Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 31 March 2022 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | HDdUHB Palliative & End of Life Care Strategy |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Jill Paterson, Director of Primary Care, Community & Long Term Care |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Jina Hawkes, General Manager Community & Primary Care & Alison Bishop, USC Lead |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This paper introduces the Palliative & End of Life Care Strategy, which Hywel Dda University Health Board (HDdUHB) commissioned from Attain, Healthcare Consultancy.

## Cefndir / Background

In April 2020, in response to the COVID-19 pandemic, Welsh Government issued the COVID-19 Hospital Discharge Service Requirements (Wales), and as a result a regional approach, through the West Wales Care Partnership (WWCP), outlining standards and principles was agreed which sought to describe equitable outcomes for our population across the three Counties, whilst allowing for local variation in delivery.

The WWCP Palliative & End of Life Care Principles (PEOLC) were agreed in September 2020, and this document highlighted that whilst there were some reference documents available in Wales and across the UK, there was no All Wales PEOLC Strategy nor a related HDdUHB Strategy.

The WWCP EOLC principles clearly articulated the desire to adopt the six positive ambitions defined in the National Palliative & EOL Care Partnership Ambitions for Palliative and End of Life Care framework[1]. Whilst this is a document produced for NHS England, these ambitions are equally valid for the population of Wales;

1. Each person is seen as an individual – what matters to me

2. Each person gets fair access to care – regardless of who I am, where I live or the circumstance of my life

[1] National Palliative & EOL Care Partnership (2015) Ambitions for Palliative and EOL Care; A national framework for local action 2015 - 2020

3. Maximising comfort and wellbeing – help me to be as comfortable and as free from distress as possible
4. Care is co-ordinated – getting the right help from the right people at the right time
5. All staff are prepared to care – staff bring empathy, skills & expertise and give me competent, confident & compassionate care
6. Each community is prepared to help – we all have a role to play in supporting each other in times of crisis and loss

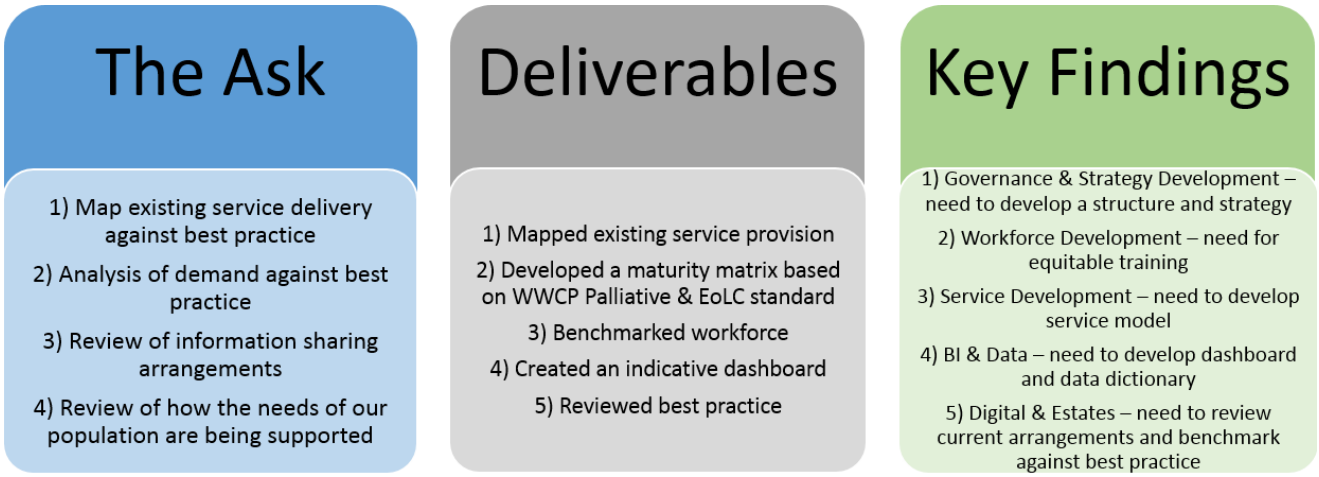
The Marie Curie report[2] assessing palliative care needs across the UK nations, confirmed that palliative care need is growing over time, and suggests that estimates of palliative care need at 75-80%, as included in the Wales report, do not take into account this increased level of need.

## Asesiad / Assessment

It was therefore considered essential that HDdUHB has a robust Strategy in place to ensure everyone at the end of life is able to access the specialist care and holistic support they need, and that this Strategy takes into account robust estimates of palliative care need and develops a robust and sustainable workforce plan to meet these increasing needs.

Utilising All Wales Palliative Care funding, HDdUHB commissioned an external review by Attain of palliative care and end of life services. This discovery phase was undertaken January – April 2021 and the key findings are outlined below:

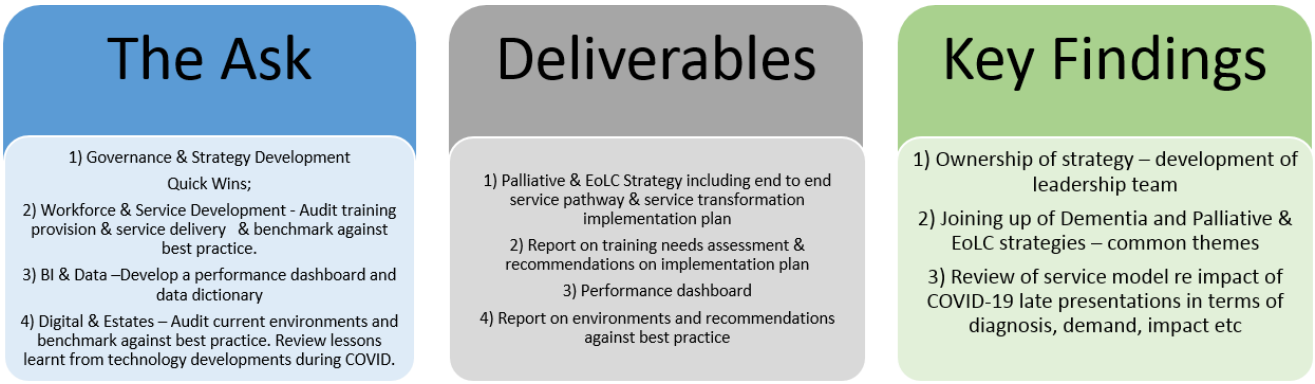
**Discovery Phase 1 January – April 2021**




One of the key findings from this discovery phase was the absence of a HDdUHB Strategy, therefore to bridge this gap, a further phase was commissioned to work with Attain to develop this Strategy for the Health Board. This work was undertaken with engagement from a wide range of stakeholders during spring/summer 2021.

[2] Marie Curie (2016) An Updated Assessment on Need, Policy and Strategy – Implications for Wales

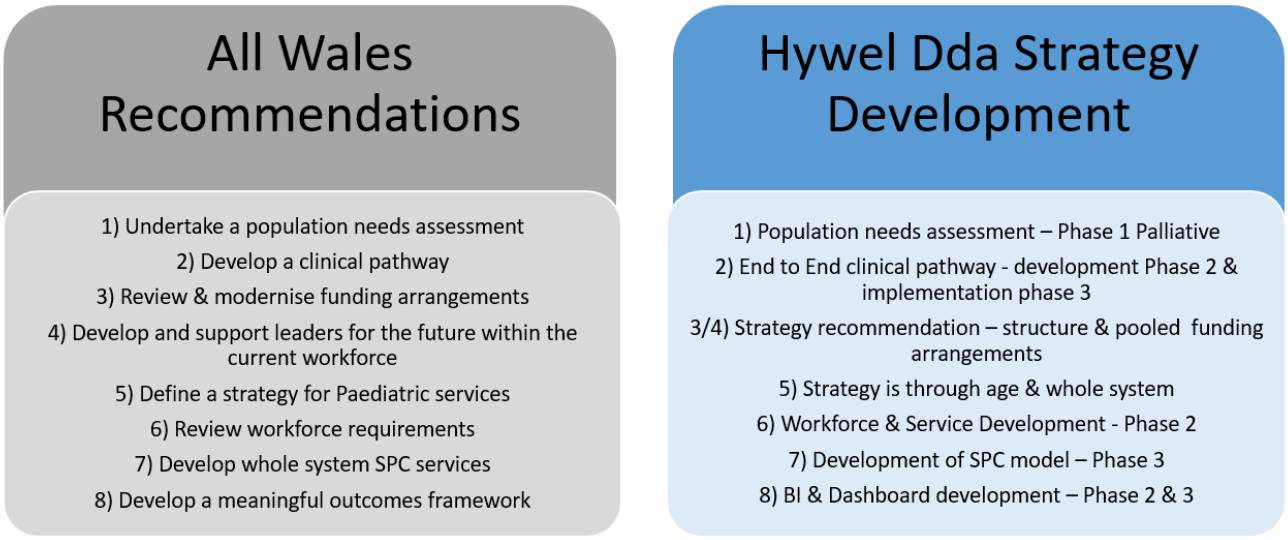
**Strategy Development Phase 2 April - June 2021**




The HDdUHB PEOLC steering group has approved the Strategy document, and the final phase of the commissioned work is ongoing to develop the service specification for PEOLC and associated workforce plan.

The PEOLC priorities are in line with the Ambitions for Palliative & EOLC National Framework, and the 2019 National Audit of Care at the End of Life builds on the initial continuous improvement programme.

An All Wales PEOLC service review has recently been undertaken and a review of the final report document has been undertaken to ensure that the local Strategy will align to the direction of travel across Wales in the absence of an All Wales Strategy;




The Strategic Development and Operational Delivery Committee (SDODC) considered the Strategy at its meeting on 24th February 2022, and supported its onward presentation to Board for approval.

## Argymhelliad / Recommendation

The Board is requested to **APPROVE** the Palliative & End of Life Care Strategy and its implementation.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable – there is no corporate risk associated with PEOLC however there may be service level risks on each county risk register |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 3. Effective Care<br>4. Dignified Care<br>5. Timely Care |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019 | 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS<br>5. Offer a diverse range of employment opportunities which support people to fulfill their potential<br>8. Transform our communities through collaboration with people, communities and partners |

| Gwybodaeth Ychwanegol:<br>Further Information: | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Welsh Government (WG) 2017 PEOLC Delivery plan<br>WG (2008) Palliative Care Planning Group Wales Report to the Minister for Health & Social Services<br>National Palliative & EOL Care Partnership (2015) Ambitions for Palliative and EOL Care; A national framework for local action 2015 – 2020<br>WG (2020) COVID-19 Hospital Discharge Service Requirements (Wales)<br>HDdUHB (2016) End of Life Delivery Plan<br>HDdUHB (2019) Together for Health Delivering End of Life Care<br>Marie Curie (2016) An Updated Assessment on Need, Policy and Strategy – Implications for Wales<br>WWCP (2020) PEOLC Principles |
| Rhestr Termau:<br>Glossary of Terms: | Explanation of terms is included within the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Palliative Care Steering Group<br>Integrated Executive Group/ Regional Partnership Board<br>Strategic Development & Operational Delivery Committee |

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | All accounted through funding streams outlined above |

| | |
|---|---|
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | Equitable outcomes for the population across all ages. |
| **Gweithlu:**<br>**Workforce:** | Not Applicable |
| **Risg:**<br>**Risk:** | Not Applicable |
| **Cyfreithiol:**<br>**Legal:** | Not Applicable |
| **Enw Da:**<br>**Reputational:** | The Strategy is the first of its kind in Wales. |
| **Gyfrinachedd:**<br>**Privacy:** | Not Applicable |
| **Cydraddoldeb:**<br>**Equality:** | The Strategy reflect the needs of the current population and the workforce plan reflects the changing demographics. |

# Hywel Dda University Health Board (HDuHB) Palliative and End of Life Care (PEOLC) Strategy

Attain
Improving health and wellbeing

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

September 2021 v2.1

This strategy should be read in in conjunction with the Attain EOLC best practice examples report published February 2021 and the HDuHB palliative care discovery final report v2.7 published May 2021

**'To provide excellent palliative and end of life care across West Wales enabling people to be cared for and die in their preferred place of care'**

# Contents

# Background

Hywel Dda University Health Board (HDuHB) is comprised of three Counties - Carmarthenshire, Ceredigion and Pembrokeshire. Each County operates Palliative and End of Life Care (PEOLC) services configured to their individual geography, population need and assets. However, recently, a regional approach, through the West Wales Care Partnership (WWCP), outlining standards and principles has been agreed which seeks to align the three Counties in meeting equitable outcomes for the population across all ages.

The HDUHB PEOLC Strategy development programme commenced with a Discovery Phase as a precursor to formal strategy development.

The Discovery Phase provided evidence and insight into:

- National and international best practice
- Benchmarking (via use of a maturity matrix) of the "as is" position across the region, which identifies different practices and gaps versus the best practice articulated in the West Wales PEOLC Principles (Published October 2020)
- Data and Business Information gaps, resulting in weaknesses in the evidence base, inhibiting effective decision making and service transformation

The Discovery Phase, founded on deep stakeholder engagement, energised ownership and commitment to deliver, has been sustained while this strategy has been developed. The Discovery Phase also demonstrated that there were a range of short term improvements which should be undertaken because they will benefit service delivery and which should not wait for a fully signed-off strategy.

Building on the key outcomes from the Discovery Phase, the next phase of work took place over a 3-4 month period and addressed both integrated Strategy Development and Continuous Improvement, utilising a programme approach with key workstreams and continued deep stakeholder engagement.

This strategy is aspirational and sets out the collective ambitions we want to achieve across Hywel Dda to improve PELOC for our citizens. In developing this strategy we have worked with organisations that provide PEOLC services, their staff, local voluntary organisations and other partners. We have also considered previous research and sensitively carried out our own insight work with individuals who are receiving PEOLC and their relatives. Their experiences have helped ensure individuals, their families and carers are at the centre of our strategy, vision and service model. It is now for HDuHB services and local partners to work together to continue to deliver these improvements for their local communities. *N.B. There is a separate report summarising progress made with the Continuous Improvement Programme.*

# Project requirements and activities

Below summarises the strategy development project requirements, the outcomes from the work undertaken and key actions.

## The Ask:

**1. Strategy development:**

- Deep stakeholder engagement through structured interviews, groups and workshops – to be agreed per county and a final strategy summary session across all three counties, resulting in a PEOLC vision and service pathway.
- Online surveys tailored for children, young people and adult patients, parents/carers of children and young people and partners of adult patients.
- Analysis of service demand for specialist palliative care and workforce capacity.

**2. A final strategy to include:**

- A PEOLC vision and end to end service pathway.
- A service transformation programme plan
- Alignment of priorities with regional ICF funding.

## Attain have:

**1. Strategy development:**

Due to the limitations of COVID-19 and the ability to meet in person, Attain:

- Carried out a series of 5 workshops during May 2021.
- Summarised the themes stemming from the interviews with stakeholders in phase 1, together with interviews with patients and carers of all ages.
- Developed 4 patients' and carers' surveys to enable further inputs.
- Worked with colleagues to develop a high-level strategy, service vision and model, based on best practice.
- Included a summary of current and future population demand and prevalence - the impact of demand on the workforce cannot be determined at this stage and will require further analysis.

**2. The strategy also includes:**

- A service vision and end to end pathway, plus recommendations in relation to implementation of the new service model. However, the extent of further funding allocation is not known at this time.
- Recognition that stakeholders have identified that COVID-19 has impacted timely diagnosis due to late presentations, but the extent of this impact is not fully known at this stage.

## Key Recommendations:

**1. Ownership of strategy, implementation of the service vision and model:**

- Once formally approved by the HDuHB, to realise the strategy and service vision, the new service model will require implementation.
- The strategy provides a series of priorities which is a significant programme of work that will require resourcing.
- HDuHB have approved the recruitment of a clinical lead to work as part of a triumvirate team to oversee the implementation of the new strategy through pooled budgets across the region.
- The strategy and service model should be reviewed once information is available regarding the impact of COVID-19 upon late presentations and diagnosis and the probable increase in demand on PELOC services.

# What is Palliative Care?

Palliative care has been defined by the World Health Organization as 'an approach that improves the quality of life of patients and their families facing the problems associated with life limiting illness, through the prevention of, and relief of, suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual.'

Palliative care as defined in the Sugar report can be split into 2 categories;
1) General palliative care, delivered by health professionals in a generalist setting
2) Specialist palliative care, delivered by specialist multi-disciplinary teams dedicated to palliative care

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Source: WEST WALES CARE PARTNERSHIPS PALLIATIVE AND END OF LIFE CARE PRINCIPLES

# What is end of life care?

People can receive palliative care at any stage in their illness. Having palliative care doesn't necessarily mean that the person is likely to die soon – some people receive palliative care for years. People can also have palliative care alongside treatments, therapies and medicines aimed at controlling their illness, such as chemotherapy or radiotherapy.

However, palliative care does include caring for people who are nearing the end of life – this is sometimes called end of life care.

**End-of-life** is the timeframe during which a person lives with, and is impaired by, a life-limiting, terminal, or fatal condition. Even if the prognosis is ambiguous or unknown. Those approaching end-of life will be considered likely to die during the forthcoming days, weeks or months. End-of-life care is care needed for people who are likely to die in the forthcoming months due to progressive, advanced or incurable illness, frailty or old age. During this period, people may experience rapid changes and fluctuations in their condition and require support from a range of people, including health services, as well as family and carers.

End of life care involves treatment, care and support for people who are nearing the end of their life. It's an important part of palliative care.

Source: WEST WALES CARE PARTNERSHIPS PALLIATIVE AND END OF LIFE CARE PRINCIPLES

# 2. Population needs analysis summary

# Population is up…

Hywel Dda has an aging population that is **above the Welsh average** for over 65s.

**UP 0.5%** by 2025, **2%** by 2040

The population of Hywel Dda is increasing overall

**Ageing population**

The over 65 population is set to increase by **6% over 5 years** and a massive **27% by 2040**

Hywel Dda Over **75% aged 85+ have 2 or more** long term conditions.

Over **85s** become **over 10%** of the population

And over 65s will become over a **third of the population by 2040**

Increasingly complex and longer term end of life care.

**Care becoming more complex**

Pre-Covid the leading individual causes of death in Hywel Dda were **Dementia and Heart disease representing 11% each**** (UK wide dementia 12.7%)

Hywel Dda Adult population is decreasing, **overall population increasing***.

*Source*: ONS, *Ceredigion total population will decrease but elderly population increase

**2019 NOMIS, defined by ONS using ICD10, high variation across counties with Ceredigion lowest at 9% dementia and Carmarthenshire highest at 11.7%, likely to increase all around due to ageing

# Conditions and mortality

Dementia **accounts for 12.7% of deaths** and is the **leading cause** of death across the UK

In **Hywel Dda** dementia is closer to 11% with variation across counties largely due to age profiles

**IHD** is still a main cause of death in the UK despite falling as a **proportion from 14% (2010) to 10.4%**

**IHD** has similar proportions to dementia across **Hywel Dda** at 11% on the whole

There are over **14,000 people** in Hywel Dda on GP registers with a diagnosis of **cancer** at some stage

There are over **4,800 people** in Hywel Dda registered with **Heart Failure**

**1 in 8 deaths** across England and Wales were attributed to Dementia in 2018

Alzheimer's society expects the number of dementia patients living alone will double by 2040

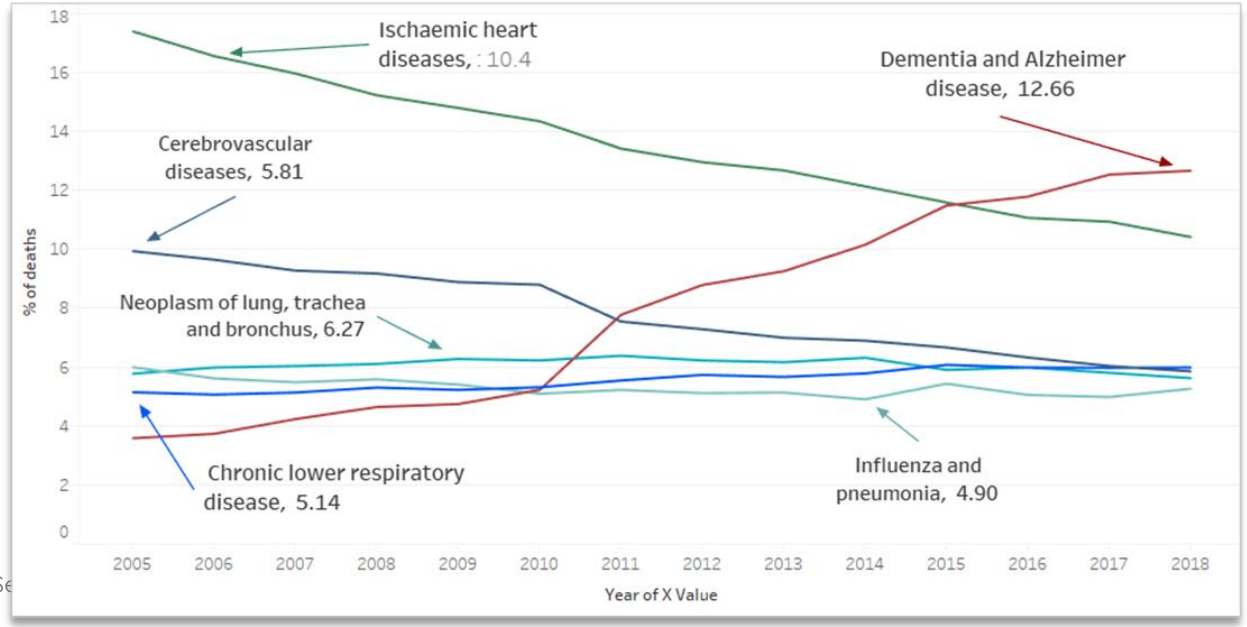
**Ischaemic heart disease** remains the leading cause of death **for men,** overall

**9,000 people** on the GP register, in Hywel Dda had a **diagnosis of COPD**

COVID-19 impacted mortality resulting in an increase in **excess deaths of around 14% across England and Wales**

It is, as yet **unknown what the future impact** of COVID-19 on mortality and end of life care will be

**Leading causes of mortality, UK up to 2018 (showing most recent % of total deaths)**

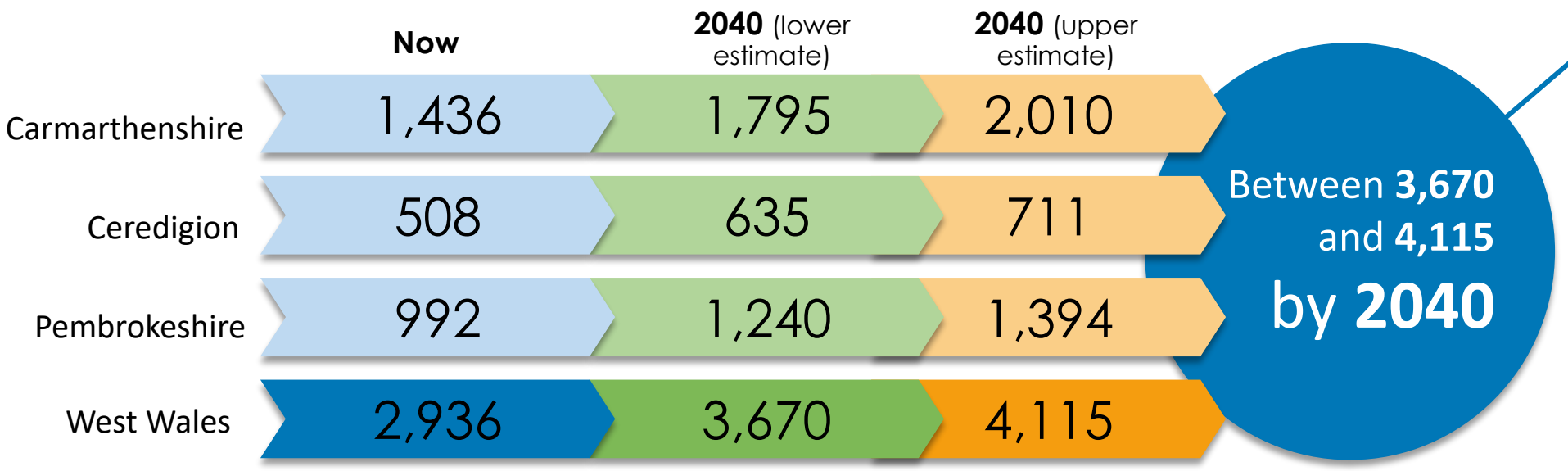


# Mortality and palliative care

From the All Wales PEOLC Delivery Plan 2017, it is **estimated that 0.75% of the Welsh population have palliative care needs** at a given time. Further, "The [plan] suggests an estimated prevalence rate for children and young people likely to require palliative care services as 15 per 10,000 population aged 0–19" **this equates to 12-13 children in Hywel Dda.**

It is indicated that over 65%* of people who are dying or die will have a palliative care requirement and the number of people needing palliative care will grow by 25% by 2040*.

**Estimated Palliative care need***




To put this into perspective…

The ***upper*** estimate is equivalent to everyone in **Tenby** needing services for end-of-life care

NB: CYP data included in totals: Numbers are very low and in cases where the 5 year age grouping was below 5, numbers were supressed and automatically rounded up to 5. This means that this number is likely a slight over estimation of deaths for 0-19 year olds but not a significant impact

* How many people will need palliative care in 2040? Past trends, future projections and implications for services - S. N. Etkind et al – this paper was used for estimates, 25% growth from 2014, data above is 2019, however 25% as report suggested it could be as high as 42% from 2014-2040

# 3. What does best practice tell us?

# The Welsh Government's PEOLC delivery plan

Published in March 2017, Wales was the first of two nations in the United Kingdom to have a current and overarching delivery plan for palliative and end of life care.

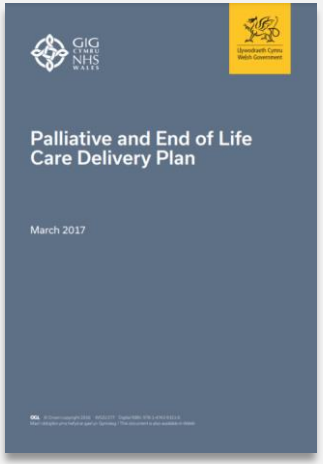
Reports published during the term of the first End of Life Care Delivery Plan also highlighted areas where improvement is required. Living and Dying with Dementia in Wales: Barriers to Access' Alzheimer's Society Wales Marie Curie 2015 and People with a Learning Disability 'A Different Ending: Addressing Inequalities in End of Life Care' Care Quality Commission 2016, identified barriers including access to care for people living with learning disabilities and dementia, and a lack of effective advance care planning and timely diagnosis for both groups.

The need to improve access to palliative care services for Black, Asian and Minority Ethnic (BAME) and Lesbian Gay Bisexual Transgender (LGBT) communities were highlighted in South East Cardiff Marie Curie (2014) and "Hiding who I am" 'The reality of end of life care for LGBT' people Marie Curie (2016) respectively.

The plan recognises there is a need to adopt a combined approach of Advance Care Planning, shared decision making and training for healthcare professionals in this field to support these patients and their families and carers, and to learn the best ways to meet the individual's needs.

