NHS Commissioning Board

DH Department of Health

Care in local communities

A new vision and model for district nursing

Qni The Queen's Nursing Institute

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Care in local communities

A new vision and model for district nursing

This document will be of interest to professionals, provider organisations and commissioners. It will be a resource for those designing and providing local community health services including nurse leaders, health and wellbeing boards, Clinical Commissioning Groups and Area Teams and others with an interest in developing integrated care for older people.

The document is produced within the framework of *'Compassion in Practice' National Vision and Strategy for Nurses, Midwives and Care Staff* https://www.wp.dh.gov.uk/commissioningboard/files/2012/10/nursing-vision.pdf. The actions set out will be used nationally as the detailed action plans for implementation of 'Compassion in Practice' are developed by March 2013 and are a 'call to action' for consideration by local professionals in their practice and local organisations in their planning.

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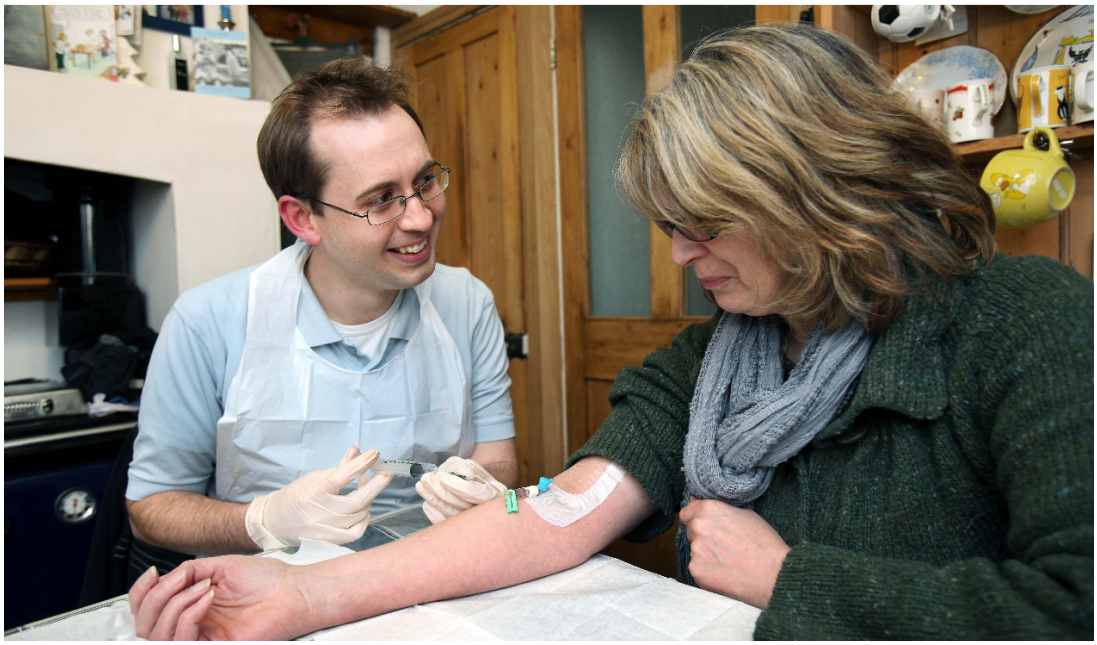

Photo courtesy of Tim George, RCN Publishing

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Foreword

Our population demographics and the health problems we face as a society are changing rapidly. We require innovative approaches to health, care and support systems to meet the needs that arise from these changes. As more people live into older age we need services that support people to remain as well as possible for as long as possible within their own homes and communities. The ambition is to increase the healthy years of life and reduce the social isolation that many older people experience and improve the quality of their lives.

We also need health services that are responsive to people's wishes and choices and to ensure that we provide care that consistently delivers a positive experience as well as the best of patient outcomes. We know that more care will be needed outside of hospitals, in communities and in people's homes, that it will involve sustained relationships to support people to manage their long term conditions - and we know that nurses will be key professionals in planning, providing and managing this care.

We also know from people in our care that they value and trust nurses. We know that this confidence in nursing is founded on the enduring values and behaviours which demonstrate excellence in nursing. District nursing is a part of the profession with a long history of providing high quality, complex care in community settings, including the care of some of our most vulnerable citizens and often in extremely challenging environments.

This document has been produced by a strategic partnership of The Queen's Nursing Institute (QNI), Department of Health and NHS Commissioning Board, working with professionals from district nursing services, higher education, wider community nursing and social care.

This document sets out a vision and model for district nursing to meet future health needs which are based on those enduring values, as documented within 'Compassion in practice: A vision for nurses midwives and care staff', the national vision and strategy in England. We have responded to what we heard from district nurses about the need to raise the profile of their community specialist practitioner role and to promote district nursing as a dynamic career pathway for nurses who wish to make a tangible and positive impact on the quality of the patients' and carers' lives in the communities they serve.

We know that district nursing services can make a real difference to the patient's experience of health and wellbeing. We know that service users and partner agencies also need clarity about the community nursing services available. We heard from managers and commissioners of services that a clear service model linked to good health outcomes was critical to inform the future of district nursing service and education commissioning.

This document will be of interest to local commissioners including Clinical Commissioning Groups, other local commissioners, and health and wellbeing boards, in developing coordinated care for older people, provider organisations, nurse leaders, nurses and care staff.

