Meeting Date	**23 August 2022**	**Agenda Item**	**3.2**
Report Title	External Review of the Children's Community Nursing Team Service – Progress Update		
Report Author	Jane Phillips – Quality Improvement Lead Neath Port Talbot & Singleton Service Group		
Report Sponsor	Lesley Jenkins – Group Nurse Director Neath Port Talbot & Singleton Service Group		
Presented by	Lesley Jenkins – Group Nurse Director Neath Port Talbot & Singleton Service Group Jane Phillips – Quality Improvement Lead Neath Port Talbot & Singleton Service Group		
Freedom of Information	Open		
Purpose of the Report	To provide an update to the Quality & Safety Committee on progress of the Improvement Plan for the Childrens Community Nursing Team following the publication of the report into the External Review of the service commissioned by the Health Board in April 2021.		
Key Issues	Key issues identified in the report were: • Lack of clear team governance structures with concerns being managed internally with no robust consistent process in place; • The service model for the children's community nursing focused primarily on continuing care and not the delivery of the wider community provision of care; • Limited evidence of the team working in partnership with families; • The culture of care was identified as being complex with what appeared to be an inflexible leadership style.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: • **NOTE** the key findings of the report. • **NOTE** the update on the Children's Community Improvement plan acknowledging lack of progress

	in a number of the actions against the timescales in the following: • ensuring the recommendations relating to multiagency pathways and assurance are achieved through the Transformation Boards; • the Children & Young People Business case which describes the resources required to fully progress the recommendations in the report to be supported; • the risks associated with not supporting the business case to be acknowledged and accepted on the Health Board risk register; • the Health Board and NPTSSG to consider the most appropriate position for the CCN Service within the HB structure.

External Review of the Children's Community Nursing Team Service – Progress Update

1. INTRODUCTION

The purpose of the paper is to provide the Quality & Safety Committee with an update on the progress of the Children's Community Nursing Improvement Plan. The Improvement Plan was developed in response to the recommendations identified in the external report (Appendix 1) into the Health Board's Childrens Community Nursing Team. Previous reports to the Quality & Safety (Q&S) Committee have been to share the report and its findings and provide an initial update on the immediate actions taken by the Children & Young People Division following the publication of the executive summary and recommendations. At the Board meeting on 25 November it was agreed the Q&S Committee would receive a quarterly update on the progress made against the Childrens Community Nursing Improvement Plan (Appendix 2).

2. BACKGROUND

In the autumn of 2020 the Executive team commissioned an external review of the Children's Community Nursing Team Service. The review was commissioned in response to concerns raised by families who used the service. The review was undertaken by two external reviewers who were commissioned for their experience in providing social care services for families with children and long term commissioning. The focus of the review was on identifying key areas of strength to build on, and areas of potential risk, where further action might be recommended.

The review focused in more detail on:

- the culture of care, particularly focussing on family involvement;
- direct experience of children and families using the service;
- direct engagement with staff within the service; and
- how professional nursing standards are delivered.

The Children's Community Nursing Service team are one of the teams at the forefront of caring for children and young people with complex needs and providing the required level of support for this cohort of families.

The reviewers spoke to families and dedicated skilled nurses and support workers, most with many years' experience. However, limitations were identified that prevented families from receiving the standard of service that given to the Health Board would have been expected or which fully represented the Health Board values. The executive summary of the report is attached as Appendix 1.

In summary, there were several key factors identified that affected the service being able to fully deliver to the Health Board standards and values:

- The lack of clear governance team structures; these were ambiguous and did not support easy oversight or the ability to identify concerning trends arising, to address issues in a timely manner, or to support decisions made. It was not possible to see how the Board could be assured as to the standards or safety of the service provided. There was also an accepted practice of incidents not being reported (via Datix) which also served to conceal emerging trends from the wider Health Board. Some immediate issues were identified at the time of the review and were addressed as soon as they were raised.

- The service model; whilst this provided services for three distinct categories of children (acute, chronic and continuing care), continuing care was the primary focus and formed the basis of funded establishment for the whole service. There were concerns about key management data being captured, and its use to support the service as a whole was limited. Service design itself had built-in challenges including the time taken to deliver an approved package of care, registered nurses working office hours whilst HCSWs work mostly at night, and meeting a child's needs in a family home which was also the workplace for the HCSW.