The PEOLC Delivery Plan has clearly defined the specific priorities for Health Boards for the period 2017-2020 across 7 key delivery themes;

1. Supporting Living and Dying Well,
2. Detecting and identifying patients early,
3. Delivering fast, effective End of Life Care,
4. Reducing the distress of terminal illness for the patient and those close to them,
5. Improving Information,
6. Targeting research,
7. Education.




**N.B. The Welsh Government have recently carried out a stocktake summarising the progress made in delivering the plan which is due for publication soon.**



Source: https://gov.wales/sites/default/files/publications/2019-01/palliative-&-end-of-life-care-delivery-plan-2017_0.pdf

# Ambitions for PEOLC Care: A national framework for local action 2015 - 2020.

In 2015 in England the National PEOLC Partnership (NPEOLCP) published the Ambitions for PELOC: A national framework for local action 2015 -2020.

Although the ambitions focus on the experience of the dying person, the partners' concern is broader. Each statement should also be read as an ambition for carers, families, those important to the dying person, and, where appropriate, for people who have been bereaved.

The main aim of the framework is to provide the foundations and building blocks which local health and social care leaders can use to build accessible, responsive, effective and personal care needed at the end of life.

**HDuHB have recently developed the West Wales Care Partnerships PEOLC principles building on the foundations of the Ambitions for palliative and EOLC framework** (published October 2020) which recognise that whilst the National Framework is a document produced for NHS England, the ambitions and building blocks are equally valid for the population of Wales.

Along with the Welsh Governments 7 key delivery themes, the West Wales Partnership have therefore adopted the framework ambitions and building blocks and have confirmed that the HDuHB's Primary and Community Care Guidelines and the Hospital Discharge Requirements align with these foundations and building blocks and provide further clarity.

Attain

## Ambitions for Palliative and End of Life Ca

01 **Each person is seen as an individual**
*I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.*

02 **Each person gets fair access to care**
*I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.*

03 **Maximising comfort and wellbeing**
*My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.*

04 **Care is coordinated**
*I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.*

05 **All staff are prepared to care**
*Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.*

06 **Each community is prepared to help**
*I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.*

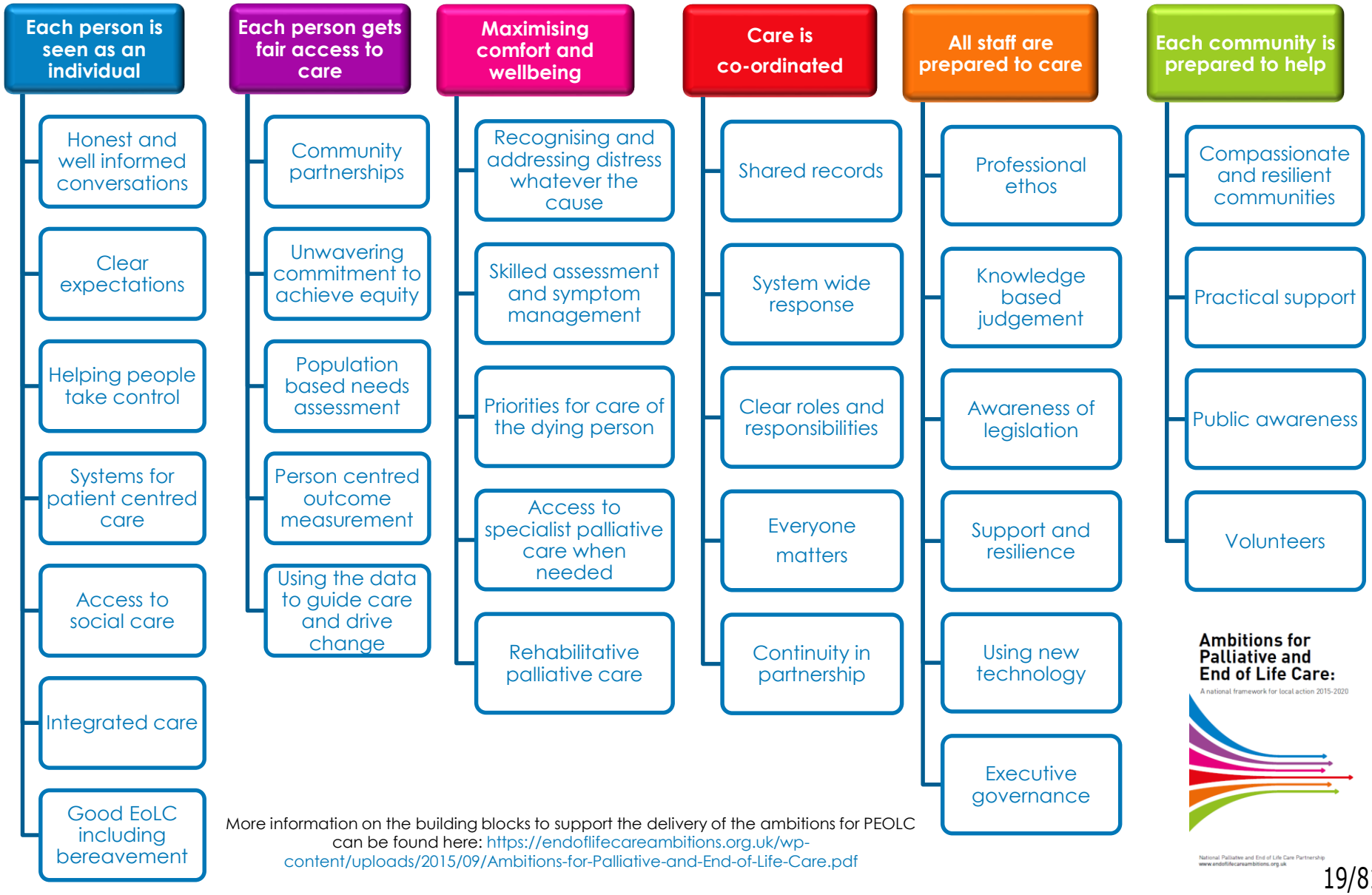
More information on the ambitions for palliative and EoLC can be found here: https://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

# The building blocks to deliver the Ambitions for PEOLC Care national framework.

To realise the ambitions, the NPEOLCP identified eight foundations/building blocks that need to be in place. They are all necessary and underpin the ambitions.

These foundations are the pre-conditions for delivering the rapid and focused improvement that the Partnership seeks.

For West Wales, they are the starting point from which the new and collective endeavour must be built.




More information on the building blocks to support the delivery of the ambitions for PEOLC can be found here: https://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

Attain

Ambitions for Palliative and End of Life Care:
A national framework for local action 2015-2020

National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk

# Best practice summary

**As part of our best practice review we researched a wide range of current local, national and international examples of best practice focusing on the following areas that will be key to any new service development**

**The common workforce delivery model:**
Should be adopted in line with the Sugar Report June 2008 where staff across the region provide:

1) General palliative care, delivered by health professionals in a generalist setting e.g. community and secondary care
2) Specialist palliative care, delivered by specialist multi-disciplinary teams dedicated to palliative care

**Services models:**

- To achieve consistency in provision, the West Wales Care Partnership should agree the PEOLC pathway for the area in line with best practice
- The HDuHB should consider whether the best practice examples, such as the Midhurst and SWAN/Cygnet models should be adopted

**Training:**

- All healthcare workers and volunteers, regardless of role, should have access to education and training in EOL and bereavement, with the level being dependent on the nature of their role and their exposure to death and dying

**Use of technology:**

- In addition to home care, telehealth and remote patient monitoring (RPM) has numerous benefits to patients across the healthcare spectrum, including those receiving palliative care

**Supporting Carers:**

- Partners should review the learning from caring for those with dementia, COIVD-19 and for those who are bereaved and think about whether they can be applied to current service delivery, or built into relevant strategies and/or service transformation plans
- All environments where end of life care occurs should provide appropriate places to support the families and carers

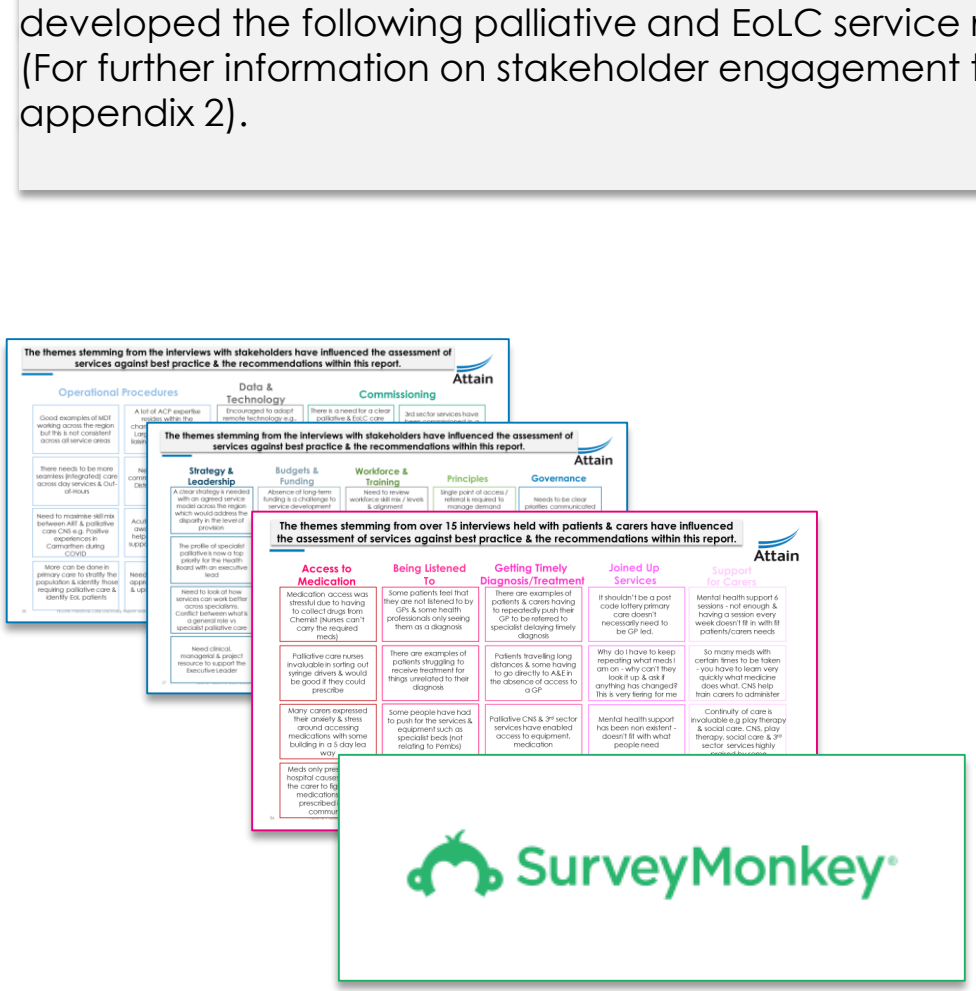
**Bereavement:**

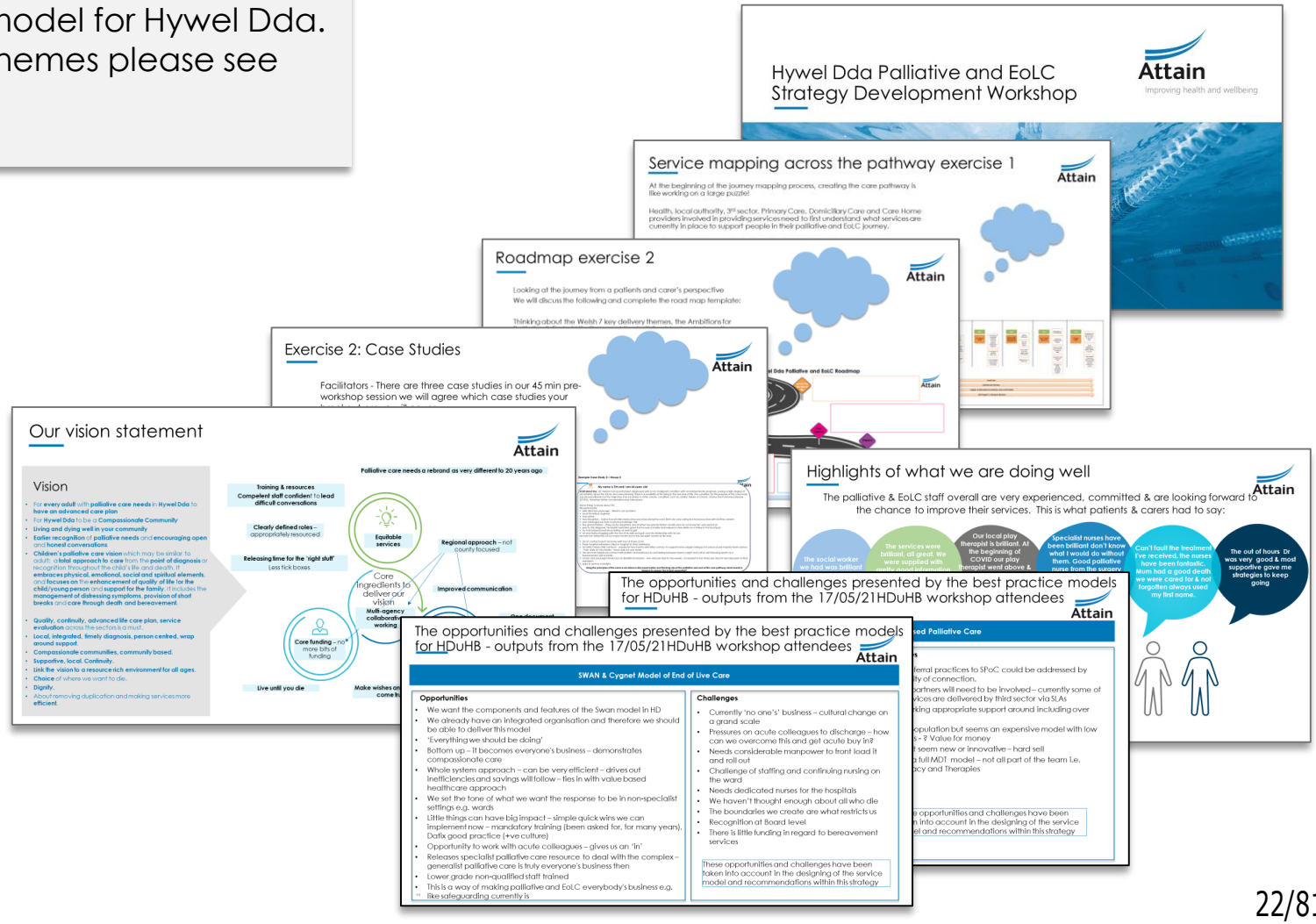
- Strategies across the globe include the importance of engaging with the local community, spiritual and other leaders to build bereavement capacity within the community
- Adopt compassionate communities' policies and practices, to support bereaved people
- A framework for bereavement currently being developed should be included into all relevant service specifications and built into standard operating procedures across all services

# 4. Our service model pathway

# Developing the Hywel Dda PEOLC service model blueprint

Following a series of workshops held during May 2021, interviews with stakeholders in phase 1, together with interviews with patients and carers of all ages, plus further input via patients' and carers' surveys, we have developed the following palliative and EoLC service model for Hywel Dda. (For further information on stakeholder engagement themes please see appendix 2).



# Hywel Dda PEOLC service vision

**'To provide excellent palliative and end of life care across West Wales enabling people to be cared for and die in their preferred place of care'**

Specialist palliative care support – in the community and in hospital.

Intermediate care to support people at the time of increasing need. We maximise comfort and wellbeing – supporting people in their home if possible.

Proactive care and care planning as a multi-disciplinary team. Care is co-ordinated ensuring the right help, at the right time.

Prevention, planning and education within our communities.

Communities prepared to support and help.


**Key enablers to delivery:**

- Clear regional PEOLC vision, strategy and service model in line with WWCP PEOLC principles
- Integrated governance arrangements
- Strategic and collaborative patient/carer centred commissioning arrangements
- Cross-organisational working
- Collective financial and performance management

- Joint commissioning for integrated care ensuring equity of access and provision across West Wales
- Health Board and provider (including 3rd Sector) alliances, delivering services into local networks and enabling frontline integration
- Shared system transformation programmes and plans
- Consideration of local risk and reward mechanisms, alignment of incentives, and new contractual forms

- Provision of primary care services at scale
- Staff across organisations trained and working together across the region in an integrated way to best meet the needs of the population
- Interpret population health data and patient/family feedback, design services for integrated networks and draw in support from wider services


Source: West Wales Care Partnership Palliative and EoLC Principles 23/10/20

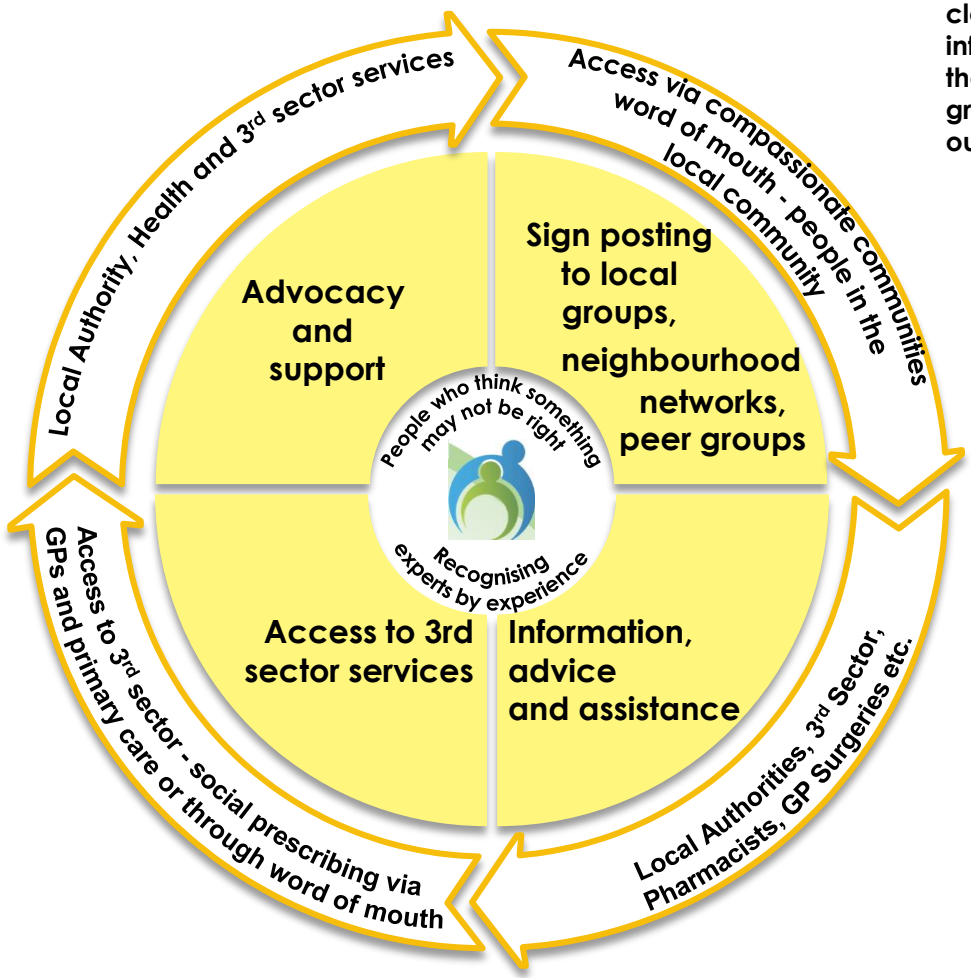
# What good looks like for Hywel Dda – The PEOLC service model pathway

Attain

## Looking after our physical and mental wellbeing, raising awareness and understanding


## Getting help and support in the early stages

- Carers and palliative care patients need clear and accessible information connecting them to local peer groups for support at the outset.

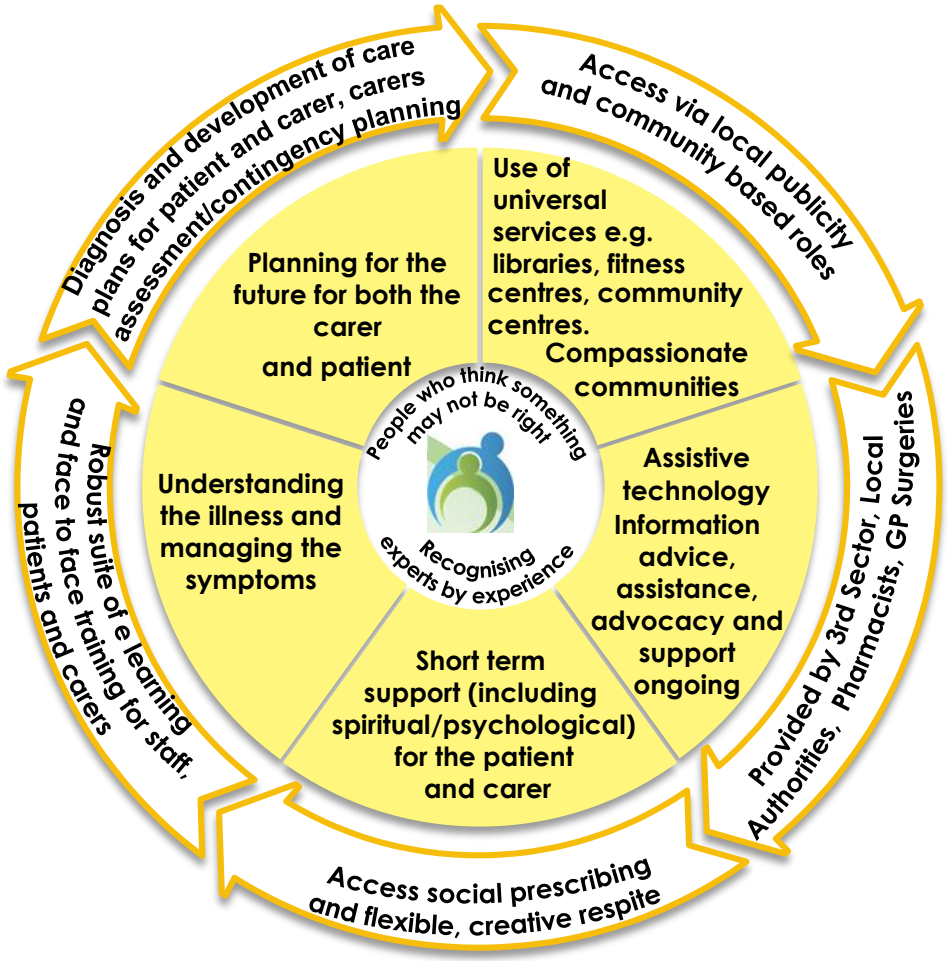



**Underpinned by training across all staff**

# What good looks like for Hywel Dda – The PEOLC service model pathway

## Identification, assessment and diagnosis

- Enabling generic services (e.g. social work, domiciliary care, care homes, district nursing, OT, physio etc.) to support people with a palliative diagnosis - education - what signs to look for and what to expect

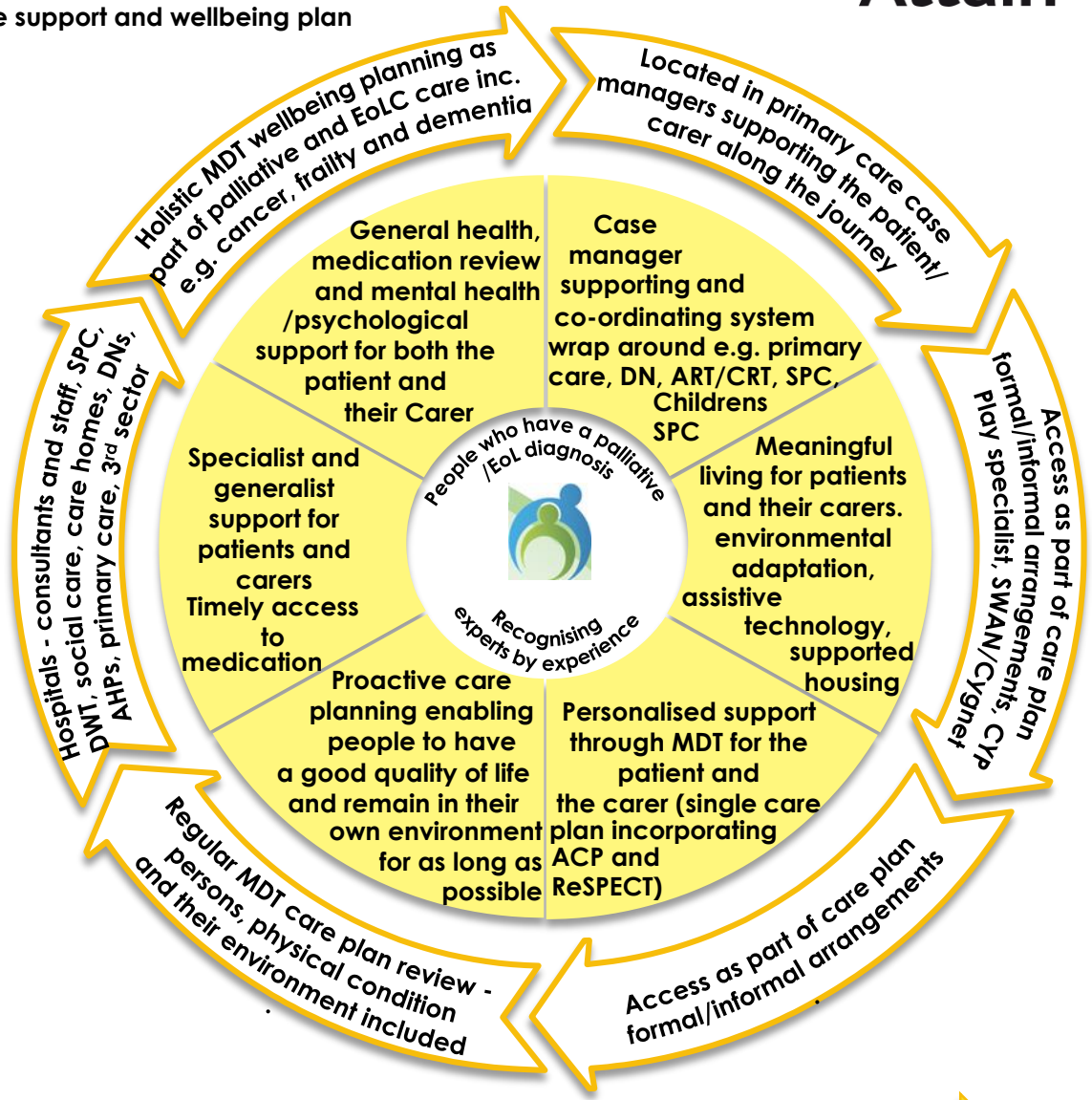



## Living with a palliative/EoL diagnosis

Holistic MDT = providing stable support and wellbeing plan around the person including:

- Case manager
- Social care
- Allied health professionals (AHPs)
- District nursing (DN)
- Key workers/ assistive technology lead
- Specialist nurses e.g. admiral, cancer etc.
- Primary care
- Pharmacists
- 3rd sector
- Older Adult mental health
- Advice and training as required from the dementia wellbeing team (DWT)
- Secondary care consultants
- 3rd sector
- SPC adults/children's

