing colleagues identified variation in service provision across Wales, including in NHS and general practice environments. Whilst this enables individualised support and care for patients and families, there is a risk of not having ‘gold standards’ across Wales. For example, in development of new roles such as community nursing health care support workers at band 4 and general practice-based advanced nurse practitioners.

The variation of service provision within general practice nursing is celebrated for its ability to meet the needs of local population, whilst also appreciated as a limiting factor in achieving consistent standards and role development across Wales. For example, an all-Wales policy for every primary care and community nursing team to include at least one independent nurse prescriber would singularly improve the ability of primary care and community nurses to provide complete episodes of support for people with long-term conditions. There should be a renewed Welsh Government focus on rolling out nurse independent prescribing within primary care.

Primary care nursing leadership is neither formalised nor standardised within Wales, despite the policy direction of travel. An all-Wales policy for every Cluster to include a Nurse Consultant in Primary and Community Care would ensure locally-based leadership for clinical development, education, learning and research, based on the needs of local communities (see role descriptors at appendix 1).

Primary care and community nursing colleagues recognise the place of Primary Care Clusters as the vehicles for transformational change. However, it can be difficult for primary care and community nurses to take part in Cluster activities, especially where there is a dominant focus on general practice and the business model of independent contractor-based primary care. Primary care and community nurses are key partners in achieving the strategic and policy-led aspirations being developed through Cluster working and call for nursing leadership to maximise the ability to contribute expertise and work in closer partnerships through this model.

Whilst celebrating the unique ways of working that general practice nursing offers in partnership with GP teams, GPNs proposed that opportunities could be enhanced through direct connectivity to nursing leadership at Health Board level, including to Directors of Nursing. Some workshop participants argued that Health Board employment would benefit patient care, through the ability to address standards, education, CPD and other professional issues on a broader basis than employment by individual, independent contractor practices currently allows.

It is reported that, as community children’s nursing (CCN) services and teams often sit within secondary care funding, this impacts on fully maximising the CCN collaboration within primary and community care. This could be considered when seeking ways of improving community-focused, place-based care and support for children and young adults’ health and well-being.
Requirements for sustainability and growth of primary care and community nursing in Wales

- Primary care and community nurses are mindful of the need for a contemporary understanding of the range and scope of their roles, to enable flexible responses that meet patients’ needs.

- There is a need for continued and appropriate education provision and opportunities suited to the contemporary context of care.

- There is recognition of the value of a joint training culture, to support MDT sharing and learning.

- The need for technological support is highlighted as an enduring concern, to enable continuity and safety through access to patient information, information capture and sharing.

- There is a need for investment in workforce planning structures and processes, such as a career pathway and education framework within general practice nursing. This is an explicit requirement relating to a workforce that falls outside NHS terms and conditions of employment.

- A career pathway and education framework which is focused specifically on general practice nursing is identified as central to the achievement of consistent, safe levels of nursing care and support within general practice.

- There is an identified need for investment in primary care and community nursing leadership roles, development and succession planning, including at Consultant Nurse and Cluster Lead level.

- There is an identified need to support a culture of enquiry and learning through a research-based approach within primary care and community nursing clinical practice, which is not currently addressed through existing structures or processes. The role of Consultant Nurse within Clusters would enable a focused, professionally-led emphasis on practice and service development through use of empirical approaches to research and evaluation (see role descriptors at appendix 1).

- There is an identified need for investment in primary care and community nursing leadership roles, development and succession planning, including at Consultant Nurse and Cluster Lead level.

- There is a need for continued and appropriate education provision and opportunities suited to the contemporary context of care.

- There is a need for continued and appropriate education provision and opportunities suited to the contemporary context of care.

- There is an identified need for investment in primary care and community nursing leadership roles, development and succession planning, including at Consultant Nurse and Cluster Lead level.

- There is an identified need to support a culture of enquiry and learning through a research-based approach within primary care and community nursing clinical practice, which is not currently addressed through existing structures or processes. The role of Consultant Nurse within Clusters would enable a focused, professionally-led emphasis on practice and service development through use of empirical approaches to research and evaluation (see role descriptors at appendix 1).

- There are opportunities for Primary Care and Community Nursing to improve healthcare continuity for the people of Wales. For example, a minimum of one nurse independent prescriber in every Primary Care and Community Nursing team would result in the ability to complete episodes of care within the home or surgery setting, without the need to involve a medical health professional. This would also reduce time pressures on GPs, thereby improving access to GP resources.
## А Healthier Wales

<table>
<thead>
<tr>
<th>A Healthier Wales</th>
<th>Primary care and community nurses ...</th>
<th>Primary care and community nurses commit to ...</th>
<th>To achieve this, primary care and community nursing requires ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services will be designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.</td>
<td>Consider the whole person and their biological, psychological, social, cultural or spiritual needs.</td>
<td>Understand the health and care needs of local populations and individuals, based on available information, data and evidence.</td>
<td>Recognition of the need for time and resources (including connected IT systems) to undertake meaningful, focused health and care needs assessments.</td>
</tr>
<tr>
<td>Everyone in Wales should have longer healthier and happier lives, able to remain active and independent, in their own homes, for as long as possible.</td>
<td>Empower people to achieve, maintain or recover independence.</td>
<td>Take time to work with individuals and families to understand a person’s wishes and capacity for independence.</td>
<td>Recognition of the need for time and resources to undertake meaningful, individualised holistic assessments that result in collaborative care plans.</td>
</tr>
<tr>
<td>There will be a ‘wellness’ system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.</td>
<td>Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.</td>
<td>Use knowledge and skills to maximise opportunities for illness prevention interventions with individual or groups of people.</td>
<td>Recognition of the need for time and resources to undertake meaningful, assessments of a person’s wishes and capacity for independence.</td>
</tr>
<tr>
<td>There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives.</td>
<td>Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.</td>
<td>Ensure that local, community-based resources and assets are used to their best, for the benefit of every citizen’s holistic needs.</td>
<td>Focused resources to enable primary care and community nurses to access directories of information, such as DEWIS, as routine part of their clinical activities.</td>
</tr>
</tbody>
</table>

*Note: The content in the table is a simplified representation of the original document.*
<table>
<thead>
<tr>
<th>A Healthier Wales</th>
<th>Primary care and community nurses …</th>
<th>Primary care and community nurses commit to …</th>
<th>To achieve this, primary care and community nursing requires …</th>
</tr>
</thead>
<tbody>
<tr>
<td>When people need support, care or treatment, they will be able to access a range of services which are made seamless, and delivered as close to home as possible.</td>
<td>Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences</td>
<td>Ensure that people do not experience avoidable physical, psychological or other harm or distress, by seeking to understand their perceptions and perspectives of their health-related circumstances.</td>
<td>Education in clinical triage and care navigation, to ensure safe and effective signposting at first point of contact to the most appropriate health and care support.</td>
</tr>
<tr>
<td>People will only go to a general hospital when that is essential.</td>
<td></td>
<td>Ensure development of well-balanced primary care and community nursing teams, so that people can receive safe and competent care from staff at all clinical skill levels, from 3 to 8. Ensure at least one nurse independent prescriber within each primary care and community nursing team within Wales.</td>
<td>Focused planning, funding and educational support for developing independent prescribers within all primary care and community nursing teams across Wales.</td>
</tr>
<tr>
<td>Improve the physical and mental well-being of all, throughout their lives, from birth to a dignified end.</td>
<td>When death is inevitable, help to maintain the best possible quality of life until its end.</td>
<td>Provide sensitive, individualised, nursing care for people, assisting their wishes for a preferred place of death.</td>
<td>Co-ordinated education in psychological approaches to supporting health, well-being and decision making. Co-ordinated education for end of life care and certification of death.</td>
</tr>
<tr>
<td>This whole system approach will be equitable. Services and support will deliver the same high quality of care, and achieve more equal health outcomes, for everyone in Wales.</td>
<td>Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of community-based care</td>
<td>Contribute expertise to and support the development of career pathways for primary care and community nursing teams, to enable equal health outcomes for people receiving care from a consistently well-educated skill mix, with standardised job descriptions. Lead, contribute to and support the development of ‘gold standard’ best practice for all areas of primary care and community nursing.</td>
<td>Focused education and career framework for primary care nursing teams, as committed by the Cabinet Secretary for Health and Social Services in Wales. Health and care systems continuity to ensure consistent, joined-up approaches.</td>
</tr>
<tr>
<td>The shift in resources to the community will mean that when hospital-based care is needed, it can be accessed more quickly.</td>
<td>Use the experiences and learning from pilots and new initiatives in primary care and community nursing, to shape teams that help people receive safe and relevant community-based care, where hospital would otherwise be the only available option. Continue to shape, lead and provide individualised and population-based, evidence-led, evaluated, efficient and sensitive nursing care to meet the contemporary needs of patients and the community-focused NHS in Wales.</td>
<td>Focused support and resources for primary care and community nurses to generate evaluations of the impact of nursing practice, including the use of frameworks such as Time Spent at Home, Economic Analysis, Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs). A Welsh Clinical Leadership Training Fellowship scheme, to develop high quality clinical leaders in primary care and community nursing. Focused development of primary care clinical leadership roles, to ensure increased numbers of nurses with the knowledge, skills and experience for Primary Care Cluster Lead roles. Recruitment of one Nurse Consultant in Primary and Community Care within each Primary Care Cluster in Wales (see role descriptors at appendix 1).</td>
<td></td>
</tr>
</tbody>
</table>
Summary

In continuing to meet the health and well-being needs with the people of Wales, primary care and community nurses will...

1. Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.

2. Consider the whole person and their biological, psychological, social, cultural or spiritual needs.

3. Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.

4. Empower people to achieve, maintain or recover independence.

5. Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences.

6. When death is inevitable, help to maintain the best possible quality of life until its end.

7. Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of care.
Appendices

Appendix 1: A Selection of Primary Care and Community Nursing Role Descriptors (taken from RCN Wales, 2017)

General Practice Nurse (NMC Registered with additional specialist registerable qualification)
- Autonomous practitioner
- Work closely with the general practice team to meet the needs of patients, whilst supporting the delivery of policy and procedures, providing nurse leadership
- Assess, plan, develop, implement and evaluate wellbeing programmes
- Implement and evaluate individual treatment plans for patients with long-term conditions
- Undertake a range of practice nurse duties including management of long term conditions, wound care, cervical cytology, travel vaccinations and childhood immunisations, undertake relevant diagnostic tests
- Prioritise health problems and intervene appropriately to assist the patient in complex, urgent or emergency situations, including initiation of effective emergency care
- Promoting the Public Health including national screening programmes

Advanced Nurse Practitioner (NMC Registered with additional specialist recordable qualification, opportunity to be RCN credentialed)
- Autonomous, advanced practice, with an extended scope of practice delivering care within relevant specialism following referral
- Provide specialist assessment, diagnosis, treatment and evaluation of care
- High level of clinical reasoning /diagnostic skills, offering a wide range of treatment/rehabilitation programmes to patients with highly complex needs
- Provide a first point of contact within the Practice for patients presenting with undifferentiated, undiagnosed problems, making use of skills in history taking, physical examination, problem-solving and clinical decision-making, to establish a diagnosis and management plan
- Initiate, lead and develop regular research, audit, evaluation and implementation of evidence based practice and support others undertaking research projects
- Demonstrate advanced critical thinking and analytical skills acting as a source of clinical expertise and knowledge to other professionals
- Advise on recommended management across the whole patient pathway, which includes prevention, community, long term and end of life care
- Order, interpret and act upon medical investigations and expedite access to appropriate medical staff

Consultant Nurse in Primary and Community Care (NMC Registered with additional specialist registerable / recordable qualification)
- Autonomous practitioner with a minimum of 50% provision of direct care
- Expert advanced practice working with patients, clients and/or communities making critical clinical judgements and decisions where a precedent may not exist
- Responsible for management of a complex caseload providing and managing an expert clinical advisory service
- Ensure there is adherence to the ethical and moral dimensions of practice
- Fulfil a role in clinical governance, providing expert input and working to secure quality improvement across a wide spectrum of care provision
- Contribute to strategic planning and local implementation of national policies
- Evaluate clinical services, leading development of new services and/or redesign
- Take the lead in initiating and developing cross-disciplinary services and interagency working that contribute to multi-professional standards and guidelines
- Make and receiving direct patient/client referrals; undertaking an assessment of individual need and drawing on appropriate interagency and cross-boundary collaboration and expertise to best meet the needs of the patient/client.
Provide effective leadership and example that inspires and sustains commitment of colleagues and facilitates empowerment of others
Publish research or have, or be working towards a doctorate
Contribute to the development, and evaluation of educational programmes
Lead research and audit and contribute to the wider research agenda, establishing research partnerships with HEIs and other research communities.

General Practice Health Care Support Worker (Non-registered)
Deliver nursing care as part of a nursing team under direct or indirect supervision within an agreed framework, and report any changes without delay
Assist in communicating and sign-posting towards self-care and health promotion
Work within guidelines, undertake delegated activities including stock control, vaccines cold chain, patient chaperone and infection control
Work within guidelines, provide care such as spirometry, health checks, venepuncture and physiological measurements, reporting results to the registered nurse

District Nursing Team Leader (NMC Registered with additional specialist registerable qualification)
Provide enhanced clinical support and expertise to the patients within the locality attending complex MDT’s in the hospital & community settings
Coordination between caseload holders, community resource services, secondary care wards and specialist nurses to ensure safe effective discharges and proactive preventative interventions to maintain people within their home environment
Lead on standards and professional practice supporting staff in new ways of working
Work closely with primary care teams within the networks, ensuring effective communication and safe effective care pathways within the networks including assessment and referral to prevent unnecessary hospital admission

Community Nurse (NMC Registered)
Take responsibility for all aspects of ongoing nursing care and provide comprehensive packages of nursing care in people’s own home under the indirect supervision of the Caseload Holder
Ensure close collaboration with the multi-disciplinary team participating in MDT discussions in relation to risk assessments to ensure safety of the individual, fellow patients and staff
Conduct interim first visit/patient contact, which will be re-assessed by the Caseload holder within 24 hours. Signpost individuals to appropriate community services to meet their ongoing needs
Report any risks or hazards and assist in developing and establishing methods and procedure to prevent/minimise the risk
Ensure the health, safety and welfare of self, colleagues, patients/clients, carers and all other persons involved in their field of practice
Make changes to care plans following review, reporting these to the Senior Nurse

Occupational Health Nurse (NMC Registered with additional specialist registerable qualification)
Provide clinical support and expertise to the patients within the locality attending complex MDT’s in the hospital & community settings
Coordination between caseload holders, community resource services, secondary care wards and specialist nurses to ensure safe effective discharges and proactive preventative interventions to maintain people within their home environment
Lead on standards and professional practice supporting staff in new ways of working
Work closely with primary care teams within the networks, ensuring effective communication and safe effective care pathways within the networks including assessment and referral to prevent unnecessary hospital admission

Improve end of life care planning and implementation
Operationally line manage and professionally lead, the community nursing team
**Children’s Community Nurse (NMC Registered with additional specialist recordable qualification)**

- Support the child, family and carers, in response to maximise the child or young person’s independence and quality of life
- Provide nursing care to children and young people with complex care needs, including complex medical support as part of everyday or end-of-life care
- Support children and young people receiving Continuing Care packages and end of life care across 24/7 including weekends and bank holidays
- Provide clinical assessment and support for children in community settings who have a health care need as part of working with primary care services preventing unnecessary hospital admissions and facilitate early discharge
- Carry out specific health care assessments or interventions in community settings
- Plan care for children with acute health needs for review with the senior staff as appropriate, report changes in the child’s condition or outcomes of interventions
- Participate in the administration of medicines, including intravenous therapy and be aware of current drugs/therapies in the treatment of pain and other symptoms.