- Partnership working; The *'what matters to me'* and *'voice and control'* requirements that underpin the Social Services and Well-being (Wales) Act (2014) do not appear to have been reflected in the way services have been developed and offered to parents. There was little evidence to show families were partners in the delivery of care. Parents were found to be frustrated due to poor communication and relationship management from the leaders of the CCN Service, leading to a breakdown in the parent / service provider relationship. There was a perception of sanctions being imposed by the service should families complain leading to a lack of trust and / or total breakdown in the relationship with the team.

- Culture of care; This was identified as being complex with what appeared to be an inflexible leadership style. Staff were left feeling demoralised and frustrated having raised concerns relating to workload and their ability to sustain a safe service during the pandemic. No evidence was found to reassure the Board that concerns were appropriately addressed or resolved. The review highlighted that any continuing care decisions for paediatric cases were made by the adult panel who had limited knowledge to support decision making in such cases. There also appeared to be a lack of knowledge and understanding of the Continuing Care process within the wider health board management and governance arrangements, which reduced the ability to audit and monitor the implementation of the Welsh Government guidance to provide adequate assurance to the Board

- The experience of children and families; None of the families were critical of the CCN Service as a whole and many praised aspects of the service but there were concerns about specific issues which were not appropriately addressed. A recurrent theme included the Continuing Care assessment process. Many families spoke positively

about the HCSWs that actually deliver the care and of registered nurses who helped and supported them to navigate the process to access care.

- The views of the CCN Team; In analysing the views and responses from all registered nurses in the team and a cross-section of HCSWs, it was clear staff were aware of the challenges and issues faced by the families and were keen to help resolve them. The review team felt the staff they met were caring and committed with innovative ideas that could help shape the team moving forward.

3. GOVERNANCE AND RISK ISSUES

The Children & Young People (CYP) Division Improvement Plan was developed by the service in response to the external report into the Childrens Community Nursing Team which was approved by the Health Board in November 2021. This Improvement plan has been evolving as parents/families and staff engage with the service and contribute to ongoing improvements and developments.

For this reporting period a number of actions in the Improvement Plan remain off track. This position was highlighted in the April 2022 report to the Quality & Safety Committee (Q&S) and are mainly due to the financial constraints on the Children & Young People Business Case which was submitted for consideration and support through the Health Board's Business Case Assurance Group (BCAG) process.

3.1 FEEDBACK

- **Staff Feedback**

Each member of the Childrens Community Nursing team received a copy of the executive summary and the recommendations. A 100% of the registered nursing staff have taken up the offer of formal feedback from the reviewers.

We have previously reported that less than 20% of the unregistered workforce attended for the feedback. HCSW training days were established in December 2021 to incorporate the learning and ensure opportunities were given for them to contribute to developing the community service for the future. Due to staffing shortages since March 2022, these sessions have been postponed in order to maintain care delivery for children and their families.

- **HCSW's patient/parent feedback**

In April 2022 we reported to Q&S Committee on the development of a system using the mobile devises issued to the community staff to assist the 40+ HCSWs to provide their feedback about the service. These HCSW's work in the patient's homes for a full shift each night and have a very close working relationship with the parents and carers. This system called '*What's the Noise'* provides an opportunity to gain the views and feedback from the HCSW's as they work with families.

The system commenced at the end of May 2022 and to date there have been 6 comments from the team – these are reported via the Health Board Patient Feedback team to the Division for sharing and to be acted upon. Whilst the number is quite low we are continuing to encourage the team to commit to providing us with feedback.

- **Formal Family Feedback of the Review Findings**

Just over 50% of the families met with the reviewers and the senior nursing team to receive formal feedback. Summaries of the discussion have been recorded and shared with the families.

At the end of March 2022 an update letter was sent to all the families in receipt of continuing care from the Service Group Director. It included an update on progress of the improvement plan and a request for the families to comment on the proposed feedback questions to be used to further gain their views and experience. The letter also requested the families advise us if they were interested in being involved with the service improvements. Only one family responded advising they would be interested in being involved.