(N.B. this list is not exhaustive)




**Underpinned by training across all staff**

# What good looks like for Hywel Dda – The PEOLC service model pathway

**The need for increased support in the end days**

**Holistic MDT = providing stable support wellbeing plan around the person including:**

- Case manager
- Secondary care consultants
- SPC adults/children's
- Social care
- 3rd sector
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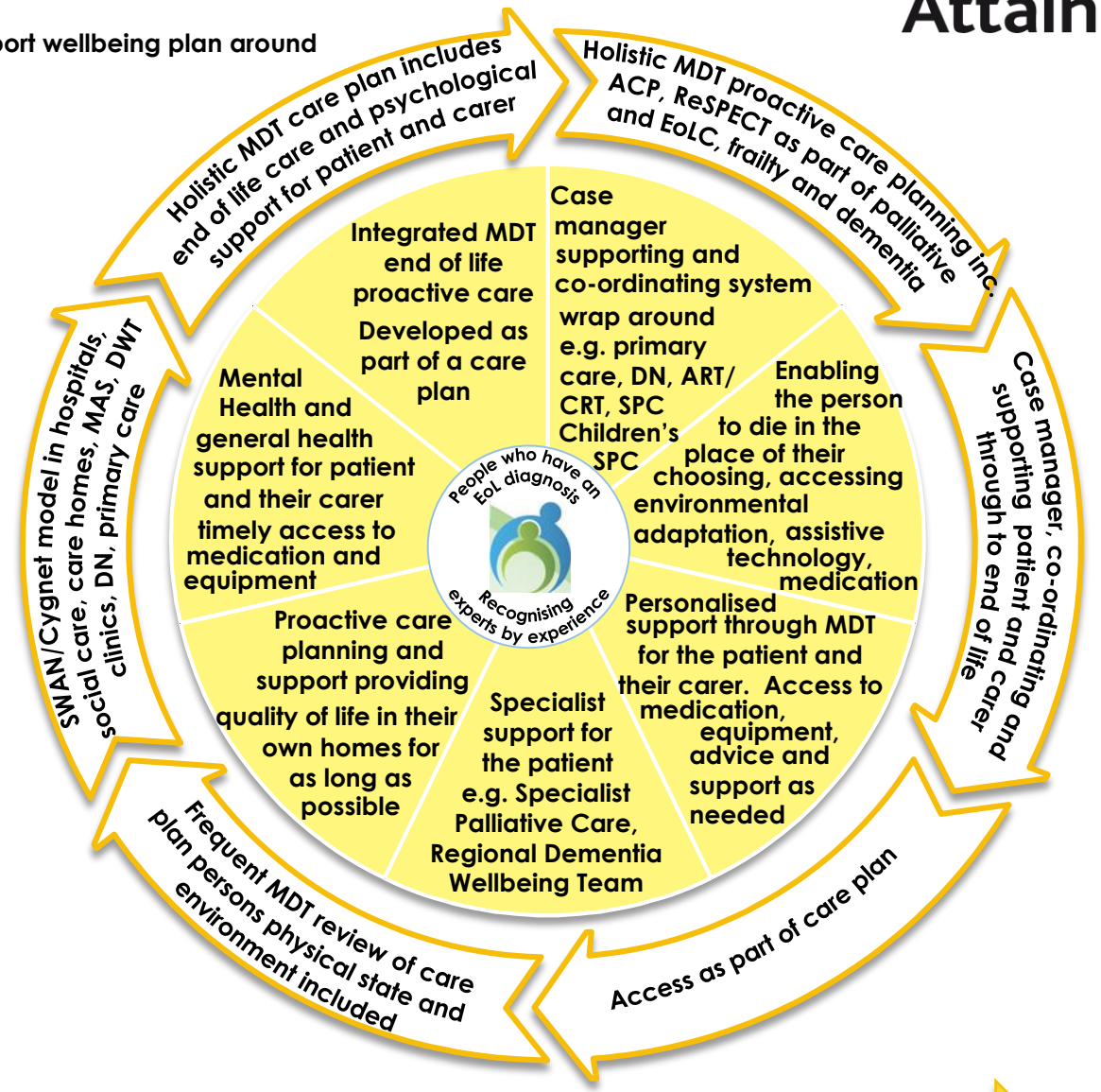


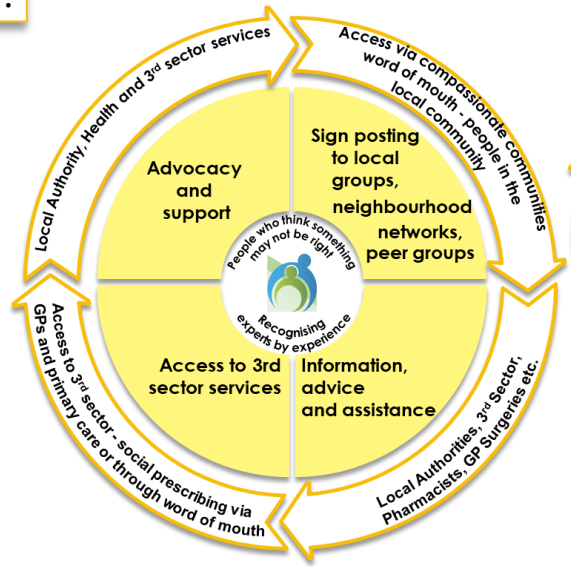

- **Implementation of the best practice Scottish Education and Training Framework PEOLC adapted for West Wales -** we need to consider the learning and development needs of everyone who is affected in some way by a palliative/EOL diagnosis. This includes patients of all ages, carers, frontline staff, managers, commissioners, regulators, researchers, shopkeepers, next door neighbours etc. Resulting in people who are informed, people who are skilled and people who can provide the right support at the right time

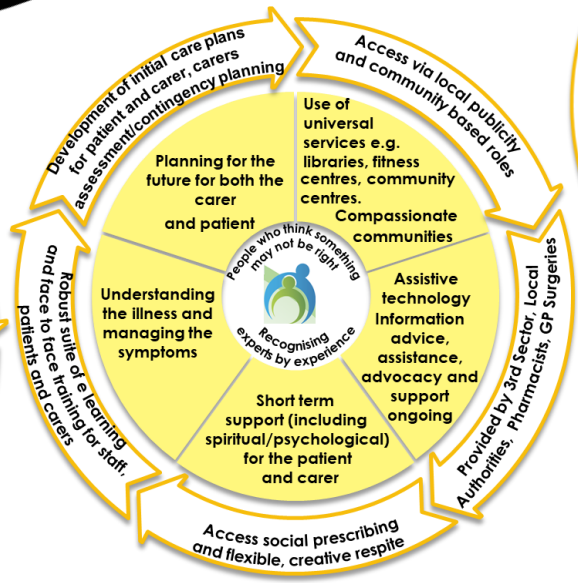
**Underpinned by training across all staff**

# What good looks like for Hywel Dda – The PEOLC service model pathway

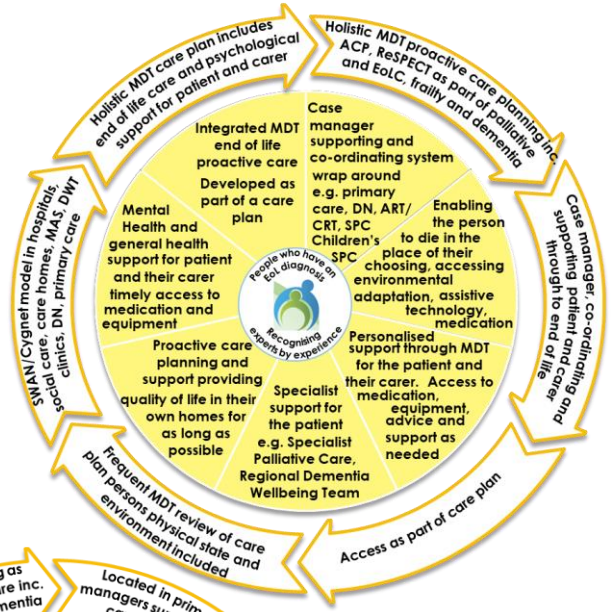
- This draft model, illustrates a new integrated way of providing services. It is based on best practice and existing services within West Wales.
- The service model should be underpinned with an agreed set of service delivery principles which need to be to be developed through the 'All staff are prepared to care' workstream (See section 5).










**Underpinned by training across all staff**

# Next steps

**Finalising the strategy:**

- Seek **feedback on the strategy, service vision and model pathway**
- **Finalise the vision and service model pathway** and socialise them so all partners are aware of the direction of travel for PEOLC services within West Wales
- **Update the programme plan with the new service developments** required to deliver the vision and service model pathway
- **Ensure robust governance is in place** to oversee the implementation of the new service initiatives, ensuring all new initiatives take a programme approach reporting progress regularly to the PEOLC Steering group

**Delivering the programme:**

- We will **develop our programme of work** whilst keeping a close eye on the developing NHS Wales National Clinical Framework (NCF); within which, End of Life Care has been afforded National Programme status and the roll out of the Dementia Standards
- **Identify resource to set up and manage the programme of work** across partners
- We will revise the current programme of work and update the programme plan, **prioritise projects and revise timelines** to ensure that there is a realistic and deliverable plan in place. Use Workstream management as the process for delivery
- We will **identify additional Workstream SROs** to drive work with PMO support, provide ownership and accountability to deliver
- **Regular progress updates** will continue to be provided at the monthly PEOLC Steering Group

**Implementation of the new PEOLC Strategy**

# 5. Our approach to implementing the new service model

# Implementing the new service model using the Ambitions for PEOLC National Framework.

Given the West Wales PEOLC principles embraces the Ambitions for PEOLC Framework, it makes sense to align the implementation of the new service model against the 6 ambitions and the 8 building blocks.

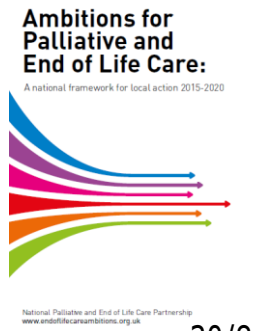
It is important to recognise that there is an All Wales SPC service model and team approach to children's services funded centrally and that, while part of the central Welsh team, this service will be built upon locally through the local initiatives outlined in the following recommendations.



Attain

- **Each person is seen as an individual**
  - Honest and well informed conversations
  - Clear expectations
  - Helping people take control
  - Systems for patient centred care
  - Access to social care
  - Integrated care
  - Good EoLC including bereavement
- **Each person gets fair access to care**
  - Community partnerships
  - Unwavering commitment to achieve equity
  - Population based needs assessment
  - Person centred outcome measurement
  - Using the data to guide care and drive change
- **Maximising comfort and wellbeing**
  - Recognising and addressing distress whatever the cause
  - Skilled assessment and symptom management
  - Priorities for care of the dying person
  - Access to specialist palliative care when needed
  - Rehabilitative palliative care
- **Care is co-ordinated**
  - Shared records
  - System wide response
  - Clear roles and responsibilities
  - Everyone matters
  - Continuity in partnership
- **All staff are prepared to care**
  - Professional ethos
  - Knowledge based judgement
  - Awareness of legislation
  - Support and resilience
  - Using new technology
  - Executive governance
- **Each community is prepared to help**
  - Compassionate and resilient communities
  - Practical support
  - Public awareness
  - Volunteers

More information on the building blocks to support the delivery of the ambitions for PEOLC can be found here: https://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf



# Ambition 1

## Each person is seen as an individual

*I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me.*
*Those who care for me know that and work with me to do what's possible.*

**What we are doing and our plans in this area**

| | |
|---|---|
| **Honest conversations** | • We will review the Scottish Training Framework for Palliative Care and consider adopting it across the region. In line with the 2019 NACEL audit, we will develop a training programme stemming from the framework and roll it out across all staff across the region.<br>• We will review and consider adapting and adopting the SWAN/Cygnet model in secondary care and in the community (see appendix 4), and develop a workforce plan to support delivery, which is in line with the Compassionate Cymru approach, across all ages which will provide further training to ensure staff across the system have the skills and confidence to have conversations about death with individuals of all ages and their families and carers. |
| **Clear expectations** | • We will provide individuals, families and carers with information and will develop an information booklet for carers with information and advice on what to expect at the end of someone's life. |
| **Helping people take control**<br>**Systems for patient centred care**<br>**Access to social care**<br>**Integrated (joined up) care** | • In line with the 2019 NACEL audit recommendations:<br>  • We will continue to deliver ACP training to health, social care, 3rd sector and care home staff, stressing the importance of involving families and carers in these conversations enabling them to take control over their care plan.<br>  • Following Welsh Government guidelines, we will implement the All Wales Advance and Future Care Planning when it is ready. We will also explore the possibility of adopting the ReSPECT form as part of ACP's (See appendix 5) across health and social care and the development of a Hywel Dda central care plan to share information. |
| **Good EOLC including access to bereavement services** | • We will review access to bereavement services and address any barriers to ensure fair access for all.<br>• We will consider the outcome of the All Wales bereavement review and implement recommendations. |

# Ambition 2

## Each person gets fair access to care

*I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.*

**What we are doing and our plans in this area**

| | |
|---|---|
| **Community Partnerships** | • We will endeavour to understand where communities may not be accessing PEOLC and any barriers that exist.<br>• We will address inequalities and gaps in services and work with partners to overcome barriers e.g. access to syringe drivers and medication. |
| **Unwavering commitment to achieve equity** | • Through the relevant workstream, we will review what elements of current adult service delivery (including the role of pharmacists) algin with or are more advanced than the Midhurst Model (See appendix 6) and ensure there is a consistent approach to delivery across the region, including the development of regional standard service operating procedures.<br>• We will address the inconsistent access to community equipment across Hywel Dda for palliative and end of life care patients.<br>• We will ensure a consistent approach to implementing the adapted SWAN/Cygnet model across the region for children and adults.<br>• We will agree a consistent regional approach to identifying those who are at the end of their lives.<br>• We will monitor information to understand where people are dying and if people's preferences are being achieved. |
| **Population based needs assessment**<br>**Person centred outcomes measurement**<br>**The use of data to drive change** | • We have carried out a population needs based assessment and will continue to work towards establishing a HB approach to the collation of data and of person-centred outcomes in line with the all Wales movement to adopt the OACC outcome measures for specialist palliative care. This will be built into our central reporting mechanism process and we will be able to measure person-centred outcomes. We will align our work with the All Wales Children's Specialist Palliative care team to ensure reporting at a central All Wales level.<br>• Building on the best practice research, we will continue to gain insight and work with colleagues to identify and spread best practice on end of life care. |

# Ambition 3

## Maximising comfort and wellbeing

*My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.*

**What we are doing and our plans in this area**

| | |
|---|---|
| **Recognising and addressing distress whatever the cause** | • Training delivered to staff and carers will include recognising the signs of distress.<br>• As part of our approach to data collation, we will investigate adapting the NHS Wales Experience Questionnaire for those receiving palliative and EoLC services; this will help us understand if comfort and wellbeing needs (including physical, psychological, emotional and social needs) are being met in secondary care. |
| **Symptom management** | • In line with the NACEL audit, we will increase training and education in managing symptoms for all staff (particularly for carers and non specialist staff) and also further enhance the work already underway in accessing medications in a timely fashion in both secondary care and the community.<br>• With partners we will develop flexible respite.<br>• We will aim to increase training and education around the use of the Care Decisions Document to support care in the last days of life. |
| **Access to services and specialist support** | • We will carry out a demand and capacity modelling exercise to clarify patient and workforce need for all SPC provision this will include the modelling of SPC bed demand in secondary care.<br>• To ensure equitable access including access to hospital at home, we will deliver SPC for adults at a regional HB level and consider utilising a similar approach to that of the regional Dementia Wellbeing Team and the All Wales Specialist Palliative and EoLC Team for Children, so that specialists provide training advice and support on symptom management for generalists e.g. care home staff, SALT, therapists, DN's and Social Care staff. Enabling 24/7 access for advice and information for professionals, carers and patients needs to be addressed immediately.<br>• The implementation of the adapted SWAN/Cygnet model will mean the inclusion of a 24/7 advice and support help line for professionals and carers, enabling access to specialist, general and bereavement advice 24/7. The All Wales SPC for Children are also about to roll out a similar service for those working with children across Wales. |

# Ambition 4

## Care is co-ordinated

*I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.*

**What we are doing and our plans in this area**

| | |
|---|---|
| **Shared records** | • We will work together to create a shared care plan that is accessible across partners (health, social care and 3rd sector) systems and is owned by the patient and carer. |
| **System wide response** | • We will work as equal partners with GP practices and primary care, allied health professionals and secondary care, to enable them to understand how they can best support end of life care.<br>• Where appropriate, we will work with our partners to map day service opportunities across the region, identify any gaps and work together to try to address them.<br>• We will develop a consistent approach to the delivery of MDTs across the Hywel Dda region and will support primary care MDTs through, pharmacist, PEOLC representation to provide advice and help to the teams.<br>• The children's SPC team will continue to be part of the All Wales Children's SPC MDT and will share best practice. |
| **Clear roles and responsibilities** | • The detail and role of the adults' SPC team will be made clear following the mapping of services against the Midhurst model and the subsequent development of a regional SOP for SPC. This will include mapping capacity and the need for different settings to provide PEOLC.<br>• Children's SPC will be enhanced by the adapted SWAN/Cygnet model and a clear SOP will be developed ensuring the lines of accountably, reporting and interface with the All Wales Children's SPC service. |
| **Everyone matters** | • SOP development for children transitioning into adult services will improve co-ordination of care.<br>• SOP development for the adult SPC service will improve the co-ordination of those with chronic conditions including those living with dementia and learning disability. |
| **Continuity in partnership** | • We will work wherever possible to create a palliative and EoLC service offer that is consistent across the region.<br>• We will work together across the system reviewing our processes to ensure people receive joined up services. |

# Ambition 5

## All staff are prepared to care

*Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.*

**What we are doing and our plans in this area**

| | |
|---|---|
| **Professional ethos**<br>**Knowledge based judgement**<br>**Awareness of legislation** | • All staff across health, social care and 3rd sector use an holistic, person-centred approach to assessments, care planning and reviews. The needs of the carer will be considered at each step of the way.<br>• The Health Board will commit to supporting both children and adult SPC services having protected time to deliver education and will work with colleagues in primary and secondary care to support the release of generalist staff to attend such training.<br>• The new Adult SPC and Children's SPC teams SOPs will include the requirement for staff to help train generalist staff in the community and secondary care in relation to some of the more complex elements of palliative care thereby enabling the delivery of high quality palliative and EoLC. |
| **Support and resilience** | • Through the adoption and implementation of the Scottish Training Framework for Palliative Care, all staff will receive formal training on EoLC legislation and the Mental Capacity Act 2005. Formal palliative and EoLC training will include training on difficult conversations, negotiation and overall resilience.<br>• Teams will be required to keep a training log capturing a record of those trained. |
| **Using new technology** | • We will build on the use of technology in the phase one report e.g. virtual/remote assessments and consultations, remote monitoring of patients and are reviewing where more specialist roles may be needed. These need to be developed with local providers but could include specialist roles in end of life care for people with learning disabilities. |
| **Executive governance** | • In line with the NACEL audit recommendations, HDuHB have approved the recruitment of a clinical lead to work as part of a triumvirate team to oversee the implementation of the new strategy through regional pooled budgets.<br>• The Heath board should appoint a named pharmacist to support improvement of medicine management for seriously ill and dying patients in line with the Welsh Government and NHS Wales, 2017, Palliative and End of Life Care Delivery Plan. |

# Ambition 6

Attain

**Each community is prepared to help**

*Death and dying are inevitable. Palliative and end of life care must be a priority. The quality and accessibility for this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.*

**What we are doing and our plans in this area**

| | |
|---|---|
| **Compassionate and resilient communities**<br>**Volunteering** | • We will be active in supporting the https://compassionate.cymru/ Charter and the Welsh Government's ambitious project to make Wales the world's first Compassionate Country and at neighbourhood and at street level we will form flexible teams which make the most of medical and formal social care input by identifying and enabling community support in ways which genuinely address the question, **'What matters most to you?'** This will enable the adapted SWAN/cygnet model roll out at neighbourhood level. |
| **Practical support** | • We will support the compassionate communities initiative and explore implementing Compassionate Cymru across Hywel Dda and we will join up our services wherever possible to maximise resources and reduce duplication of effort.<br>• As identified in our stakeholder workshops, there is a need to start conversations about death and dying earlier. We will explore with partners what we can do to best support teachers and staff working in children and young peoples' services to start conversations with children and young people. |
| **Public awareness** | • We will raise public awareness about death and dying, one way will be through Dying Matters Awareness Week – focusing on the importance of being #InAGoodPlace to die. https://www.dyingmatters.org/ |

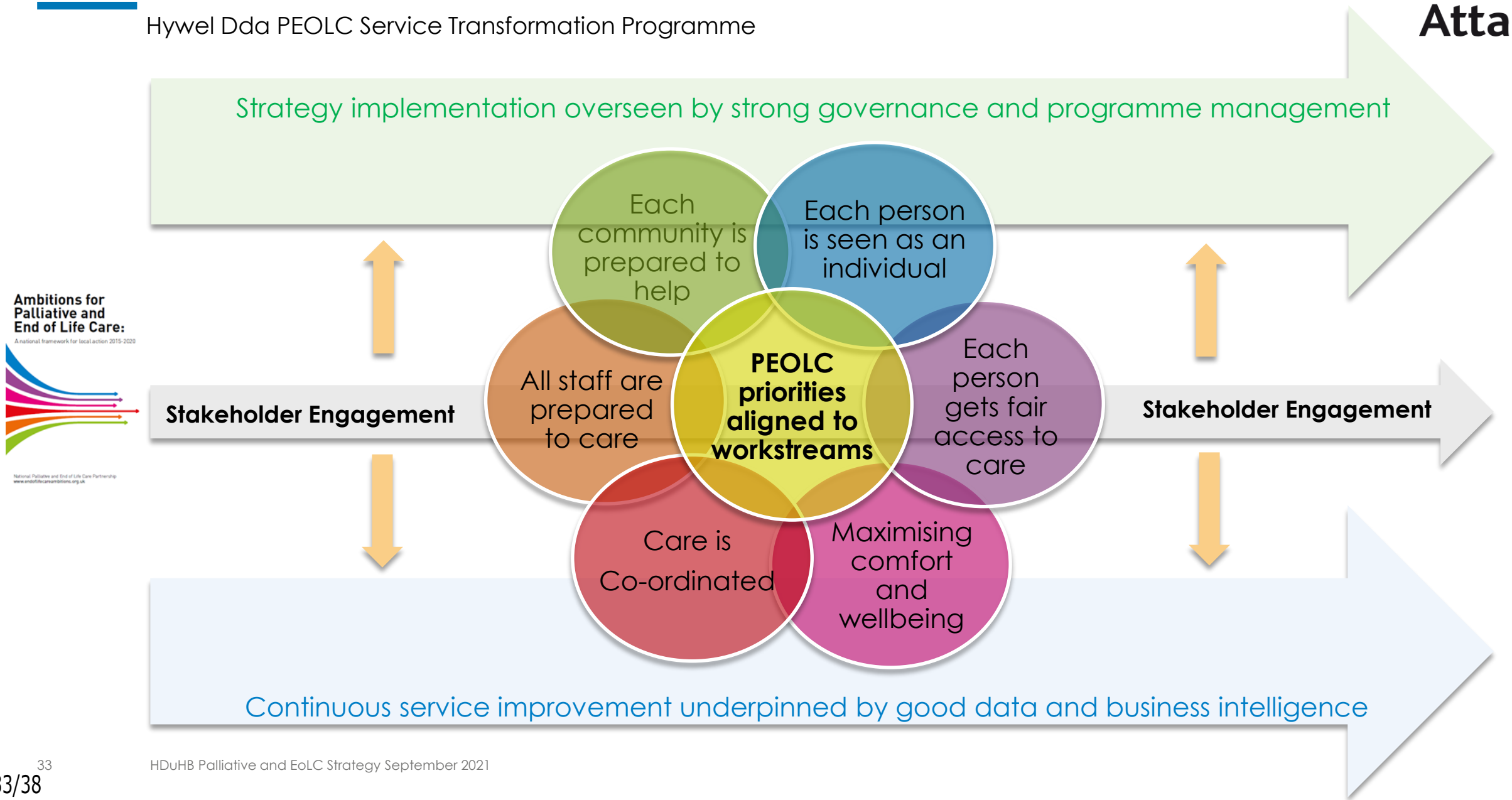
# Delivering the strategy ambitions through programme management

Building on the new PEOLC programme approach, implemented following the key outcomes from the discovery phase, this next phase of work in relation to PEOLC will take place over a 5 year period with integrated service transformation and continuous improvement, utilising a key workstream and deep stakeholder engagement approach.