The document sets out to provide a clear vision and model, which can be used locally to support the provision of the district nursing services that patients and carers require. It will raise the profile of the critical work that district nurses deliver within their communities and assist in planning nursing services to meet the changing needs of our society.

I am delighted to provide the foreword on behalf of Viv Bennett, Director of Nursing, Department of Health & Acting Lead Nurse, Public Health England and Jane Cummings, Chief Nursing Officer. I would like to thank everyone who has shared their expertise so generously in the preparation of this document. My thanks also to Wendy Nicholson, Professional Officer - Nursing, for chairing the advisory group so proficiently in the production of such a timely and valuable document for district nursing.

Crystal Oldman
Chief Executive
The Queen's Nursing Institute

Introduction

The need for high quality care delivered in local communities including in people's homes is self-evident. Indeed much recent health policy points to the importance of improving and extending services to meet the health and care needs of an increasingly older population and provide services which may have previously been provided in hospital within community settings. Health services need to be responsive to people's wishes and choices and to ensure that care delivers positive experience as well as best outcomes. More care will increasingly be out of hospital, in communities and people's homes and will involve long-term relationships to support people to manage long-term conditions and co-morbidity and we know that district nurses will be key professionals in planning and providing this care**.**

The Community Nurse Development Programme sets out the range of services within local communities and thus the importance of strong relationships and, where appropriate, integration of services to provide joined up care to local people. This has been developed as a visual representation which can be found at:
https://www.wp.dh.gov.uk/vivbennett/files/2012/10/Draft-model-of-Community-Nursing-for-Improved-Health-and-Wellbeing.pdf

This programme also encompasses 'Support for Carers' and 'Maximising the Nursing Contribution to the Dementia Challenge,' which will be launched next year.

This document sets out how district nursing services can do this most effectively.

District nurses are qualified nurses who have undertaken a further graduate specialist practitioner programme. They lead and support a team to deliver care in a variety of community settings. The nature of districting nursing has changed to meet the needs of patients in the community. Complex care once only delivered in acute settings is now being provided by district nursing teams in collaboration with key partners. The case studies in annexe 1 demonstrate the diverse and dynamic nature of district nursing services.

Integration of services is needed to provide joined-up care for patients at best value. The Department of Health's Transforming Community services[1] programme created opportunities for great alignment between services. The learning from the programme indicated that integrated care can improve quality outcomes whilst improving efficiency through better use of resources. The Care and Support White Paper restated the Department's commitment to a clear, ambitious and measurable goal to drive further improvements in people's experience of integrated care. Research work, aimed at advancing a methodology for capturing people's experience of integrated care, is currently underway and, once

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126111.pdf

available, this will inform the development of suitable outcome measures for the NHS and Adult Social Care Outcomes Frameworks.

District nursing services are increasingly required to find new way of working within teams and with other professionals and agencies to support complex care and manage workloads more efficiently.

The use of technology to support patient care and enhance mobile working is being embraced by district nurses[2]. The recent government announcement[3] of resources to develop new ways of utilising technology within nursing, will provide new opportunities and enhance service delivery, building on the lessons learnt from the community mobile technology pilots[4].

In this document as we set out a model for district nursing to meet future health needs, set within a framework of 'Compassion in Practice: A vision for nurses midwives and care staff'[5] the national vision and strategy in England. The values or 6Cs of care, compassion, competence, communication, courage and commitment are at the heart of district nursing service delivery. The priority actions from 'Compassion in Practice' provide a basis for the 'call to action' and offer direction in determining the next steps to ensure implementation of this district nursing vision.

2 http://www.qni.org.uk/docs/smart_new_world_final_web.pdf

3 http://mediacentre.dh.gov.uk/2012/10/08/next-generation-nursing-and-midwifery-to-free-up-more-time-for-patients/

4 National Mobile Health Work Project Final Report , Department of Health 2012 (Gateway 18096)

5 https://www.wp.dh.gov.uk/commissioningboard/files/2012/10/nursing-vision.pdf

Community and District Nursing Development Programme

Purpose

The purpose of the programme is to provide focus on leadership and support to maximise the role of district nurses and their teams to develop the services that deliver the best possible care and outcomes for our patients.

By district nurses, we mean:

- Qualified nurses with a graduate level education and specialist practitioner qualification recordable with the Nursing and Midwifery Council.

By district nursing teams, we mean:

- A team led by a district nurse supported by registered nurses, health care assistants and support staff.

By district nursing services, we mean:

- Care provided in a variety of community settings by district nursing teams. This care includes a wide range of care, for example, supporting patients with long-term conditions in their own homes and providing complex and palliative care. Comprehensive high quality district nursing services have the potential to reduce use of hospital sector and residential social care.

The task of strategic partners (Department of Health, NHS Commissioning Board, The Queen's Nursing Institute) district nurses, community nurses, partner organisations and other professionals was to design a vision and model for district nursing to:

- Clarify the scope and impact of the role for commissioners;
- Give provider organisations a clear framework in which to describe and develop district nursing;
- Support commissioners, providers and professionals to have informed clinically led discussion regarding both current district nursing services and how these need to develop to meet emerging national and local health needs in ways that are right for local people;
- Support professionals through raising profile of the role, making best practice available, promoting district nursing careers and identifying ways in which the service and practitioners can develop.