- **Family experience feedback**

In the meantime, the Corporate Patient Feedback Team have developed a specific QR code which has been given to all the families receiving continuing care. The named CCN for each child has introduced the QR code to the families and added it to the child's home nursing record. This allows the parents to provide immediate feedback about the service which is monitored by the Health Board and responded to by the CYP Division. This is a quick and simple method for families to pick up their phones at any time and send something in about the service/care. Unfortunately, only one of the 18 families have provided feedback so far. This is a little disappointing as we have asked the nursing team to encourage parents to provide any feedback – positive and negative.

3.2 ENGAGEMENT & PARTICIPATION

- **Staff Participation**

Registered staff now have a weekly 'lunch and learn' session which includes updates and discussion on the improvement plan. From May 2022 weekly 'catch up' meetings have been established for the HCSW's to meet via teams with the community manager and Lead for the Improvement Plan to give them an open forum to discuss the service needs and the improvement plan. Attendance has been positive and a log of the suggestions and comments has been collated.

<u>Risks:</u> There continues to be constraints with staff availability due to staffing levels within the team and the clinical commitments. A recruitment process is ongoing to recruit to essential posts in order to increase the staffing

establishment. Fixed term posts have been made permanent in an action to retain current team members.

- **Family Participation / Engagement**

The Service group has met with the Health Board Engagement leads to discuss the need to work towards developing an engagement plan for the CYP Division. It is recognised that for many of these families' time is very limited and it will be necessary to ensure the engagement plans are built with their needs and wishes as the primary focus. Through the Family Engagement Task and Finish group planning has commenced for a proposed engagement events with a provisional date to write to the families in October 2022 offering them an opportunity to take part. This will include opportunities to be involved in one or all of the following:

- Focus groups
- One to one experience interviews
- Developing a 'In your Shoes' plan to assist in establishing what works well, what doesn't work well and what can we do differently

- **Participation from wider stakeholders**

The Continuing Health Care Transformation Board established with the two local authorities has a wide membership already contributing to the future development of continuing care services. The CYP services continue to be members of the groups linked to the transformation work however progress with multiagency implementation and quality assurance monitoring at present is slow. The CYP services have met with the Health Board lead for the transformation board to discuss how the multiagency work can progress.

Risks: There are currently two actions on the improvement plan relating to multiagency partnership working which are 'red' - we will update on what progress can be made following discussion with the corporate lead for the transformation board. These are:

- **Recommendation 26**: Ensure appropriate audit processes for Children and Young People Continuing Care are in place that measure compliance with WG Guidance.
  Action - Report compliance via the multi-agency transformation programme.

- **Recommendation 19**: Explore a multiagency approach to develop local pathways agreed and jointly owned by the HB and its partners
- **Action** - Fully embed the transforming continuing care pathways and monitor via the Quality Assurance meetings.

Due to the lack of progress in embedding the guidance across the agencies through the transformation board in Childrens services – the new Health Board Lead has proposed establishing a smaller a sub group to assist in mapping the key issues and challenges which have contributed to the delay. It will also include Primary and

Community service group as ‘Looked after children’ are also contributing to some of the current challenges in fully embedding the guidance.

In the meantime, the service continues to work to new Standard Operating Procedures developed from the national guidance and commenced monitoring compliance against the guidance via a newly developed assurance framework. The assurance framework was ratified by the CYP quality and safety forum and has been registered as an audit on the Health Board Audit plan. Audit outcomes will be reported via the Division Quality & Safety forum and the NPTSSG monitoring meetings.

3.3 WORKFORCE

- **Leadership**

As previously reported the new Head of Nursing for Children & Young People commenced in post in January 2022, this offers a great opportunity to develop the nursing team across the CYP Division. The Division has reviewed the senior nursing structure following that key appointment to ensure there is a robust succession plan, particularly as the Head of Nursing post had taken over a year to recruit into. To prevent future delays in appointing into senior nursing posts the CYP nursing workforce plan now has a Deputy Head of Nursing role in the structure. The benefits and opportunities of having this post is described in the workforce business case which was presented to Business Case Assurance Group. The business case remains under discussion; exploration of funding source is ongoing.