## What does good programme management look like?

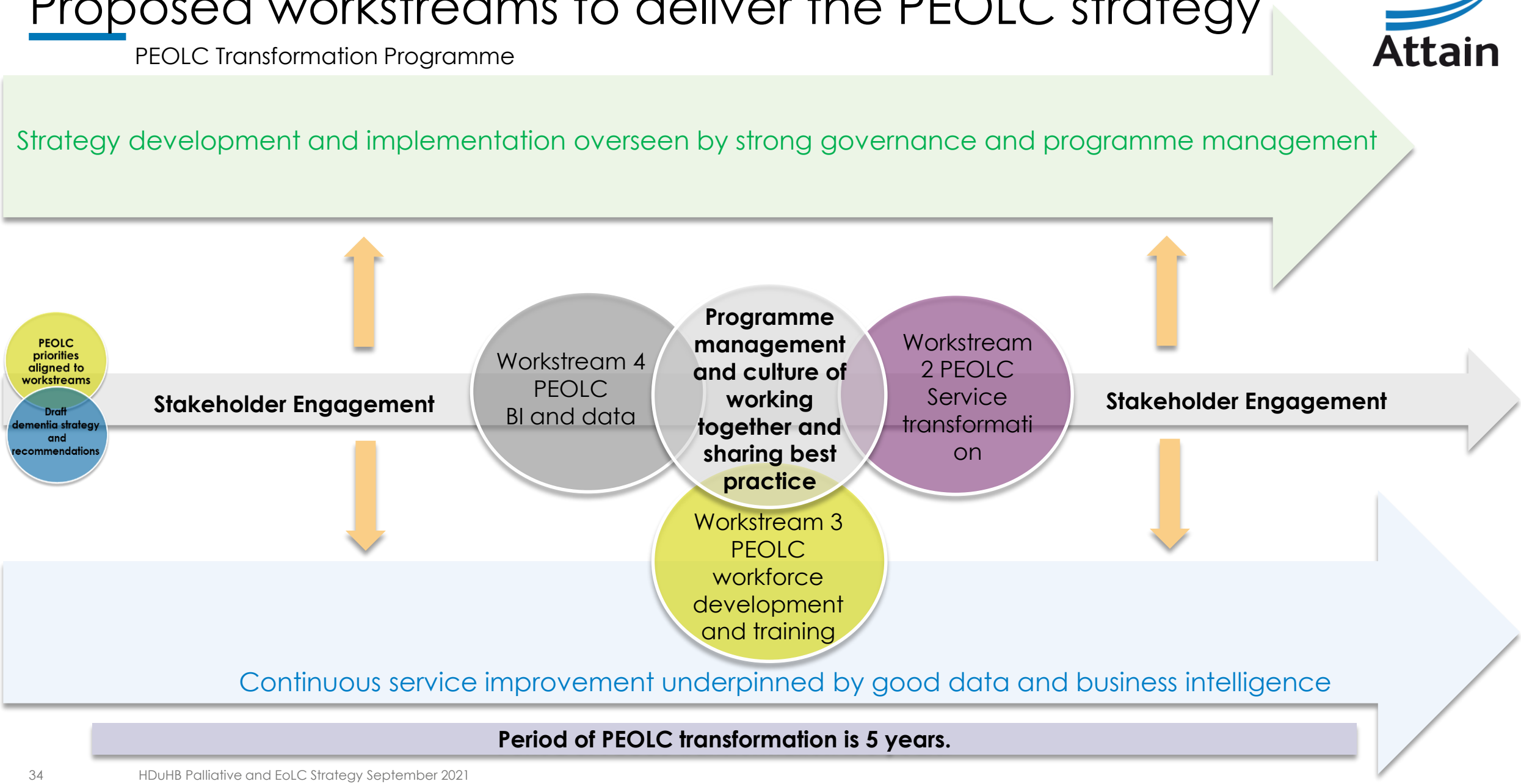
# Approach to implementing the PEOLC strategy ambitions and new model of care

Hywel Dda PEOLC Service Transformation Programme



# Proposed workstreams to deliver the PEOLC strategy

PEOLC Transformation Programme

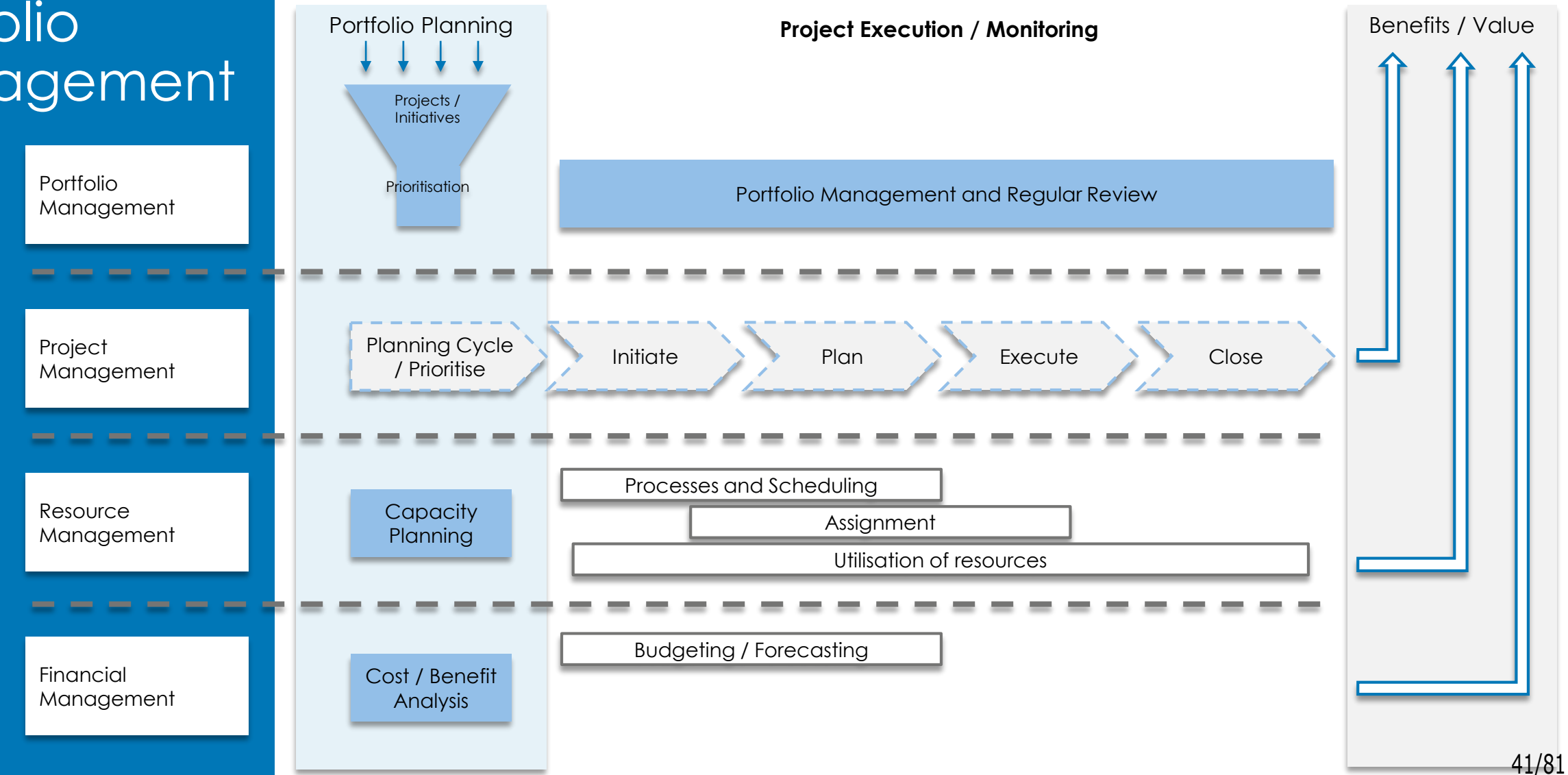


# Proposed Delivery Approach: Portfolio Management

The PEOLC priorities are in line with the Ambitions for Palliative and EoLC National Framework, the 2019 NACEL audit and builds on the initial continuous improvement programme. Any outstanding work from the continuous improvement programme will be merged with the appropriate workstream within this new programme of work. The PEOLC priorities will be overseen by the triumvirate within the Health Board PEOLC steering group and each portfolio will be led by an SRO from across the system. However, the whole programme of work will also be overseen by the WWCP. Resources will need to be idenfied over the life of the programme to enable continuation of service delivery whilst frontline staff work to design and develop the services.

| | PEOLC transformation | Workforce development and training | BI and data |
|---|---|---|---|
| **Aim** | Implement priorities stemming from the PEOLC strategy that relate to achieving each person gets fair access to care. | Implement priorities stemming from the PEOLC strategy that relate to achieving maximising comfort and wellbeing. | Implement priorities stemming from the PEOLC strategy that relate to a uniformed approach to collection business intelligence and outcomes. |
| **Priority Areas** | • SPC service mapping and development of a new regional SPC service including a transition SOP between Children's and Adults' services. The use of technology will be built into the new service.<br>• Development of PEOLC model for the region with supporting business case, using the best practice principles from the SWAN and Midhurst models.<br>• Development of bereavement services in line with the All Wales Bereavement framework.<br>• Implementation of the PEOLC strategy recommendations in relation to service transformation. | • Adaptation of the Scottish Palliative and EoLC training framework and development of implementation plan<br>• Development of a workforce plan to support service transformation delivery<br>• Continuation of ACP training<br>• Implementation of the All Wales Advance and Future Care Planning when ready and development of a central care plan (across frailty, dementia and PEOLC<br>• Implementation of the PEOLC strategy recommendations in relation to workforce development and training. | • Population needs, workforce and demand and capacity modelling for new regional SPC with supporting business case.<br>• Data driving change – development of a reporting dashboard and development of a new job description for an analytics role PEOLC.<br>• Implementation of the PEOLC strategy recommendations in relation to BI and data. |

# Proposed Delivery Approach: Portfolio Management



# Next steps

**Finalising the strategy:**

- Seek **feedback on the strategy, service vision and model pathway**
- **Finalise the vision and service model pathway** and socialise them so all partners are aware of the direction of travel for PEOLC services within West Wales
- **Update the programme plan with the new service developments** required to deliver the vision and service model pathway
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**Delivering the programme:**

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- **Identify resource to set up and manage the programme of work** across partners
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- **Regular progress updates** will continue to be provided at the monthly PEOLC Steering Group

**Implementation of the new PEOLC Strategy**

# Contacts

| | | |
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| Cherie Cope | cherie.cope@Attain.co.uk | 07787 427341 |

# Bwrdd Iechyd Prifysgol Hywel Dda – Strategaeth Gofal Lliniarol a Gofal Diwedd Oes

Attain
Improving health and wellbeing

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

Medi 2021 Fersiwn 2.1

Dylid darllen y strategaeth hon ar y cyd ag adroddiad Attain ynghylch enghreifftiau o arfer gorau ym maes gofal diwedd oes, a gyhoeddwyd ym mis Chwefror 2021, a fersiwn 2.7 adroddiad darganfod terfynol y Bwrdd Iechyd ynghylch gofal lliniarol, a gyhoeddwyd ym mis Mai 2021

**'Darparu gofal lliniarol a gofal diwedd oes ardderchog ar draws y gorllewin, sy'n galluogi pobl i gael gofal a marw yn y lleoliad y maent yn ei ffafrio'**

# Cynnwys

# Cefndir

Mae Bwrdd Iechyd Prifysgol Hywel Dda yn cynnwys tair sir – Sir Gaerfyrddin, Ceredigion a Sir Benfro. Mae pob sir yn gweithredu gwasanaethau gofal lliniarol a gofal diwedd oes sydd wedi'u teilwra i ddiwallu anghenion unigol pob sir, angen ei phoblogaeth, a'i hasedau. Yn ddiweddar fodd bynnag, drwy Bartneriaeth Gofal Gorllewin Cymru, cytunwyd ar ddull gweithredu rhanbarthol sy'n amlinellu safonau ac egwyddorion ac sy'n ceisio alinio'r tair sir o safbwynt cyflawni canlyniadau teg i bobl o bob oed yn y boblogaeth.

Cam cyntaf y rhaglen i ddatblygu Strategaeth Gofal Lliniarol a Gofal Diwedd Oes ar gyfer y Bwrdd Iechyd oedd Cam Darganfod, a ragflaenodd y gwaith ffurfiol o ddatblygu'r strategaeth.

Yn ystod y Cam Darganfod, cafwyd tystiolaeth a daethpwyd i ddeall y canlynol:

- Arfer gorau yn genedlaethol ac yn rhyngwladol
- Trefniadau meincnodi'r sefyllfa bresennol ar draws y rhanbarth (drwy ddefnyddio matrics aeddfedrwydd), sy'n nodi amryw arferion a bylchau o gymharu â'r arfer gorau a nodwyd yn Egwyddorion Gofal Lliniarol a Gofal Diwedd Oes Gorllewin Cymru (a gyhoeddwyd ym mis Hydref 2020)
- Bylchau mewn data a gwybodaeth fusnes, sy'n arwain at wendidau yn y sylfaen dystiolaeth ac sy'n rhwystro'r broses o wneud penderfyniadau a thrawsnewid gwasanaethau'n effeithiol.

Mae'r Cam Darganfod, a oedd yn seiliedig ar waith ymgysylltu trylwyr â rhanddeiliaid, perchnogaeth frwdfrydig ac ymrwymiad i gyflawni, wedi parhau wrth i'r strategaeth hon gael ei datblygu. At hynny, dangosodd y Cam Darganfod y dylid ymgymryd ag ystod o welliannau byrdymor a fyddai o fantais i'r gwaith o ddarparu gwasanaethau ac na ddylid eu gohirio nes y byddai'r strategaeth wedi'i chymeradwyo yn llawn.

Gan adeiladu ar brif ganlyniadau'r Cam Darganfod, digwyddodd cam nesaf y gwaith dros gyfnod o 3-4 mis pan aethpwyd ati i ddatblygu'r strategaeth a sicrhau gwelliant parhaus mewn modd integredig, gan ddefnyddio dull rhaglen o weithredu a oedd yn cynnwys ffrydiau gwaith allweddol a chamau parhaus i ymgysylltu'n drylwyr â rhanddeiliaid.

Mae'r strategaeth hon yn llawn dyheadau ac yn egluro'r uchelgeisiau cyffredin yr ydym am eu gwireddu ar draws Hywel Dda er mwyn gwella gofal lliniarol a gofal diwedd oes i'n dinasyddion. Wrth ddatblygu'r strategaeth, rydym wedi gweithio gyda sefydliadau sy'n darparu gwasanaethau gofal lliniarol a gofal diwedd oes, eu staff, mudiadau gwirfoddol lleol a phartneriaid eraill. Rydym hefyd wedi ystyried ymchwil flaenorol ac wedi cyflawni ein gwaith ein hunain yn sensitif er mwyn meithrin dealltwriaeth, gydag unigolion sy'n cael gofal lliniarol a gofal diwedd oes a'u perthnasau. Mae eu profiadau nhw wedi helpu i sicrhau bod unigolion, eu teuluoedd a'u gofalwyr wrth wraidd ein strategaeth, ein gweledigaeth a'n model gwasanaeth. Yn awr, cyfrifoldeb gwasanaethau'r Bwrdd Iechyd a phartneriaid lleol yw cydweithio â'i gilydd er mwyn parhau i gyflawni'r gwelliannau hyn ar gyfer eu cymunedau lleol. *D.S. Ceir adroddiad ar wahân sy'n crynhoi'r cynnydd a wnaed o ran y Rhaglen Gwelliant Parhaus.*

# Gofynion a gweithgareddau'r prosiect

Isod, ceir crynodeb o ofynion y prosiect datblygu strategaeth, canlyniadau'r gwaith a wnaed, a'r camau gweithredu allweddol.

## Y gofyn:

**1. Datblygu'r strategaeth:**

- Ymgysylltu'n drylwyr â rhanddeiliaid drwy gyfweliadau strwythuredig, grwpiau a gweithdai – i'w cytuno fesul sir – gyda sesiwn derfynol ar draws y tair sir i grynhoi'r strategaeth, a fydd yn arwain at weledigaeth a llwybr gwasanaeth ar gyfer gofal lliniarol a gofal diwedd oes.
- Arolygon ar-lein wedi'u teilwra ar gyfer cleifion sy'n blant, yn bobl ifanc ac yn oedolion, rhieni/gofalwyr plant a phobl ifanc, a phartneriaid cleifion sy'n oedolion.
- Dadansoddiad o'r galw am wasanaeth gofal lliniarol arbenigol ac o gapasiti'r gweithlu.

**2. Dylai'r strategaeth derfynol gynnwys:**

- Gweledigaeth ar gyfer gofal lliniarol a gofal diwedd oes, a llwybr gwasanaeth o'r dechrau i'r diwedd.
- Cynllun ar gyfer rhaglen trawsnewid gwasanaethau.
- Camau i alinio blaenoriaethau â chyllid rhanbarthol y Gronfa Gofal Integredig.

## Yr hyn a wnaeth Attain:

**1. Datblygu'r strategaeth:**

Oherwydd cyfyngiadau COVID-19 a chyfyngiadau ar y gallu i gwrdd wyneb yn wyneb, gwnaeth Attain:

- Gynnal cyfres o 5 gweithdy yn ystod mis Mai 2021.
- Crynhoi'r themâu a oedd yn deillio o'r cyfweliadau â rhanddeiliaid yng ngham 1, yn ogystal â chyfweliadau â chleifion a gofalwyr o bob oed.
- Datblygu 4 arolwg i gleifion a gofalwyr er mwyn cael mewnbwn pellach.
- Gweithio gyda chydweithwyr i ddatblygu strategaeth lefel uchel, a gweledigaeth a model ar gyfer y gwasanaeth, ar sail arfer gorau.
- Cynnwys crynodeb o'r galw ac o gyffredinolrwydd yn y boblogaeth yn awr ac yn y dyfodol – ni ellir cadarnhau effaith y galw ar y gweithlu ar hyn o bryd, a bydd angen dadansoddi hynny ymhellach.

**2. Mae'r strategaeth hefyd yn cynnwys:**

- Gweledigaeth ar gyfer y gwasanaeth, a llwybr o'r dechrau i'r diwedd, ynghyd ag argymhellion ynghylch gweithredu'r model gwasanaeth newydd. Fodd bynnag, ni wyddys beth yw hyd a lled dyraniad pellach o ran cyllid ar hyn o bryd.
- Cydnabyddiaeth bod rhanddeiliaid wedi nodi bod COVID-19 wedi effeithio ar y gallu i gael diagnosis prydlon, oherwydd bod pobl wedi oedi cyn mynd at y meddyg. Fodd bynnag, ni wyddys yn iawn beth yw hyd a lled yr effaith hon ar hyn o bryd.

## Y prif argymhellion:

**1. Perchenogi'r strategaeth a gweithredu'r weledigaeth a'r model ar gyfer y gwasanaeth:**

- Ar ôl cael cymeradwyaeth ffurfiol gan y Bwrdd Iechyd, bydd angen i'r model gwasanaeth newydd gael ei weithredu er mwyn gwireddu'r strategaeth a'r weledigaeth ar gyfer y gwasanaeth.
- Mae'r strategaeth yn darparu cyfres o flaenoriaethau sy'n rhaglen waith sylweddol y bydd angen adnoddau ar ei chyfer.
- Mae'r Bwrdd Iechyd wedi cymeradwyo recriwtio arweinydd clinigol i weithio'n rhan o dîm o dri er mwyn goruchwylio'r broses o weithredu'r strategaeth newydd, drwy gyllidebau cyfun ar draws y rhanbarth.
- Dylid adolygu'r strategaeth a'r model gwasanaeth pan fydd gwybodaeth ar gael am effaith COVID-19 yng nghyswllt achosion lle mae pobl wedi oedi cyn mynd at y meddyg i gael diagnosis, a'r cynnydd tebygol a fydd yn y galw am wasanaethau gofal lliniarol a gofal diwedd oes.

# Beth yw gofal lliniarol?

Yn ôl Sefydliad Iechyd y Byd, gofal lliniarol yw dull o weithredu sy'n gwella ansawdd bywyd cleifion a'u teuluoedd sy'n wynebu'r problemau a ddaw yn sgil salwch sy'n cyfyngu ar fywyd. Mae'n golygu atal a lleddfu dioddefaint drwy adnabod problemau'n gynnar ac asesu a thrin yn berffaith unrhyw boen a phroblemau eraill, boed yn rhai corfforol, seicolegol neu ysbrydol.

Yn ôl adroddiad Sugar, gellir rhannu gofal lliniarol yn 2 gategori:
1) Gofal lliniarol cyffredinol a ddarperir gan weithwyr iechyd proffesiynol mewn lleoliad cyffredinol
2) Gofal lliniarol arbenigol a ddarperir gan dimau amlddisgyblaethol arbenigol sy'n ymwneud yn benodol â gofal lliniarol

Bydd gofal lliniarol yn gwneud y pethau canlynol:

- bydd yn lleddfu poen a symptomau eraill sy'n achosi trallod;
- bydd yn cadarnhau gwirionedd bywyd ac yn ystyried bod marw'n broses normal;
- ni fydd yn prysuro nac yn gohirio marwolaeth;
- bydd yn integreiddio'r agweddau seicolegol ac ysbrydol ar ofal i gleifion;
- bydd yn cynnig system gymorth er mwyn helpu cleifion i fod mor weithgar ag sy'n bosibl nes y byddant yn marw;
- bydd yn cynnig system gymorth er mwyn helpu aelodau'r teulu i ymdopi yn ystod salwch y claf a'u profedigaeth;
- bydd yn defnyddio dull tîm o ddiwallu anghenion cleifion a'u teuluoedd, a fydd yn cynnwys gwasanaeth cwnsela adeg profedigaeth os nodwyd bod ei angen;
- bydd yn gwella ansawdd bywyd, a gallai ddylanwadu'n gadarnhaol ar gwrs salwch;
- bydd yn cael ei roi yn ystod camau cynnar salwch, ar y cyd â therapïau eraill y bwriedir iddynt ymestyn bywyd, er enghraifft cemotherapi neu radiotherapi, a bydd yn cynnwys yr ymchwiliadau sy'n ofynnol er mwyn deall a rheoli'n well gymhlethdodau clinigol sy'n achosi trallod.

Ffynhonnell: EGWYDDORION GOFAL LLINIAROL A GOFAL DIWEDD OES PARTNERIAETH GOFAL GORLLEWIN CYMRU

# Beth yw gofal diwedd oes?

Gall pobl gael gofal lliniarol unrhyw bryd yn ystod eu salwch. Nid yw cael gofal lliniarol yn golygu o reidrwydd bod y person yn debygol o farw'n fuan – bydd rhai pobl yn cael gofal lliniarol am flynyddoedd. At hynny, gall pobl gael gofal lliniarol ochr yn ochr â thriniaethau, therapïau a meddyginiaethau y bwriedir iddynt reoli eu salwch, er enghraifft cemotherapi neu radiotherapi.

Fodd bynnag, mae gofal lliniarol yn cynnwys gofalu am bobl sy'n nesáu at ddiwedd eu hoes – caiff gofal o'r fath ei alw'n ofal diwedd oes weithiau.

**Diwedd oes** yw'r cyfnod pan fydd person yn byw gydag anhwylder sy'n cyfyngu ar fywyd ac sy'n angheuol neu'n farwol, a phan fydd yr anhwylder hwnnw'n amharu ar fywyd y person, hyd yn oed os yw'r prognosis yn amwys neu'n anhysbys. Ystyrir y bydd y sawl sy'n nesáu at ddiwedd eu hoes yn debygol o farw yn ystod y diwrnodau, yr wythnosau neu'r misoedd sydd i ddod. Gofal diwedd oes yw gofal y mae ei angen ar gyfer pobl sy'n debygol o farw yn ystod y misoedd sydd i ddod oherwydd salwch, eiddilwch neu henaint cynyddol, datblygedig neu ddiwella. Yn ystod y cyfnod dan sylw, mae'n bosibl y bydd pobl yn gweld bod eu hanhwylder yn newid ac yn amrywio'n sydyn ac y bydd angen cymorth arnynt gan amryw bobl, gan gynnwys gwasanaethau iechyd, yn ogystal â theulu a gofalwyr.

Mae gofal diwedd oes yn golygu rhoi triniaeth, gofal a chymorth i bobl sy'n nesáu at ddiwedd eu hoes. Mae'n rhan bwysig o ofal lliniarol.

Ffynhonnell: EGWYDDORION GOFAL LLINIAROL A GOFAL DIWEDD OES PARTNERIAETH GOFAL GORLLEWIN CYMRU

# 2. Crynodeb o'r dadansoddiad o anghenion y boblogaeth

# Poblogaeth fwy…

**0.5% YN UWCH** erbyn 2025, **2% YN UWCH** erbyn 2040

Mae poblogaeth Hywel Dda yn tyfu'n gyffredinol

Mae poblogaeth Hywel Dda o ran oedolion yn lleihau, **ond mae'r boblogaeth gyffredinol yn cynyddu***.

Mae gan Hywel Dda boblogaeth sy'n heneiddio, sy'n cynnwys **mwy na chyfartaledd Cymru** o bobl dros 65 oed.

**Poblogaeth sy'n heneiddio**

Disgwylir y bydd y boblogaeth dros 65 oed yn cynyddu **6% dros gyfnod o 5 mlynedd** a **27% erbyn 2040**, sy'n gynnydd enfawr

Yn Hywel Dda, mae gan dros **75% o bobl 85+ oed 2 neu fwy** o anhwylderau hirdymor.

**Pobl dros 85 oed** fydd **dros 10%** o'r boblogaeth

A phobl dros 65 oed fydd dros **un o bob tri o'r boblogaeth erbyn 2040**

Gofal diwedd oes sy'n fwyfwy cymhleth a maith.

**Gofal yn mynd yn fwy cymhleth**

Cyn Covid, prif achosion unigol marwolaeth yn Hywel Dda oedd **dementia a chlefyd y galon, sef 11% yr un****  (dementia yn 12.7% ar lefel y DU)

*Ffynhonnell*: Y Swyddfa Ystadegau Gwladol, *Bydd cyfanswm poblogaeth Ceredigion yn gostwng ond bydd nifer y bobl hŷn yn cynyddu

** 2019 NOMIS, diffiniwyd gan y Swyddfa Ystadegau Gwladol gan ddefnyddio ICD10; ceir llawer o amrywiaeth ar draws y siroedd, gyda'r gyfradd isaf ar gyfer dementia yng Ngheredigion, sef 9%, a'r gyfradd uchaf yn Sir Gaerfyrddin, sef 11.7%, sy'n debygol o gynyddu'n gyffredinol oherwydd poblogaeth sy'n heneiddio

# Anhwylderau a marwolaeth

Mae dementia **yn gyfrifol am 12.7% o farwolaethau**, a dementia yw **prif achos** marwolaeth ar draws y DU

Yn **Hywel Dda**, mae'r gyfradd ar gyfer dementia yn agosach i 11%, a cheir amrywiaeth ar draws y siroedd, oherwydd proffiliau oedran yn bennaf

**Clefyd isgemia'r galon** yw prif achos marwolaeth o hyd yn y DU, er i'r gyfradd ostwng o ran **cyfran o 14% (yn 2010) i 10.4%**

Mae'r gyfran ar gyfer **clefyd isgemia'r galon** yn debyg i'r gyfran ar gyfer dementia ar draws **Hywel Dda**, sef 11% yn gyffredinol

Mae dros **14,000 o bobl** yn Hywel Dda sydd ar gofrestrau meddygon teulu wedi cael diagnosis o **ganser** ar ryw adeg

Mae dros **4,800 o bobl** yn Hywel Dda wedi'u cofrestru yn bobl sydd â **methiant y galon**

**Cafodd 1 o bob 8 marwolaeth** ar draws Cymru a Lloegr eu priodoli i ddementia yn 2018

Mae'r Gymdeithas Alzheimer yn disgwyl y bydd nifer y cleifion dementia sy'n byw ar eu pen eu hunain yn dyblu erbyn 2040

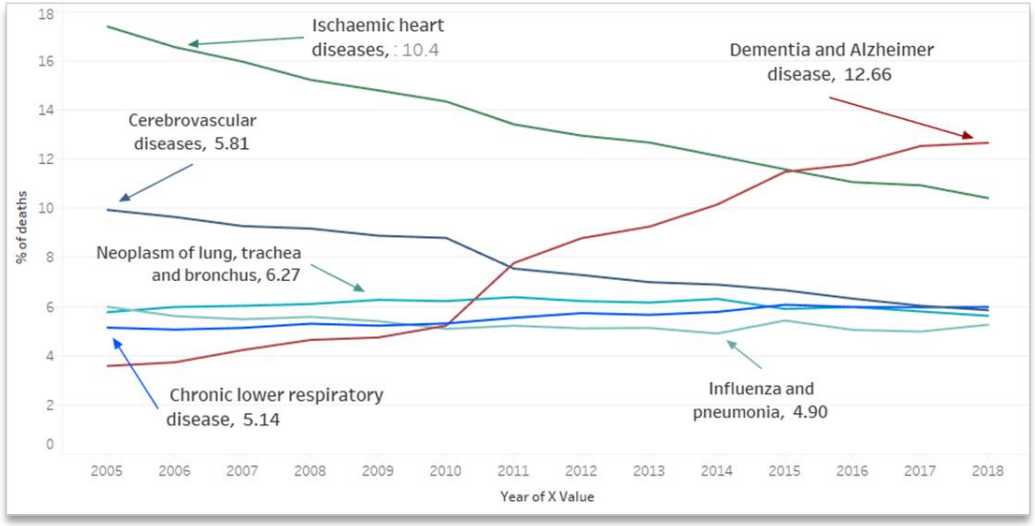
**Clefyd isgemia'r galon** yw prif achos marwolaeth o hyd **i ddynion**, yn gyffredinol

Roedd **9,000 o bobl** sydd ar gofrestrau meddygon teulu yn Hywel Dda wedi cael **diagnosis o glefyd rhwystrol cronig yr ysgyfaint**

Effeithiodd COVID-19 ar farwolaethau, gan achosi cynnydd o **oddeutu 14% ar draws Cymru a Lloegr yn nifer y marwolaethau ychwanegol**

Ar hyn o bryd, **ni wyddys beth fydd effaith COVID-19 yn y dyfodol** ar nifer y marwolaethau ac ar ofal diwedd oes

**Prif achosion marwolaeth yn y DU hyd at 2018 (yn dangos y % ddiweddaraf o gyfanswm y marwolaethau)**



# Marwolaeth a gofal lliniarol

O Gynllun Cyflawni Cymru Gyfan ar gyfer Gofal Lliniarol a Gofal Diwedd Oes 2017, **amcangyfrifir bod gan 0.75% o boblogaeth Cymru anghenion o ran gofal lliniarol** ar unrhyw adeg. At hynny, "mae'r [cynllun] yn awgrymu cyfradd mynychder a amcangyfrifir ar gyfer plant a phobl ifanc sy'n debygol o fod angen gwasanaethau gofal lliniarol o 15 ym mhob 10,000 o'r boblogaeth 0–19 oed". **Mae hynny'n gyfwerth â 12-13 o blant yn Hywel Dda.**

Nodir y bydd angen gofal lliniarol ar dros 65%* o'r sawl sy'n marw ac y bydd nifer y bobl y mae angen gofal lliniarol arnynt yn cynyddu 25% erbyn 2040*.