This will inform new types of care are that are needed, which will:

- Focus on enabling the move from acute to community settings;
- Enhance partnership between district nursing, health, social care, voluntary sector partners and patients to support care in people's homes (including care homes) and in other community settings;
- Promote and support self-care and the role of the district nurse as enabler;
- Tackle social isolation and mental as well as physical health needs especially in frail older people;
- Promote the district nurse as a leader and case-manager for complex care when it is needed and provide skilled care in acute episodes, long-term conditions and at the end of life.

Developing the vision and service model

The Community Nursing Development Programme is a contribution to the Government's intention to enable patient-centred care through delivery closer to home. The Department of Health and NHS Commissioning Board, with our strategic partners, The Queen's Nursing Institute, have developed the programme with professional organisations, district nurses and their key partners. The developmental approach and progress to date can be found in annexe 2.

The new model for district nursing sets out to strengthen the service and provide evidence and good practice to support targeting resources effectively to meet local needs, to enhance delivery closer to home and improve health outcomes. The model captures the importance of technology to promote more effective mobile working and support care delivery and the need for joined up care across professions and agencies.

The District Nursing Service Model

The model shows 'Compassion in Practice' applied to district nursing and aims to promote innovation and disseminate the good practice that exists in many services across the country, to reduce variation and ensure patients and their families everywhere receive high quality services, which improve health and reduce health inequalities. It is based on extensive work with all our stakeholders.

It is a service model, which:

- Clarifies the district nurse contribution to care whilst promoting enhanced integration between health and social care, using the views of professionals and key partners, whilst building on the best evidence of what works;

- Sets out the programme and its relationship to quality and outcomes including: the NHS Outcomes Framework, Public Health Outcomes Framework and the Adult Social Care Outcomes Framework;

- Consists of three core elements: Population and Case load management; Support and care for patients who are unwell, recovering at home; at the end of people's lives; and Support and care for independence.

Figure 1 shows the service model.

An integrated visual[6] has been developed which outlines how district nursing services interfaces between services and the need to ensure the patient and family in often complex local service arrangements.

We are also developing:

- New professional pathways focussing on supporting carers;

- Fact sheets to promote the programme to key audiences;

- Approaches for robust service user feedback to ensure quality;

- Approaches to promote technology in community care;

- Case studies to improve quality and reduce variation/inequalities.

The integrated model aims to help professionals, commissioners and stakeholders to understand the scope and potential of the district nursing service. It builds on a wide range of recommended programmes and initiatives for local areas to consider including the Carers Strategy[7] and End of Life Strategy[8].

For district nurses this means leading and co-ordinating the team to provide a service that encompasses the three core elements:

- Population and case load management;

- Support and care for patients who are unwell, recovering at home and at the end of life;

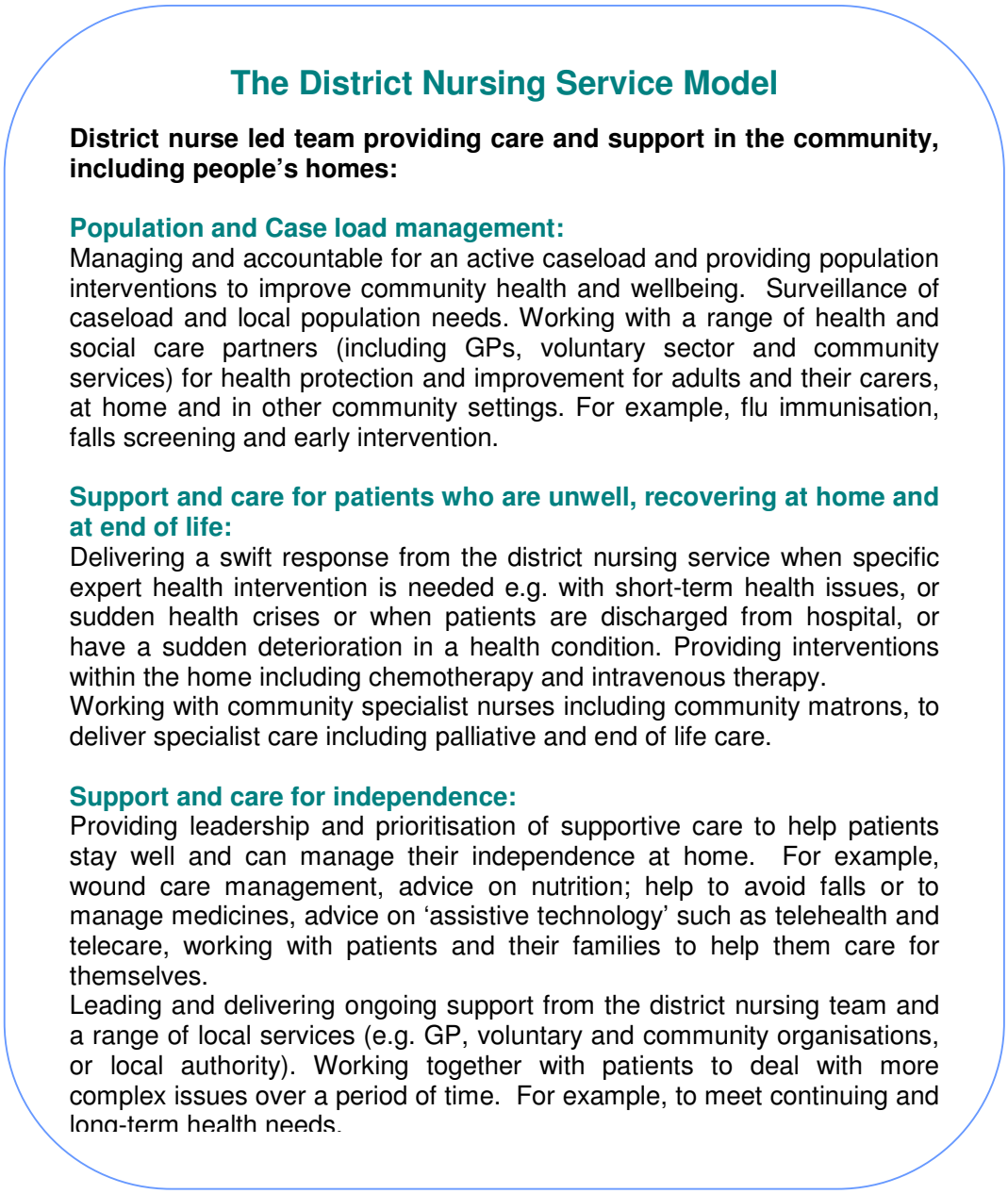
- Support and care for independence.