**Community Clinical Nurse Specialist (NMC Registered with additional specialist recordable qualification)**

- Work autonomously and plays a pivotal role in leading clinical practice and improving standards of care, promote a seamless service through clinical practice, management, education, research, audit and professional activities
- Work as part of a team, developing nurse led services and provide specialist nursing input at all stages of the patient’s episode of care
- Lead clinical care by managing a defined patient caseload, providing an expert assessment, plan and evaluation, facilitate education for patients and their families
- Provide Rapid Access Clinics that do not require Consultant supervision
- Ordering, analysis and interpretation of pathology, radiology and microbiology investigations
- Act as a point of referral for patients in the community experiencing problems arising from their condition and/or its treatment by providing a telephone help line service
Appendix 2: Programme, RCN Wales Primary Care and Community Nursing Summit: June 12th 2019

<table>
<thead>
<tr>
<th>TIME</th>
<th>RCN Wales Primary Care and Community Nursing Summit: ‘Meeting the Agenda for A Healthier Wales’ June 12th 2019 PROGRAMME</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.00 – 13:00</td>
<td>Registration &amp; Lunch</td>
</tr>
<tr>
<td>13:00 – 13:10</td>
<td>WelcomeNicola Davis-Job, Interim Associate Director (Professional Practice) RCN Wales</td>
</tr>
<tr>
<td>13:10 – 13:15</td>
<td>Chair’s Introduction to the SummitDr Sue Thomas, Primary Care, Community and Independent Sector Adviser, RCN Wales</td>
</tr>
<tr>
<td>13:15 – 13:35</td>
<td>The Strategic Programme for Primary Care in WalesSue Morgan, National Director &amp; Strategic Programme Lead for Primary Care</td>
</tr>
<tr>
<td></td>
<td>Questions</td>
</tr>
<tr>
<td>13.40 – 14.05</td>
<td>The Contemporary Picture for Primary Care and Community NursingDr Crystal Oldman,Director, Queen’s Nursing Institute, UK</td>
</tr>
<tr>
<td></td>
<td>Questions</td>
</tr>
<tr>
<td>14.10 – 14.30</td>
<td>The Role of Health Education and Improvement Wales (HEIW) and Primary Care and Community NursingStephen Griffiths, Director of Nursing, Health Education and Improvement Wales</td>
</tr>
<tr>
<td></td>
<td>Questions</td>
</tr>
<tr>
<td>14:40 – 15:00</td>
<td>Tea and Coffee</td>
</tr>
<tr>
<td>15:00 – 16:30</td>
<td>WorkshopsDelegates will be invited to work with colleagues to address key questionsFacilitators: Sue Thomas, Diane Powles, Lisa Turnbull</td>
</tr>
<tr>
<td>16:30 – 16:50</td>
<td>Feedback, Early Conclusions, Recommendations and The Way Forward</td>
</tr>
<tr>
<td>16:50 – 17:00</td>
<td>Summary and Closing RemarksStephen Griffiths, Director of Nursing, Health Education and Improvement Wales</td>
</tr>
<tr>
<td>17:00</td>
<td>Close</td>
</tr>
</tbody>
</table>
References


King’s Fund (2012a) Transforming the Delivery of Health and Social Care: The case for fundamental change. King’s Fund, London


Queen’s Nursing Institute (2011) Nursing People at Home: The issues, the stories, the actions. Queen’s Nursing Institute, London


RCN Wales (2017) Role Descriptors: The unique contribution of primary and community nursing throughout the life course. RCN Wales, Cardiff

RCN Wales (2018) Nursing Numbers in Wales. RCN Wales, Cardiff


NYRSIO GOFAL SYLFAENOL A CHYMUNEDOL AR GyFER CYMRU IACHACH
Nyrsio Gofal Sylfaenol a Chymunedol

go faults a gwyfogir i weithio mewn tim nyrsio ymarfer cyffredinol, fel arfer i gynorthwyo à bodloni gofynnion cytundebol meddygon teulu yn y GIG yng Nghymru. Mae gwraith y tim nyrsio ymarfer cyffredinol yn canolbwyntio ar ddarparu cymorth nyrsio i bobl o bob oedran, ond i oedolion yn bennaf. Mae Nyrsio Cymunedol yn cyfeirio at nyrsys a gwyfogir i weithio mewn tim o nyrsys cymunedol a elwir ar y cyd yn dim nyrsio ardal. Mae nyrs ardal yn nyrs gofrestrwyd a elwir cael addysg benodol à phwyslais ar y gymuned ar ôl cofrestru ac sy’n arwain tím nyrsio ardal. Gan amaf, mae prif gyd-destun y ddarpariaeth gofal nyrsio ardal ar gyfer oedolion nad ydynt yn gallu gadael eu cartrefi i gael cymorth nyrsio. Mae nyrsys cymunedol plant yn darparu cymorth i blant mewn lleoliadau cymunedol, gan atal derbyniodd diangen i'r ysbyty a hwyluso rhyddhad cynnar.

Ynglŷn â'r Coleg Nyrsio Brenhinol (RCN)

Y Coleg Nyrsio Brenhinol yw'r sefydliad proffesiynol a'r undeb llafrwm mwyaf yn y byd ar gyfer nyrsys, ac mae'n cynrychioli dros 435,000 o nyrsys, bydwragedd, ymwelwyr iechyd, gweithwyr cymorth gofal iechyd a myfyrywyr nyrsio, gan gynnwys dros 25,000 o aelodau yng Nghymru. Mae'r RCN yn sefydliad sy'n gwasanaethu'r DU gyfan ac mae ganddo ei Byrdiau Cenedlaethol ei hun yng Nghymru, Yr Alban a Gogledd Iwerddon. Mae'r RCN yn cyfrani â pharisoedd a pholisi cyhoeddus sy'n effeithio ar iechyd a nyrsio. Mae'r RCN yn gweithio ar lefel leol, genedlaethol a phhyngniadaeth mewn arfer nyrsio a buiddiant cleifion, nyrsys a'r profesiwn nyrsio. Mae aelodau'r RCN yn gweithio ym mhob lleoliad, gan gynnwys gofal sylfaenol, cymunedol, cartrefi gofal, ysgolion, carcharhaedig dychwelyd, a hynny yn y sector annibynnol a'r GIG. Mae tua dwy ran o dair o'n haelodau wedi'i lleoli yn y gymuned.

Cysylltwch â Choleg Nyrsio Brenhinol Cymru i gael rhagor o wybodaeth am unrhyw bwyntiau a godwyd ym yr adroddiad hwn.
NYRSIO GOFAIL SYLFAENOL A CHYMUNEDOL
AR GYFER CYMRU IACHACH

Cynnwys

Cyfranogwyr 2

Crynodeb Gweithredol 4

Cyflwyniad 6

Cefndir 7

Y gweithlu nyrsio gofal sylfaenol a chymunedol yng Nghymru 9

Ymrwymiadau nyrsio gofal sylfaenol a chymunedol 10

Ymrwymiadau nyrsio gofal sylfaenol a chymunedol
Gweithio gydag unigolion, eu teuluoedd a'u gofalwyr i nodi anghenion nyrsys; 10
ymyriadau therapiwtig a gofal personol; gwybodaeth, addysg, cyngor ac
eiriolaeth; a chymorth corfforol, emosiynol ac ysbrydol

Gweithio mewn partneriaeth â chieffion, eu perthnasau a gofalwyr eraill, 11
ac mewn cydweithrediad ag aelodau eraill o dîm amiddisgyblaeth, yn aml fel
cydgysylltydd gofal

Ystyried y person cyfan a'i anghenion biolegol, seicolegol, cymdeithasol, 13
diwylliannol neu ysbrydol

Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, 14
anafladau ac anabledd

Grymuso pobl i gyflawni, cynnal neu adfer annibyniaeth 18
Lleihau gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â'u cyflwr,
triniaeth a chanlyniadau

Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl
hyd y diwedd 20

Heriau ar gyfer datblygu nyrsio gofal sylfaenol a chymunedol yng Nghymru 22

Gofynion ar gyfer cynaliadwyedd a thwf nyrsio gofal sylfaenol a chymunedol 23
yng Nghymru

Y cysylltiad rhwng Cymru Iachach, yr ymrwymiad nyrsio gofal sylfaenol 24
a chymunedol a’r gofynion adegol i gyflawni’r ymrwymiad

Crynodeb o’r ymrwymiad nyrsio gofal sylfaenol a chymunedol 26

Atodiadau 27

Cyfeiriadau 31
Dymuna’r Coleg Nyrsio Brenhinol (RCN) ddiolch i’r unigolion canlynol am gyfrannu at Uwchgynhadledd Nyrsio Gofal Sylfaenol a Chymunedol RCN Cymru ac i’r adroddiad hwn:

Deborah Armstrong
Pennaeth Addysg, Ymarfer Profesiynol a Chlinigol (Nyrsio) Dros Dro Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru

Thomas Barton
Uwch-ymarferydd Arweiniol (ACT Pen-y-bont ar Ogwr) Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Hannah Bauch
Rheolwr Tim, Nyrsys Ardal Bwrdd lechyd Prifysgol Aneurin Bevan

Carole Bell
Cyfarwyddwr Nyrsio ac Ansawdd Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Catherine Blakemore
Nyrs Ardal Gogledd Sir Benfro Bwrdd lechyd Prifysgol Hywel Dda

Catherine Davies
Nyrs Gymunedol Bwrdd lechyd Prifysgol Caerdydd a’r Fro

Anita Davies
Pennaeth Nyrsio De Powys Bwrdd lechyd Addysgu Powys

Catherine Davies
Nyrs Gymunedol Bwrdd lechyd Prifysgol Bae Abertawe

Nicola Davis-Job
Cyfarwyddwr Cyswllt Dros Dro (Ymarfer Profesiynol) RCN Cymru

Melissa Duffy
Nyrs Gymunedol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Kerry Collins
Nyrs Gymunedol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Caroline Frost
Datblygiad Proffesiynol ac Ymarferol Cymunedol Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Paul Crank
Dirprwy Bennaeth Nyrsio ar gyfer Gofal Sylfaenol ac Ardaloedd Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Lynne Cronin
Uwch-nyrs Gofal Sylfaenol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Nicola Darroch
Nyrs Datblygiu Ymarfer - Cymunedol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Anita Davies
Pennaeth Nyrsio De Powys Bwrdd lechyd Addysgu Powys

Catherine Davies
Nyrs Gymunedol Bwrdd lechyd Prifysgol Bae Abertawe

Nicola Davis-Job
Cyfarwyddwr Cyswllt Dros Dro (Ymarfer Profesiynol) RCN Cymru

Melissa Duffy
Nyrs Gymunedol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Kerry Collins
Nyrs Gymunedol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Caroline Frost
Datblygiad Proffesiynol ac Ymarferol Cymunedol Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Paul Crank
Dirprwy Bennaeth Nyrsio ar gyfer Gofal Sylfaenol ac Ardaloedd Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Lynne Cronin
Uwch-nyrs Gofal Sylfaenol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg

Nicola Darroch
Nyrs Datblygiu Ymarfer - Cymunedol Bwrdd lechyd Prifysgol Cwm Taf Morgannwg
Lucy Kings
Arweinydd Clinigol ar gyfer Nyrsio Gofal Sylfaenol
Bwrdd Iechyd Prifysgol Aneurin Bevan

Paul Labourne
Swyddog Nyrsio ar gyfer Gofal Sylfaenol, Integreiddio ac Arloesi
Llywodraeth Cymru

Lynwen Law
Uwch-nyrs ar gyfer Nyrsio Ardal
Bwrdd Iechyd Prifysgol Aneurin Bevan

Polly Leett
Uwch-nyrs Gofal Sylfaenol
Bwrdd Iechyd Prifysgol Hywel Dda

Lesley Lewis
Cyfarwyddwr Cyswllt Nyrsio, Gofal Sylfaenol a Chymunedol
Bwrdd Iechyd Prifysgol Aneurin Bevan

Sian Lewis
Nyrs Arweiniol Glinigol ar gyfer y Gymuned, Ceredigion
Bwrdd Iechyd Prifysgol Hywel Dda

Amanda Liddon
Nyrs Datblygu Ymarfer
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Eve Lightfoot
Tim Ymateb Acíwt Nyrsys Ardal
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Alison Magor
Aelod o Fwrdd RCN Cymru ac Arweinydd Tim Nyrsys Ardal
RCN Cymru a Bwrdd Iechyd Prifysgol Aneurin Bevan

Sue Morgan
Cyfarwyddwr Cenedlaethol ac Arweinydd Rhaglenni Strategol ar gyfer gofal Sylfaenol
GIG Cymru

Teresa Neate
Nyrs Gymunedol
Bwrdd Iechyd Prifysgol Caerdydd a’r Fro

Chloe Neave
Arweinydd Tim, Tim Adnoddau Cymunedol
Bwrdd Iechyd Prifysgol Caerdydd a’r Fro

Gina Newbury
Darlithydd: Nyrsio Gofal Sylfaenol a lechyd Cyhoeddus
Prifysgol Caerdydd

Juliet Noorwood
Nyrs Arweiniol Rhanbarthol De-ddwyrain
Cymru, Fframwaith Canser Gofal Sylfaenol
Macmillan
Iechyd Cyhoeddus Cymru

Crystal Oldman
Prif Weithredwr Sefydiad Nyrsio’r Frenhines

Donna Pace
Darlithydd Astudiaethau Iechyd Cymunedol
Prifysgol De Cymru

Diane Powles
Cynghorydd Addysg a Dysgol Gydol Oes
RCN Cymru

Carol Preece
Uwch-nyrs
Bwrdd Iechyd Prifysgol Caerdydd a’r Fro

Ruth Richardson
Nyrs Arweiniol ar gyfer Plant a Phobl Ifanc
Bwrdd Iechyd Addysgu Powys

Rhys Roberts
Arweinydd Tim Nyrsys Ardal
Bwrdd Iechyd Prifysgol Caerdydd a’r Fro

Katrina Rowlands
Cyfarwyddwr Cynorthwyol Nyrsio
Bwrdd Iechyd Addysgu Powys

Cathryn Smith
Darlithydd: Gofal Sylfaenol ac lechyd Cyhoeddus
Prifysgol Caerdydd

Andrea Surridge
Cyfarwyddwr Rhaglen – BS/MSc Nyrsio Ardal
Ymarfer Arbenigol
Prifysgol Abertawe

Sue Thomas
Nyrs Ymgynghorol lechyd Plant Cymunedol
Bwrdd Iechyd Prifysgol Aneurin Bevan

Sian Thomas
Consultant Nurse Community Child Health
Aneurin Bevan UHB

Michelle Treasure
Nyrs Datblygiad Profesiynol ac Ymarfer, Tim Gofal Sylfaenol
Bwrdd Iechyd Prifysgol Caerdydd a’r Fro