Since May 2022 the Childrens nursing community team have appointed a new Band 7 nursing manager who has an extensive knowledge of community nursing and continuing care. The appointment of this post is positive in ensuring the team is supported through this period of change and the families build confidence in the new management team which for them was one of the main contributory factors of their poor experience with the service in the past.

- **Workforce requirements**

The Division has prepared a business case detailing the resources required to meet the staffing needs and future leadership of the team. At the Management Board in February 2022 it was highlighted there was likely to be significant cost implications in order to fully achieve the required actions. This funding requirement has been outlined within business case, decision regarding funding source remains outstanding.

<u>Risks:</u> There are number of key posts identified in the workforce business case which the Division is awaiting approval for.

There have been delays as additional information is requested and further reviews of the key posts outlined in the business are reassessed. There are

currently seven actions on the plan which could be completed if the business case was supported. These seven actions are currently 'red' on the improvement plan as there are no alternative solutions to achieving the staffing resources required and therefore these actions cannot be progressed.

The external review report found a lack of clear governance team structure; the leadership structures reviewed were ambiguous and did not support easy oversight or the ability to identify concerning trends arising, to address issues in a timely manner, or to support decisions made. It was not possible to see how the Board could be assured as to the standards or safety of the service provided.
The risk of not approving these key posts relate to a number of key recommendations identified by the reviewers many of which relate to key governance issues such as:

- **Recommendation 14** Having appropriately skilled experts to undertake the Nurse assessor role in line with the Childrens Continuing Care Guidance (WG 2020). Failure to appoint could result in delays in assessing new referrals for continuing care in line with guidance, under reviews of current children receiving continuing care resulting either insufficient levels of care or providing more care than required.
- **Recommendation 32:** Ensuring that the care delivered by the Health Care Support workers during the night shifts is provided in line with the individual care plans developed for each child by the registered nurse. Additional Band 6 hours in the team is essential to support and monitor standards of care which are predominately delivered out of hours. In the review parents have commented on the lack of support out of hours when problems arise and concern about how HCSW's who may be under performing are supported. In other Health care settings this would be achieved by having a qualified member of staff involved.
- **Recommendation 25:** Due to the lack of support out of hours there is an increased risk of admission to hospital when these children with complex health needs develop a problem and the HCSW's and parents only have access to the acute ward areas. The lack of knowledge in the acute areas of the complexity of these children usually results in admission to hospital which in many instances isn't always appropriate.
- **Recommendation 33:** Due to insufficient levels of HCSW's at Band 3 and 4 level available to support care packages there was a risk of delays in care packages being commenced. Additionally, short and long term absences of the team could result in increased cost to the Health Board to support care packages by using external and private care providers to meet the needs.
- **Recommendation 16:** The Lone Working practices of the HCSW's working in homes out of hours was highlighted by the parents and the staff as a concern and risk. The reviewers recommended robust Lone Working procedures were implemented into the team. In addition to developing a bespoke lone working standard operating procedure (SOP) the Band 6 posts and additional band 4 supernumerary role are required to ensure appropriate levels of support.

- **Recommendation 4:** Strengthening the governance arrangements was highlighted by the reviews and the CYP services proposed to appoint a full time Governance lead utilising 0.6wte budget of a recently vacated patient experience nurse. This role is required to cover across the division focusing on strengthening quality and safety agenda including patient/parent feedback and improvement engagement.
- **Recommendation 21**: The leadership and nursing structure was proposed to be strengthened by introducing a Deputy Head of Nursing role. This and other key roles are described in a workforce plan shortly to be presented to the NPTSSG board. Failing to successfully recruit a Head of Childrens Nursing for over 12 months was concerning and acknowledged a risk both to service continuity but also reputational damage to the Health Board following significant media and political coverage of the service.
- Potential impact on the wellbeing of staff who remain in work. The current risk scoring for maintaining services in the community team is 20.

The Director of Nursing discussed the CYP business case at the Business Case Review Group on 9th August 2022 and there was general agreement of support with the Directors of Finance and Planning. The business case will go to formal executive team next week and then to Management Board.

- **Work Force Task & Finish Group**

The Neath Port Talbot & Singleton Service Group (NPTSSG) workforce task and finish group continue to oversee the actions relating to workforce requirements, organisational development programmes and ongoing support for the nursing team.