[6] https://www.wp.dh.gov.uk/vivbennett/files/2012/10/Draft-model-of-Community-Nursing-for-Improved-Health-and-Wellbeing.pdf

[7] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085338.pdf

[8] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf

Figure 1: The District Nursing Service Model



District nurses value the uniqueness of individual patients and understand the complexity of care within home or community settings. The dynamic nature of care in the community calls upon the district nursing service to build on their strong foundations, which include:

- **Strong values and behaviours** - the 6Cs underpinning the service and delivery;
- **Trust** - which starts with therapeutic relationships between patients and carers;
- **Partnerships across GP and other services** - collaborative working across agencies to support care;

- **Supporting transition of care** - working with partners to provide seamless support including discharge planning, transition to residential or hospice care;
- **Supporting patient choice** - working with patients and carers to encourage active participation in care and decision making;
- **Managing risk -** reducing social isolation through supportive care co-ordination**,** supporting the needs of carers and safeguarding vulnerable patients.

The service model builds on the strong foundations and, coupled with innovation, this provides opportunities to develop new ways of working which include:

- **Making every contact count -** providing opportunistic public health interventions and supporting the health and wellbeing of carers;
- **Maximising efficiency -** use of productive community services and innovation to enhance care;
- **Integrated working with health and social care -** developing strengthened ways of working with partners to maximise resources;
- **Delivering complex care** - supporting care in community settings eg administering chemotherapy at home, reducing avoidable hospital admissions and promotion of early discharge;
- **New technology to enhance care** – the use of tele-health and mobile technology to support complex care in the home.

'Healthcare in the community is the most essential place for new technologies. Technology can give patients a new sense of control and involvement in their care, and give nurses new ways to deploy their expertise'.

QNI Smart New World Report 2012

Measuring impact and enhancing the patient experience

Outcomes

Measuring outcomes and improving impact is an essential part of service delivery. This model sets out the contribution made by district nursing service to the NHS and Public Health Frameworks and Adult Social Care Outcome Framework.

Figure 2 illustrates where district nursing services will have a specific contribution.

Figure 2

Measuring Impact: Outcomes and indicators:
District nurses contributing to population health needs:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

(Public Health Outcome Framework)

District Nurses leading care and contributing to healthy communities:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

(NHS Outcome Framework)

District nurses working in partnership with social care to;

- Enhance quality of life of people with care and support needs
- Delay and reduce the need for care and support
- Ensure people have a positive experience of care
- Safeguard adults whose circumstances make them vulnerable and protect from avoidable harm

(Adult Social Care Outcome Framework)

The reach of district nursing services into local communities means they have the potential for positive impact across all domains. Local service leaders will identify local needs and agree local priorities for improving outcomes through Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) both of which will inform the NHS Commissioning Board, Clinical Commissioning Groups and local authority commissioning plans. District nursing service specifications will include outcome measures to reflect local priorities.

Patient experience

All health services are being encouraged to become more patient focussed. Enhancing the patient experience is fundamental to the model and we want to ensure district nursing teams work with patients to ensure services are fit for purpose and do deliver high quality care in the way local people want.

Figure 3 outlines the core measures that are fundamental to enhancing the patient and carer experience. The district nursing service success can be measured against these locally to determine quality from a patient perspective.

Figure 3

Patients empowered and in control of their care

Enhancing the patient experience – promoting a positive patient and carer experience

- **Making a difference** – recognising what is important to the patient and carer including support and anticipation of needs;
- **Family/home centred** - Adapting to the care setting and respecting patients' homes;
- **Respect -** diversity and disability**;**
- **Dignity** – supporting independence and individuality;
- **Advocacy** - supporting decision making with patients;
- **Continuity** – flexibility and responsiveness; seamless services;
- **Co-ordination** – the key to multi-agency care;
- **Harm free care** - recognising and pro-actively managing risk and safeguarding patients.