Kate Wakeling
Uwch-nyrs Practis
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Jo Webber
Pennaeth Nyrsio – Is-adran Gymunedol
Bwrdd Iechyd Prifysgol Aneurin Bevan

Shirley Willis
Darlithydd: Nyrsio Gofal Sylfaenol a lechyd Cyhoeddus
Prifysgol Caerdydd

Fiona Wood
Uwch-nyrs, Tim Adnoddau Cymunedol
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg
### Crynodeb Gweithredol

<table>
<thead>
<tr>
<th>MAE NYRYSYS GOFAL SYLFAENOL A NYRYS CYMUNEDOL YN YMRWYMO I...</th>
<th>MAE’R GOFYNION ATEGOL I GYFLAWNIR’R YMRWYMIADAU YN CYNNWYS...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deall anghenion iechyd a gofal poblogaethau lleol ac unigolion ar sail yr wybodaeth, data a thystiolaeth sydd ar gael.</td>
<td>Adnabod yr angen am amser ac adnoddau (gan gynnwys systemau TG cysylltiedig) i gynnal asesiadau iechyd a gofal ystyrlon a phenodol.</td>
</tr>
<tr>
<td>Cynnal asesiad unigol a chyfannol o anghenion biolegol, seicolegol, cymdeithasegol, diwylliantol ac ysbrydol, gan ddechrau gyda’r cwestiwn o ‘beth sy’n bwysig i chi?’</td>
<td>Adnabod yr angen am amser ac adnoddau i gynnal asesiadau cyfannol unigol ac ystyrlon sy’n arwain at gynlluniau gofal cydweithredol.</td>
</tr>
<tr>
<td>Deall elfennau canlyniadau ansawdd a diogelwch a’r hyn sy’n bwysig i’r cleifion a’u gofal trwy greu, casglu a defnyddio ymchwil a thystiolaeth.</td>
<td>Cymorth ac adnoddau penodol er mwyn i nyrsys gofal sylfaenol a chymunedol lunio ymchwil empirig yn ymwneud â chanlyniau ansawdd a diogelwch a’r hyn sy’n bwysig i gleifion.</td>
</tr>
<tr>
<td>Neilltuo amser i weithio gydag unigolion a theuluoedd i ddeall dymuniadau a gallu unigolyn i fod yn annibynnol.</td>
<td>Adnabod yr angen am amser ac adnoddau i gynnal asesiadau ystyrlon o ddymuniadau a gallu unigolyn i fod yn annibynnol.</td>
</tr>
<tr>
<td>Neilltuo amser i gyntudo ar gynllun gofal sy’n meithrin annibyniaeth ac yn cefnogi’r anghenion a fynegwyd.</td>
<td>Adnabod yr angen am amser i gyntudo ar gynllun gofal sy’n meithrin annibyniaeth a chefnogi’r cynllun hwnnw.</td>
</tr>
<tr>
<td>Adolygu effaith gofal nyrso ar weithgarwch ac annibyniaeth yr unigolyn.</td>
<td>Cymorth ac adnoddau penodol er mwyn i nyrsys gofal sylfaenol a chymunedol lunio ymchwil empirig yn ymwneud ag effaith gofal nyrso ar weithgarwch ac annibyniaeth unigolyn.</td>
</tr>
<tr>
<td>Defnyddio gwybodaeth a sgiliau i greu’r cyfleodd gorau posibl ar gyfer ymyriadau atal saith gydag unigolyn neu grwpiau o bobl.</td>
<td>Adnabod yr angen am amser i greu’r cyfleodd gorau posibl ar gyfer ymyriadau atal saith gydag unigolyn.</td>
</tr>
<tr>
<td>Defnyddio ffframweithiau cydnabbeddig, megis Gnweud i Bob Cyswllt Gyfrif (MECC), Cyfweli Ysgogiadiol, neu Gymhorthol cynoes eraill, i gfenogri pobl i’w weud newidiadau mewn modd perthnasol ac effeithiol.</td>
<td>Cymorth ac adnoddau i nyrsys gofal sylfaenol a chymunedol i ddysgu am fframweithiau cydnabbeddig sy’n helpu pobl i weud newidiadau sy’n ymwneud ag lechyd, ffordd o fyw neu rai eraill, a defnyddio’r fframweithiau hynny.</td>
</tr>
<tr>
<td>Sicrhau y califf adnoddau ac asedau lleol a chymunedol eu defnyddio yn y ffordd orau er bod anghenion cyfannol pob dinesydd.</td>
<td>Adnoddau penodol i alluogi nyrsys gofal sylfaenol a chymunedol i defnyddio cyfeiriadur gwybodaeth megis DEWIS, fel mater o drefn yn y eu gweithgareddau clinigol.</td>
</tr>
<tr>
<td>Gweithio ar cyd ag amrywiaeth eang o weithwyr iechyd a gofal profesiynol a/neu eu cydgysylltu, i wella’r cymorth unigol sydd ar gael i bobl.</td>
<td>Hwyluso amgylcheddi sy’n ysgogi gwraith tim, gan gynnwys systemau TG ar y cyd, cydleoli ardalodd gweithio a thrwy ddulliau eraill o gyfaithrebu ar unwaith.</td>
</tr>
<tr>
<td>MAE NYRSYS GOFAL SYLFAENOL A NYRSYS CYMUNEDOL YN YMRWYMO I...</td>
<td>MAE’R GOFYNION ATEGOL I CYNNWYS...</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicoleg neu arall trwy geisio deall eu canfyddiadau a’u safbwyntiau o ran eu hamgyrchladiad iechyd.</td>
<td>Addysg mewn brysbennu clinigol a llywio gofal, i sicrhau y caiff pobl eu cyfeirio’n ddigol ac yn effeithiol ar y pwynt cyswllt cyntaf i’r cymorth iechyd a’r gofal mwyaf priodol.</td>
</tr>
<tr>
<td>Sicrhau y datblygir timau nyrsw gofal sylfaenol a chymunedol cytbwys fel bod gofal diogel a chymwys ar gael i bobl gan staff ar bob lefel o sgil unigol, o lefel 3 i 8. Cyfrannu arbenigedd a chynorthwyo datblygiad llwybrau gyrfa ar gyfer timau nyrsw gofal sylfaenol a chymunedol, i alluogi canlyniaidau iechyd cydradd i bobl sy’n derbyn gofal gan gymysgedd sgiliau hydlysg iawn a chyson, a disgrifiadau sywyd safonol.</td>
<td>Addysg benodol â phwyslais a ffframwaith gyrfa ar gyfer timau nyrsw gofal sylfaenol yn unol ag ymrwymiad Ysgrifennydd y Cabinet dros Iechyd Gwasanaethau Cymdeithasol yng Nghymru.</td>
</tr>
<tr>
<td>Sicrhau bod o leiaf un nyr sy’n rhagnodi’n anibynnol ym mhob tîm nyrsw gofal sylfaenol a chymunedol yng Nghymru.</td>
<td>Cyllido, cymorth addysgol a chynllunio penodol i ddatblygu o leiaf un nyr sy’n rhagnodi’n anibynnol ym mhob tîm nyrsw gofal sylfaenol a chymunedol yng Nghymru.</td>
</tr>
<tr>
<td>Darparu gofal nyrsw sensitif ac unigol i bobl, gan gynomorthwyo â’u dymuniadau o ran eu dewis o le i farw.</td>
<td>• Addysg gydgysylltiedig o ddulliau seicolegol o gefnogi iechyd, llesiant a phenderfyniadau. \n• Addysg gydgysylltiedig ar gyfer gofal diwed oedd o a thystysgrif marwolaeth.</td>
</tr>
<tr>
<td>Arwain, cefnogi a chyfrannu at ddatblygiad arfer gorau ‘safon aur’ ym mhob maes nyrsw gofal sylfaenol a chymunedol.</td>
<td>Parhad systemau iechyd a gofal i sicrhau dulliau cyson cydgysylltiedig.</td>
</tr>
<tr>
<td>Defnyddio’r profiadau a’r gwersi a ddysgwyd o raglenii treialu a mentrau newydd mewn gofal sylfaenol a nyrsw ym mhob tîm nyrsw i lunio timau sy’n helpu pobl i gael gofal diogel a pherthnasol yn y gymuned, lle byddai’r ysbyty yn unig ateb fel arall.</td>
<td>Cymorth ac adnoddau penodol er mwyn i nyrsw gofal sylfaenol a chymunedol liniog gwerthusiadau o effaith arfer nyrsw; gan gynnwys defnyddio fframweithiau megis Amser a Dreulir Gartref, Dadansoddiai Economaidd, Mesurau Canlyniaidau a Adroddwyd gan Gleifion (PROM), Mesurau Profiadau a Adroddwyd gan Gleifion (PREM).</td>
</tr>
<tr>
<td>Parhau i ffurfio, arwain a darparu gofal nyrsw unigol, sensitif ac effeithlon sy’n seilliedig ar y boblogaeth ac wedi’i arwain gan dysiolieth, i ddiwallu angenhion cyfoes cleifion a’r GIG yng Nghymru sy’n canolbwyntio ar y gymuned.</td>
<td>• Cynllun Cymrodoriaeth Hyfforddiad Arweinyddiaeth Glinigol Cymru i ddatblygu arweinwyr clinigol a safon mewn nyrsw gofal sylfaenol a chymunedol. \n• Datblygiad penodol o swyddi arweinyddiaeth glinigol gofal sylfaenol, i sicrhau bod gan fwy o nyrswyr yr wybodaeth, y sgiliau a’r profiad i gyfraniad y swyddi arweinwyr Clystryrau Gofal Sylfaenol. \n• Recriwtio un Nyr’s Ymgynghorol ym maes Gofal Sylfaenol a Chymunedol o fewn pob Clwstwr Gofal Sylfaenol yng Nghymru.</td>
</tr>
</tbody>
</table>
Mae’r adroddiad hwn yn nodi barn yr RCN a chlinigwyr arbenigol ar Nyrsio Gofal Sylfaenol a Chymunedol yng Nghymru.

Mae’r adroddiad yn tynnu sylw at ymateb Nyrsio Gofal Sylfaenol a Chymunedol i ‘Cymru Iachach’ (2018) a’r Rhaglen Strategol ar gyfer Gofal Sylfaenol a Chymunedol (2018) Mae’n diffinio’r cyfraniad sydd ei angen gan Nyrsio Gofal Sylfaenol a Chymunedol i gyrraedd nodau trawsnewid Gofal yn Nes at y Cartref yng Nghymru. Mae’r adroddiad yn ffrwyth ymgyngoriad eang â nyrsys a rheolwyr gofal sylfaenol a chymunedol ledled Cymru; y nod yw llywio a chynorthwyo'r rhanddeiliaid dan sylw i ddarparu a chefnogi iechyd a gofal yng Nghymru.

Mae gwireddu'r uchelgeisiau a nodir yn yr adroddiad hwn yn gofyn am weithio’n strategol mewn part neriaeth, a gefnogio addewidion a wnaed gan nyr sy sylfaenol a chymunedol yng Nghymru. Edrychw ymlaen at weithio ar yr ymrwymiadau hyn a’u datblygu wrth i bobl gael cymorth gan nyr sy sylfaenol a chymunedol, Llywodraeth Cymru, Byrddau Iechyd GIG Cymru, Addysg a Gwella Iechyd Cymru, darparwyr Addysg a’r holl randdeiliaid.

Wrth ddiwallu anghenion iechyd a llesiant gyda phobl Cymru ac ar eu cyfer, mae Nyrsys Gofal Sylfaenol a Chymunedol ar gyfer Cymru Iachach.
ysbrydol ac maent yn aml yn gyfuniad o'r rhain. Mae'r term pobl yn cynnwys unigolion o bob oedran, teuluoedd a chymunedau, drwy'r rhychwant bywyd cyfan.

4. Mae pwyslais nyrsio gofal sylfaenol a chymunedol ar y person cyfan a'r ymateb dynol, yn hytrach nag agweddu benodol ar y person neu gyflwr patholegol penodol.

5. Mae nyrsio gofal sylfaenol a chymunedol yn seiliedig ar werthoedd moesegol sy'n parchu urddas, ymreolaeth ac unigrwydd bodau dynol, y berthynas freintieig rhwng y nyrs a'r claf, a derbyn ateolrwydd personol am benderfyniadu a gweithredoedd. Mynegir y gwerthoedd hyn mewn codau ysgrifenedig moeseg a'u cefnogi gan system o reoleiddio proffesiynol.

6. Mae nyrsys gofal sylfaenol a chymunedol yn gweithio mewn partneriaeth â chleifion, eu perthnasau a gofalwyr eraill, mewn cydweithrediaid ag aelodau eraill o dîm amladdyddiaeth, Pan fo'n briodol maent yn arwain tîm, yn rhagnodi, dirprwy o goruchwyliau gwaith eraill; ar adegau eraill byddant yn cymryd rhan cyflym a darllen yr arweinyddiaeth eraill. Fodd bynnag, maent yn atebol yn bersonol ac yn broffesiynol am eu penderfyniadu a'u gweithredoedd eu hunain bob amser.

(O Defining Nursing; RCN, 2014)

Mae gofal iechyd sylfaenol yn darparu'r pwynt cyntaf cyntaf a'r prif bwynt cyflym pan fo gofal yn parhau i gleifion yn y system iechyd a gofal. Mae ymarferwyr gofal iechyd sylfaenol yn cydgyfysglu gofal arbenigol a chymunedol. Yn y GIG yng Nghymru y brif ffiniau o ofal iechyd sylfaenol yw trwy'r meddyg teulu (SB 25/2016. StatsCymru, 2016).

Mae gweledigaeth Llywodraeth Cymru o "Cymru Iachach" wedi rhoi mwy o bwyslais ar wasanaethau iechyd a gofal ar lefel gofal sylfaenol a chymunedol, ac mae'r Rhaglen Strategol ar gyfer Gofal Sylfaenol a Chymunedol yn nodi'r ffyrdd y caiff dyheadau Cymru Iachach a Gofal yn Nes at y Cartref eu cyflawni.

Mae Cymru Iachach (2018) yn nodi'r dyheadau canlynol:

- Dylai pawb yng Nghymru gael bywydau hirach, iachach a hapusach, a dylent allu parhau i gadw'n brysur a bod yn annibynnol yn eu cartref eu hunain gyhyd â phosib.
- Byddwn yn edrych ar iechyd a gofal cymdeithasol fel system gyfan, gyda'r gwasanaethau yn un efen yn unig wrth gefnogi pobl i fwynhau gwell iechyd a lleisiant drwy gydol eu bywydau.
- Bydd yna system 'iachusrwydd' sy'n ceisio cefnogi a rhagweld anghenion iechyd, atal salwch a lleihau effaith iechyd gwael.
- Bydd yr system gyfan yn deg. Bydd gwasanaethau a chymorth yn darparu'r un gofal o ansawdd uchel, ac yn cyflawn canlyniadau iechyd cyfartal, i bawb yng Nghymru.
- Bydd yn gwella lleisiant corfforol a meddyliol pawb, drwy gydol eu bywydau, o'u geni hyd at ddweud urddasol.
- Bydd pan fydd angen cymorth, gofal neu driniaeth ar bobl, bydd modd iddynt ddefnyddio ystod o wasanaethau di-dor, sy'n cael eu darparu mor agos â phosibl at y cartref.
- Bydd gwasanaethau'n cael eu llunio o amgylch yr unigolyn a'r hyn sy'n bwysig iddynt, yn ogystal â chanlyniadau ansawdd a diogelwch.
- Bydd holobol ychydig i ysbty cyffredinol dim ond os yw hynny'n hanfodol.
- Bydd symud y pwyslais at adnoddau yn y gymuned yn golygu bod modd cyrraedd y gofal mewn ysbty yn gyflymach pan fo angen hynny.
Mae Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 yn amlinellu'r pum ffordd o weithio, sy’n cynnwys yr Hirdymor, Atal, Integreiddio, Cydweithredu a Chynnwys; sy’n cyd-fynd yn agos â dyheadau Cymru Iachach.