**Amcangyfrif o'r angen am ofal lliniarol***

| | Yn awr | 2040 (amcangyfrif isaf) | 2040 (amcangyfrif uchaf) |
|---|---|---|---|
| Sir Gaerfyrddin | 1,436 | 1,795 | 2,010 |
| Ceredigion | 508 | 635 | 711 |
| Sir Benfro | 992 | 1,240 | 1,394 |
| Gorllewin Cymru | 2,936 | 3,670 | 4,115 |

Rhwng **3,670** a **4,115** erbyn **2040**

I roi'r amcangyfrifon mewn persbectif…

Mae'r amcangyfrif ***uchaf*** yr un fath â phe bai ar bawb yn **Ninbych-y-pysgod** angen gwasanaethau gofal diwedd oes

DS: Y data am blant a phobl ifanc sydd yn y cyfansymiau: Mae'r niferoedd yn fach iawn, ac mewn achosion lle'r oedd y nifer mewn grŵp oedran o 5 mlynedd yn llai na 5, cafodd y niferoedd eu hatal a'u talgrynnu i fyny yn awtomatig i 5. Mae hynny'n golygu bod y nifer dan sylw'n debygol o fod yn amcangyfrif ychydig yn rhy uchel o nifer y marwolaethau ymhlith unigolion 0-19 oed, ond nid yw'n effaith sylweddol.

*How many people will need palliative care in 2040? Past trends, future projections and implications for services - S. N. Etkind et al – Cafodd y papur hwn ei ddefnyddio ar gyfer amcangyfrifon. Cynnydd o 25% ers 2014, data 2019 sydd uchod, ond o gymryd y ganran a awgrymir yn yr adroddiad, sef 25%, gallai'r cynnydd fod gymaint â 42% rhwng 2014 a 2040.

# 3. Beth y mae arfer gorau'n ei ddweud wrthym?

# Cynllun Cyflawni Llywodraeth Cymru ar gyfer Gofal Lliniarol a Gofal Diwedd Oes

Attain

Cafodd y Cynllun ei gyhoeddi ym mis Mawrth 2017, a Chymru oedd y wlad gyntaf o blith dwy o wledydd y Deyrnas Unedig i gael cynllun cyflawni cyfredol a throsfwaol ar gyfer gofal lliniarol a gofal diwedd oes.

At hynny, nododd adroddiadau a gyhoeddwyd yn ystod cyfnod y Cynllun Cyflawni cyntaf ar gyfer Gofal Diwedd Oes feysydd lle mae angen gwella. Nododd 'Living and Dying with Dementia in Wales: Barriers to Care' gan y Gymdeithas Alzheimer a Marie Curie yn 2015 a 'People with a Learning Disability - A Different Ending: Addressing Inequalities in End of Life Care' gan y Comisiwn Ansawdd Gofal yn 2016 rwystrau a oedd yn cynnwys diffyg mynediad i ofal ar gyfer pobl sy'n byw gydag anableddau dysgu a dementia, a diffyg camau effeithiol i gynllunio gofal ymlaen llaw a diagnosio anhwylderau'n brydlon ar gyfer y ddau grŵp.

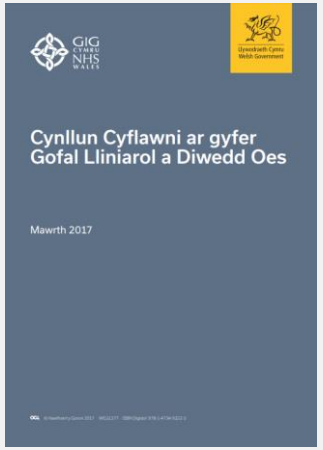
Cafodd yr angen i wella mynediad i wasanaethau gofal lliniarol ar gyfer pobl o gymunedau du, Asiaidd a lleiafrifoedd ethnig yn ne-ddwyrain Caerdydd ac ar gyfer pobl lesbiaidd, hoyw, ddeurywiol a thrawsryweddol ei nodi mewn adroddiad ynghylch gwella mynediad gan Marie Curie (2014) a '"Hiding who I am": The reality of end of life care for LGBT people' gan Marie Curie (2016).

Mae'r cynllun yn cydnabod bod angen mabwysiadu dull cyfun o gynllunio gofal ymlaen llaw, gwneud penderfyniadau ar y cyd, a rhoi hyfforddiant i weithwyr gofal iechyd proffesiynol yn y maes hwn, er mwyn cynorthwyo'r cleifion hyn a'u teuluoedd a'u gofalwyr ac er mwyn dysgu'r ffyrdd gorau o ddiwallu anghenion yr unigolyn.

Mae'r Cynllun Cyflawni ar gyfer Gofal Lliniarol a Gofal Diwedd Oes wedi diffinio'n glir y blaenoriaethau penodol i Fyrddau Iechyd ar gyfer y cyfnod 2017-2020 ar draws 7 thema gyflawni allweddol:

1. Cynorthwyo â byw a marw gydag urddas,
2. Canfod ac adnabod cleifion yn gynnar,
3. Darparu gofal cyflym ac effeithiol,
4. Lleihau trallod salwch angheuol i'r claf a'r rheiny sy'n agos ato,
5. Gwella gwybodaeth,
6. Targedu ymchwil,
7. Addysg.

**D.S. Yn ddiweddar, mae Llywodraeth Cymru wedi cynnal gwerthusiad sy'n crynhoi'r cynnydd a wnaed o safbwynt cyflawni'r cynllun, y disgwylir iddo gael ei gyhoeddi'n fuan.**






Ffynhonnell: https://llyw.cymru/sites/default/files/publications/2019-01/cynllun-cyflawni-ar-gyfer-gofal-lliniarol-a-diwedd-oes-2017.pdf

# ‘Ambitions for PEOLC Care: A national framework for local action 2015 - 2020’

Yn 2015 yn Lloegr, cyhoeddodd y Bartneriaeth Genedlaethol ar gyfer Gofal Lliniarol a Gofal Diwedd Oes fframwaith o’r enw ‘Ambitions for PEOLC: A national framework for local action 2015 -2020’.

Er bod yr uchelgeisiau’n canolbwyntio ar brofiad y person sy’n marw, mae’r hyn sy’n bwysig i’r partneriaid yn ehangach. Dylid ystyried bod pob datganiad yn uchelgais ar gyfer gofalwyr, teuluoedd, y sawl sy’n bwysig i’r person sy’n marw ac, os yw’n briodol, y sawl sydd wedi dioddef profedigaeth.

Prif nod y fframwaith yw darparu’r sylfeini a’r conglfeini y gall arweinwyr lleol ym maes gofal iechyd a gofal cymdeithasol eu defnyddio i greu’r gofal hygyrch, ymatebol, effeithiol a phersonol y mae ei angen ar ddiwedd oes.

**Yn ddiweddar, mae’r Bwrdd Iechyd wedi datblygu Egwyddorion Gofal Lliniarol a Gofal Diwedd Oes Partneriaeth Gofal Gorllewin Cymru, gan adeiladu ar sylfeini’r fframwaith ‘Ambitions for PEOLC Care’** (a gyhoeddwyd o’r newydd ym mis Hydref 2020). Mae’n cydnabod bod y ddogfen yn un a luniwyd ar gyfer y GIG yn Lloegr, ond mae’r uchelgeisiau a’r conglfeini sydd yn y fframwaith cenedlaethol hwnnw yr un mor ddilys ar gyfer poblogaeth Cymru.

Ochr yn ochr â 7 thema gyflawni allweddol Llywodraeth Cymru, mae Partneriaeth Gofal Gorllewin Cymru hefyd wedi mabwysiadu uchelgeisiau a chonglfeini’r fframwaith yn Lloegr ac wedi cadarnhau bod Canllawiau’r Bwrdd Iechyd ar gyfer Gofal Sylfaenol a Chymunedol a’r Gofynion ar gyfer Rhyddhau Cleifion o’r Ysbyty yn cyd-fynd â’r sylfeini a’r conglfeini hynny ac yn cynnig eglurder pellach.

Attain

## Uchelgeisiau’r fframwaith yn Lloegr ar gyfer Gofal Lliniarol a Gofal Diwedd Oes

01 **Each person is seen as an individual**
*I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what’s possible.*

02 **Each person gets fair access to care**
*I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.*

03 **Maximising comfort and wellbeing**
*My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.*

04 **Care is coordinated**
*I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.*

05 **All staff are prepared to care**
*Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.*

06 **Each community is prepared to help**
*I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.*

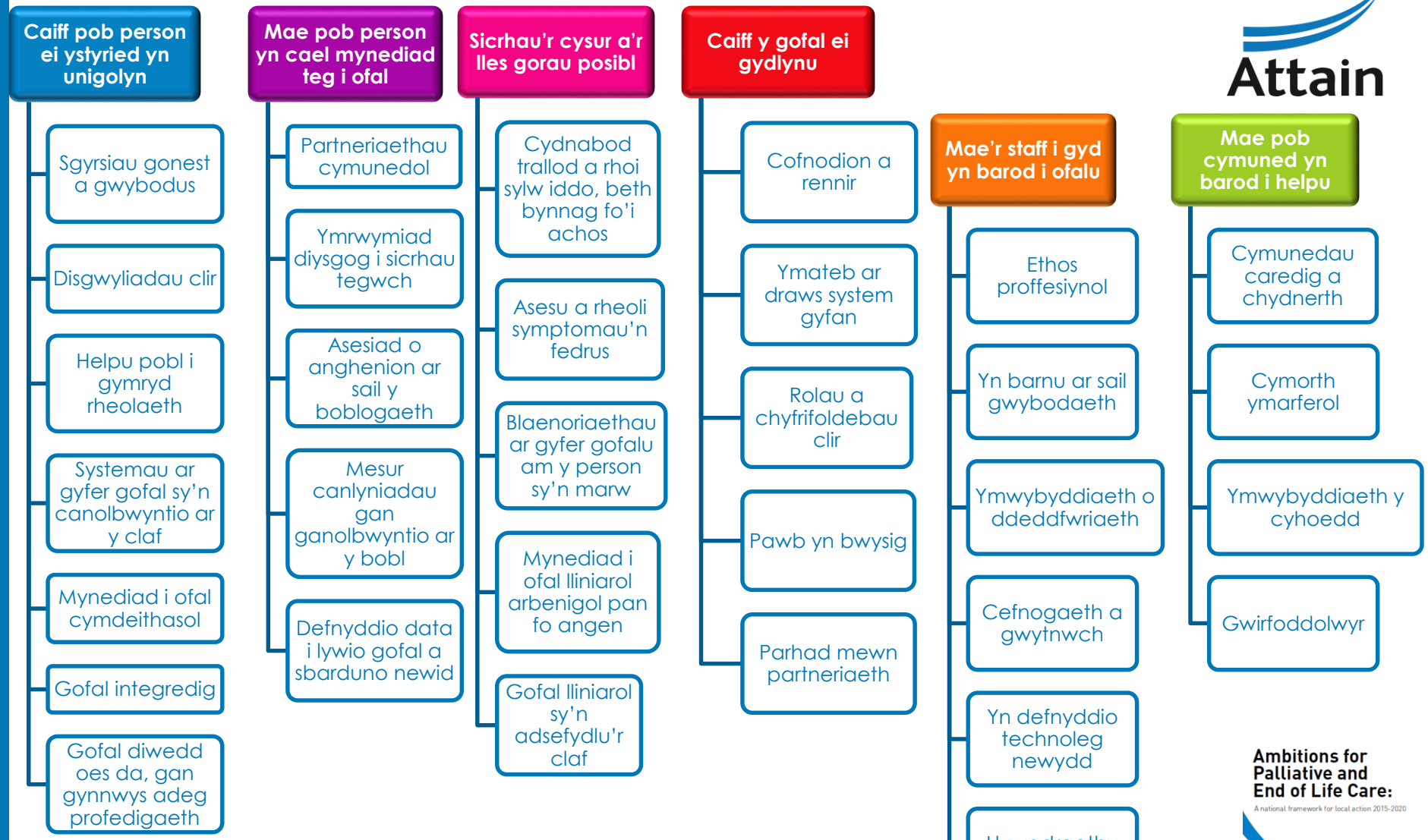
Mae rhagor o wybodaeth am yr uchelgeisiau ar gyfer gofal lliniarol a gofal diwedd oes i’w chael yma : https://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

# Y conglfeini ar gyfer cyflawni'r fframwaith cenedlaethol 'Ambitions for PEOLC Care'.

Er mwyn gwireddu'r uchelgeisiau, nododd y Bartneriaeth Genedlaethol yn Lloegr wyth sylfaen/conglfaen yr oedd angen eu cael. Maent i gyd yn angenrheidiol ac yn ategu'r uchelgeisiau.

Y sylfeini/conglfeini hyn yw'r rhagamodau ar gyfer sicrhau'r gwelliant cyflym wedi'i dargedu y mae'r Bartneriaeth am ei weld.

Yn achos gorllewin Cymru, maent yn fan cychwyn y mae'n rhaid datblygu'r ymdrech newydd, gyfun ar ei sail.




Mae rhagor o wybodaeth am y conglfeini i ategu'r gwaith o wireddu'r uchelgeisiau ar gyfer gofal lliniarol a gofal diwedd oes i'w chael yma: https://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

# Crynhoi arfer gorau

**Yn rhan o'n hadolygiad o arfer gorau, buom yn ymchwilio i ystod eang o enghreifftiau lleol, cenedlaethol a rhyngwladol cyfredol o arfer gorau, gan ganolbwyntio ar y meysydd canlynol a fydd yn allweddol i ddatblygu unrhyw wasanaeth newydd**

**Model cyflawni gan y gweithlu cyffredin:**
Dylid ei fabwysiadu'n unol ag Adroddiad Sugar ym mis Mehefin 2008, lle mae staff ar draws y rhanbarth yn darparu:

1) Gofal lliniarol cyffredinol a ddarperir gan weithwyr iechyd proffesiynol mewn lleoliad cyffredinol, e.e. gofal cymunedol ac eilaidd
2) Gofal lliniarol arbenigol a ddarperir gan dimau amlddisgyblaethol sy'n ymwneud yn benodol â gofal lliniarol

**Modelau gwasanaethau:**
- Er mwyn sicrhau cysondeb o ran darpariaeth, dylai Partneriaeth Gofal Gorllewin Cymru gytuno ar y llwybr ar gyfer gofal lliniarol a gofal diwedd oes i'r ardal, yn unol ag arfer gorau
- Dylai'r Bwrdd Iechyd ystyried a ddylid mabwysiadu'r enghreifftiau o arfer gorau, megis model Midhurst a'r model SWAN/Cygnets

**Hyfforddiant:**
- Dylai fod gan bob gweithiwr gofal iechyd a phob gwirfoddolwr, waeth beth fo'u rôl, fynediad i addysg a hyfforddiant ynghylch gofal diwedd oes a phrofedigaeth, gyda'r lefel yn dibynnu ar natur eu rôl ac ar eu cysylltiad â marwolaeth a marw

**Y defnydd a wneir o dechnoleg:**
- Yn ogystal â gofal yn y cartref, mae teleiechyd a chyfleusterau monitro cleifion o bell yn cynnig manteision niferus i gleifion ar draws y sbectrwm gofal iechyd, gan gynnwys y sawl sy'n cael gofal lliniarol

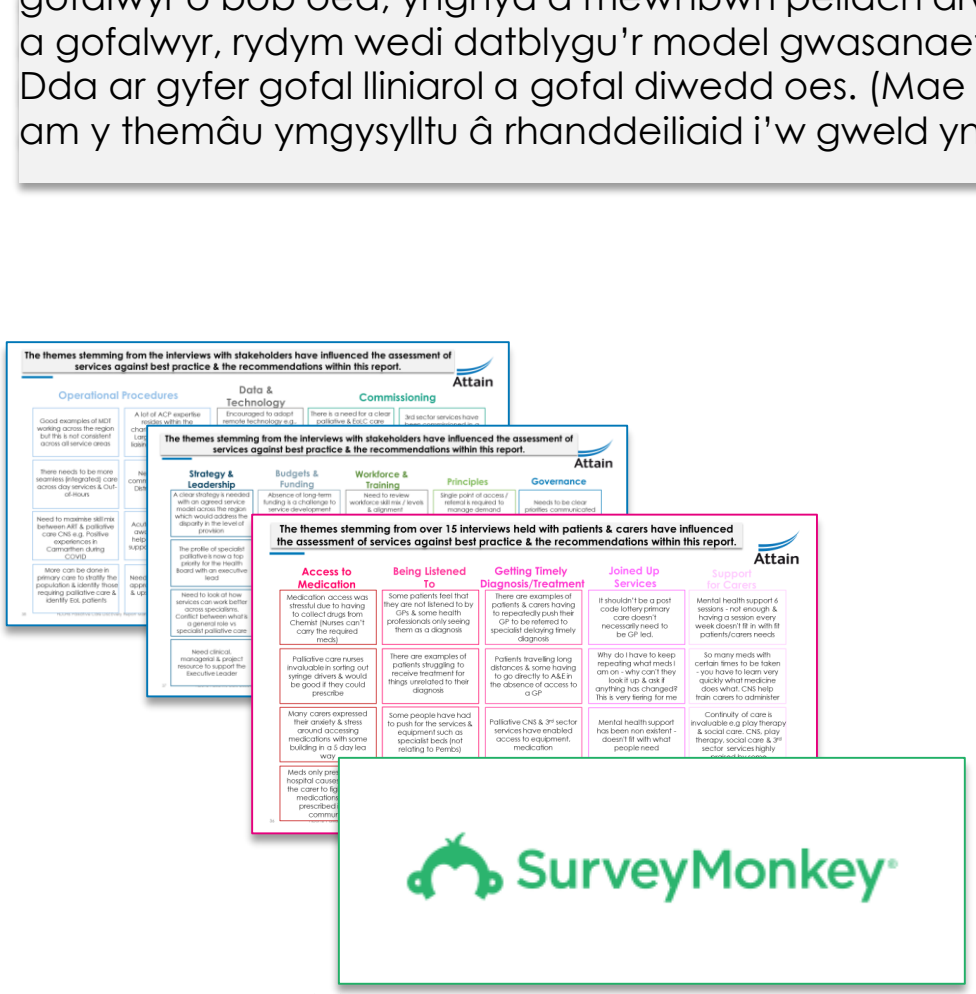
**Cynorthwyo gofalwyr:**
- Dylai partneriaid adolygu'r gwersi a ddysgwyd o ofalu am bobl â dementia a COVID-19 a phobl sydd wedi dioddef profedigaeth, a dylent ystyried a ellir cymhwyso'r gwersi i'r modd y caiff gwasanaethau eu darparu ar hyn o bryd, neu'u hymgorffori mewn strategaethau perthnasol a/neu gynlluniau trawsnewid gwasanaethau
- Dylai pob amgylchedd lle mae gofal diwedd oes yn digwydd ddarparu lleoedd priodol i gynorthwyo teuluoedd a gofalwyr

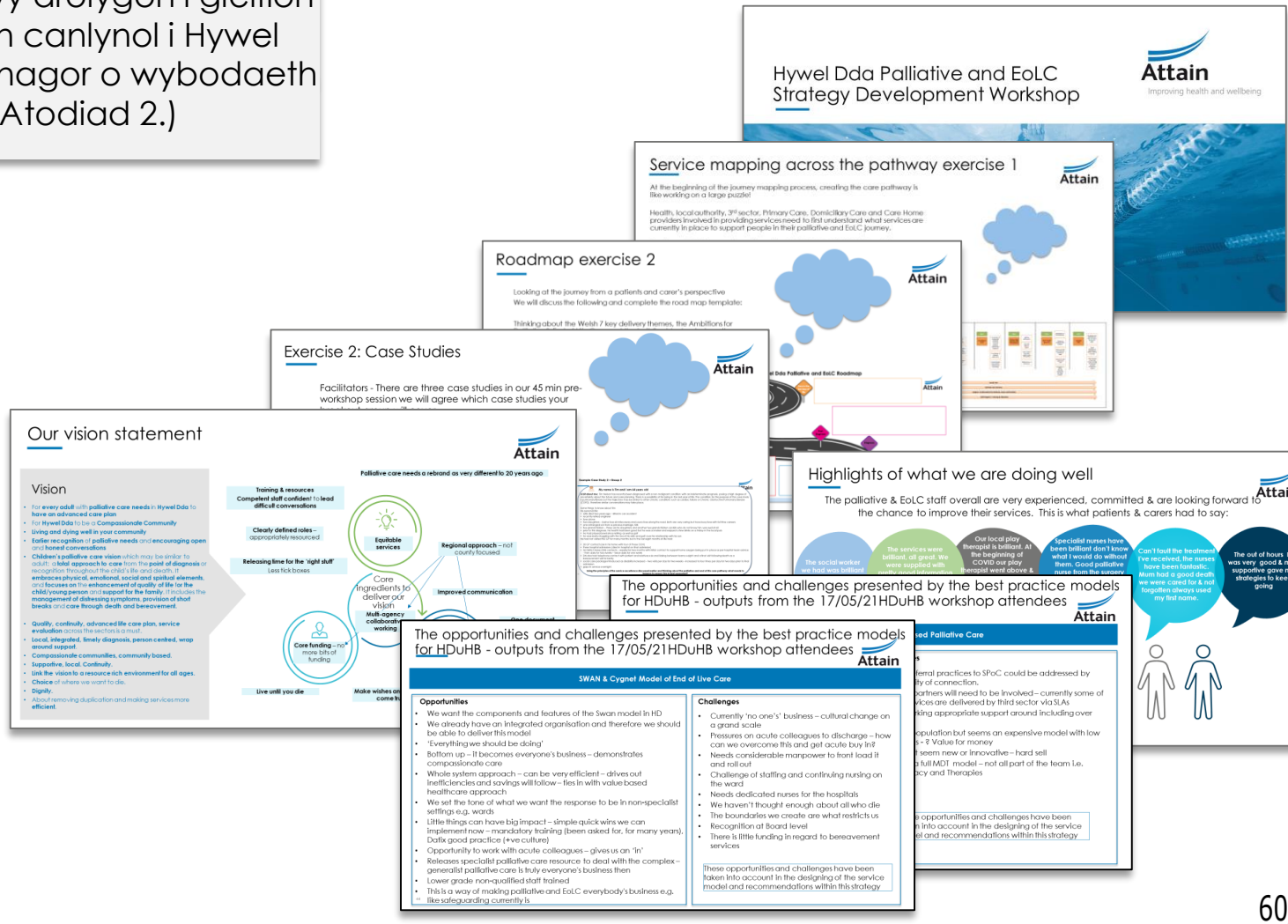
**Profedigaeth:**
- Mae strategaethau ar draws y byd yn cynnwys pwysigrwydd ymgysylltu â'r gymuned leol, arweinwyr ysbrydol ac arweinwyr eraill er mwyn meithrin capasiti yn y gymuned i gynnig cymorth adeg profedigaeth
- Mabwysiadu polisïau ac arferion cymunedau caredig er mwyn cynorthwyo pobl sydd wedi dioddef profedigaeth
- Dylai fframwaith ar gyfer profedigaeth, sydd wrthi'n cael ei ddatblygu ar hyn o bryd, gael ei gynnwys ym mhob manyleb gwasanaeth berthnasol a'i ymgorffori mewn gweithdrefnau gweithredu safonol ar draws pob gwasanaeth

# 4. Ein llwybr model gwasanaeth

# Datblygu glasbrint model gwasanaeth Hywel Dda ar gyfer gofal lliniarol a gofal diwedd oes

Yn dilyn cyfres o weithdai a gynhaliwyd yn ystod mis Mai 2021, cyfweliadau â rhanddeiliaid yng ngham 1 a chyfweliadau â chleifion a gofalwyr o bob oed, ynghyd â mewnbwn pellach drwy arolygon i gleifion a gofalwyr, rydym wedi datblygu'r model gwasanaeth canlynol i Hywel Dda ar gyfer gofal lliniarol a gofal diwedd oes. (Mae rhagor o wybodaeth am y themâu ymgysylltu â rhanddeiliaid i'w gweld yn Atodiad 2.)