  - Progress has been made in reaching a point where finalising a CYP Division Nursing Workforce plan will be achieved. The plan identifies key nursing roles to safely provide the nursing input to support Childrens services across the Health Board.

  - A standard operating procedure (SOP) for 'out of hours' working for the Health Care support workers has been completed and partially implemented. The final implementation requires resources to have a registered community nurse available until midnight to support the unregistered staff particularly at the beginning of their shift when taking over care from the parents or carers. This post may also support attendance at the home to provide additional support and guidance for the HCSW. This post is included in the workforce Business Case awaiting approval. In the meantime, processes for risk assessing work places, agreeing a 'buddy' system for support are progressing.

<u>Risks:</u> Fully implementing the Bespoke Lone worker procedure in the Childrens community nursing service is currently 'red' on the improvement plan.

- The workforce group has overseen the development of the Band 4 Job description with specific attention to the opportunities to extend the roles and responsibilities of this Band of staff. This needs to be in line with educational and competency based skills requirements. There is further benchmarking with other HB's across Wales to establish the extent of the roles within other community teams.

- The Organisational Development team have supported the task and finish group in developing a bespoke training programme for the registered staff.

- **Training for the Childrens Community Nursing team**

Training sessions for the registered nursing staff was held in June 2022 facilitated by the Organisational Development team using values based learning, appreciative enquiry and civility. 100% of the registered nursing team attended these sessions with feedback being very positive from the participants and the facilitators.

The HCSW training which includes values based discussion and learning and appreciative enquiry had to be postponed earlier in the year due to significant staffing constraint. A date for another eight of the team to attend is booked for 8th August 2022. The service is aiming to achieve 100% compliance for all staff by end of Quarter 3.

Additional training requirements being planned through the task and finish group will include accessing Health Board training programmes to promote leadership and ensure future successful succession planning:

- Footprints
- Bridges
- Impact training
- Coaching for performance

- **Wellbeing support**

The Childrens Community Nursing team have been under significant stress since before the review was initiated and maintaining the wellbeing of the team has been a priority. It is positive to report that the team are rebuilding with new appointments and the plan to ensure community nursing offers opportunities for rotation from the general paediatric ward will assist in maintaining staffing levels.

During the review and since the staff have been sign posted to Wellbeing and Guardian services with many taking up the support. The Guardian service have

recently escalated feedback they have received from staff that staffing pressures with the delay in key appointments remains a concern for them.

The Health Board Psychology services have also supported the team.

- **Risk Assessment**

The impact of the external review on the Childrens Community Nursing team, and a number of senior staff leaving or moving out of the service created a new risk as less experienced staff were offered opportunities to work within the team. The number of qualified staff with the level of knowledge and experience in children's community nursing and continuing care is very small.

Additionally, there remain a number of vacancies in the HCSW role which has an impact on safely being able to cover the care packages. Recruitment plans continue to attract new staff into a service which is quite different to other areas of Healthcare. Bank and agency support has been sought although this is limited due to the specialist nature of the care required for these children.

The current risk assessment for the children's community teams is **20** and has been included on the risk register.

3.4 QUALITY & SAFETY

- **Incident reporting & Concerns management**

All the actions on the improvement plan relating to incident reporting and concerns management have been completed, with 100% of the registered staff receiving updating on reporting requirements. They have meet with the Women & Child Health Governance team and are now attending the Divisional incident review meetings. The Division is monitoring themes and trends to ensure continued compliance with guidance and policy. Incident reporting numbers have increased with staff now reporting issues/incidents and cancelled night cover routinely. An exception report is produced and discussed at the Divisional Quality and Safety and Business meetings, chaired by the Head of nursing/Divisional Manager.

- **Audit & Assurance**

The Community Nursing Team have a record keeping audit programme which has been implemented and is undertaken by all the registered staff. Adhoc monitoring of the audits has been undertaken by the Community Nursing Manager and Quality Improvement Lead to provide additional assurance.

The Division has developed a Continuing Care assurance audit framework to monitor compliance with the Children and Young People's Continuing Care Guidance (WG

2020) which was ratified in May 2022. The assurance audit has been registered and logged in the Health Board Audit Plan.