Mae'r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru yn rhoi camau a gweithgareddau iechyd yng Nghymru o fewn fframwaith strwythurledig. Mae'r Chwe Phrif Ffrwd Gwaith yn cynnwys:

1. Atal a llesiant
2. Y Model 24/7
3. Data a Thechnoleg Ddigidol
4. Datblygiad Sefydliadol a'r Gweithlu
5. Cyfathrebu, Ymgysylltu
6. Y Rhaglen Drawsnewid a'r Weledigaeth ar gyfer Clystyrau

Mae egwyddorion Gofal Iechyd Darbodus (2016) yn llywio datblygiad gwasanaeth iechyd a gofal yng Nghymru, a'r nod yw:

- Cyflawni iechyd a llesiant gyda'r cyhoedd, cleifion a gweithwyr proffesiynol yn bartinariaid cyfartal yn y broses drwy gyd-gynhwyrch
- Gofalu am y rhai sydd â’r anghenion iechyd mwyaf yn gyntaf, gan wneud yr defnydd mwyaf effeithiol o’r holl sgiliau ac adnoddau
- Gwneud dim ond yr hyn sydd angen ei wneud, dim mwy, dim llai; a phheidio ag achosi niwed
- Lleihau amrywiadau amhriodol gan dddefnyddio arferion sy’n seiliedig ar dystiolaeth mewn modd cyson a thrwylyw.

Ceir cysoniad clir rhwng sgiliau, arbenigedd a chyfraniad nyrsgio a’r cyd-destun polisi cyffredinol yng Nghymru. Mae yr Rhaglen Gofal Sylfaenol a chymunedol yn croesawu’r symudiad cyson tuag at ddull integredig a chydweithredol o weithio gyda chydweithwyr o amryw o asiantaethau a grwpiau proffesiynol er mwyn cefnogi iechyd a llesiant i bobl Cymru. Mae’r Rhaglen Gofal Sylfaenol a chymunedol yn iawn i symud ar gynorthwyo i bobl Cymru a chyflawni nodau cyfathrebu ar gyfer iechyd yng Nghymru, bob awr o’r dydd yn ystod oriau gwaith a thu allan i oriau gwaith.

Y diffiniad o nyrsgio yw defnyddio barn glinigol wrth ddarparu gofal i alluogi pobl i wella, cynnau neu adfer iechyd, ymdopi à phroblemau iechyd, a chyflawni’r ansawdd bywydgorol posibl ni waeth beth fo’n hafiechyd neu anabledd, hyd eu manwolaeth (RCN, 2014). Nid yw’r diffiniad hwn yn fwy perthnasol gynhwysfawr na mewn lleoliadau gofal sylfaenol a chymunedol.
Mae'r RCN eisoes wedi cofnodi ei bryderon am y diffyg data cywir a chadarn ar y gweithlu nyrsio gofal sylfaenol a chymunedol (RCN Cymru, 2018) ac mae Llywodraeth Cymru wedi ymdrechu i fynd i’r afael â hyn. Fodd bynnag, ceir anawsterau o hyd wrth geisio cael gafael ar wybodaeth ddibynadwy am y gweithlu hwn.

Mae Datganiad Ystadegol Cyntaf Llywodraeth Cymru (SFR 21/2019) yn nodi bod 42% o’r holl staff a gyflogir yn uniongyrchol gan y GIG yng Nghymru yn nyrsis, ymwelwyr iechyd neu fydwredigedd. Dengys hyn bod angen mynd i’r afael â chyfraniad nyrsio at ‘Cymru lachach’.

Nid yw’r SFR 21/2019 yn cynnwys nyrsys practis a gyflogir gan y 462 o gontractwyr meddygol yng Nghymru (Bwletin Ystadegol: SB 25/2016). Mae swyddogaethau nyrsio yn cynyddu ym maes ymarfer cyffredinol, oherwydd anawsterau o ran recriwtio a chadw meddygon teulu; felly mae’n symbywyrol i chi bod o leiaf un swydd nyrs ym mhob practis, ond mae fel arfer yn dîm sy’n cynnwys cynorthwyydd gofal gofal iechyd, nyrsis practis cyffredinol ac uwch-ymarferwyr nyrsio.


Dulliau

Mae RCN Cymru yn cyflwyno’r adroddiad hwn, sy’n amlinellu llawer o drafodaethau rhwng ymarferwyr arbenigol a sefydliadau sy’n ymwneud â darparu cymorth nyrsio gofal sylfaenol a chymunedol i bobl Cymru. Mae’n cynnwys cyfraniad nyrsio gofal sylfaenol a chymunedol i bobl Cymru. Mae’r Fforwm Nyrsys Ardal Cymru Gyfan a Fforwm Nyrsis Gofal Sylfaenol Cymru Cymru wedi mynd i’r afael â chyfraniad nyrsio gofal sylfaenol, ardal a chymunedol at ‘Cymru lachach’ a’r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru. Cyflwynir eu saifbwyntiau ar y cyd yma.

Cynhaliwyd Uwchgynhadledd Nyrsio Gofal Sylfaenol a Chymunedol RCN Cymru ym mis Mehefin 2019. Y nodau oedd:

1. Hwyluso trafodaeth broffesiynol ar gyfraniad presennol nyrsys gofal sylfaenol a chymunedol a’u gyfraniad yn y dyfodol a gyflawni agenda Cymru lachach a’r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru. Cyflwynir eu safbwyntiau ar y cyd yma.

2. Darparu cymorth a chefnogaeth i Lywodraeth Cymru, Addysg a Gwella Iechyd Cymru (AaGIC) a rhanddeiliaid eraill i ddatblygu’r rhaglen i gyflawni’r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru.
Ymrwymiadau Nyrsio Gofal Sylfaenol a Chymunedol

Gweithio gydag unigolion, eu teuluoedd a’u gofalwyr i nodi anghenion nyrsio; ymryiadau theriwtig a gofal personol, gywbodaeth, addysg, cyngor ac eirolaeth; a chymorth corfforol, emosiynol ac ysbydrool.

Mae nyrsys cymunedol ac ardal yn disgrifio eu hunain yn “gyffredinwyr arbenigol”. Mae hyn wedi bod yr unigolion a’u gofalwyr i nodi anghenion nyrsio, a chymorth corfforol, emosiynol ac ysbydrool. Mae Barrett, Latham a Levermore (2007) a awgrymodd fod nyrsys ardal yn cynnig model gofal nyrsio cyffredinol i gleifion â phroblemau iechyd ac anghenion cymdeithasol lluosog trwy lunio darlun cyfannol o’r claf a’u amgylchiadau personol.

Diffinnir cyffredinrwydd gan Brindle (2011) fel ymrwymiadau i barhad gofal wedi ei gyfuno â'r gallu i reoli gwahanol fathau o gofal a cymorth. At hynny, dywedodd fod yr unigolion a’u teuluoedd a gofalwyr i nodi anghenion nyrsio, a chymorth corfforol, emosiynol ac ysbydrool. Mae Coleg Brenhinol yr Ymarferwyr Cyffredinol (RCGP) y DU yn cynnig eu diffiniad nhw o gyffredinoliaeth, sef ystyried y person cyfan ac yng nghyd-destun teulu ac amgylchedd cymdeithasol. Mae'r RCGP a'r Sefydliad Iechyd (2011) yn tynnu sylw at bwysigrwydd diffinio gyffredinrwydd, er mwyn gallu i reoli gwahanol fathau o gofal a cymorth.

Wrth adolygu angen claf o Gyflaenol Brys y Tu Allan i Orriau hefyd yn gysylltu gyffredinrwydd a gyffredinolrwydd, bydd y nyrs ymarfer cyffredinol yn wreiddiol i dweud eu bod nhw yn ‘gweld’ i ofal iechyd a chymorth. Mae hyn wedi eu hymgorffori yng Nghymru, a rhyngwladol, pan fo meddygion a gymsylltu gyda phroblemau iechyd a chymorth. Mae hyn wedi eu hymgorffori yng Nghymru, a rhyngwladol, pan fo meddygion a gymsylltu gyda phroblemau iechyd a chymorth.

Mae'r adroddiad hwn yn cyflwyno'r achos dros gydnabod y swyddogaethau nyrsio gofal sylfaenol a chymunedol cyffredinol a'r angen wedyn i fuddsoddi mewn addysg a datblygiadau datblygiadol.
Gweithio mewn partneriaeth â chleifion, eu perthnasau a gofalwyr eraill, a mewn cydweithrediad ag aelodau eraill o dîm amlddisgyblaeth, yn aml fel cydgysylltydd gofal

Un o’r themâu a fu’n gyfrifol yw’r nyrsys gofal syfâaenol a’r nyrsys cymunedol i gyd yng nwyddo gofal; un a’i dilyn atgyfeirio i dimau Nyrsys Ardal neu’n unionyrchol i dimau nyrsys Ymarfer Cyffredinol.

Diffinnir cydlynydd gofal gan Hickam et al (2013 tud.3) fel asiant y claf, wneud dull “person cyfan” o ofal yn hytrach na dull sy’n canolbwyntio ar y clinicol neu’r clefyd yn unig, a phontio rhwng y claf, tîm y practis, y system iechyd, ac adnoddau cymunedol”.

Nododd cyfranwyr yr uwchgynhadledd swyddogaeth gydlynu nyrsys gofal syfâaenol a nyrsys cymunedol o’r pwnt pan ofynnwyd am gymgod. Roedd cydnabyddiaeth o’r sgiliau a briodolir i nyrsys gofal syfâaenol a chymunedol, gan arwain at ystod eang o atgyfeiriadau, gan gynnwys rhuddhau claf o’r ysbyty. Cofnodwyd y cysyniad o “ward heb waliau” eisoes (QNI, 2006; Haycock-Stuart et al, 2008). Fodd bynnag, mae hyn yn adlewyrchu realiti arbenigedd nyrsys gofal sylfaenol a chymunedol fel cydlynydd gofal ar ran cleifion y maent yn eu cyfarfod ac yn eu cefnogi. Mae cydlynu gofal o’r cynnwys rhewi angenhion cymhleth y claf, drwy weithio gyda’r holl bersonol sy’n ymwneud ag iechyd, gofal cymdeithasol, gofalwyr a asiantaethau gwirfoddol.

Wrth nodi ac ymdrin ag anghenion gofal personol, mae nyrsys ardal yna gweithio’n agos â chydywthwyr o sefydliadau partner megis yr awdurdod lleol, gwasanaethau cymdeithasol a chymunedol, ac osodwyd dull, i gydweithreu, cydnalu a chyfeirio i dymorth ag adnoddau addasu. Mae’r agwedd hon ar swyddogaeth nyrsys ardal yn cyfrannu at sicrho iechyd a llenwi pobl yna cyfraniad, y mynegiad a llaith yr hyder i siaru iawd a wydroddiant personol gyda’r teuluoedd.

Mae’r nyrs plant gymunedol yn cefnogi’r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â’r claf. Mewn achos pobl ar ddydd o hyd, mae yr ymgyrch mwyaf ar ôl eu hyder, gan gynnwys gyda’r teuluoedd a amlwg, i gydweithwyr a chwaer gyda’r teuluoedd. Yn aml mae’r ymgyrchau cyflogiadau hynny’n ei ddechrau a’r nhw’r merc fawr o’i wneud yn cyflogiadau hynny.

Mae nyrsys practis yn defnyddio egwyddorion gofal iechyd darbodus wrth gyfeirio pobl i’r gweithiwr proffesiynol mwyaf perthnasol i gefnogi eu hanghenion. Yn amlybydd hyn, mae’r ymgyrchau cyflogiadau hynny’n ei ddechrau a’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae’r nyrs plant gymunedol yn cefnogi’r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth ongoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn wneud y pentre a’r teuluoedd gyda’r nhw’r merched fawr o’i wneud yn cyflogiadau hynny.
Fel rhan o adolygiad Clefyd Rhwystrol Cronig yr Ysgyfaint (COPD), mae Nyrsys Ymarfer Meddygol sydd wedi eu lleoli yng Nghaerdydd a'r Fro yn asesu sgôr diffyg anadl claf, ac yn seiliedig ar hyn, y cydlynu cefnogaeth o'r cwrs adsefydlu cleifion yr ysgyfaint lleol. Mae hwn yn gwr 6 wythnos pan gefnogir y claf gan ffisiotherapyddion, therapyddion galwedigaethol, cynghorwyr rhoi’r gorau i ysmygu a maethewyr i wella iechyd a llesiant.

Gan gydnabod y gall cael diagnosis o ddiabetes Math 2 fod yn brofiad brawychus, mae nyrsys practis yn cydlynu cefnogaeth o'r rhaglen X-pert. Mae hon yn rhaglen 6 wythnos, sy’n cael ei rhedeg gan ddeietegwyr cymunedol, ac syd wedi ei chynnilnio i roi gwybodaeth a dealltwriaeth ynghylch diabetes i unigolion ac i roi gwybodaeth ynghylch sut i reoli eu hiechyd eu hunain. Yn ardaloedd Caerdydd a’r Fro caiff hyn ei gyflwyno bellach i gynnwys cyfeithwywr yr ysgyfaint lleol a ethnig anodd ei gyraedd a chaiff ei gynnig hefyd mewn cyfarfodydd gyda’r nos i’w gwneud hi’n haws i ddiwallu anghenion y boblogaeth sy’n gweitho.

Mae nyrsys practis yng Nghlwstwr De-ddwyrain Caerdydd a’r Fro yn cydlynu cefnogaeth i bobl sy’n ynysig, drwy eu cyflwyno i ’grwpiau garddio lleol’.

Mae nyrsys ardal wedi chwarae rhan allweddol wrth ddatblygu cyfarfod ward rithwir/tim amliddisgyblaethol wythnosol wedi ei leoli yn y gymdeithas o fewn Casnewydd. Un enghraifft o sut y mae’r ward rithwir wedi cefnogi anghenion claf unigol: Roedd nyrs ardal yn poeni bod iechyd a llesiant unigolyn yn dirywio ac roedd yn credu y byddai adnodd cyfunol y ward rithwir yn helpu i osgoi argywng. Yn ogystal ag anawsterau biofeddygol, roedd yn ymddangos bod heriau seicolegol heb eu trin, yn ymysg cymmVISIBLE蘋果e i ddeintal, cartref mewn cyflwr gwael, dim bwyd yn yr oergell, a gweddidau cyffredinol yng Nghaerdydd a threfnwyd ac roedd hyn yno arwain at bryderon ynghylch ei allu i aros gartref yn ddiogel.