# Gweledigaeth Hywel Dda ar gyfer gwasanaeth gofal lliniarol a gofal diwedd oes

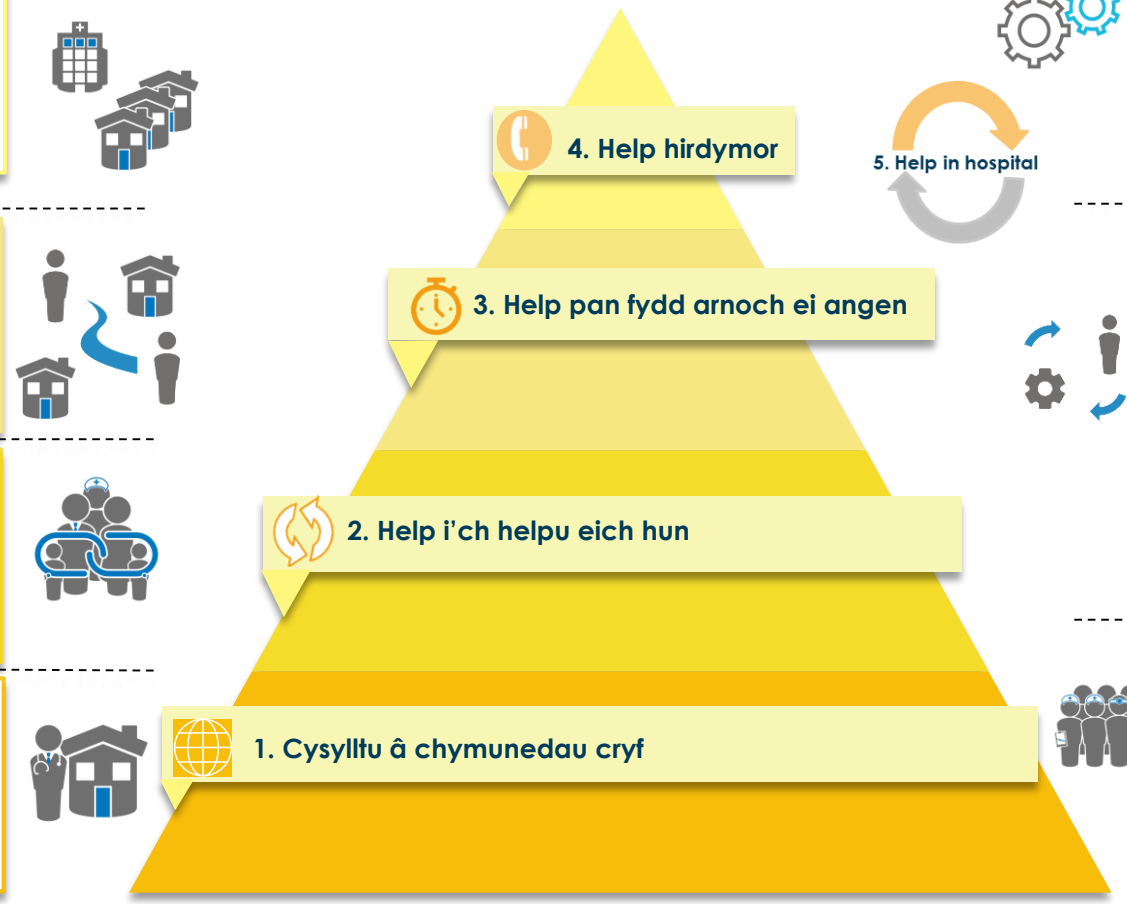
**'Darparu gofal lliniarol a gofal diwedd oes ardderchog ar draws y gorllewin, sy'n galluogi pobl i gael gofal a marw yn y lleoliad y maent yn ei ffafrio'**

Cymorth o ran gofal lliniarol arbenigol – yn y gymuned a'r ysbyty.

Gofal canolraddol i gynorthwyo pobl pan fydd eu hangen yn mynd yn fwy. Rydym yn sicrhau'r cysur a'r lles gorau posibl – gan gynorthwyo pobl yn eu cartref os oes modd.

Gofal rhagweithiol a chynllunio gofal fel tîm amlddisgyblaethol. Caiff y gofal ei gydlynu gan sicrhau bod yr help iawn yn cael ei roi ar yr adeg iawn.

Gwaith atal, gwaith cynllunio ac addysg yn ein cymunedau.
Cymunedau'n barod i gynorthwyo a helpu.




**Ffactorau allweddol sy'n galluogi gwaith cyflawni:**

- Gweledigaeth, strategaeth a model gwasanaeth rhanbarthol clir ar gyfer gofal lliniarol a gofal diwedd oes, yn unol ag egwyddorion Partneriaeth Gofal Gorllewin Cymru ar gyfer gofal o'r fath
- Trefniadau llywodraethu integredig
- Trefniadau comisiynu strategol a chydweithredol sy'n canolbwyntio ar y cleifion/gofalwyr
- Gweithio ar draws sefydliadau
- Rheoli materion ariannol a pherfformiad ar y cyd

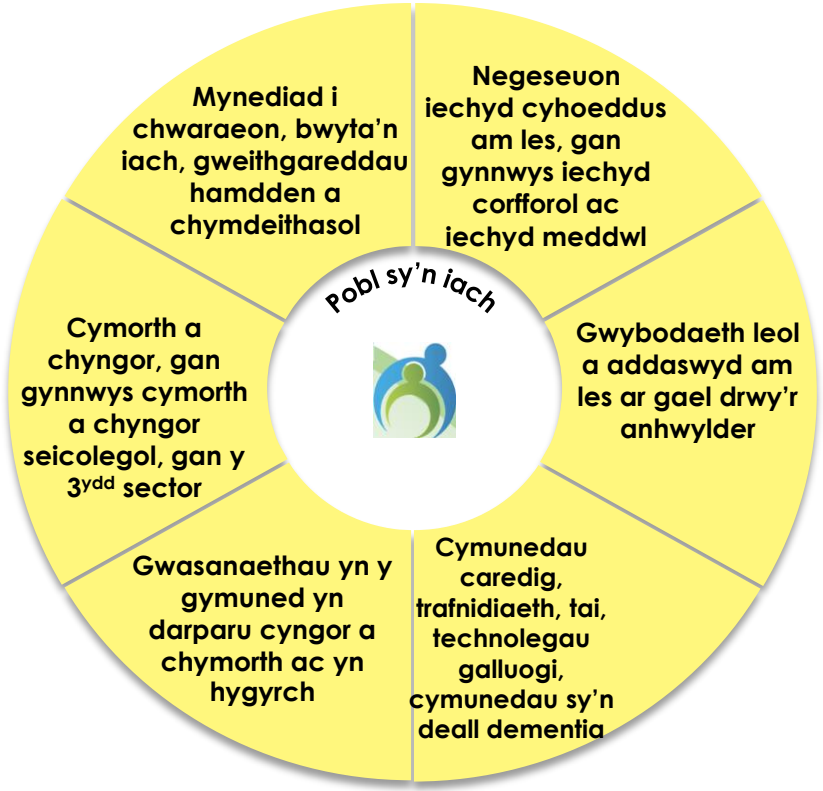
- Comisiynu ar y cyd ar gyfer gofal integredig, gan sicrhau mynediad a darpariaeth deg ar draws y gorllewin
- Cynghreiriau rhwng y Bwrdd Iechyd a darparwyr (gan gynnwys y 3ydd sector), sy'n cyflwyno gwasanaethau i rwydweithiau lleol ac yn galluogi integreiddio yn y rheng flaen
- Rhaglenni a chynlluniau a rennir ar gyfer trawsnewid systemau
- Ystyried systemau risg a budd lleol, alinio cymhellion, a ffurflenni contract newydd

- Darparu gwasanaethau gofal sylfaenol ar y raddfa briodol
- Staff ar draws sefydliadau wedi'u hyfforddi ac yn cydweithio mewn modd integredig ar draws y rhanbarth er mwyn diwallu anghenion y boblogaeth yn y ffordd orau posibl
- Dehongli data ynghylch iechyd y boblogaeth ac adborth gan gleifion/teuluoedd, dylunio gwasanaethau ar gyfer rhwydweithiau integredig, a manteisio ar gymorth gan wasanaethau ehangach

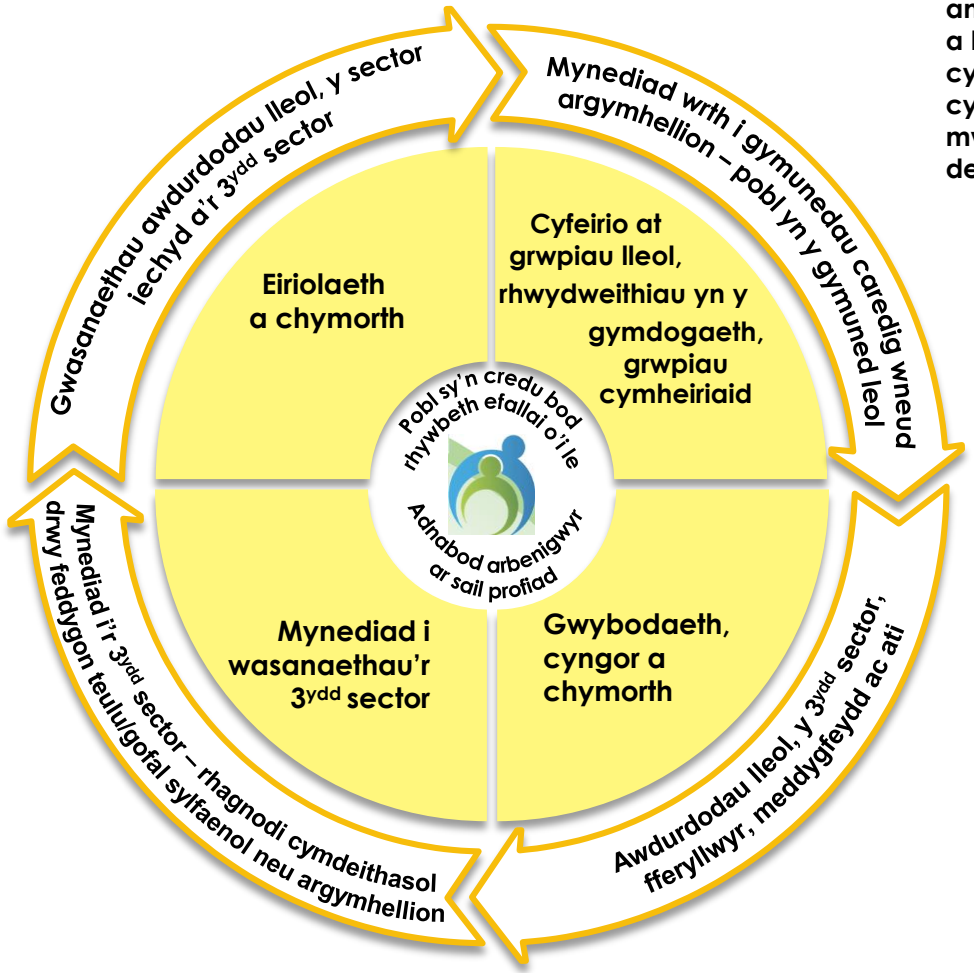
Ffynhonnell: Egwyddorion Gofal Lliniarol a Gofal Diwedd Oes Partneriaeth Gofal Gorllewin Cymru 23/10/20

# Sut beth yw da i Hywel Dda – Y llwybr model gwasanaeth ar gyfer gofal lliniarol a gofal diwedd oes

## Gofalu am ein lles corfforol a meddyliol, codi ymwybyddiaeth a gwella dealltwriaeth




## Cael help a chymorth yn gynnar



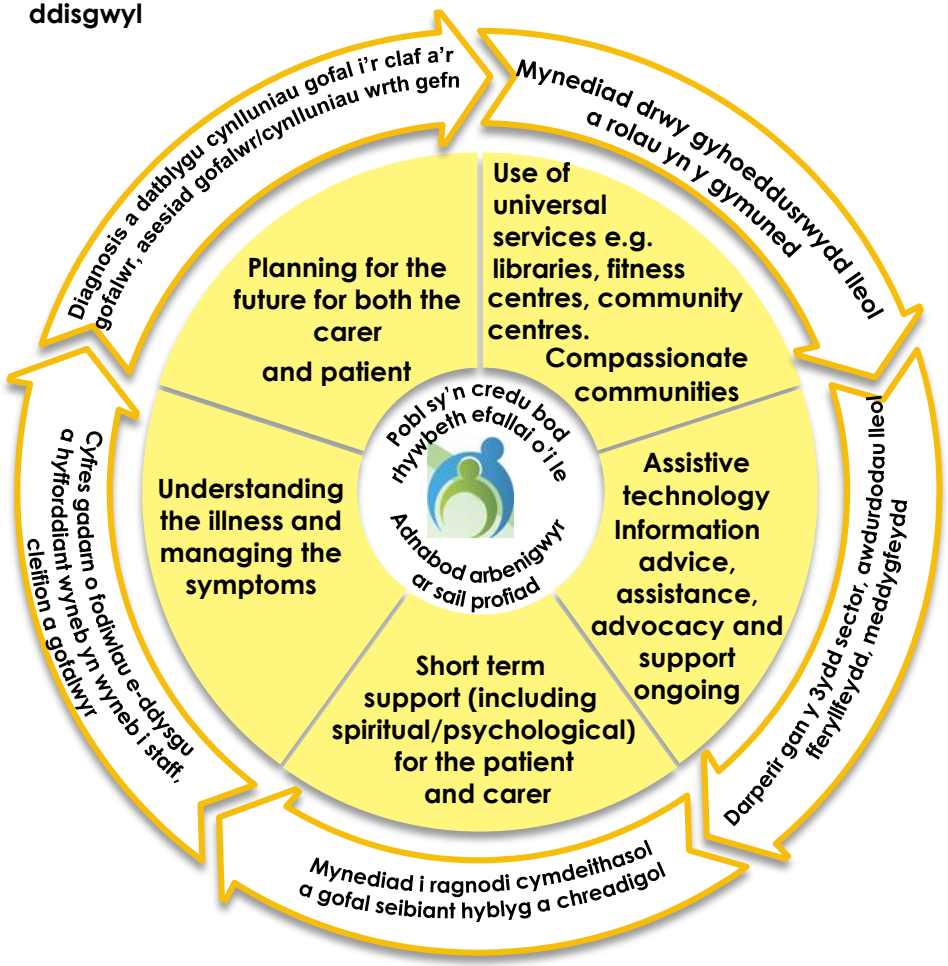

- Mae ar ofalwyr a chleifion gofal lliniarol angen gwybodaeth glir a hygyrch sy'n eu cysylltu â grwpiau cymheiriaid lleol er mwyn cael cymorth o'r dechrau'n deg.

**Wedi'i ategu gan hyfforddiant i bob aelod o staff**

# Sut beth yw da i Hywel Dda – Y llwybr model gwasanaeth ar gyfer gofal lliniarol a gofal diwedd oes

## Adnabod, asesu a diagnosio

- Galluogi gwasanaethau generig (e.e. gwaith cymdeithasol, gofal yn y cartref, cartrefi gofal, nyrsys ardal, therapi galwedigaethol, ffisiotherapi, ac ati) i gynorthwyo pobl drwy ddiagnosis gofal lliniarol - addysg - pa arwyddion i chwilio amdanynt a beth i'w ddisgwyl

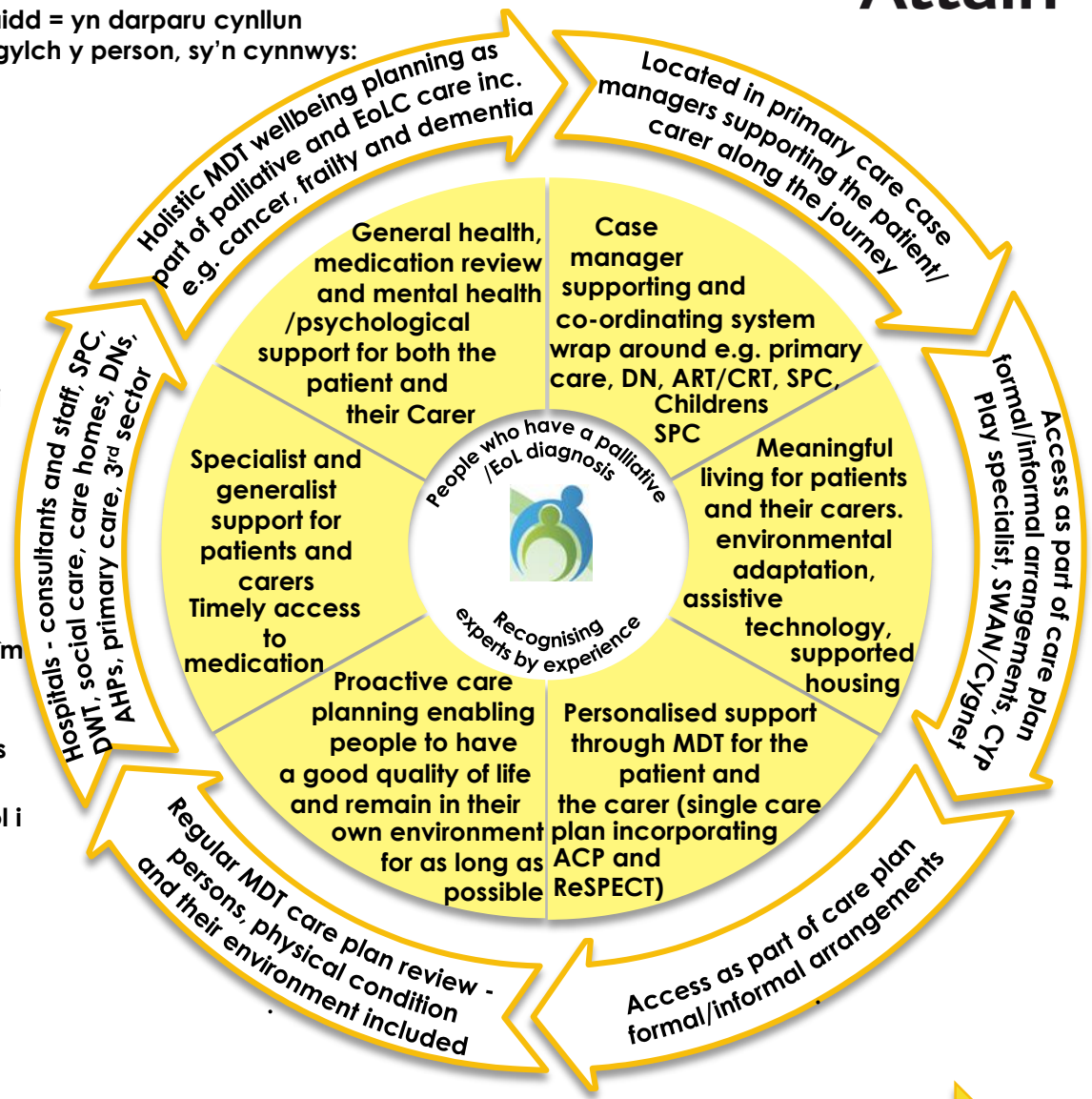



## Byw gyda diagnosis gofal lliniarol/gofal diwedd oes

Tîm amlddisgyblaethol holistaidd = yn darparu cynllun cymorth a lles sefydlog o amgylch y person, sy'n cynnwys:

- Rheolwr achosion
- Gofal cymdeithasol
- Gweithwyr proffesiynol perthynol i iechyd
- Nyrsys ardal
- Gweithwyr allweddol / arweinydd technoleg gynorthwyol
- Nyrsys arbenigol, e.e. Admiral, canser, ac ati
- Gofal sylfaenol
- Fferyllfeydd
- Y 3ydd sector
- Iechyd meddwl pobl hŷn
- Cyngor a hyfforddiant yn ôl yr angen gan y Tîm Lles Dementia
- Meddygon ymgynghorol ym maes gofal eilaidd
- Gofal lliniarol arbenigol i oedolion/plant

(D.S. Nid yw'r rhestr hon yn gyflawn)




**Wedi'i ategu gan hyfforddiant i bob aelod o staff**

# Sut beth yw da i Hywel Dda – Y llwybr model gwasanaeth ar gyfer gofal lliniarol a gofal diwedd oes

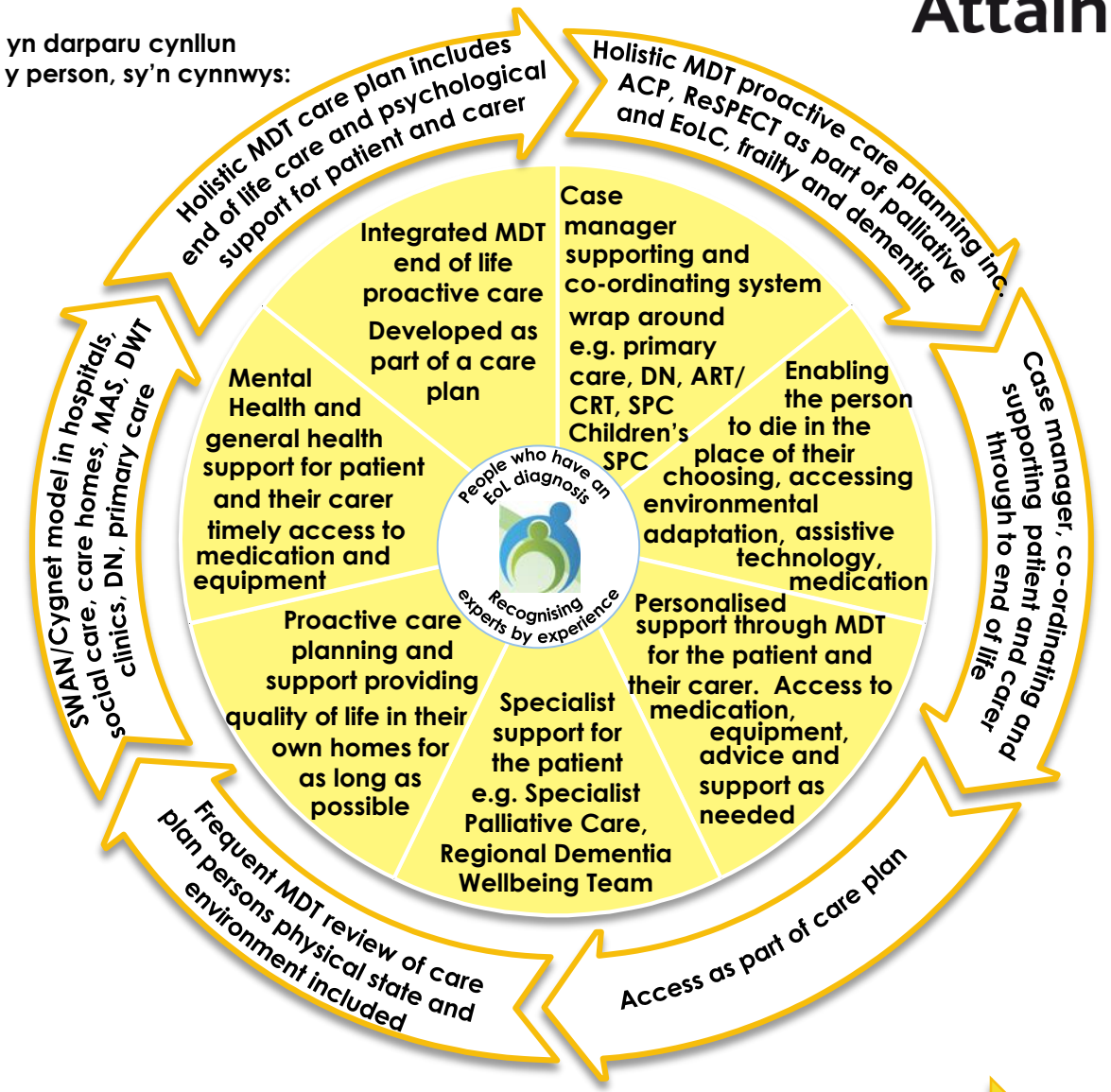
**Yr angen am fwy o gymorth yn ystod diwrnodau diwedd oes**

- **Gweithredu Fframwaith Addysg a Hyfforddiant yr Alban ar gyfer gofal lliniarol a gofal diwedd oes, sy'n seiliedig ar arfer gorau, a addaswyd ar gyfer gorllewin Cymru** – mae angen i ni ystyried yr anghenion o ran dysgu a datblygu sydd gan bawb y mae diagnosis gofal lliniarol/gofal diwedd oes yn effeithio arnynt mewn rhyw fodd neu'i gilydd. Maent yn cynnwys cleifion o bob oed, gofalwyr, staff rheng flaen, rheolwyr, comisiynwyr, rheoleiddwyr, ymchwilwyr, perchnogion siopau, cymdogion, ac ati. Bydd hynny'n arwain at bobl wybodus, pobl fedrus a phobl sy'n gallu darparu'r cymorth iawn ar yr adeg iawn

**Tîm amlddisgyblaethol holistaidd = yn darparu cynllun cymorth a lles sefydlog o amgylch y person, sy'n cynnwys:**

- **Rheolwr achosion**
- **Meddygon ymgynghorol ym maes gofal eilaidd**
- **Gofal lliniarol arbenigol i oedolion/plant**
- **Gofal cymdeithasol**
- **Y 3ydd sector**
- **Gweithwyr proffesiynol perthynol i iechyd**
- **Nyrsys ardal**
- **Gweithwyr allweddol/ arweinydd technoleg gynorthwyol**
- **Nyrsys arbenigol, e.e. Admiral, canser, ac ati**
- **Gofal sylfaenol**
- **Fferyllwyr**
- **Iechyd meddwl pobl hŷn**
- **Cyngor a hyfforddiant yn ôl yr angen gan y Tîm Lles Dementia**

**(D.S. Nid yw'r rhestr hon yn gyflawn)**



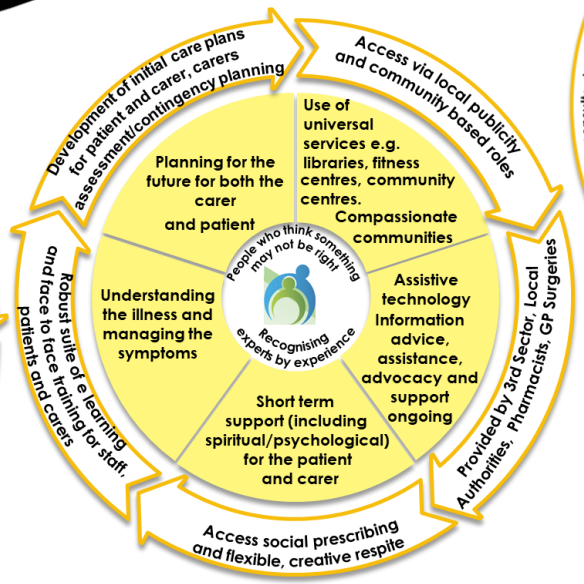

**Wedi'i ategu gan hyfforddiant i bob aelod o staff**

# Sut beth yw da i Hywel Dda – Y llwybr model gwasanaeth ar gyfer gofal lliniarol a gofal diwedd oes

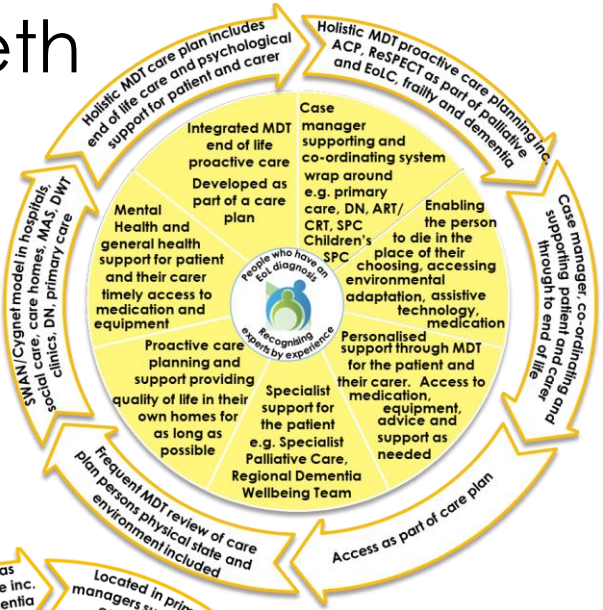
- Mae'r model drafft hwn yn dangos ffordd integredig newydd o ddarparu gwasanaethau. Mae'n seiliedig ar arfer gorau a gwasanaethau sy'n bodoli eisoes yng ngorllewin Cymru.
- Dylai'r model gwasanaeth gael ei ategu gan gyfres y cytunwyd arni o egwyddorion darparu gwasanaeth y mae angen eu datblygu drwy'r ffrwd waith 'Mae'r staff i gyd yn barod i ofalu' (gweler adran 5).