Implementation

National action

The NHS Commissioning Board will be the lead agency for this phase. National actions for the Programme Board to support the implementation are shown below. National bodies in the new health and care system, including Health Education England and Public Health England, have agreed lead action to implement 'Compassion in Practice' and will be producing plans by March 2013. Where relevant the actions below will be taken forward through these planning processes. The areas for action for 'Compassion in Practice' are:

1. Maximising health and wellbeing. Helping people to stay independent;
2. Working with people to provide a positive experience;
3. Delivering care and measuring impact;
4. Building and strengthening leadership;
5. Ensuring we have the right staff, with the right skills in the right place;
6. Supporting positive staff experience.

Actions for the Partnership Board at national level

The 'strategic partners' - Department of Health, NHSCB, and the QNI, will continue to work together through the programme board and with professionals and professional bodies, partners' agencies and patient and user representatives on the programme in 2013.

This will include:

Support for implementation

- Working with Area Team nurses to support commissioners of the district nursing service to ensure the 'model' is delivered to meet local needs and there is evidence to support delivery of NHS outcomes and return on investment;
- Promoting a system that embraces real time feedback and has responsive culture so that a variety of feedback methods are used by commissioners, providers and their staff;
- Promoting the opportunities and value of information technology and improved information in implementing the new service model;
- Working with Health Education England and Centre for Workforce Intelligence to support local areas in evidence based workforce planning for district nursing teams and encouraging use of appropriate skill mix using national data and dissemination of good practice;

- Designing and producing a suite of professional pathways clearly commissioned to support the delivery of the district nursing services model. These will include:
    - health and wellbeing needs of carers;
    - supporting people with dementia;
- Design and delivery of fact sheets in partnership with service users.

Professional mobilisation and communication

- Developing and delivering the communications and engagement strategy and plan;
- Exploring leadership development opportunities to support district nursing leaders to manage and support existing district nursing teams;
- Promoting learning, development and dissemination of good practice to establish and support a network with cross cutting membership to reflect the range of community services.

The 'call to action' for local development and implementation

Developing district nursing services for improved patient care requires action to be taken locally. This section calls to action local organisations and practitioners to make a difference and sets out suggestions for local consideration. These are suggestions based on evidence and expert professional advice to support local approaches as part of ensuring that 'Compassion in Practice' is implemented in all care settings.

Actions are thus set out as the 'Compassion in Practice' six action areas:

1. Maximising health and wellbeing. Helping people to stay independent.

Commissioners

- Supporting health and wellbeing boards to understand and commit to meeting the needs of older people;
- Ensure patients, public and providers are engaged in developing local service specifications and evaluation of services;
- Developing robust JSNAs and JHWSs which identify local needs and agree priorities to address to improve health and wellbeing outcomes for the local community;
- Developing service specifications to include all three elements of the service model set out for district nursing services, where patients are offered a full range of services which are tailored to their needs;
- Utilising the national model contract for community services, complemented by local schedules where appropriate.

Provider organisations

- Supporting new and innovative ways of working to enhance delivery through multi-disciplinary working;
- Reviewing and strengthening local joint working arrangements for health and social care services to deliver care closer to home, providing the best support to patients and their carers, helping them find the right support at the right time.

District nurse leaders, practitioners and teams

- Leading, delivering, and evaluating care nearer home;
- Prioritising care and case management according to need and complexity of care;
- Utilising decision making skills and providing expertise to support care and respond to patient needs in their own home;
- Leading and co-ordinating an holistic assessment and whole system approach through key working;
- Providing care in any community environment and supporting a smooth transition from primary to secondary care or residential care;
- Local health and wellbeing boards will bring together local authority and NHS Leaders with other local partners. They will have an important role to ensure that all local health and care services, including district nursing, are designed to best meet the local needs identified in the Joint Strategic Needs Assessment (JSNA) and to meet joint local priorities agreed in JHWSs;
- Developing with their team sustainable partnerships with those involved in commissioning and providing care, this should ensure that there is joined up care for individuals, joined up planning for services, systems to reduce health inequality and delivery of good health outcomes;
- Collecting and utilising robust population data and qualitative evidence to inform JSNAs and JHWSs.

2. Working with people to provide a positive experience

Commissioners and provider services

- Developing with delivery partners and patients a robust system to capture qualitative service user feedback. This should capture improved experience of services;
- Systematic and regularisation of user feedback to be key component of local quality strategy using transparency and triangulation with other Key Performance Indicators.

District nurse leaders, practitioners and teams

- Developing the local service offer for district nursing based on local needs, working with general practice, social care and other local partners;
- Developing a service which meets local needs and reflects the family and friend test;
- Identifying the need for early help and managing crisis intervention or long term or continuing care;
- Measuring impact of service delivery through patient feedback and publishing results;
- Minimising social isolation by utilising care support networks.

3. Delivering care and measuring impact

Commissioners and provider organisations

- Utilising the NHS outcomes framework, Adult Social Care Outcomes Framework and Public Health Outcomes Framework to develop local quality indicators to measure quality and impact of local service delivery;
- Agreeing with service providers a process to implement the new service, and where this cannot be achieved within one commissioning year, to consider, along with providers, a staged implementation of the new service, evidenced by a delivery plan towards full implementation;
- Facilitating and maximising provider contribution, including for example representation on bodies set up to determine the best use of resources. Their input into the JSNA and JHWS process will be will be important to ensure that health and wellbeing boards have a fully detailed understanding of local needs, and can take action to meet those needs.