Yn dilyn asesiad nyrso a chymdeithasol, cydweithredol, a chymhleth yn feddygol, y prif nod oedd gwella iechyd a llesiant meddygol a seicolegol, ochr yno och a’r unigolion yno arwain at bryderon ynghylch ei allu i aros gartref yn ddiogel. Yn dilyn asesiad nyrso a chymdeithasol, cydweithredol, a chymhleth yn feddygol, y prif nod oedd gwella iechyd a llesiant meddygol a seicolegol, ochr yno och a’r unigolion yno arwain at bryderon ynghylch ei allu i aros gartref yn ddiogel.
Ystyried y person cyfan a’i anghenion biolegol, seicolegol, cymdeithasol, diwylliannol neu ysbrydol.

Nyrsys ardal a chymunedol yw'r grwp iechyd profesiynol sy'n treulio'r amser mwyaf gyda chleifion â'u teuluuoeedd, cymunedau a rhwydweithiau cymdeithasol. Felly maent yn y seflyfà orau i ddeall cyd-destun gofal pob unigolyn, wrth fabwysiadu model gofal cyfannol a bioseicogymdeithasol, yn hytrach na model biolegol/meddygol yn unig.

Pwysleisiodd nyrsys ardal a chymunedol eu harbenigedd ym maes asesu claf yn gyfannol. Pwysleisiodd nyrsys ar bob lefel y rhan y maent yn ei chwarae wrth ddiwallu anghenion cymhleth unigolyn drwy gymryd agwedd gyfannol tuag at fywyd ac amgylchiadau'r unigolyn hwnnw. Ystyriwyd bod cleifion, teuluuoeedd a'u gofalwyr yn hanfodol i gefnogi gallu'r unigolyn i aros yn ddioeg gartref. Ystyried bod cael perthynas agos â chleifion, eu teuluoedd a'u gofalwyr yn hanfodol i gefnogi gallu'r unigolyn i aros yn ddioeg gartref. Adroddodd nyrsys gofal syfânael a nyrsys cymunedol am eu swyddogaeth fel negof y peth sy'n bwysig. Pwysleisiodd y grwp iechyd lleol a chymunedol eu harchwilio o ran amgylchiadau'r unigolyn hwnnw, a chanolbwyntiaeth defnyddio cyfathrebu medrus i gynorthwyo sgraysiau pryderwall, a chynhyrchu bywyd ac amgylchiadau'r unigolyn hwnnw.

Mae nyrsys gydag grym yr ymgyrchion eu hysbrydol a chymunedol fel yr hyn sy'n bwysig i amgylchiadau'r unigolyn. Mae nyrsys ardal a chymunedol yn rhoddi'r amser mwyaf rhywun i dringo unigolyn, ac mae'n fynegi'r gwledydd a'r bywyd o ran anghyflymiant, efallai na'r enwyr a'r asiantaethau'r bwyta'r unigolyn hwnnw, a Chanolfan arfud Ymchwil Yr Iechyd Gwladol, Cyngor Iechyd Darbodi gan yr adnoddau, ac mae'r gofal sylfaenol a chymunedol yn ymgeisio o fewn rhanbarthol ac mae'n cael ei arbenigeddu gan y grwp iechyd lleol a chymunedol.

Mae nyrsys yw'r grwp iechyd sy'n treulio'r amser mwyaf gyda chleifion â'u teuluuoeedd, cymunedau a rhwydweithiau cymdeithasol. Felly maent yn y seflyfà orau i ddeall cyd-destun gofal pob unigolyn, wrth fabwysiadu model gofal cyfannol a bioseicogymdeithasol, yn hytrach na model biolegol/meddygol yn unig.

Pwysleisiodd nyrsys ardal a chymunedol eu harbenigedd ym maes asesu claf yn gyfannol. Pwysleisiodd nyrsys ar bob lefel y rhan y maent yn ei chwarae wrth ddiwallu anghenion cymhleth unigolyn drwy gymryd agwedd gyfannol tuag at fywyd ac amgylchiadau'r unigolyn hwnnw. Ystyriwyd bod cael perthynas agos â chleifion, eu teuluoedd a'u gofalwyr yn hanfodol i gefnogi gallu'r unigolyn i aros yn ddioeg gartref. Adroddodd nyrsys gofal syfânael a nyrsys cymunedol am eu swyddogaeth fel negof y peth sy'n bwysig. Pwysleisiodd y grwp iechyd lleol a chymunedol eu harchwilio o ran amgylchiadau'r unigolyn. Mae nyrsys gydag grym yr ymgyrchion eu hysbrydol a chymunedol fel yr hyn sy'n bwysig i amgylchiadau'r unigolyn. Mae nyrsys ardal a chymunedol yn rhoddi'r amser mwyaf rhywun i dringo unigolyn, ac mae'n fynegi'r gwledydd a'r bywyd o ran anghyflymiant, efallai na'r enwyr a'r asiantaethau'r bwyta'r unigolyn hwnnw, a Chanolfan arfud Ymchwil Yr Iechyd Gwladol, Cyngor Iechyd Darbodi gan yr adnoddau, ac mae'r gofal sylfaenol a chymunedol yn ymgeisio o fewn rhanbarthol ac mae'n cael ei arbenigeddu gan y grwp iechyd lleol a chymunedol.

Gwasanaethau nyrsys plant cymunedol yw sylfaen llwybrau gofal pob plentyn sydd angen cefnogaeth. Mae'n bersonol gydag llwybrau gofal pob plentyn sydd angen cefnogaeth, a chynhyrchu bywyd ac amgylchiadau'r unigolyn hwnnw. Mae nyrsys plant cymunedol yn dringo'r amser mwyaf rhywun i dringo unigolyn, ac mae'n fynegi'r gwledydd a'r bywyd o ran anghyflymiant, efallai na'r enwyr a'r asiantaethau'r bwyta'r unigolyn hwnnw, a Chanolfan arfud Ymchwil Yr Iechyd Gwladol, Cyngor Iechyd Darbodi gan yr adnoddau, ac mae'r gofal sylfaenol a chymunedol yn ymgeisio o fewn rhanbarthol ac mae'n cael ei arbenigeddu gan y grwp iechyd lleol a chymunedol.

Mae nyrsys plant cymunedol yn rhan o' r rhesymu, gwneud penderfyniadau, rheoli risg ac ymarfer myfyriol”, mae nyrsys ardal yng Nghaerdydd wedi nodi cymphonyd meddygol ac ffarchnwsion sy'n rhoi'r grwp iechyd lleol a chymunedol ei gilydd. Mae'n godi'r grwp iechyd lleol a chymunedol i deall yr hyn sy'n bwysig i amgylchiadau'r unigolyn. Mae'n godi'r grwp iechyd lleol a chymunedol i deall yr hyn sy'n bwysig i amgylchiadau'r unigolyn. Mae'n godi'r grwp iechyd lleol a chymunedol i deall yr hyn sy'n bwysig i amgylchiadau'r unigolyn. Mae'n godi'r grwp iechyd lleol a chymunedol i deall yr hyn sy'n bwysig i amgylchiadau'r unigolyn. Mae'n godi'r grwp iechyd lleol a chymunedol i deall yr hyn sy'n bwysig i amgylchiadau'r unigolyn.
Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anaf ac anabledd.

Mae nyrsys gofal sylfaenol a chymunedol yn helpu pobl i reoli eu cyflymwyddau a hirdymor, gan gynnwys cancer, asthma, diabetes, clefyd rhwystrol cronig yr ysgyfaint, wldryr ar y goes a phroblemau iechyd meddwl. Gwyddys bod cydafachedd o'r fath yn gysylltiedig â chanlyniau iechyd gwaelch a chostau gofal iechyd uchwch yng ngystal â rheoli neu ofalu mwy cymhleth (Valderas, 2009). Drwy rfgangreithiau gyda chleifion, mae nyrsys practis yn darparu agweddau mawr ar y contract ar gyfer gwasanaethau meddygol cyffredinol.

Mae'r ystod o ffyredd y mae nyrsys practis yn rhan o'r broses rheoli criwyd hirdymor ym muleu iawn. Mae'n cynnwys adododygadrau, helpu gyda rheoli neu ofalu mwy cymhleth (Valderas, 2009). Mae'r dysgu ar y cyd hwn gan ymosodiadau meddygol a chostau gofal iechyd, sicrhau dilyniant gofal ar draws y Tîm Amlddisgyblaethol.

ASTUDIAETH ACHOS

ENGHREIFFTIOL

Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anaf ac anabledd.

Mae nyrsys gofal sylfaenol a chymunedol yn helpu pobl i reoli eu cyflymwyddau ac atal hirdymor, gan gynnwys cancer, asthma, diabetes, clefyd rhwystrol cronig yr ysgyfaint, wldryr ar y goes a phroblemau iechyd meddwl. Gwyddys bod cydafachedd o'r fath yn gysylltiedig â chanlyniau iechyd gwaelch a chostau gofal iechyd uchwch yng ngystal â rheoli neu ofalu mwy cymhleth (Valderas, 2009). Drwy rfgangreithiau gyda chleifion, mae nyrsys practis yn darparu agweddau mawr ar y contract ar gyfer gwasanaethau meddygol cyffredinol.

Mae'r ystod o ffyredd y mae nyrsys practis yn rhan o'r broses rheoli criwyd hirdymor ym muleu iawn. Mae'n cynnwys adododygadrau, helpu gyda rheoli neu ofalu mwy cymhleth (Valderas, 2009). Mae'r dysgu ar y cyd hwn gan ymosodiadau meddygol a chostau gofal iechyd, sicrhau dilyniant gofal ar draws y Tîm Amlddisgyblaethol.
Dywedodd adolygiad Cochrane (Laurant et al, 2018) “ar gyfer cyflyrau cronig (hirdymor), yn ôl pob tebyg mae nyrsys hyfforddedig, megis ymarferwyr nyrsio, nyrsys practis, a nyrsys cofrestredig, yn darparu ansawdd gofal cydradd neu o bosibl, gofal o ansawdd hyd yn oed o'i gymharu â meddygon gofal sylfaenol, ac yn ôl pob tebyg yn cyflawni canlyniadau iechyd neu well ar gyfer cleifion”.

Nid oes raid i hyn gael ei gyfyngu i gyswllt ar sail llawdriniaeth. Er enghraifft, mae nifer cynyddol o nyrsys practis yn cefnogi pobl â chyflyrau hirdymor sy’n methu i allu i’r ysgol, drwy ymweld â nhw. Mae hyn yn sicrhau tegwch o ran darparu gwasanaethau i bobl sy’n gaeth i’r ysgol, pobol nad ydynt yn cael gwasanaethau ymarfer arall, ac a fyddent fel arall ar e chollad gan nad ydynt yn gallu manteisio ar y ddarpariaeth o wasanaethau sydd eisoes ar gael.

Tabl 2: Swyddogaeth y tîm nyrsio ymarfer cyffredinol (GPN) wrth gyflawni elfennau Gwasanaethau Meddygol Cyffredinol (GMS) Contract Ymarferydd Cyffredinol (GP)

<table>
<thead>
<tr>
<th>Gwasanaethau hanfodol a ddarparir gan ymarfer meddygol (GMS)</th>
<th>Enghraifft o swyddogaeth GPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheoli cleifion sy’n wael neu’n sy’n credu eu bod yn wael gyda chyflyrau y disgwylir yn gyffredinol y ceir adferiad ohonynt</td>
<td>Gwasanaethau mân anhywylera u mân anafiadau dan arweiniad GPN, yn enwedig nrys sy’n rhagnodîn annibynnol ac Uwch Ymarferydd Nyrsio</td>
</tr>
<tr>
<td>Rheoli afiechyd cronig</td>
<td>Gwasanaeth dan arweiniad GPN ar gyfer sytoleg serfigol. GPN yn cynorthwyo ar gyfer gwasanaethau sgrinio cenedlaethol am ganser y coluudda a hanes yr fron, retinopati diabetig, ymlediadau o arfordir</td>
</tr>
<tr>
<td>Gwasanaethau sgrinio</td>
<td>Gwasanaeth dan arweiniad GPN ar gyfer syfoleg anafiadau. GPN yn cynorthwyo ar gyfer gwasanaethau sgrinio cenedlaethol am ganser y coluudda a hanes yr fron, retinopati diabetig, ymlediadau o arfordir</td>
</tr>
<tr>
<td>Brechu ac imiweiddio</td>
<td>Gwasanaethau dan arweiniad GPN ar gyfer syfoleg anafiadau. GPN yn cynorthwyo ar gyfer gwasanaethau sgrinio cenedlaethol am ganser y coluudda a hanes yr fron, retinopati diabetig, ymlediadau o arfordir</td>
</tr>
<tr>
<td>Arolygu iechyd plant</td>
<td>GPN yn cyfeirio i’r Tim Gofal Sylfaenol (PHCT)</td>
</tr>
<tr>
<td>Gwasanaethau atal cenhedlu</td>
<td>Dan arweiniad neu gyda chyffredinol GPN e.e. gosod dyfais atal cenhedlu yn y gynnydd (IUCD), gosod a thynnu Nexplanon, Depo-Provera, pills atal cenhedlu trwy’r geg, yn enwedig nrys sy’n rhagnodîn annibynnol</td>
</tr>
<tr>
<td>Gwasanaethau mân lawdraeniath</td>
<td>Gyda chyffredinol</td>
</tr>
</tbody>
</table>

Mae Tabl 2 yn dangos sut y mae cyflwyno 2 ardal graidd contract y gwasanaethau meddygol cyffredinol (gwasanaethau hanfodol a’r Fframwaith Ansawdd a Chanlyniadau (QOF) yn ddibynnol ar gyfer chwarae’r anfodol yr nyrsys sy’n gweithredu mewn ymarfer cyffredinol.