The Division has developed an assurance framework for the Childrens community nursing team to monitor incident reporting, concerns, feedback, staff training compliance. The first assurance report will be completed for July 2022 and reported to the CYP Division Q&S group and the NPTSSG Improvement plan monitoring group.

- **Benchmarking with other Continuing Care providers**

Benchmarking across Wales has been challenging and as a result the actions on the improvement have remained red. The main reason for this is that the configuration of services appears to be very different. SBUHB has presented the findings of the external review to an All Wales Childrens Continuing Care Group. The sharing of lessons learnt has prompted many of the Health Boards to review their services and assess themselves against the recommendations from the review. There has recently been an All Wales Childrens Nursing Group to develop KPI's for Childrens services including continuing care, this will assist in future benchmarking.

- **Data monitoring of activity in Childrens Community Nursing Services**

The reviewers identified a lack of any performance activity for the Children's Community nursing services for the three areas:

  - Continuing care
  - Chronic conditions
  - Acute services

As a consequence of no reporting and monitoring mechanism for the activity there was no way of establishing the appropriate workforce requirements for the community services apart from the HCSW worker shifts required for each of the continuing care packages. The reviewers advised that the establishment for all of the Children's Community services appeared to only take into consideration the continuing care element of the service. The CYP Division has liaised with the Health Board information team to develop a reporting system for all community activity via WPAS. It is anticipated all the current manual collection of activity which commenced in May 2022 will soon be collected electronically. We are awaiting a final completion date of this piece of work.

3.5 UPDATE ON OTHER ACTIONS CURRENTLY RED ON THE IMPROVEMENT PLAN

- **Plan future assurance monitoring process to incorporate peer review (which could be external to the Division).**
  Update - The All Wales continuing care group have developed a draft terms of reference to support national peer reviews. The terms of reference have been

agreed and SBUHB will be taking the first case for review at the next All Wales Continuing Care Group.

- **The Division to work in partnership with the Service Group and corporate team to agree the future structure of the CCN Service.**
  This action continues to be delayed until wider discussions and consultation has been planned with the Service Group and the Health Board. (new date not yet agreed).

4. FINANCIAL IMPLICATIONS

The CYP Division has developed a Business Case which outlines key resource implications, which need to be funded and which are essential to successfully implementing the recommendation from the external report.

Areas identified as requiring early attention are:

- Develop a sustainable senior nursing leadership structure;

- Additional staffing requirements identified in the action plan which will need to be quantified to meet the staffing levels required. Establishing the exact staffing levels will require the development of a dataset of key management information relating to the community service to capture the level of activity;

- Meeting the Children & Young People's Continuing Care Guidance recommendations for additional roles such as a lead nurse assessor and LD nurse assessor roles will need to be funded and appointed;

- To provide 'out of hour' support for a service providing 24-hour care in a community setting.

5. RECOMMENDATION

The Quality & Safety Committee to receive an update on the Children's Community Improvement Plan acknowledging lack of progress in a number of the actions against the timescales in the following actions:

- Support to ensure the recommendations relating to multiagency pathways and assurance are achieved through the Transformation Boards.

- The Children & Young Business case which describes the resources required to fully progress the recommendations in the report to be supported.

- The risks associated with not supporting the business case to be acknowledged and accepted on the Health Board risk register.

- The Health Board and NPTSSG to consider the most appropriate position for the CCN Service within the HB structure.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Implementation of the improvement plan will improve the quality and safety of the children's community nursing service (see appendix 2)		
Financial Implications		
There are financial implications to implementing the improvement plan which will be better understood once key actions are completed.		
Legal Implications (including equality and diversity assessment)		
Staffing Implications		
The children's community nursing team are being supported throughout the process, there is a risk to sustaining the services which has been included on the Children & Young People Risk Register		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The 'what matters to me' and 'voice and control' requirements that underpin the Social Services and Well-being (Wales) Act (2015) do not appear to have been reflected in the way services have been developed and offered. The improvement plan has been developed to comply with this Act.		
Report History	The Quality & Safety Committee have received regular updates of the external review whilst in progress. An initial progress following publication of the report was shared at the Q&S Committee on 22nd December 2021.	
Appendices	**Appendix one - Executive Summary** **Appendix two – Community Nursing Improvement Plan**	