District nurse leaders, practitioners and teams

- Enhancing work with partners, especially social care and acute services, where patients have ongoing needs requiring multi-agency and complex support;
- Using their expertise and business acumen to influence and direct commissioning plans;
- Using an evidence base to report outcomes;
- Identifying and measuring harm as a way of quality improvement;
- Benchmarking to measure effectiveness of care;
- Identifying and responding to vulnerable adults including those at risk of social isolation to protect them from avoidable harm;
- Ensuring effective communication between primary and secondary care to improve discharge planning.

4. Building and strengthening leadership

Provider organisations

- Acting as a champion for the district nursing service and community services;
- Securing opportunities for district nursing to develop leadership capacity through training and development opportunities;
- Enabling district nurses to contribute to clinically led commissioning shaping services and providing local intelligence.

District nurse leaders, practitioners and teams

- Acting as a professional role model for all nurses working in a community setting;
- Providing leadership, education and support to the team;
- Empowering the team through supervision;
- Using technology to support care in the home;
- Leading and supporting complex care at home using technological supportive tools such as tele-health and tele-care;
- Supporting the independent sector and care homes to set standards and develop skills;
- Identifying and managing safeguarding incidents;
- Engaging with local commissioners via local clinical networks or assemblies.

5. Ensuring we have the right staff, with the right skills in the right place

Commissioners, provider organisations and educationalists

Health Education England (HEE) will be leading a range of work on this action area of 'Compassion in Practice' nationally. HEE and its Local Education and Training Boards (LETBs) will support workforce development planning and education locally. For district nursing the following have been identified as requiring specific attention:

- Working with higher education institutions to ensure the curriculum will equip district nurses with the skills and knowledge to enable them to deliver the new service offer;
- Promoting professional development training, including specific training in new technology approaches to support care;
- Supporting high quality professional practice, including the model of practice for effective district nursing and clinical supervision and providing development to ensure that this can be embedded through the leadership role of the district nurse;

- supporting local areas to develop joint training between district nurses, other community nursing services, primary care and social care;
- securing sufficient training commissions to deliver the service offer.

Locally service and education commissioners, provider organisations and professionals will need to develop service and workforce plans to ensure high quality district nurses and teams for current and future services.

6. Supporting positive staff experience

Provider services

- Growing and supporting the workforce through appropriate mentorship and preceptorship;
- Identifying and supporting continuing professional development, which reflects the skill mix within local team;
- Listening to, and acting on, staff feedback.

District nurses leaders and practitioners

- Creating opportunities and supporting teams;
- Ensuring pro-active and structured development for teams;
- Developing nurse leaders of the future by providing excellent practice placements.

Conclusions and Next Steps

'Care in local communities: vision and model for district nursing' is an early product of 'Compassion in Practice' National Vision and Strategy for Nurses, Midwives and Care Staff. It shows how 'Compassion in Practice's' six values and six actions areas apply within district nursing services. It sets out actions which the Partnership Board and national bodies in the new system will take and a 'call to action' for local organisations and practitioners. The local implementation will, of course, vary according to primary and community care service in local areas. But the underpinning values and overarching ambition for high quality and best outcomes are constant.

The focus of this work was to provide clarity regarding the role and responsibilities of district nurses to ensure wider stakeholders understand and appreciate the scope and complexity of the service and to support local developments. In this way the full potential of community nursing services including supporting independence, health and social care outcomes and best value across local health and social care economies can be realised.

District nursing services have robust foundations and a desire to provide high quality services to patients closer to home. There are currently a number of national levers to support implementation of the service offer including:

- Priority to progress towards better integration between health and social care;

- A new focus on community based care;

- Emphasis on technology provides an opportunity to explore new ways of working, which will enhance and extend care that can be delivered at home (including with Tele-health support) and support mobile working enabling real time clinical information and reducing bureaucracy and increasing time to care and efficiency.

Next steps for this programme are thus:

- Work led by the Programme Board to ensure continued focus on district nursing;

- Work by national bodies to implement 'Compassion in Practice';

- A local 'call to action' based on evidence and expert professional advice as part of ensuring that 'Compassion in Practice' is implemented in all care settings and to develop district nursing services to meet the current and future health needs of local people delivering good experiences of care and best possible outcomes.

This programme of work will now be led by NHS Commissioning Board with support from national bodies. The NHS Commissioning Board will develop work streams within the new vision and strategy for nurses, midwives and care staff that will make explicit the contribution district nurses will make to the NHS, Public Health Outcomes Framework and where relevant the Adult Social Care Outcomes Framework.

The professional roles of Directors of Nursing at national, regional and local level will be clearly articulated in relation to the professional support and commissioning requirements of district nursing. In addition, the NHS Commissioning Board will consider how best to support the role of the Clinical Commissioning Group governing body nurse and other clinical colleagues within Clinical Commissioning Groups and Area Teams. NHS Commissioning Board performance frameworks will incorporate the district nurse impact on NHS and Public Health Outcomes at national, regional and local level.

'Working together nationally and locally, we can deliver the vision for improved services closer to home to; maximise health and wellbeing outcomes thus supporting independence and reducing social isolation.''

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Annexe 1

The following case studies demonstrate the diverse and challenging role of the district nursing service.