Mae Tabl 2 yn dangos sut y mae cyflwyno 2 ardal graidd contract y gwasanaethau meddygol cyffredinol (gwasanaethau hanfodol a’r Fframwaith Ansawdd a Chanlyniadau (QOF) yn ddibynnol ar gyfer chwarae’r anfodol yr nyrsys sy’n gweithredu mewn ymarfer cyffredinol.

| Mae meysydd y QOF/Fframwaith Sicroydd Ansawdd a Dweliant (QAIFF) yn cynnwys: |
|---------------------------------------------------------------|-----------------------------|
| Clinigol – mae gan y maes hwn ddangosyddion ar draws gwahanol feysydd clinigol e.e. Clefyd Coronadd y Galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu. | Fel arfer dan arweiniad GPN |

Mae enghraifft o swyddogaeth GPN gan ymarfer meddygol (GMS) gan ymarfer meddygol (QOF) yn cynnwys:

<table>
<thead>
<tr>
<th>Rheoli lawdraeniath</th>
<th>GPN ym mhentiant y galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheoli lawdraeniath</td>
<td>GPN ym mhentiant y galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu.</td>
</tr>
<tr>
<td>Rheoli lawdraeniath</td>
<td>GPN ym mhentiant y galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu.</td>
</tr>
</tbody>
</table>

Mae mae enghraifft o swyddogaeth GPN gan ymarfer meddygol (GMS) gan ymarfer meddygol (QOF) yn cynnwys:

| Rheoli lawdraeniath | GPN ym mhentiant y galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu. |


Mae enghraifft o swyddogaeth GPN gan ymarfer meddygol (QOF) yn cynnwys:

| Rheoli lawdraeniath | GPN ym mhentiant y galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu. |

Mae enghraifft o swyddogaeth GPN gan ymarfer meddygol (QOF) yn cynnwys:

| Rheoli lawdraeniath | GPN ym mhentiant y galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu. |

Mae enghraifft o swyddogaeth GPN gan ymarfer meddygol (QOF) yn cynnwys:

| Rheoli lawdraeniath | GPN ym mhentiant y galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaethu. |
Mae Nyrs Ymarfer Cyffredin yn ymgymryd ag adolygiad blynyddol o ofal a rennir ar gyfer pobl sy’n byw ag Arthritis Gwynegol. Mae hyn yn cynnwys; ymgymryd â Sgoriau Gweithgaredd Clefyd a sgorio Osteoporosis; adolygu a thrafod rheoli meddyginiaeth ar bresgripiau; sicrhau bod lefelau gwaed DMARD yn cael eu monitro ar gyfnod a argymhellir; cyfeirio at sgan DEXA pan fo’n briodol; cynnig cyngor hybu iechyd ynghylch llithrau risg a anhwylerdu cardiofasgwaidd.

Mae Nyrs Ymarfer Cyffredin yn darparu amrywiaeth eang o wasanaethau atal cenhedlu i fenywod, drwy bractis cyffredinol. Mae nyrsys yn adnodd allweddol a ddefnyddir yn y gwasanaeth Gofal Sylfaenol Brys y Tu Allan i Oriau. Mae’r Nyrs Ymarfer Cyffredin yn darparu amrywiaeth eang o wasanaethau atal cenhedlu i fenywod, drwy bractis cyffredinol.

Dangosodd data poblogaeth llawer o achosion o feichiogrywdd anfwriadol ymysg pobl ifanc yn eu harddegau o fewn practis meddyg teulu. I ehangu’r dwisiauadau a gyfer atal cenhedlu hirdymor, cafodd Nyrsys Ymarfer Cyffredin hyfforddiant achrededig er mwyn cymhysgu wal i wastad ar gyfer gwasanaeth gostod a thynnu dyfeisiadau IUD/IUS a Nexplanon. Mae’r Nyrsys Ymarfer Cyffredin nawr yn cynnig apwyntiadau bywthnosol yn y practis ac maent wedi diwallu anghenion cleifion yn llwyddiannus sydd wedi arwain at lal o anhwy y wasanaethau bydwreigiaeth. Yn bwysicach, mae’r fenter hon i chwechdiant, mae’r fenter hon wedi ei lleoliad ar gyfer nhw ychwanegol, yr ysgyfaint, ychwanegol aelodau Priodol o’r tîm gofal sylfaenol.

Gan gydnabod bod 30% o apwyntiadau ym maes ymarfer cyffredinol yn ymwneud â phryderon yng Nghymru. Mae’n hawdd cael gafael arnynt a chynnal efyddiau ymarfer cyffredinol i gilydd â phobl a’u teuluid, ac mae’n hawdd cael gafael arnynt â phobl a’u teuluid ym mynyddoedd Cymru. Mae’r fenter hon i chwechdiant, mae’r fenter hon wedi ei lleoliad ar gyfer nhw ychwanegol, yr ysgyfaint, ychwanegol aelodau Priodol o’r tîm gofal sylfaenol.

Mae’r Nyrs Ymarfer Cyffredin yn darparu amrywiaeth eang o wasanaethau atal cenhedlu i fenywod, drwy bractis cyffredinol.

Mae’r Nyrs Ymarfer Cyffredin yn darparu amrywiaeth eang o wasanaethau atal cenhedlu i fenywod, drwy bractis cyffredinol.
Ymarferydd Brysbennu y Tu Allan i Oriau:
Mae’r nyrsys neu barafeddygon hyn wedi eu hyfforddi hyd at o leiaf lefel BSc (gradd) ac fel arfer mae ganddy nhw gefndir o weithio yn un neu fwy o’r meysydd gofal canlynon: ymarfer meddygol, cymunedol, gwاسanaeth ambiwlans Cymru neu adran Damweiniau ac Achosion Brys (A+E). Maent yn ymgyrnwrd â brysbennu dros y ffôn gan ddefnyddio templedi gwneud penderfyniadau sy’n help i frysbennu cleifion yn ddiogel drwy ymgyngor iad dros y ffôn. Gallant roi cyngor ar hunanofal, cyfeirio i wasanaethau amgen (yn cynnwys ambiwlans, A+E, eu meddyg teulu) neu gyfeirio cleifion i’r canolfannau gofal sylfaenol ar gyfer ymgyngor iad clinigol a fydd yn cael ei gynnal gan feddyg teulu, Ymarferydd Clinicigol neu Ymarferydd Mân Salwch Gallant weithio ar eu pen eu hunain ond cânt eu cefnogi o fewn y gwasanaeth y tu allan i oriau gan yr Ymarferwyr Clinicigol neu Feddygon Teulu. Mae pob un o’r ymarferwyr hyn yn brysibennu cleifion sy’n 3 oed a hyn.

Ymarferydd Mân Salwch y Tu Allan i Oriau: Mae’r nyrsys neu barafeddygon hyn wedi eu hyfforddi hyd at o leiaf lefel BSc (gradd) ac wedi cwblhau cymhwyster diploma ychwanegol mewn Mân Salwch. Gallant gynnal ymgyngoriadau gyda chleifion à symptomau mân salwch yn unig. Gallant weithio ar eu pen eu hunain ond cânt eu cefnogi yn y gwasanaeth y tu allan i oriau gan Ymarferwyr Clinicigol neu Feddygon Teulu.

Mae pob un o’r ymarferwyr hyn yn gweld cleifion 5 oed a hyn. Mae gan rai o’r nyrsys hyn gynhwyster Rhagnodi Annibynnol sy’n eu galluogi i gynhyrchu a llofnodi presgripsiynau; tra bo’r rhai nad ydymnt yn Rhagnodi Annibynnol yn defnyddio Cyfarwyddiadau Grwpiau Cleifion (PGD) i’w galluogi i weinyddu o’r fferyllfa y tu allan i oriau.

Ymarferydd Clinicigol y Tu Allan i Oriau: Mae’r nyrsys neu barafeddygon hyn wedi eu hyfforddi hyd at lefel MSc (Meistr) ac maent naill ai’n Uwch-ymarferydd Nyrsio neu’n Uwch-ymarferydd Parafeddygol. Gallant gynnal ymgyngoriadau awtonomyaid a gallant asesu, rhoi diagnosis, trin/rhagnodi a chyfeirio ymlaen i weithwyr gofal iechyd proffesiynol eraill fel y bo’r galw. Mae ganddy nhw hawliau i dilyn diwydiannau (A+E, Clust, Gwddf (ENT), uned asesu plant (dros 5 oed), ac A+E. Os oes angen cefnogaeth gallent alw un o’u cydweithwyr ymarfer cyffredinol y tu allan i oriau. Mae pob un o’r ymarferwyr hyn yn gweld cleifion 5 oed a hyn. Mae gan rai o’r nyrsys gynhwyster Rhagnodi Annibynnol sy’n eu galluogi i gynhyrchu a llofnodi presgripsiynau ac mae’r parafeddygon ar hyn o bryd yn defnyddio PGD i’w galluogi i weinyddu o’r fferyllfa y tu allan i oriau.
Gan ddefnyddio dealltwriaeth fioseicogymdeithasol o iechyd, mae 
cyflyrau cymhleth yn cyfeirio at bresenoldeb anhwylerddau iechyd neu fwy. Diffinnir 
angen cymhleth fel rhywbeth sy’n ymwneud â chleifion y mae eu hanghenion yn 
amllffactoraidd, yn gorgyffwrdd ac yn amryvio o ran symptomau o unigolyn i unigolyn. Mae 
ffactorau cyfrannol yn fiolegol, seicolegol neu’n gymdeithasegol o ran natur; gan gynnwys 
cyflyrau hirdymor (cronig), cydafiachedd, heneiddio, eiddilwch, yn ymwneud ag iechyd seicolegol neu feddyliol, ac amgylchiadau 
cymdeithasol neu deuluol. Gall fod yn ofynnol i unigolyn ag angen cymhleth gael cefnogaeth 
gwasanaethau iechyd a gwasanaethau cymdeithasol.

Ynghyd â'r newid yng ngofal sylfaenol a newidiadau demograffig ym mhroffil oedran a 
chlefyd, dywedir fod cleifion bellach angen gofal am gyflyrau cymhleth gartref (Sefydliad Nyrsio'r 
Frenhines, 2011) neu fod gan gleifion gartref fwy o angen gofal iechyd (Cromfa'r Brenin, 2012a; Yr Adran Iechyd, 2013). 
Felly, bydd yn fwy tebygol y bydd cleifion wedi eu lleoli yn y gymuned ag anghenion cymhleth (Cromfa'r Brenin, 2012b).

Mae angen i luosogrywdd a chymhlethdod 
anghenion cleifion wedi eu lleoli yn y gymuned 
gael ei ddigwydd fel “care quake” (Yr Adran Iechyd, 2010) ac mae 
nysrysgol gyfandir yw'r Tîm Ymateb Acíwt sy'n darparu gofal i'r boblogaeth leol. Eu nod yw atal pobl rhag cael eu derbyn i 
ysbyty a chyflymu'r broses o ryddhau pobl o 
ysbytai. Eu prif arbenigeddau yw: rhoi 
meddyginiaeth fewnwythiennol yn yr ysbyty 
(Coronhaeth, 2012a), Monitro therapi gwrthgeulo ar ôl 
cyfnod mewn ysbyty; pontio cyn ac ar ôl 
llawdriniaeth; a chwnsela Therapi Gwrthgeulo 
Trwy'r Geg/llwytho warfarin ar ôl 
cyfnod mewn ysbyty; pontio cyn ac ar ôl 
lawdriniaeth; a chwnsela Therapi Gwrthgeulo 
Trwy'r Geg/llwytho warfarin ar ôl 
diagnosis o 

Gymuned. Gelir 
wneu lawr i lawr i lawr i lawr i lawr i lawr i

Gymuned. Gelir 
wneu lawr i lawr i lawr i lawr i lawr i

Gymuned. Gelir 
wneu lawr i lawr i lawr i lawr i lawr i

Gymuned. Gelir 
wneu lawr i lawr i lawr i lawr i lawr i

Gymuned. Gelir 
wneu lawr i lawr i lawr i lawr i lawr i

Gymuned. Gelir 
wneu lawr i lawr i lawr i lawr i lawr i

Gymuned. Gelir 
wneu lawr i lawr i lawr i lawr i lawr i
Nod astudiaeth PhD a ariannwyd gan Cydweithrediad Cynyddu Gwaith Ymchwil Cymru oedd datblygu a dilysu offerny i nodi a mesur anghenion cymhleth ar gyfer cleifion yn gymuned. Aeth yr ymchwiliad i’r afael â asesiadau nyrsys ardal ar gyfer cleifion yn y gymuned ag anghenion cymhleth a nod Llywodraeth Cymru i “alluogi nyrsys i asesu pa mor ddifrifol yw cyflwr cleifion, a ydynt yn debygol o ddirpywio, a beth fydd eu hanghenion parhaus”.

Roedd y gwaith o ddatblygu’r Offerny Cymhlethdod Cleifion (PCI) yn cynnwys cyfranogiad eang gan randdeiliaid ac ymgynghori parhaus. Trwy gael cytundeb Cymru gyfan o amryviaeth eang o safbwyntiau, roedd eitemau’r offerny yn targedu’r meysydd y mae clinigwyr nyrsys ardal, rheolwyr a chynllunwyr strategol yn eu hystyried yn gyd-draennau hanfodol o gymhlethdod ar gyfer cleifion yn y gymuned. Profwyd y PCI yn ymarferol gan nyrsys ardal, yn ystod asesiadau o anghenion cleifion yn y gymuned. Sefydlwyd dilyswydd a dibynadwyedd yr offerny yn ei gyd-destun cymhwysol.

Mae’r canlyniadau yn dangos y problemau, a nodwyd gan nyrsys ardal, sy’n gyflawn iawn o debygol i ganu’r offerny eu hystyried yn hynod ac y blencwm o anghenion cymhleth. Mae’r canlyniadau yn dangos y problemau, a nodwyd gan nyrsys ardal, sy’n gyflawn iawn o debygol i ganu’r offerny eu hystyried yn hynod ac y blencwm o anghenion cymhleth.
Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl tan y diwedd.

Gan fod y boblogaeth yn gynyddol heneiddio, cyflyrau hirdymor di-rif, triniaeth well i reoli symptomau ac ymestyn bywyd a mwyr o bwyslais ar ofal yn y gymuned i bobl sy’n byw gyda chyflyrau hirdymor a/neu sy’n cyfyngub yr eu bywydau, mae angen cynyddu i ddarparu gofal liñiarol a diweddi o-dor sydd wedi'i drefnu'n dda, yn y gymuned ac yn y cartref i bobl, gan gynnwys plant.

Diffiniad Sefydliad Nyrsio'r Frenhines (QNI) o ofal lliniarol yw gofal cyfannol gweithredol i gleifion â salwch datblygedig sy’n gwaethygu. Mae rheoli symptomau, a darparu cymorth seicolegol, cymdeithasol ac ysbrydol yn hollbwysig. Nod allweddol gofal liñiarol yw cyflawnir’r ansawdd bywyd gorau ar gyfer cleifion a’u teuluuodd.

Mae’r materion allweddol ar gyfer nyrsio gofal sylfaenol a nyrsio gofal liñiarol yn cynnwys; darparu cymorth i gleifion a chyflyrau sy’n cyflyngu ar eu bywydau heblaw am ganser, cynllunio gofal uchaf i bobl sy’n iawn o eu cyflyrau, gwella’r cymorth i ofalwyr a hunanofal, rheolaeth a darpariaeth gwasanaeth clinigol 24 awr y dydd o ansawdd uchel, cyflawni disgwyliadau safon aur a chyfatrefri da ar draws ffiniau iechyd, gofal a’r trydlydd sector.

Mae timau nyrsio gofal sylfaenol a chymunedol yn darparu gofal liñiarol rhagorol i gleifion ar ddiweddi eu hoes ac mae’n galluogi cleifion i gael marwolaeth da lle bynnag y maent yn dewis, wrth gael eu cefnogi gan gynyrach a chynllunio gofal uchaf. Mae’r materion arall yn cynnwys gofal liñiarol gyda chyflyrau sy’n sylfaenol, a chynllunio rhan o’r ansawdd o cleifion a’u teuluuodd. Mae Tiwmawr Ardal yn galluogi cleifion i gynllunio cleifion, teuluuodd a chyfatrefri da ar gael liñiarol yr ym myned. Le treulir tua 40% o amser nyrsio ardal ym mhyd hwn.