**Y cymorth yn cynyddu gyda'r anghenion**
**Arbenigwyr yn dylanwadu ar draws y llwybr**










**Wedi'i ategu gan hyfforddiant i bob aelod o staff**

# Camau nesaf

**Cwblhau'r strategaeth:**

- Ceisio **adborth ynghylch y strategaeth a'r weledigaeth a'r llwybr model ar gyfer y gwasanaeth**
- **Cwblhau'r weledigaeth a'r llwybr model gwasanaeth** a'u rhannu ag eraill fel bod pob partner yn gwybod i ba gyfeiriad y mae gwasanaethau gofal lliniarol a gofal diwedd oes yn mynd yn y gorllewin
- **Diweddaru'r cynllun rhaglen â datblygiadau newydd o ran gwasanaeth** sy'n ofynnol er mwyn rhoi'r weledigaeth a'r llwybr model gwasanaeth ar waith
- **Sicrhau bod trefniadau llywodraethu cadarn ar waith** i oruchwylio'r gwaith o weithredu'r mentrau newydd o ran gwasanaeth, gan sicrhau bod pob menter newydd yn mabwysiadu dull rhaglen o weithredu, gan adrodd yn rheolaidd ynghylch cynnydd wrth y Grŵp Llywio ar gyfer Gofal Lliniarol a Gofal Diwedd Oes

**Gweithredu'r rhaglen:**

- Byddwn **yn datblygu ein rhaglen waith** gan gadw llygad barcud ar Fframwaith Clinigol Cenedlaethol GIG Cymru sydd wrthi'n cael ei ddatblygu; yn y Fframwaith, mae gofal diwedd oes wedi cael statws Rhaglen Genedlaethol a bydd y Safonau Dementia yn cael eu cyflwyno
- **Clustnodi adnoddau i sefydlu a rheoli'r rhaglen waith** ar draws partneriaid
- Byddwn yn adolygu'r rhaglen waith gyfredol ac yn diweddaru'r cynllun rhaglen, **yn blaenoriaethu prosiectau ac yn diwygio amserlenni** er mwyn sicrhau bod cynllun realistig ar waith, y mae modd ei gyflawni. Y broses a ddefnyddir ar gyfer cyflawni fydd y dull rheoli ffrydiau gwaith
- Byddwn yn **nodi uwch-berchnogion cyfrifol ychwanegol ar gyfer ffrydiau gwaith** er mwyn sbarduno gwaith gyda chymorth y Swyddfa Rheoli Prosiectau a darparu perchnogaeth ac atebolrwydd i gyflawni
- Bydd **diweddariadau rheolaidd ynghylch cynnydd** yn dal i gael eu darparu yng nghyfarfodydd misol y Grŵp Llywio ar gyfer Gofal Lliniarol a Gofal Diwedd Oes

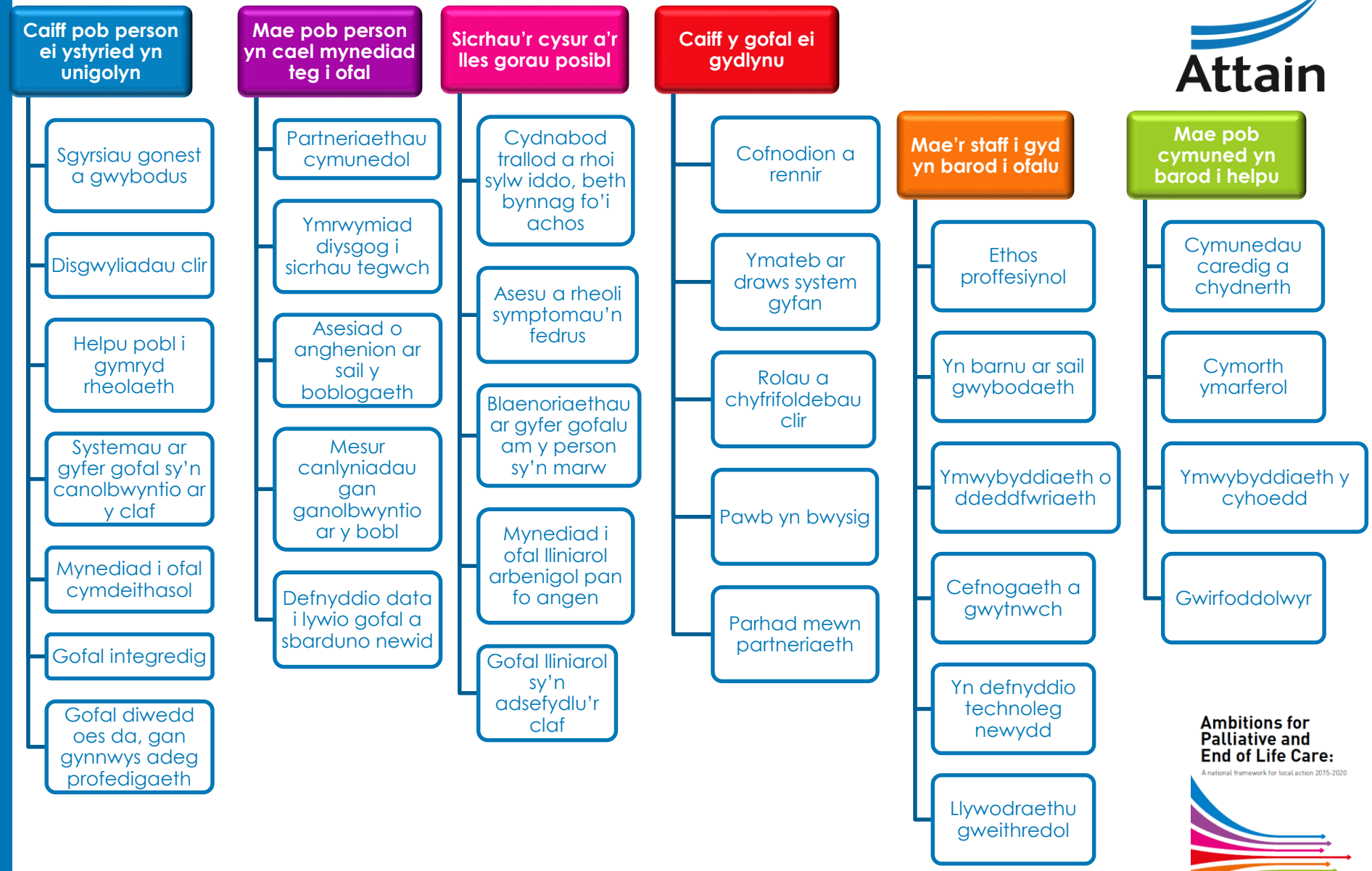
**Gweithredu'r strategaeth newydd ar gyfer gofal lliniarol a gofal diwedd oes**

# 5. Ein dull o weithredu'r model gwasanaeth newydd

# Gweithredu'r model gwasanaeth newydd gan ddefnyddio fframwaith cenedlaethol Lloegr o uchelgeisiau ar gyfer gofal lliniarol a gofal diwedd oes

O ystyried bod Egwyddorion Gofal Lliniarol a Gofal Diwedd Oes Gorllewin Cymru yn ymgorffori'r fframwaith uchod o uchelgeisiau, mae'n gwneud synnwyr i ni alinio'r gwaith o weithredu'r model gwasanaeth newydd â'r 6 uchelgais a'r 8 conglfaen.

Mae'n bwysig cydnabod bod yna fodel gwasanaeth Cymru Gyfan ar gyfer gofal lliniarol arbenigol a dull tîm o ddarparu gwasanaethau i blant, a ariennir yn ganolog, ac y bydd y gwasanaeth hwn, er yn rhan o dîm canolog Cymru, yn cael ei ddatblygu'n lleol drwy'r mentrau lleol a amlinellir yn yr argymhellion canlynol.




Mae rhagor o wybodaeth am y conglfeini i ategu'r gwaith o wireddu'r uchelgeisiau ar gyfer gofal lliniarol a gofal diwedd oes i'w chael yma: https://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

# Uchelgais 1

## Caiff pob person ei ystyried yn unigolyn

*Rwyf i, a'r bobl sy'n bwysig i fi, yn cael cyfleoedd i gael sgyrsiau gonest, gwybodus ac amserol ac i wybod y gallwn farw'n fuan. Gofynnir i fi beth sydd bwysicaf i fi.*

*Mae'r sawl sy'n gofalu amdanaf yn gwybod hynny ac yn gweithio gyda fi i wneud yr hyn sy'n bosibl.*

**Yr hyn yr ydym yn ei wneud a'n cynlluniau yn y maes hwn**

| | |
|---|---|
| **Sgyrsiau gonest** | • Byddwn yn adolygu Fframwaith Hyfforddiant yr Alban ar gyfer Gofal Lliniarol ac yn ystyried ei fabwysiadu ar draws y rhanbarth. Yn unol ag Archwiliad Cenedlaethol o Ofal Diwedd Oes 2019, byddwn yn datblygu rhaglen hyfforddiant sy'n deillio o'r fframwaith ac yn ei chyflwyno i bob aelod o staff ar draws y rhanbarth.<br>• Byddwn yn adolygu'r model SWAN/Cygnets ac yn ystyried ei addasu a'i fabwysiadu ym maes gofal eilaidd ac yn y gymuned (gweler Atodiad 4). Byddwn hefyd yn datblygu cynllun gweithlu ar gyfer pob oed er mwyn hybu cyflawni, sy'n cyd-fynd â dull gweithredu Cymru Garedig ac a fydd yn darparu hyfforddiant pellach er mwyn sicrhau bod gan staff ar draws y system y sgiliau a'r hyder i gael sgyrsiau am farwolaeth ag unigolion o bob oed, a'u teuluoedd a'u gofalwyr. |
| **Disgwyliadau clir** | • Byddwn yn rhoi gwybodaeth i unigolion, teuluoedd a gofalwyr a byddwn yn datblygu llyfryn gwybodaeth i ofalwyr, sy'n cynnwys gwybodaeth a chyngor ynghylch beth i'w ddisgwyl ar ddiwedd oes rhywun. |
| **Helpu pobl i gymryd rheolaeth**<br>**Systemau ar gyfer gofal sy'n canolbwyntio ar y claf**<br>**Mynediad i ofal cymdeithasol Gofal integredig (cydgysylltiedig)** | • Yn unol ag argymhellion Archwiliad Cenedlaethol o Ofal Diwedd Oes 2019:<br>  • Byddwn yn parhau i ddarparu hyfforddiant ynghylch cynllunio gofal ymlaen llaw, i weithwyr iechyd a gofal cymdeithasol, y 3ydd sector a staff cartrefi gofal, gan bwysleisio pwysigrwydd cynnwys teuluoedd a gofalwyr yn y sgyrsiau hyn a'u galluogi i gymryd rheolaeth ar eu cynllun gofal.<br>  • Gan ddilyn canllawiau Llywodraeth Cymru, byddwn yn gweithredu Cynlluniau Gofal Ymlaen Llaw ac at y Dyfodol Cymru Gyfan pan fyddant yn barod. Byddwn hefyd yn archwilio'r posibilrwydd o fabwysiadu'r ffurflen ReSPECT yn rhan o Gynlluniau Gofal Ymlaen Llaw (gweler Atodiad 5) ar draws y sector iechyd a'r sector gofal cymdeithasol, a datblygu cynllun gofal canolog Hywel Dda er mwyn rhannu gwybodaeth. |
| **Gofal diwedd oes da, gan gynnwys mynediad i wasanaethau profedigaeth** | • Byddwn yn adolygu mynediad i wasanaethau profedigaeth ac yn mynd i'r afael ag unrhyw rwystrau er mwyn sicrhau mynediad teg ar gyfer pawb.<br>• Byddwn yn ystyried canlyniad adolygiad o wasanaethau profedigaeth Cymru gyfan ac yn gweithredu'r argymhellion. |

# Uchelgais 2

**Mae pob person yn cael mynediad teg i ofal**

*Rwy'n byw mewn cymdeithas lle rwy'n cael gofal diwedd oes da, waeth pwy ydw i, ble'r ydw i'n byw neu beth yw amgylchiadau fy mywyd.*

**Yr hyn yr ydym yn ei wneud a'n cynlluniau yn y maes hwn**

| | |
|---|---|
| **Partneriaethau cymunedol** | • Byddwn yn ceisio deall sefyllfaoedd lle mae'n bosibl nad yw cymunedau'n gallu cael mynediad i ofal lliniarol a gofal diwedd oes, a byddwn yn ceisio deall unrhyw rwystrau sy'n bodoli.<br>• Byddwn yn mynd i'r afael ag anghydraddoldebau a bylchau mewn gwasanaethau, a byddwn yn gweithio gyda phartneriaid i oresgyn rhwystrau, e.e. mynediad i feddyginiaeth a gyrwyr chwistrell. |
| **Ymrwymiad diysgog i sicrhau tegwch** | • Drwy'r ffrwd waith berthnasol, byddwn yn adolygu pa elfennau o'r gwasanaeth cyfredol i oedolion (gan gynnwys rôl fferyllwyr) sy'n cyd-fynd â model Midhurst neu sydd ar y blaen i'r model hwnnw (gweler Atodiad 6), a byddwn yn sicrhau bod cysondeb rhwng dulliau cyflawni ar draws y rhanbarth, a fydd yn cynnwys datblygu gweithdrefnau gweithredu safonol rhanbarthol ar gyfer y gwasanaeth.<br>• Byddwn yn mynd i'r afael â mynediad anghyson i offer cymunedol ar draws Hywel Dda ar gyfer cleifion sy'n cael gofal lliniarol a gofal diwedd oes.<br>• Byddwn yn sicrhau dull cyson o weithredu'r model SWAN/Cygnets, a addaswyd, ar draws y rhanbarth ar gyfer plant ac oedolion.<br>• Byddwn yn cytuno ar ddull rhanbarthol cyson o adnabod pwy sy'n cyrraedd diwedd eu hoes.<br>• Byddwn yn monitro gwybodaeth er mwyn deall ble y mae pobl yn marw ac a yw dymuniadau pobl yn cael eu gwireddu. |
| **Asesiad o anghenion ar sail y boblogaeth**<br>**Mesur canlyniadau gan ganolbwyntio ar y bobl**<br>**Defnyddio data i sbarduno newid** | • Rydym wedi cynnal asesiad ar sail anghenion y boblogaeth, a byddwn yn parhau i weithio tuag at sefydlu dull Bwrdd Iechyd o gasglu data a chanlyniadau sy'n canolbwyntio ar yr unigolyn, yn unol ag awydd Cymru gyfan i fabwysiadu mesurau canlyniadau OACC ar gyfer gofal lliniarol arbenigol. Bydd hynny'n cael ei ymgorffori ym mhroses ein system adrodd ganolog, a byddwn yn gallu mesur canlyniadau sy'n canolbwyntio ar yr unigolyn. Byddwn yn alinio ein gwaith â Thîm Gofal Lliniarol Arbenigol i Blant Cymru Gyfan er mwyn sicrhau trefniadau adrodd ar lefel ganolog sy'n berthnasol i Gymru gyfan.<br>• Gan adeiladu ar yr ymchwil i arfer gorau, byddwn yn parhau i feithrin dealltwriaeth a gweithio gyda chydweithwyr er mwyn adnabod a rhannu arfer gorau ym maes gofal diwedd oes. |

# Uchelgais 3

## Sicrhau'r cysur a'r lles gorau posibl

*Caiff fy ngofal ei adolygu'n rheolaidd a gwneir pob ymdrech i sicrhau fy mod yn cael y cymorth, y gofal a'r driniaeth a allai fod yn ofynnol er mwyn fy helpu i fod mor gysurus a didrallod ag sy'n bosibl.*

**Yr hyn yr ydym yn ei wneud a'n cynlluniau yn y maes hwn**

| | |
|---|---|
| **Cydnabod trallod a rhoi sylw iddo, beth bynnag fo'i achos** | • Bydd yr hyfforddiant a roddir i staff a gofalwyr yn cynnwys hyfforddiant ynghylch adnabod arwyddion o drallod.<br>• Yn rhan o'n dull o gasglu data, byddwn yn ystyried addasu Holiadur Profiad GIG Cymru ar gyfer y sawl sy'n cael gwasanaethau gofal lliniarol a gofal diwedd oes; bydd hynny'n ein helpu i ddeall a yw anghenion o ran cysur a lles (sy'n cynnwys anghenion corfforol, seicolegol, emosiynol a chymdeithasol) yn cael eu diwallu ym maes gofal eilaidd. |
| **Rheoli symptomau** | • Yn unol â'r Archwiliad Cenedlaethol o Ofal Diwedd Oes, byddwn yn cynyddu hyfforddiant ac addysg ynghylch rheoli symptomau ar gyfer pob aelod o staff (yn enwedig gofalwyr a staff nad ydynt yn staff arbenigol), a byddwn hefyd yn ymestyn y gwaith sydd eisoes ar y gweill o safbwynt cael meddyginiaethau'n brydlon ym maes gofal eilaidd ac yn y gymuned.<br>• Byddwn yn datblygu gofal seibiant hyblyg gyda phartneriaid.<br>• Byddwn yn ceisio cynyddu hyfforddiant ac addysg ynghylch defnyddio'r Ddogfen Penderfyniadau am Ofal er mwyn hybu gofal yn ystod diwrnodau olaf bywyd unigolyn. |
| **Mynediad i wasanaethau a chymorth arbenigol** | • Byddwn yn cynnal ymarfer modelu galw a chapasiti er mwyn egluro angen cleifion a'r gweithlu yng nghyswllt pob darpariaeth o ran gofal lliniarol arbenigol. Bydd hynny'n cynnwys modelu'r galw am welyau gofal lliniarol arbenigol ym maes gofal eilaidd.<br>• Er mwyn sicrhau mynediad teg, gan gynnwys mynediad i'r ysbyty gartref, byddwn yn darparu gofal lliniarol arbenigol i oedolion ar lefel ranbarthol/y Bwrdd Iechyd ac yn ystyried defnyddio dull gweithredu tebyg i ddull y Tîm Lles Dementia rhanbarthol a Thîm Gofal Lliniarol Arbenigol a Gofal Diwedd Oes i Blant Cymru Gyfan, fel bod arbenigwyr yn darparu hyfforddiant, cyngor a chymorth ynghylch rheoli symptomau i staff nad ydynt yn arbenigwyr, e.e. staff cartrefi gofal, therapyddion lleferydd ac iaith, therapyddion, nyrsys ardal a staff gofal cymdeithasol. Mae angen mynd ati'n syth i sicrhau bod gweithwyr proffesiynol, gofalwyr a chleifion yn gallu cael mynediad bob awr o'r dydd a'r nos i gyngor a gwybodaeth.<br>• Bydd gweithredu'r model SWAN/Cygnets a addaswyd yn golygu cynnwys llinell gyngor a chymorth, sydd ar agor bob awr o'r dydd a'r nos, ar gyfer gweithwyr proffesiynol a gofalwyr, a fydd yn rhoi mynediad i gyngor arbenigol a chyffredinol ac i gyngor ynghylch profedigaeth. Mae Tîm Gofal Lliniarol Arbenigol i Blant Cymru Gyfan hefyd ar fin cyflwyno gwasanaeth tebyg ar gyfer y sawl sy'n gweithio gyda phlant ar draws Cymru. |

# Uchelgais 4

## Caiff y gofal ei gydlynu

*Rwy'n cael yr help iawn ar yr adeg iawn gan y bobl iawn. Mae gen i dîm o'm hamgylch sy'n gwybod beth yw fy anghenion a'm cynlluniau ac sy'n cydweithio er mwyn fy helpu i'w diwallu a'u cyflawni. Rwyf bob amser yn gallu cyrraedd rhywun a fydd yn gwrando ac yn ymateb unrhyw awr o'r dydd neu'r nos.*

**Yr hyn yr ydym yn ei wneud a'n cynlluniau yn y maes hwn**

| | |
|---|---|
| **Cofnodion a rennir** | • Byddwn yn cydweithio i greu cynllun gofal a rennir sy'n hygyrch ar draws systemau partneriaid (ym maes iechyd a gofal cymdeithasol ac yn y 3ydd sector) ac y mae'r claf a'r gofalwr yn berchen arno. |
| **Ymateb ar draws system gyfan** | • Byddwn yn gweithio fel partneriaid cyfartal gyda phractisiau meddygon teulu a'r sector gofal sylfaenol, gweithwyr proffesiynol perthynol i iechyd a'r sector gofal eilaidd, er mwyn eu galluogi i ddeall sut y gallant gynnig y cymorth gorau o ran gofal diwedd oes.<br>• Os yw'n briodol, byddwn yn cydweithio â'n partneriaid i fapio cyfleoedd o ran gwasanaethau dydd ar draws y rhanbarth, gan adnabod unrhyw fylchau a chydweithio er mwyn mynd i'r afael â nhw.<br>• Byddwn yn datblygu dull cyson o ddarparu timau amlddisgyblaethol ar draws rhanbarth Hywel Dda, a byddwn yn cynorthwyo timau amlddisgyblaethol ym maes gofal sylfaenol drwy sicrhau cynrychiolaeth o blith fferyllwyr ym maes gofal lliniarol a gofal diwedd oes, er mwyn rhoi cyngor a help i'r timau.<br>• Bydd y tîm gofal lliniarol arbenigol i blant yn parhau'n rhan o dîm amlddisgyblaethol gofal lliniarol arbenigol i blant Cymru gyfan, a bydd yn rhannu arfer gorau. |
| **Rolau a chyfrifoldebau clir** | • Bydd manylion a rôl y tîm gofal lliniarol arbenigol i oedolion yn cael eu hegluro ar ôl mapio gwasanaethau ar sail model Midhurst a datblygu gweithdrefn weithredu safonol ranbarthol wedyn ar gyfer gofal lliniarol arbenigol. Bydd hynny'n cynnwys mapio capasiti a'r angen i wahanol leoliadau ddarparu gofal lliniarol a gofal diwedd oes.<br>• Bydd gofal lliniarol arbenigol i blant yn cael ei wella gan y model SWAN/Cygnets a addaswyd, a bydd gweithdrefn weithredu safonol glir yn cael ei datblygu gan sicrhau llinellau atebolrwydd, trefniadau adrodd, a rhyngweithio â gwasanaeth gofal lliniarol arbenigol i blant Cymru gyfan. |
| **Pawb yn bwysig** | • Bydd datblygu gweithdrefn weithredu safonol ar gyfer plant sy'n pontio i wasanaethau oedolion yn gwella'r gwaith o gydlynu gofal.<br>• Bydd datblygu gweithdrefn weithredu safonol ar gyfer y tîm gofal lliniarol arbenigol i oedolion yn gwella'r gwaith o gydlynu'r sawl sydd â chyflyrau cronig, gan gynnwys y sawl sy'n byw gyda dementia ac anabledd dysgu. |
| **Parhad mewn partneriaeth** | • Byddwn yn gweithio pryd bynnag y bo modd i greu gwasanaeth gofal lliniarol a gofal diwedd oes sy'n gyson ar draws y rhanbarth.<br>• Byddwn yn cydweithio ar draws y system gan adolygu ein prosesau er mwyn sicrhau bod pobl yn cael gwasanaethau cydgysylltiedig. |

# Uchelgais 5

## Mae'r staff i gyd yn barod i ofalu

*Ble bynnag yr ydw i, mae staff iechyd a gofal yn cynnig empathi, sgiliau ac arbenigedd ac yn gofalu amdanaf yn gymwys ac yn hyderus gan ddangos tosturi.*

**Yr hyn yr ydym yn ei wneud a'n cynlluniau yn y maes hwn**

| | |
|---|---|
| **Ethos proffesiynol**<br>**Yn barnu ar sail gwybodaeth**<br>**Ymwybyddiaeth o ddeddfwriaeth** | • Mae'r staff i gyd ym maes iechyd a gofal cymdeithasol ac yn y 3ydd sector yn defnyddio dull holistaidd sy'n canolbwyntio ar yr unigolyn o gynnal asesiadau, cynllunio gofal a chynnal adolygiadau. Bydd anghenion y gofalwr yn cael eu hystyried bob cam o'r ffordd.<br>• Bydd y Bwrdd Iechyd yn ymrwymo i sicrhau bod gwasanaethau gofal lliniarol arbenigol i blant ac oedolion yn cael amser a neilltuir i gyflwyno addysg, a bydd yn gweithio gyda chydweithwyr ym maes gofal sylfaenol a gofal eilaidd er mwyn cynorthwyo i ryddhau staff cyffredinol fel y gallant fynychu hyfforddiant o'r fath.<br>• Bydd y gweithdrefnau gweithredu safonol newydd ar gyfer timau gofal lliniarol arbenigol i oedolion a phlant yn cynnwys yr angen i staff helpu i hyfforddi staff cyffredinol yn y gymuned ac ym maes gofal eilaidd ynghylch rhai o'r agweddau mwy cymhleth ar ofal lliniarol, er mwyn gallu darparu gofal lliniarol a gofal diwedd oes o safon. |
| **Cefnogaeth a gwytnwch** | • Drwy fabwysiadu a gweithredu Fframwaith Hyfforddiant yr Alban ar gyfer Gofal Lliniarol, bydd y staff i gyd yn cael hyfforddiant ffurfiol ynghylch deddfwriaeth ym maes gofal lliniarol a gofal diwedd oes ac ynghylch Deddf Galluedd Meddyliol 2005. Bydd hyfforddiant ffurfiol ynghylch gofal lliniarol a gofal diwedd oes yn cynnwys hyfforddiant ynghylch sgyrsiau anodd, negodi a gwytnwch cyffredinol.<br>• Bydd yn ofynnol i dimau gadw cofnod o hyfforddiant, sy'n nodi'r sawl sydd wedi cael hyfforddiant. |
| **Yn defnyddio technoleg newydd** | • Byddwn yn adeiladu ar yr hyn a nodwyd yn adroddiad cam un ynghylch y defnydd o dechnoleg, e.e. cynnal asesiadau ac ymgyngoriadau rhithwir/o bell, monitro cleifion o bell, ac rydym wrthi'n adolygu'r meysydd lle gallai fod angen rolau mwy arbenigol. Mae angen i'r rheini gael eu datblygu gyda darparwyr lleol, ond gallent gynnwys rolau arbenigol ym maes gofal diwedd oes ar gyfer pobl ag anableddau dysgu. |
| **Llywodraethu gweithredol** | • Yn unol ag argymhellion yr Archwiliad Cenedlaethol o Ofal Diwedd Oes, mae'r Bwrdd Iechyd wedi cymeradwyo recriwtio arweinydd clinigol i weithio'n rhan o dîm o dri er mwyn goruchwylio'r broses o weithredu'r strategaeth newydd, drwy gyllidebau cyfun rhanbarthol.<br>• Dylai'r Bwrdd Iechyd benodi fferyllydd a enwir i gynorthwyo'r gwaith o wella'r modd y caiff meddyginiaethau eu rheoli ar gyfer cleifion sy'n ddifrifol sâl ac sy'n marw, yn unol â Chynllun Cyflawni Llywodraeth Cymru a GIG Cymru ar gyfer Gofal Lliniarol a Gofal Diwedd Oes 2017. |