Supporting people to die in the place of their choice

Providing meaningful end of life care is invaluable to individuals and their families. The majority of individuals with terminal illnesses voice a preference not to die in hospital, yet most people do. If care is planned in an individualised and coordinated way, more people can be supported to die in the place of their choice.

In Cambridge, a team of district nurses and general practitioners constructively questioned and changed how they worked to better support people in achieving their end of life care wishes. By working in more integrated ways with multi-disciplinary colleagues including working as an integrated health and social care team, they reshaped the care and support provided. Changes in practice included:

- Establishing regular Gold Standard Framework meetings at 8 weekly intervals
- Opening up the GSF patient list to include anyone believed to be in the last year of life with any underlying disease
- Proactively discussing preferred priorities for care with patients and their families
- The district nurses writing in the same electronic notes with the general practitioners
- Routinely providing and updating out of hours services with patient information

Subsequent audit of the 57 patients who died (Nov 2009 to Aug 2011) and had received community nursing showed that 91% were able to die in the place of their choice. Of these 67% were able to stay in their own home (including residential and nursing care) compared to the national average of 35%. The value of integrated primary care working and personalised care is also demonstrated in that only 12% of those patients audited died in hospital compared to the national average of 58%.

Technology to enhance care

Doncaster use Tele-health for patients with long term conditions in order that they can self manage exacerbations. In addition, heart failure and COPD patients are using Tele-health as part of a hospital at home scheme. Use of a wide range of tele-care products that enable clinicians to monitor if patients fall, leave the house, or to manage their medications in a safe and timely way. We are currently exploring Skype as a way of contacting patients and seeing them at the same time. Patients can also order medications online and book appointments with GPs.

Supporting isolated patients

Alice is 60; she has heart failure, poorly controlled type 2 diabetes and extensive pressure ulcers and leg ulcers. She has attended accident and emergency department 4 times in the last month and each time had taken her own discharge before getting treatment. Alice lives with her son who works long hours and she has daughter with a young family who lives nearby, both have been struggling to cope with their mother's deteriorating condition. Alice is not known to any other services and is isolated and vulnerable.

The district nursing team had received a referral from the hospital requesting a home visit to conduct a full health needs assessment and redress wounds. The initial assessment identified many issues including:

- Decompensated heart failure and history of a cerebral vascular accident;
- Short term memory loss and agitation;
- Non concordance with medication;
- Poor mobility and poor diet;
- Abscess on abdomen secondary to injecting in same site repeatedly.

Following assessment, Alice agreed to a home visit from the GP for antibiotics for abscess to abdomen and for a review of current medication, she declined all other support or referrals, but did agree to the district nursing service visiting to provide wound care.

The district nursing team took over the diabetes management, working with Alice to encourage her to be in control of her diabetes. Alice was referred to the heart failure nurse and medicines management team who, with the District Nurse, streamlined and reduced medication to once a day; this meant that the district nursing service could support Alice with her medication when they visited each morning.

There were further concerns about Alice's short-term memory loss and whether she was displaying early signs of vascular dementia. The joint assessment by mental health nurse and the district nurse revealed Alice had minimal short-term memory loss and had full capacity to make decisions and that her general poor physical health was affecting her mental health.

District nurses discussed this patient on a monthly basis at GP meetings to ensure continuity of care and to prevent hospital readmission. Since the initial assessment by the district nursing service, Alice has not attended A&E and has not required hospitalisation. Her pressure ulcers have healed, her heart failure and diabetes are well controlled, she is fully mobile, is even going shopping independently, and visiting friends and family, and there appears to be no evidence of short-term memory loss. The district nurses have reduced their visits and Alice now attends the GP surgery for regular reviews. Alice advised the district nurse supporting and coordinating her care, "You saved my life!"

Integrated working with social care:

The district nursing team conducted an initial assessment for Dorothy, a 75-year-old patient with vascular dementia, after referral from her GP to review a potential pressure ulcer. Dorothy was recently diagnosed with dementia, her condition was deteriorating rapidly. A few months earlier she had been mobilising with minimal assistance and was able to dress with little prompting, she was eating and drinking well.

This was understandably having a profound effect on her family, predominantly her husband who was her main carer, he was struggling to come to terms with the change in his wife's condition, and clearly struggling to care for her needs.

During assessment it was identified that Dorothy was now only able to stand with the assistance of two people, she had poor standing balance and poor co–ordination. She was at risk from malnutrition as she had lost between 5% and 10% of her body weight and stated that she had no appetite. The family were fortifying her diet, but admitted they were concerned about the weight loss.

There was a current care package provided by social services which was now insufficient. Dorothy was at risk from falls, further pressure damage and other associated complications of reduced mobility and malnutrition.

In order to effectively plan care, it was important to establish how much Dorothy understands about her condition and what was important to her. Using simple clear concise language the nurses conducted a mental capacity assessment and concluded that Dorothy was unable to make informed decisions about her care. However, she was very clear that she wanted to stay at home and not go into hospital. After discussion with her husband, it was agreed that the district nurses facilitate an increase in the care package, along with referrals to other agencies to support both Dorothy and her husband.

The district nursing team worked with the Emergency Response Team and social care to provide intensive support and to increase the care package, which included input from the dietician and occupational therapy. Dorothy was able to stay at home with the necessary support to meet her changing health needs. Her care package is now in place and Dorothy is attending a day centre once a week.