I gydnabod pwysigwrryd swyddogaeth nyrsio wrth gefnogi anghenion pobl am ofal liñiarol a diweddi oes, mae RCN (2015) yn argymell y dylid galluogi nyrsio i:

- drin pobl â thosturi
- gwrando ar bobl
- cyfatrefri â gofal
- nodi a diwallu anghenion cyfathrebu pob unigolyn
- cydnabod poen a thrallod a chymryd camau gweithredu

Mae RcN (2015) yn argymell y galluogi nyrsio i:

- drin pobl â thosturi
- gwrando ar bobl
- cyfatrefri â gofal
- nodi a diwallu anghenion cyfathrebu pob unigolyn
- cydnabod poen a thrallod a chymryd camau gweithredu

Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl tan y diwedd.
Mae nyrsys sy’n arbenigo mewn methiant y galon yn gweithio gyda Nyrssys Ymarfer Cyffredin yn y practis i ddwiwedi ar gyfer gweithrediadau gyda chyflymadau sy’n bywau mewn ddiwydiant. Mae Nyrsys Ymarfer Cyffredin yn derbyn gofal lle maent yn dewis a lle bynnag mae eu cartref, gan gynnwys mewn cartref gofal.

Mae Nyrsys Plant Cymunedol yn cymryd rhan weithredol wrth gefnogi anghenion gofal lliniarol a diweddu oes plant.

ASTUDIAETH ACHOS

ENGHREIFFTIOL

I wella’dai daith ofal i bobl sy’n bywau mewn cartrefi gofal lleol, mae nyrsys ardal yang Nghasnewydd wedi gweithio gyda chyflymadau sy’n bywau mewn cartrefi gofal lleol, o ganlyniad i ddefnyddio gyda chyflymadau sy’n bywau mewn cartrefi gofal lleol. Mae’n rhoi enfawr o lwyth o ddiwydiant i ddefnyddio gyda chyflymadau sy’n bywau mewn cartrefi gofal lleol, a phlaneg canolbwyntio ar y ddiwydiant sy’n bywau mewn cartrefi gofal lleol.

Mae nwyssyddiad ymgyrchyddol wedi eu defnyddio i dddefnyddio gyda chyflymadau sy’n bywau mewn cartrefi gofal lleol, a phlaneg canolbwyntio ar y ddiwydiant sy’n bywau mewn cartrefi gofal lleol.
Nododd y gweithdy heriau darparu'r lefelau presennol o ofal a chymorth, a'r lefelau cynyddol a rhagweld, heb nifer y gweithlu sy’n ofynnol. Nodwyd mai recrwiatio a chadw nyrsys oedd yr heriau mwyaf ar gyfer gofal sylfaenol a chymunedol.

Nododd cydweithwyr nysio sylfaenol a chymunedol amrywiad o ran darpariaeth gwwasanaeth ledled Cymru, gan gynnwys mewn amgylcheddau GIG ac ymarfer cyffredinol. Er bod hyn yn galluogi hroh cymorth a gofal unigol i gleifion a theuluoedd, mae peryd o bedi bod â 'safonau aur' ledled Cymru. Enghraiff, wrth ddadlygu swyddi newydd er enghraiff gweithwythwyr cymorth iechyd nysio cymunedol ar fand 4 ac uwch-ymarferwy nysio mewn ymarfer cyffredinol.

Mae amrywiad y ddarpariaeth gwwasanaeth o fewn ymarfer cyffredinol yn cael ei ddadlu am ei allu i fodlon anghenion y boblogaeth leol, a hefyd ei wthfawrogi fel ffract y sôn cyflymu wrth gyflawni safonau cyson a datblygiad swyddogaeth ledled Cymru. Er enghraiff, byddai polisi Cyfymru gyfan ar gyfer pob tim nyrsio gofal sylfaenol a gofal cymunedol i gynnwys o leiaf un nyrs sy’n rhagfod â’n annibynnol yn gyflymu ym mhilliau ledled Cymru. Er enghraiff, byddai polisi Cyfymru gyfan ar gyfer pob tim nyrsio gofal sylfaenol a gofal cymunedol i gynnwys o leiaf un nyrs sy’n rhagfod â’n annibynnol mewn gofal sylfaenol.

Nid yw arweinyddiaeth nysio gofal sylfaenol wedî'i ffrifio mewn safonau leol Ngythymru, er gwaethaf cyfeiriad y polisi. Byddai polisi Cyfymru gyfan ar gyfer pob tim Cyfymru gyfan ar gyfer pob tim nysio gofal sylfaenol a chymunedol yn sicrhau arweinyddiaeth leol ar gyfer datblygiad clinigol, addysg ac ymchwil, ac er ennill ei amrywiad o weithio mewn gofal sylfaenol a chymunedol:

Mae cydweithwyr gofal sylfaenol a gofal cymunedol yn cael eu cofio o gyflwyno lle de Clostryr Gofal Sylfaenol fel y cymryd gan y gweithwyr cyfan ar gyfer gofal sylfaenol a gofal cymunedol.

GweithgaredDa Cwstk., yn enwedig pan fo'r pwsyliais crysaf ar ymarfer cyffredinol a'r model busnes o ofal sylfaenol annibynnol yn seiliag ar gofynnwr. Mae nysio gofal sylfaenol a gofal cymunedol sy'n cael eu cofio o gyflwyno lle de Clostryr Gofal Sylfaenol fel y cymryd gan y gweithwyr cyfan ar gyfer gofal sylfaenol a gofal cymunedol:

Gwirioneddir, gan fod gwasanaethau a thimau nyrsio plant cymunedol yn aml yn cael eu gyflwyno lle de Clostryr Gofal Sylfaenol fel y cymryd gan y gweithwyr cyfan ar gyfer gofal sylfaenol a gofal cymunedol.
Mae nyrsys gofal sylfaenol a chymunedol yn ymwybodol o’r angen am ddealltwriaeth gyfoes o ystod a chwmpas eu swyddogaethau, i alluogi ymatebion hyblyg sy’n bodloni anghenion clefion.

Mae angen am ddarpariaeth a chyfleoedd addysg parhaus a phriodol sy’n addas i’r cyd-destun gofal cyfoes.

Ceir cydnabyddiaeth o werth diwylliant hyfforddi ar y cyd, i gefnogi rhannu a dysgu mewn tîm amlddisgyblaeth.

Amlygir yr angen am gymorth technoleg fel mater parhaus, a diogelwch drwy’r gallu weld gwybodaeth am glefion, casglu a rhannu gwybodaeth.

Mae angen buddsoddi mewn strwythurau a phrosesau cynllunio gweithlu, megis llwybr gyrfya a ffreamwaith addysg o fewn nyrsio ymarfer cyffredinol. Mae hwn yn ofyniad amlwg sy’n berthnasol i gyflawni lefelau cyson, diogel, a chymorth nyrsio o fewn ymarfer cyffredin.

Nodir bod llwybr gyrfya a ffreamwaith addysg sy’n canolbwyntio yn benodol ar nyrsio ymarfer cyffredin yn ganolog i gyflogiad lefelau cyson, diogel o fafel a chymorth nyrsio o fewn ymarfer cyffredin.

Mae angen a nodwyd am fuddsoddiad mewn swyddi arweinyddiaeth nyrsio gofal sylfaenol a chymunedol yn ogystal â datblygiad a chynllunio olyniaeth, gan gynnwys ar lefel Nyrs Ymgynghorol ac Arweinydd Clwstwr.

Ceir angen a nodwyd i gefnogi diwylliant o ymholi a dysgu drwy ddull yn seïledig ar ymchwil o fewn ymarfer clinigol nyrsio gofal sylfaenol a chymunedol, na eir i’r afael ag ef ar hyn o bryd drwy strwythurau neu brosesau presennol. Byddai swydd Nyrs Ymgynghorol o fewn y Clystyr ynn galluogi pwyslais a arweinir gan weithwyr proffesiynol drwy ddefnyddio dulliau empirig o ymchwilio a gwerthuso (gweler y disgrifyddion yn atodiad 1).

Ceir cyfleoedd i Nyrsio Gofal Sylfaenol a Chymunedol wella dilyniant gofal iechyd ar gyfer pobl Cymru. Er enghraifft, byddai lleiafswm o un nyrs sy’n rhagnodi’n annibynnol ym mhob tîm Nyrsio Gofal Sylfaenol a Chymunedol yn golygu y byddai’n bosibl cwblihau achenion gofal yn y cartref neu yn y syrjery heb yr angen i gynnwys gweithwir iechyd meddygol proffesiynol. Byddai hyn hefyd yn lleihau pwysau amser ar feddygon teulu, gan felly wella’r gallu i gael gafael ar adnoddau meddygon teulu.
<table>
<thead>
<tr>
<th>Cymru Iachach</th>
<th>Nyrsys gofal sylfaenol a chymunedol ...</th>
<th>Mae nyrsys gofal sylfaenol a nyrsys cymunedol yn ymrwymo i ...</th>
<th>I gyflawni hyn, bydd ar nyrso gofal sylfaenol a chymunedol angen ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bydd gwasanaethau’n cael eu llunio o amgylch yr unigolyn a grwpiau o bobl, ar sail eu hanghenion unigryw a’r hyn sy’n bwysig i ddyn yng ogystal à chanlyniau ansawdd a diogelwch.</td>
<td>Ystyried y person cyfan a’i anghenion biolegol, seicolegol, cymdeithasol, dwiylliannol neu ysbrydol.</td>
<td>Deall anghenion iechyd a gofal pobl gofalau lleol neu unigolion ar sail yr unigolyn a grwpiau o bobl, gan ddechrau gyda’r cwestiwn o ‘beth sy’n bwysig i chi?’</td>
<td>Adnabod yr angen am amser ac adnoddau (gan gymnwys systemau TG cysslwyddig) i gynnal ansawdd a diogelwch.</td>
</tr>
<tr>
<td>Dylai pawb yng Nghymru gael bywydau hirach, iachach a hapusach, a dylu’n mynd i gadw i’r bywyd fel eisiau.</td>
<td>Neilltu o amser i weithio gydag unigolion a theulu oedd i deall dymuniadau a gallu unigolyn i fod yn annibynnol.</td>
<td>Neilltu o amser i gynnal asesiadau iechyd a gofal trwy unigolion, a chymorth ansawdd a diogelwch.</td>
<td>Adnabod yr angen am amser ac adnoddau i gynnal asesiadau iechyd a gofal trwy unigolion.</td>
</tr>
<tr>
<td>Gwneud i Bob Cyswllt Gyfrif (MECC), Cyfweld Ysgogiadol, neu gyfroniau eraill i ddefnyddio rhai a chynnal asesiadau.</td>
<td>Deffnyddio gydwaith deall gysylltiad, dwf a datblygiadau fel ymgyrch am gwasanaethau.</td>
<td>Defnyddio gwybodaeth a sgiliau i ddefnyddio rhai a chynnal asesiadau.</td>
<td>Adnabod yr angen am amser i gynnal asesiadau.</td>
</tr>
<tr>
<td>Bydd yna system ‘achuswydd’ sy’n ceisio cefnogi a rhagweld anghenion iechyd, atal salwch a lleihau effaith iechyd gwael.</td>
<td>Defnyddio gydag unigolion, eu theulu oedd a’u gorfod trwy i nodi anghenion yr unigolion a chamwiriau.</td>
<td>Defnyddio fframweithiau effaith gwaith i ddefnyddio rhai a chynnal asesiadau.</td>
<td>Adnabod yr angen am amser i gynnal asesiadau.</td>
</tr>
<tr>
<td>Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afeichiad, salwch, a gweithredu trwy defnyddio rhai a chynnal asesiadau.</td>
<td>Defnyddio gwybodaeth a sgiliau i’r成语 i’r cydwaith.</td>
<td>Defnyddio fframweithiau effaith gwaith i ddefnyddio rhai a chynnal asesiadau.</td>
<td>Adnabod yr angen am amser i gynnal asesiadau.</td>
</tr>
<tr>
<td>Bydd yn edrych ar iechyd a gofal cymdeithasol fel system gyfan, gyda’r gwasanaethau yn un effen.</td>
<td>Gweithio gydwaith deall gyda’r gorfod trwy i nodi anghenion yr unigolion a chamwiriau.</td>
<td>Gweithio gydwaith deall gyda’r gorfod trwy i nodi anghenion yr unigolion a chamwiriau.</td>
<td>Adnabod yr angen am amser i gynnal asesiadau.</td>
</tr>
<tr>
<td>Gweithio gydwaith deall gyda’r gorfod trwy i nodi anghenion yr unigolion a chamwiriau.</td>
<td>Sichau y caiff adnoddau a hud anghenion yr unigolion.</td>
<td>Sichau y caiff adnoddau a hud anghenion yr unigolion.</td>
<td>Adnabod yr angen am amser i gynnal asesiadau.</td>
</tr>
</tbody>
</table>

Darlun o’r cysylltiad rhwng Cymru Iachach, cyfraniad ac ymrwymiad nyrso gofal sylfaenol a chymunedol, a’r gofynion cefnogol i gyflawni’r ymrwymiad.
Pan fydd angen cymorth, gofal neu driniaeth ar bobl, bydd modd iddynt ddefnyddio ystod o wasanaethau di-dor, sy’n cael eu darparu mor agos at phosibl at y cartref. Lleihau gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â’u cyflym, triniaeth a chanlyniadau

Sichau nad wy pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy gosodiell eu labsawsttau ro i ran eu hamgylchiadau iechyd.

Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny’n hanfodol. Siwllu gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â’u cyflwr, triniaeth a chanlyniadau

Bydd pobl yr un system gyfan sy’n rhagfyd yng Nghymru. Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny’n hanfodol. I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...

Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy gosodiell eu labsawsttau ro i ran eu hamgylchiadau iechyd.

Bydd pobl yr un system gyfan sy’n rhagfyd yng Nghymru. Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny’n hanfodol. I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...

Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy gosodiell eu labsawsttau ro i ran eu hamgylchiadau iechyd.

Bydd pobl yr un system gyfan sy’n rhagfyd yng Nghymru. Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny’n hanfodol. I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...

Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy gosodiell eu labsawsttau ro i ran eu hamgylchiadau iechyd.

Bydd pobl yr un system gyfan sy’n rhagfyd yng Nghymru. Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny’n hanfodol. I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...

Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy gosodiell eu labsawsttau ro i ran eu hamgylchiadau iechyd.

Bydd pobl yr un system gyfan sy’n rhagfyd yng Nghymru. Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny’n hanfodol. I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...

Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy gosodiell eu labsawsttau ro i ran eu hamgylchiadau iechyd.

Bydd pobl yr un system gyfan sy’n rhagfyd yng Nghymru. Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny’n hanfodol. I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...

Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy gosodiell eu labsawsttau ro i ran eu hamgylchiadau iechyd.
Crynodeb

Wrth barhau i fodor anghenion iechyd a lles pobl Cymru, bydd nyrsys gofal sylfaenol a chymunedol yn ym...
Atodiadau

Atodiad 1: Detholiad o Ddisgrifyddion
Swyddogaethau Gofal Sylfaenol a Nyrsio Cymunedol (wedi eu cymryd oddi wrth RCN Cymru, 2017)

Nyrs Ymarfer Cyffredinol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster cofrestradw arbenigol ychwanegol)
  ▣ Ymarferydd annibynnol
  ▣ Gweithio’n agos gyda'r tîm ymarfer cyffredinol er mwyn diwallu anghenion cleifion, wrth gefnogi'r gwaith o gyflwyno polisïau a gweithdrefnau, gan ddarparu arweinyddiaeth i nrys
  ▣ Aseu, cynllunio, datblygu, gweithredu a gwerthuso rhaglenni lies
  ▣ Gweithredu a gwerthuso cynlluniau triniaeth unigol ar gyfer cleifion â chyflyrau hirdymor
  ▣ Ymgyrryd â nifer o ddyllyseddau nyrs practis gan gynnwys rhedol cyflyrau hirdymor, gofal am glwyfau, sytoleg serfigol, brechiau teithio a brechiau ar gyfer plant, cynnal proifion diagnostig perthnasol
  ▣ Blaenorlaethu problemau icychyd ac ymyrryd yn briodoli i gynorthwyo cleifion mewn sefyllfaoedd cymhleth, brys neu argyfyngol, gan gynnwys dechrau gofal brys ei effeithiol
  ▣ Hybu icyth y Cyhoedd gan gynnwys rhaglenni sgrinio cenedlaethal

Uwch Ymarferydd Nyrsio (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster arbenigol ychwanegol)
  ▣ Ymarferydd annibynnol sy’n darparu o leiaf 50% o'r gofal yn uniongyrchol
  ▣ Ymarfer arbenigol uwch, yn gweithio gyda cleifion, cleientiaid a/neu gymunedau gan dyfarniadau a phenderfyniadau clinigol hanfodol lle na fydd cynsail yn bodoli o bosib
  ▣ Annibynnol, ymarfer uwch, gyda chwmps ymarfer estynedig sy’n darparu gofal o fewn arbenigedd perthnasol yn sgil atgyfeiriadau
  ▣ Cyflawni swyddogaeth mewn rheolaeth clinigol, gan ddarparu mewnbbwn arbenigol a gweithio i sicrâu gweliant ansawdd ar draws sbectrwm eang o ddarpariaeth gofal
  ▣ Cyflawni swyddogaeth mewn rheolaeth clinigol, gan ddarparu mewnbbwn arbenigol a gweithio i sicrâu gweliant ansawdd ar draws sbectrwm eang o ddarpariaeth gofal
  ▣ Segenniau sy’n cynnwys ystod eang o raglenni adsefydlu/triniaeth i tîm gweithredu a gweithio i sicrâu gweliant ansawdd ar draws sbectrwm eang o ddarpariaeth gofal
  ▣ Cyflawni swyddogaeth mewn rheolaeth clinigol, gan ddarparu mewnbbwn arbenigol a gweithio i sicrâu gweliant ansawdd ar draws sbectrwm eang o ddarpariaeth gofal
  ▣ Cymryd yr awenau wrth gychwn a datblygu gwasanaethau trawsddisgyblaethol a gweithio rhyngasiantaethol sy’n cyfrannu at safonau a chanllawiau amibroffesinol

Nyrs Ymgynghorol mewn Gofal Sylfaenol a Chymunedol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster arbenigol ychwanegol y gellir ei gofrestru / cofnodi)

Ymarferydd annibynnol sy’n darparu o leiaf 50% o'r gofal yn uniongyrchol
Gwneud a derbyn atgyfeiriadau uniongyrchol gan gleifion/cleientiaid; cynnal asesiad o anghenion unigol a manteisio ar gydweithrediad ac arbenigedd priodol rhwng asiantaethau ac ar draws ffiniau er mwyn diwallu anghenion cleifion/cleient orau.

Darparu arweiniad ac esampil effeithiol sy’n ysbydoli ac yn cynnal ymrwymiad cydweithwr ac yn hwyluso’r broses o rhywun eraill

Cyhoeddı gwaith ymchwil neu fod wedi, neu’n gweithio tuag at ddoethuriaeth

Cyfrannu at ddbatygu a gwerthu rhoai rhaglennadd

Cynorthwyo i gyfathrebu a chyfeirio tuag at hunanofal a'r broses o hybu iechyd

Gwel gweithrediadau a chynlluniau gofal diwedd oes

Arwain y tîm nyrsio cymunedol yn broffesiynol a bod yn rheoli ur llinell gweithredol iddynt

Cynnal yr ymweliad/cyswllt cyntaf dros dro â chlaf, a fydd yn cael ei ailasesu gan deilliad y Llwyth Achosion o fewn 24 awr. Cyfeirio unigolion i wasanaethau cymunedol priodol i ddiwallu eu hanghenion parhaus

Arwain y tîm nyrsio cymunedol yn hagwch gofal sylfaenol yn y rhwydweithiau, sicrhau bod cyfathrebiadau yn effeithiol a bod llwybrau gofal megis sbirometreg, archwiliadau iechyd, mesuriadau gwythïen-bigiadau a ffisiolegol, cofnoddi canlyniadau i'r nyrs gofrestredig

Cyfathrebu a gwerthuso rhaglenni addysgol

Arwain gwaith ymchwil ac archwilio a chyfraniuo at yr agenda ymchwil elangach, gan sefydlu partneriaethau ymchwil gyda Sefydliadau Addysg Uwch a chymunedol

Arweinydd Tim Nyrsio Y Cyllch (weddi cofrestru a'r Cyngor Nyrsio a Bydwreigiaeth gyda chymhwystyr arbenigol ychwanegol cofrestradwy) (’Ymarferwydd annibynnol

Darparu arbenigedd a chymorth clinigol dwbl i gleifion yn yr ardal sy’n ymwyd â thimau amlddisgyblaethol cymhleth a'r ysbtyt ac mewn lleoliadau cymunedol

Cyfyngydd llwch dyddiau Llwyth Achosion, gwasanaethau adnoddau cymunedol, wardiau gofal eilaidd a nyrsys arbenigol er mwyn sicrhau y caiff cleifion eu rhyddhau yn ddiogel ac yn effeithiol, ac ymyriadau aralrol rhagweithirol er mwyn cynnal pobl yn eu hamgylchedd cartref

Arwain ar safonau ac arferion proffesiynol er mwyn cefnogi staff mewn ffyrdd newydd o weithio

Gweithio’n agos gyda thimau gofal sylfaenol yn y rhwydweithiadau, sicrhau bod cyfathrebiadau yn effeithiol a bod llwybrau gofal megis sbirometreg, archwiliadau iechyd, mesuriadau gwythïen-bigiadau a ffisiolegol, cofnoddi canlyniadau i'r nyrs gofrestredig

Gweithio’r arthawr fel arweinydd a chymorth clinigol gyda thimau amlddisgyblaethol cymhleth yn yr ardal sy’n ymwyd â thimau amlddisgyblaethol cymhleth a'r ysbtyt ac mewn lleoliadau cymunedol

Nyrs Gymunedol (weddi cofrestru a'r Cyngor Nyrsio a Bydwreigiaeth

Cymryd cyfrifoldeb am bob agwedd ar ofal nyrsio parhaus a darparu pecynnau cymunedol a choethatrydion, a rhoi gwybod am unrhyw newidiadau er mwyn sicrhau eu hanghenion parhaus

Sicrhau bod cydweithrediad agos â’r tim amlddisgyblaethol sy’n cymryd rhan yn nhrafodaethau’r tim amlddisgyblaethol mewn cynhyrchiadau ag asesiadau rais er mwyn sicrhau diogelwch unigolion, eu cyd-gleifion a’r staff

Cynnol yr ymweliad/cyswllt cyntaf dros dro â chlaf, a fydd yn cael ei ailasesu gan deilliad y Llwyth Achosion o fewn 24 awr. Cyfeirio unigolion i wasanaethau cymunedol priodol i ddiwallu eu hanghenion parhaus

Adrodd unrhyw risgiau neu beryglon a helpu i ddatblygu a sefydlu dulliau a gweithdrefn er mwyn atal/leihau’r risg

Sicrhau iechyd, diogelwch a lleis eich hun, eich cydweithwyr, cleifion/cleientiaid, gofalwyr a phob unigolion arall sy’n gysylltiedig â’r maes ymarfer

Gwneud newidiadau i gynlluniau gofal yn sgil adolygiadau, gan eu hadrodd i’r Uwch-nyrs
Nyrs Iechyd Galwedigaethol (wedi cofrestru â’r Cyngor Nyrsio a Bydwreigiaeth â chymhwystyr cofrestradwy arbenigol ychwanegol)

- Ymarferwydd annibynnol
- Gweithio gydag unigolion a thimau i atal problemau iechyd, hybu amodau byw a gweithio’n iach gyda gyflymadaeth a sgiliau penodol o ran ddefaid iechyd ar iechyd ac iechyd yr y gweithle.
- Cynnal profion sgrinio iechyd, gan gynnwys monitro’r gweithlu a’r gweithle ac asesu anghenion iechyd a hybu iechyd; addysg a hyfforddiant a phan fo hynny’n briodol cwnsela a chymorth ac asesu risg a rheoli risg.
- Rheoli tîm amliddysgyblaeth o weithwyr iechyd profesiynol

Nyrs Plant Cymunedol (wedi cofrestru â’r Cyngor Nyrsio a Bydwreigiaeth â chymhwystyr cofnodadwy arbenigol ychwanegol)

- Cefnogi’r plentyn, y teulu a’r gofalwyr, mewn ymateb i wneud y gorau o annibyniaeth ac ansawdd bywyd y plentyn neu’r person ifanc
- Darparu gofal n yr ofal bob dydd neu ddiwedd oes
- Cefnogi plant a phobl ifanc sy’n cael pecynnau Gefal Parhaus a gofal diweddi oes 24/7, gan gynnwys penwynhosanau a gwyliau banc
- Darparu asesiadau clinigol a chymorth i blant mewn lleoliadau cymunedol sydd ag anghenion gofal iechyd yn rhan o weithio gyda gwasanaethau gofal sylfaenol er mwyn atal darbwniaetha diangen i’r ysbyty a hwylu’r broses o ryddhau clefion yn gynnar
- Cynnal sgrinio iechyd sydd ag anghenion gofal iechyd ac iechyd ychwanegol ychwanegol

Cynillunio gofal i blant sydd ag anghenion iechyd aciwt ar gyfer adolygiad gwasanaethau a’r gwarchod a’r staff fel sy’n briodol, a phan fo hynny’n briodol cwnsela a chymorth ac asesu risg a rheoli risg.

Arbenigwr Nyrs Glinigol Gymunedol (wedi cofrestru â’r Cyngor Nyrsio a Bydwreigiaeth â chymhwystyr cofnodadwy arbenigol ychwanegol)

- Yn gweithio’n annibynnol ac yn chwarae swyddogaeth ganolog wrth arwain ymarferion clinigol a gwella safonau gofal, hybu gwasanaeth di-dor drwy weithgareddau profesiynol, archwiliadau, gwaith ymchwil, addysg, rheolaeth ac ymarfer clinigol
- Gweithio yn rhan o dim, datblygu gwasanaethau dan arweiniad ymysg a darparu sylwadau n yr yr arbenigol yna ystod pob cam o gyfnull a chaf
- Arwain gofal clinigol drwy reoli llywch achosion diffiniedig i glefion, darparu asesiadau, cynyru a gwerthusiau arbenigol, hwylu’r addysg ar gyfer clefion a’u teuluoedd
- Darparu Clinigau Mynediad Cyflym nad oes angen goruchwyliaeth Ymgynghorydd arnynt
- Archebu, dadansoddi a dehongli ymchwiliadau patholeg, radioleg a microbioleg
- Gweithredu fel pwynt cyfeirio ar gyfer clefion yn y gymuned y mae problemau’n deillio o’u cyflwr a/neu ei driniaeth, drwy ddarparu gwasanaeth linell gymorth y ddod y ffôn.
### Atodiad 2:
Y Rhaglen, Uwchgynhadledd Nyrsio Gymunedol a Gofal Sylfaenol RCN Cymru: 12 Mehefin 2019

<table>
<thead>
<tr>
<th>AMSER</th>
<th>Uwchgynhadledd Nyrsio Gymunedol a Gofal Sylfaenol RCN Cymru: ‘Bodloni’r Agenda ar gyfer Cymru Iachach’ 12 Mehefin 2019 Y RHAGLLEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.00 – 13:00</td>
<td>Cofrestru a Chionio</td>
</tr>
<tr>
<td>13:00 – 13:10</td>
<td>Croeso</td>
</tr>
<tr>
<td></td>
<td>Nicola Davis-Job, Cyfarwyddwr Cyswllt Dros Dro (Ymarfer Proffesiynol) RCN Cymru</td>
</tr>
<tr>
<td>13:10 – 13:15</td>
<td>Cyflwyniad y Cadeirydd i’r Uwchgynhadledd</td>
</tr>
<tr>
<td></td>
<td>Dr Sue Thomas, Ymgynghorydd Gofal Sylfaenol, Y Sector Gymunedol ac Annibynnol, RCN Cymru</td>
</tr>
<tr>
<td></td>
<td>Sue Morgan, Cyfarwyddwr Cenedlaethol ac Arweinydd Rhaglen Strategol ar gyfer Gofal Sylfaenol</td>
</tr>
<tr>
<td>13.40 – 14.05</td>
<td>Cwestiynau</td>
</tr>
<tr>
<td></td>
<td>Dr Crystal Oldman,</td>
</tr>
<tr>
<td></td>
<td>Cyfarwyddwr, Queen’s Nursing Institute, y DU</td>
</tr>
<tr>
<td>14.10 – 14.30</td>
<td>Y Darlun Cyfoes ar gyfer Gofal Sylfaenol a Nyrsio Cymunedol</td>
</tr>
<tr>
<td></td>
<td>Dr Crystal Oldman,</td>
</tr>
<tr>
<td></td>
<td>Cyfarwyddwr, Queen’s Nursing Institute, y DU</td>
</tr>
<tr>
<td>14.40 – 15.00</td>
<td>Cwestiynau</td>
</tr>
<tr>
<td>15.00 – 16.30</td>
<td>Te a Choffi</td>
</tr>
<tr>
<td>16:30 – 16:50</td>
<td>Sylwadau, Cynllau Cynnar, Argymhelllon a’r Ffordd Ymiaen</td>
</tr>
<tr>
<td>16:50 – 17:00</td>
<td>Crynodeb a Sylwadau i Gloi</td>
</tr>
<tr>
<td></td>
<td>Stephen Griffiths, Cyfarwyddwr Nyrsio, Addysg a Gwella Iechyd Cymru</td>
</tr>
<tr>
<td>17:00</td>
<td>Gorffen</td>
</tr>
</tbody>
</table>
Cyfeiriau


King’s Fund (2012a) Transforming the Delivery of Health and Social Care: The case for fundamental change. King’s Fund, Llundain

King’s Fund (2012b) The care of frail older people with complex needs: time for a revolution. Uwchgyntadledd lechyd Sir Roger Bannister, Castell Leeds. King’s Fund, Llundain


Queen’s Nursing Institute (2011) Nursing People at Home: The issues, the stories, the actions. Queen’s Nursing Institute, Llundain

RCN (2013) Defining staffing levels for children and young people’s services: RCN standards for clinical professionals and service managers. RCN, Llundain

RCN (2014) Defining Nursing. RCN, Llundain