# Uchelgais 6

**Mae pob cymuned yn barod i helpu**

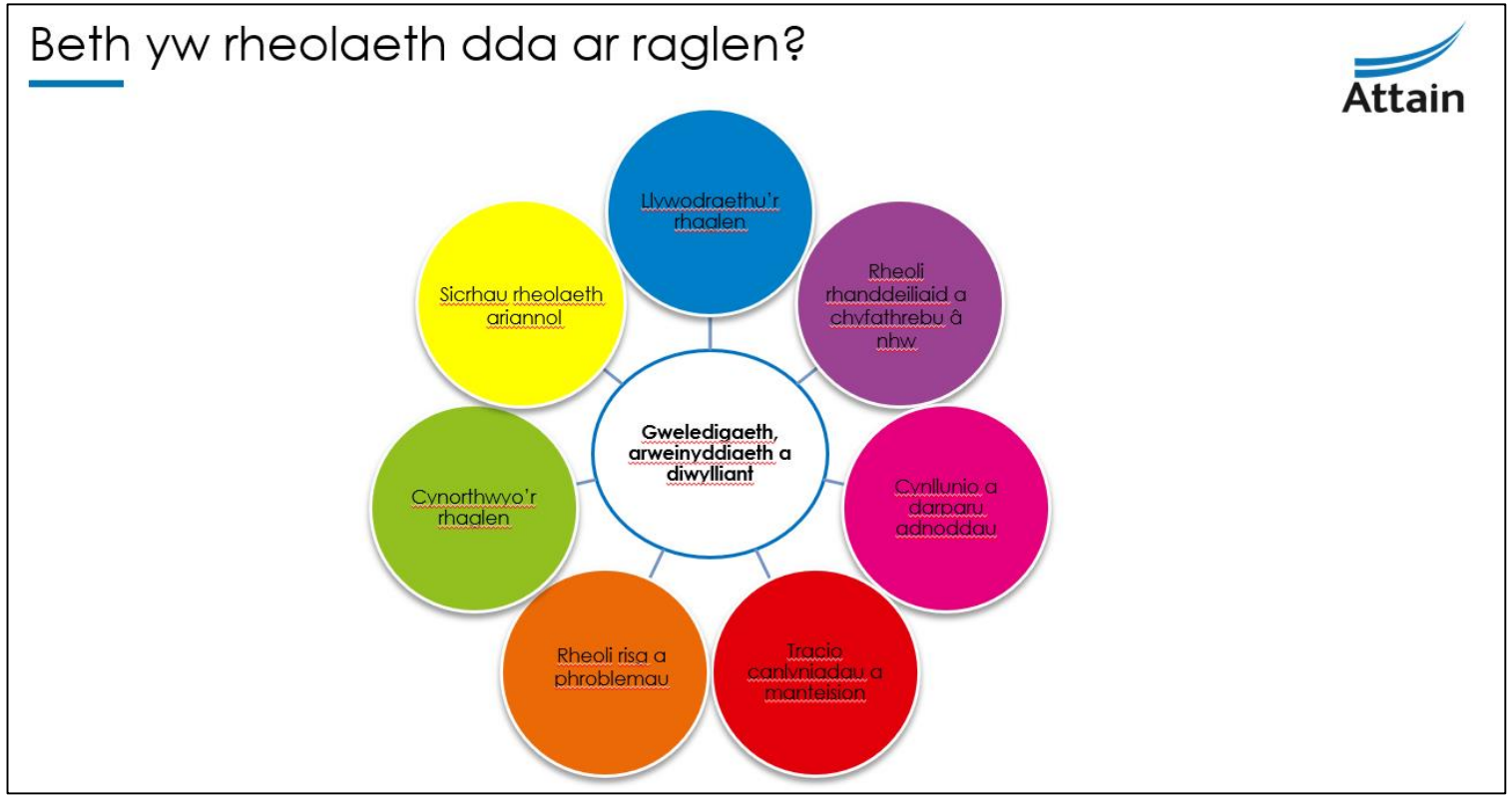
*Mae marwolaeth a marw'n anochel. Rhaid bod gofal lliniarol a gofal diwedd oes yn flaenoriaeth. Bydd ansawdd a hygyrchedd y gofal hwn yn effeithio ar bob un ohonom, a rhaid ei wella'n gyson er mwyn pob un ohonom. Rhaid rhoi sylw i anghenion pobl o bob oed sy'n byw gyda'r ffaith eu bod yn marw ac sy'n byw gyda marwolaeth a phrofedigaeth, a rhaid rhoi sylw i anghenion eu teuluoedd, eu gofalwyr a'u cymunedau gan ystyried eu blaenoriaethau, eu dewisiadau a'u dymuniadau.*

**Yr hyn yr ydym yn ei wneud a'n cynlluniau yn y maes hwn**

| | |
|---|---|
| **Cymunedau caredig a chydnerth Gwirfoddoli** | • Byddwn yn cymryd camau i gefnogi Siarter Cymru Garedig https://compassionate.cymru/cy/ a phrosiect uchelgeisiol Llywodraeth Cymru i sicrhau mai Cymru yw Gwlad Garedig gyntaf y byd. Ar lefel cymdogaeth a stryd, byddwn yn ffurfio timau hyblyg sy'n gwneud yn fawr o ofal meddygol a gofal cymdeithasol ffurfiol drwy adnabod a galluogi cymorth cymunedol mewn ffyrdd sy'n mynd i'r afael yn wirioneddol â'r cwestiwn **'Beth sydd bwysicaf i chi?'**. Bydd hynny'n ei gwneud yn bosibl i'r model SWAN/Cygnets a addaswyd gael ei gyflwyno ar lefel cymdogaeth. |
| **Cymorth ymarferol** | • Byddwn yn cynorthwyo'r fenter cymunedau caredig ac yn archwilio ffyrdd o weithredu Cymru Garedig ar draws Hywel Dda. Byddwn yn cydgysylltu ein gwasanaethau pryd bynnag y bo modd er mwyn gwneud y defnydd gorau o adnoddau a lleihau achosion o ddyblygu ymdrech.<br>• Fel y nodwyd yn ein gweithdai i randdeiliaid, mae angen dechrau sgyrsiau'n gynt am farwolaeth a marw. Byddwn yn archwilio gyda phartneriaid beth y gallwn ei wneud i gynnig y cymorth gorau i athrawon a staff sy'n gweithio ym maes gwasanaethau i blant a phobl ifanc, er mwyn dechrau sgyrsiau â phlant a phobl ifanc. |
| **Ymwybyddiaeth y cyhoedd** | • Byddwn yn codi ymwybyddiaeth y cyhoedd o farwolaeth a marw. Un ffordd o wneud hynny fydd drwy Wythnos Codi Ymwybyddiaeth 'Dying Matters' – sy'n canolbwyntio ar bwysigrwydd bod mewn lle da i farw #InAGoodPlace. https://www.dyingmatters.org/ |

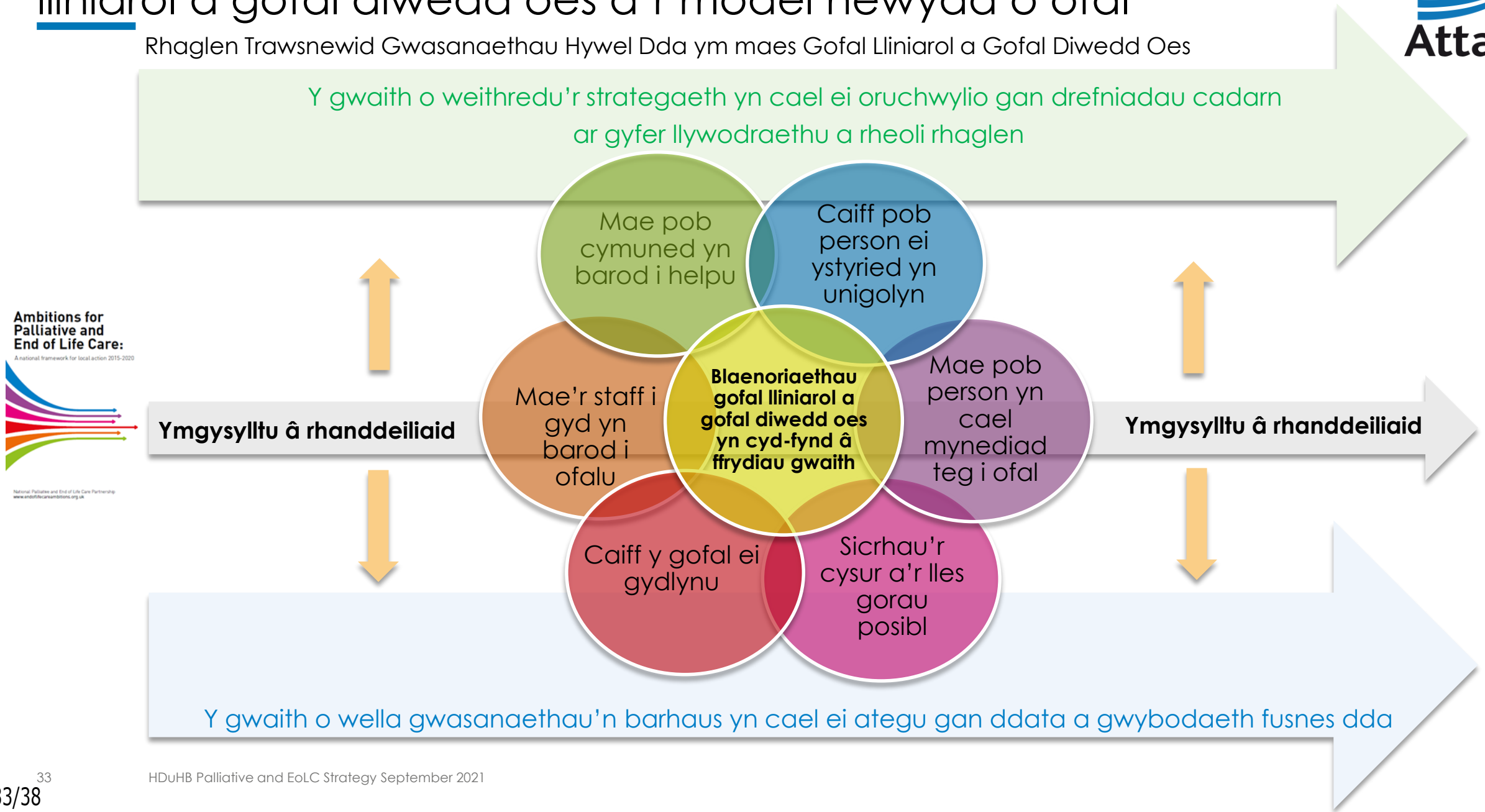
# Gwireddu uchelgeisiau'r strategaeth drwy reoli rhaglen

Gan adeiladu ar ddull rhaglen newydd o ymdrin â gofal lliniarol a gofal diwedd oes, a weithredir gan ddilyn canlyniadau allweddol y Cam Darganfod, bydd cam nesaf y gwaith yng nghyswllt gofal lliniarol a gofal diwedd oes yn digwydd dros gyfnod o 5 mlynedd, drwy drawsnewid gwasanaethau mewn modd integredig a sicrhau gwelliant parhaus, gan ddefnyddio dull sy'n golygu sefydlu ffrydiau gwaith allweddol ac ymgysylltu'n drylwyr â rhanddeiliaid.



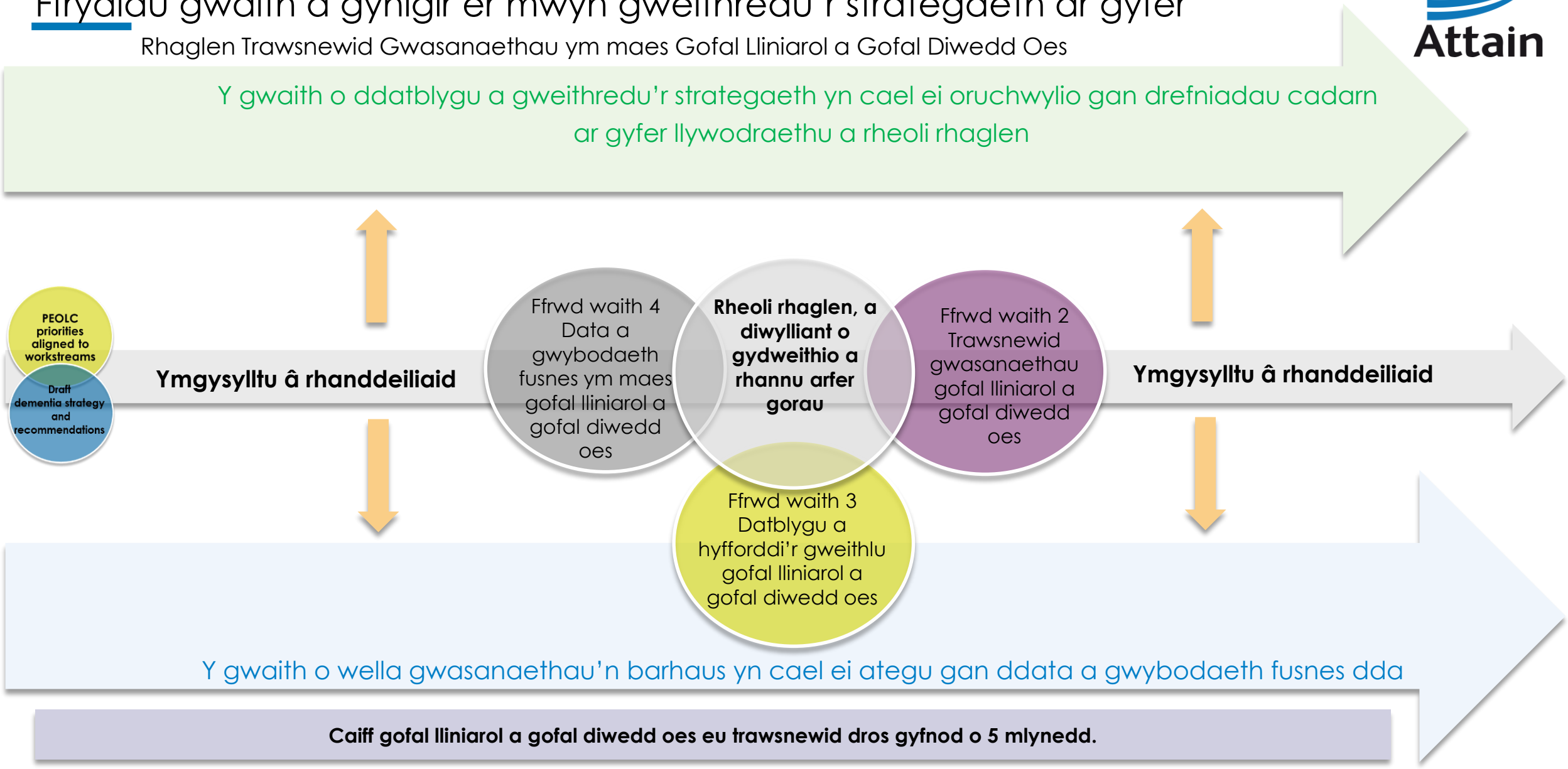
# Dull o weithredu uchelgeisiau'r strategaeth ar gyfer gofal lliniarol a gofal diwedd oes a'r model newydd o ofal

Rhaglen Trawsnewid Gwasanaethau Hywel Dda ym maes Gofal Lliniarol a Gofal Diwedd Oes



# Ffrydiau gwaith a gynigir er mwyn gweithredu'r strategaeth ar gyfer

Rhaglen Trawsnewid Gwasanaethau ym maes Gofal Lliniarol a Gofal Diwedd Oes



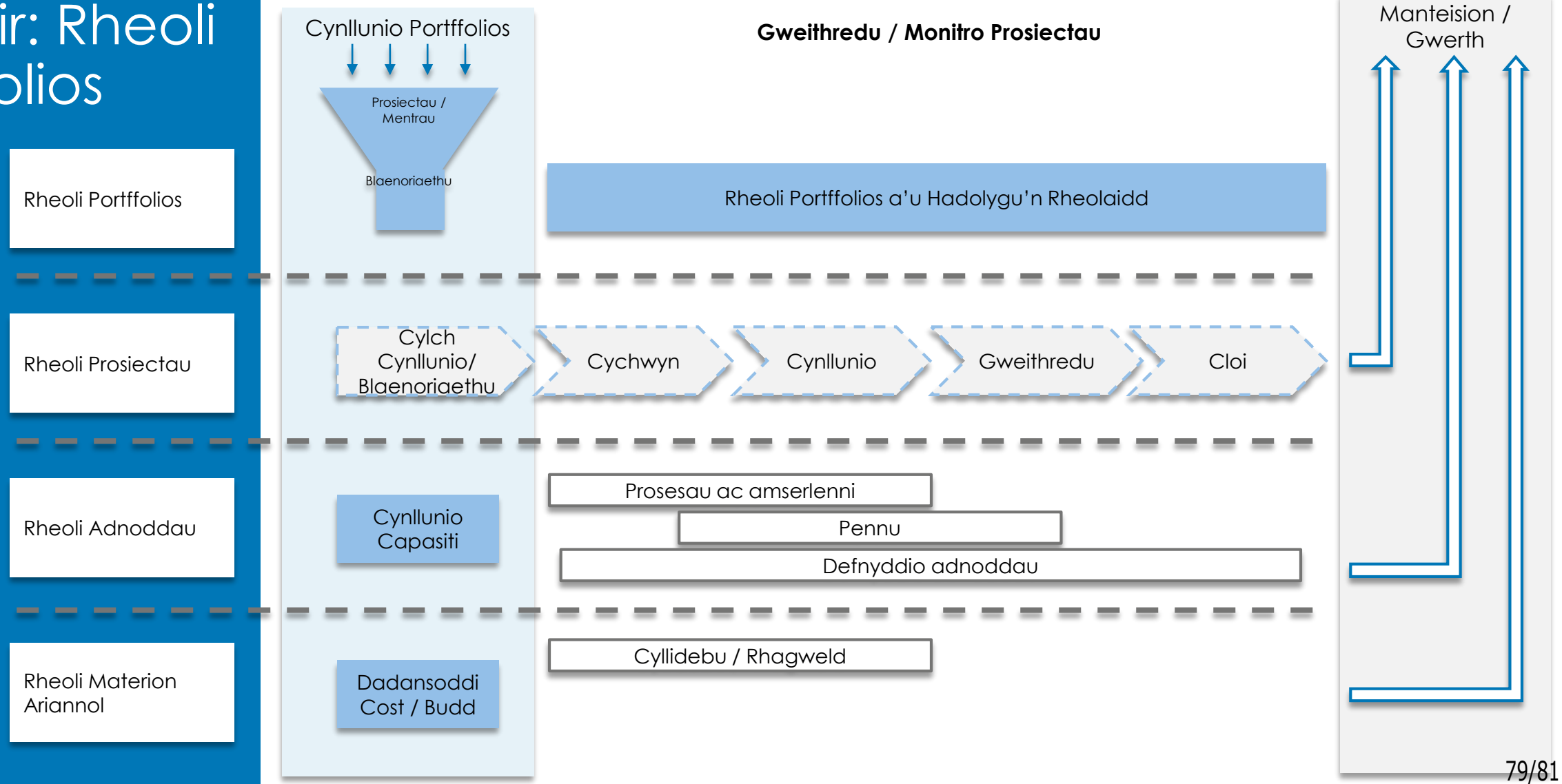

**Caiff gofal lliniarol a gofal diwedd oes eu trawsnewid dros gyfnod o 5 mlynedd.**

# Dull cyflawni a gynigir: Rheoli Portffolios

Mae'r blaenoriaethau ar gyfer gofal lliniarol a gofal diwedd oes yn cyd-fynd â'r Fframwaith Cenedlaethol yn Lloegr 'Ambitions for Palliative and EoLC' ac Archwiliad Cenedlaethol o Ofal Diwedd Oes 2019, ac maent yn adeiladu ar y rhaglen gychwynnol ar gyfer gwelliant parhaus. Bydd unrhyw waith sy'n weddill o'r rhaglen gwelliant parhaus yn cael ei gyfuno â'r ffrwd waith briodol yn y rhaglen waith newydd hon. Bydd y blaenoriaethau ar gyfer gofal lliniarol a gofal diwedd oes yn cael eu goruchwylio gan y tîm o dri yng ngrŵp llywio'r Bwrdd Iechyd ar gyfer gofal lliniarol a gofal diwedd oes, a bydd pob portffolio yn cael ei arwain gan uwch-berchennog cyfrifol o bob rhan o'r system. Fodd bynnag, bydd y rhaglen waith gyfan yn cael ei goruchwylio hefyd gan Bartneriaeth Gofal Gorllewin Cymru. Bydd angen clustnodi adnoddau dros gyfnod y rhaglen er mwyn gallu parhau i ddarparu gwasanaethau tra bydd staff rheng flaen yn gweithio i ddylunio a datblygu'r gwasanaethau.

| | Trawsnewid gofal lliniarol a gofal diwedd oes | Datblygu a hyfforddi'r gweithlu | Data a gwybodaeth fusnes |
|---|---|---|---|
| **Nod** | Gweithredu blaenoriaethau sy'n deillio o'r strategaeth ar gyfer gofal lliniarol a gofal diwedd oes, sy'n ymwneud â sicrhau bod pob person yn cael mynediad teg i ofal. | Gweithredu blaenoriaethau sy'n deillio o'r strategaeth ar gyfer gofal lliniarol a gofal diwedd oes, sy'n ymwneud â sicrhau'r cysur a'r lles gorau posibl. | Gweithredu blaenoriaethau sy'n deillio o'r strategaeth ar gyfer gofal lliniarol a gofal diwedd oes, sy'n ymwneud â sicrhau dull unffurf o gasglu gwybodaeth fusnes a chanlyniadau. |
| **Meysydd â blaenoriaeth** | • Mapio gwasanaethau gofal lliniarol arbenigol a datblygu gwasanaeth gofal lliniarol arbenigol rhanbarthol newydd, sy'n cynnwys gweithdrefn weithredu safonol ar gyfer pontio rhwng gwasanaethau i blant a gwasanaethau i oedolion. Bydd y defnydd o dechnoleg yn cael ei ymgorffori yn y gwasanaeth newydd.<br>• Datblygu model gofal lliniarol a gofal diwedd oes ar gyfer y rhanbarth gydag achos busnes i'w ategu, gan ddefnyddio egwyddorion arfer gorau o'r model SWAN a model Midhurst.<br>• Datblygu gwasanaethau profedigaeth yn unol â fframwaith gwasanaethau profedigaeth Cymru gyfan.<br>• Gweithredu argymhellion y strategaeth ar gyfer gofal lliniarol a gofal diwedd oes ynghylch trawsnewid gwasanaethau. | • Addasu Fframwaith Hyfforddiant yr Alban ar gyfer Gofal Lliniarol a Gofal Diwedd Oes a datblygu cynllun gweithredu.<br>• Datblygu cynllun gweithlu i ategu'r gwaith o drawsnewid gwasanaethau.<br>• Parhau â hyfforddiant ynghylch cynllunio gofal ymlaen llaw.<br>• Gweithredu Cynlluniau Gofal Ymlaen Llaw ac at y Dyfodol Cymru Gyfan pan fyddant yn barod, a datblygu cynllun gofal canolog (ym maes eiddilwch, dementia a gofal lliniarol a gofal diwedd oes).<br>• Gweithredu blaenoriaethau'r strategaeth ar gyfer gofal lliniarol a gofal diwedd oes, sy'n ymwneud â datblygu a hyfforddi'r gweithlu. | • Modelu anghenion y boblogaeth, y gweithlu, a galw a chapasiti ar gyfer gwasanaeth gofal lliniarol arbenigol rhanbarthol newydd gydag achos busnes i'w ategu.<br>• Data'n sbarduno newid – datblygu dangosfwrdd adrodd a datblygu disgrifiad swydd newydd ar gyfer rôl ddadansoddi ym maes a gofal lliniarol a gofal diwedd oes.<br>• Gweithredu blaenoriaethau'r strategaeth ar gyfer gofal lliniarol a gofal diwedd oes, sy'n ymwneud â data a gwybodaeth fusnes. |

# Dull cyflawni a gynigir: Rheoli Portffolios



# Camau nesaf

**Cwblhau'r strategaeth:**

- Ceisio **adborth ynghylch y strategaeth a'r weledigaeth a'r llwybr model ar gyfer y gwasanaeth**
- **Cwblhau'r weledigaeth a'r llwybr model gwasanaeth** a'u rhannu ag eraill fel bod pob partner yn gwybod i ba gyfeiriad y mae gwasanaethau gofal lliniarol a gofal diwedd oes yn mynd yn y gorllewin
- **Diweddaru'r cynllun rhaglen â datblygiadau newydd o ran gwasanaeth** sy'n ofynnol er mwyn rhoi'r weledigaeth a'r llwybr model gwasanaeth ar waith
- **Sicrhau bod trefniadau llywodraethu cadarn ar waith** i oruchwylio'r gwaith o weithredu'r mentrau newydd o ran gwasanaeth, gan sicrhau bod pob menter newydd yn mabwysiadu dull rhaglen o weithredu, gan adrodd yn rheolaidd ynghylch cynnydd wrth y Grŵp Llywio ar gyfer Gofal Lliniarol a Gofal Diwedd Oes

**Gweithredu'r rhaglen:**

- Byddwn **yn datblygu ein rhaglen waith** gan gadw llygad barcud ar Fframwaith Clinigol Cenedlaethol GIG Cymru sydd wrthi'n cael ei ddatblygu; yn y Fframwaith, mae gofal diwedd oes wedi cael statws Rhaglen Genedlaethol a bydd y Safonau Dementia yn cael eu cyflwyno
- **Clustnodi adnoddau i sefydlu a rheoli'r rhaglen waith** ar draws partneriaid
- Byddwn yn adolygu'r rhaglen waith gyfredol ac yn diweddaru'r cynllun rhaglen, **yn blaenoriaethu prosiectau ac yn diwygio amserlenni** er mwyn sicrhau bod cynllun realistig ar waith, y mae modd ei gyflawni. Y broses a ddefnyddir ar gyfer cyflawni fydd y dull rheoli ffrydiau gwaith
- Byddwn yn **nodi uwch-berchnogion cyfrifol ychwanegol ar gyfer ffrydiau gwaith** er mwyn sbarduno gwaith gyda chymorth y Swyddfa Rheoli Prosiectau a darparu perchnogaeth ac atebolrwydd i gyflawni
- Bydd **diweddariadau rheolaidd ynghylch cynnydd** yn dal i gael eu darparu yng nghyfarfodydd misol y Grŵp Llywio ar gyfer Gofal Lliniarol a Gofal Diwedd Oes

**Gweithredu'r strategaeth newydd ar gyfer gofal lliniarol a gofal diwedd oes**

# Cysylltiadau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