Complex care at home

John is a 60-year-old living alone with pulmonary hypertension in the terminal stages of illness. He uses oxygen as needed, has restricted mobility and struggles getting in and out of bed and on and off his chair. The district nursing team have co-ordinated 24-hour care, high flow oxygen via piggybacked oxygen concentrators. Carers have been taught how to move John with minimal exertion for them and him. The district nursing team administer medications intravenously at home, including ibandronic acid, which is usually given in a hospital or clinic setting. John, due to his height required a special bed extension, the district nursing services co-ordinated this and arranged an assessment with fire services due to high risk with levels of oxygen and electrical equipment needed to supply care.

Telecare – technology enhancing care

Joan is 76, lives alone, and has a past medical history of myocardial infarction, cerebral vascular accident and hypotension. Joan has been supplied with and supported to use technology to maximise her independence and her desire to remain at home. She uses a self-monitoring blood pressure machine three times a week and, if feeling unwell, she has been advised to monitor her PO2. Joan's condition is carefully monitored and there is good liaison between the GP and the district nursing service.

There is an agreed plan of care and treatment, which includes medication delivery. All care and decisions about treatment are conducted via telephone. In addition, Joan is an active participant in her care. The variations in Joan's condition are monitored via technology and can be managed via telephone, no visits are required and Joan is happy to be independent and in control of her care, knowing she can access support when it is required.

Mobile Working

In 2012, Liverpool Community Health NHS Trust initiated an exciting and challenging initiative to enable all staff, with the exception of fixed clinical services and corporate services based within our headquarters, to have a mobile device by the end of December 2013. Mobile devices will be the start of a transformational journey, it will deliver greater efficiency, allowing more time for face-to-face patient care, cost savings on travel and eventually remove the need for paper clinical records and duplicate data entry.

Collaborative working between corporate and clinical functions, together with iMerseyside and external stakeholders (clinical system and mobile technology providers) has enabled a roll-out of over 300 mobile devices (laptops and tablets) to frontline clinical staff. This has enabled staff to access emails, calendars and unrestricted access to the internet, alongside a number of clinical applications. Community nurses are currently able to access a patient's GP records via Emis Web through the use of laptops and remote connectivity via a dongle (when in a domiciliary setting) or wireless.

A successful pilot of remote work-scheduling, 'pushing' patient appointments for domiciliary visits to mobile devices, enabling staff to receive pre-triaged and prioritised workload without returning to their work base has been completed within specialist nursing teams and is due to be rolled-out to District Nursing services in the near future.

The benefits of time saved through reduced travelling will be reinvested into the service to allow for greater patient-facing contact time. Furthermore, work is ongoing with national and local partners within the arenas of Telehealth and Telecare to deliver assistive technology to patients supporting self-care.

Maximising independence

Jenny has diabetes and end stage cancer, her symptoms are well controlled with sub-cutaneous drugs via a syringe driver but her diabetes is unstable requiring daily monitoring by district nurses. Jenny wished to visit her daughter for 2 nights who lived out of the area and would thus require district nursing visits whilst there to re-prime syringe driven drugs and supervise insulin.

The team where Jenny's family lived would not accept the referral, as she was not registered with the local GP. The district nursing team currently supporting Jenny liaised with her daughter to ensure Jenny was registered as a temporary resident. The team taking over Jenny's care whilst she stayed with her daughter were not happy to change the medication, as the patient would not have been seen by the local GP. Again, the referring district nursing team liaised with the local hospice who agreed to visit and support the administration of pain relief.

Unfortunately, the hospice nurses were unable to accept the drug authorisation signed by an independent prescriber. After further negotiation with her local GP and Jenny's daughter's GP, eventually the district nursing team secured arrangements to ensure the drugs could be administered.

The type of syringe driver currently used for Jenny's pain relief caused further concern for the hospice staff. The district nursing team who were caring for Jenny arranged to switch to the hospice syringe driver on their first visit and remove it prior to the patient leaving to go home. Jenny was able to visit her daughter and engage in family life. The district nursing team maximised independence and enhanced the patient experience.

Annexe 2

The approach and progress to date

This programme focussed on district nursing services, who work as part of the wider primary care teams and community nursing services including specialist nurses and community matrons. The focus of this work is to provide clarity regarding the role and responsibilities of district nurses to ensure wider stakeholders understand and appreciate the scope and complexity of the service. This approach will:

- Support the profession to articulate the unique contribution district nurses make to deliver the NHS constitution and the new Nursing, Midwifery and Care giver strategy;

- Support community services to maximise the full potential of the district nurse service so that the NHS constitution and NHS mandate is delivered;

- Support partners to understand the role district nurses play in health and social care partnerships working in progression towards integration.

Below outlines the progress to date including the stakeholder engagement.

Community Nurse Development Programme Actions 2012	

Programme Development
 	
• Scoped District Nursing Offer
• Identified challenges and tested solutions
• Consulted and discussed with networks and advisory group
• Developed and integrated visual
• Tested 'success' with service users
• Drafted service user document
• Drafted pathways
  ○ Carers
  ○ Dementia
• Drafted and scoped fact sheets to articulate the service offer
• Scoped Practice Nurse scope and offer to ensure synergy and alignment
• Test scope with Practice Nurses
• Validated scope with practice nurses
	Engagement
	
	• Working with our strategic partners (The QNI)
	• Consulted with professionals from District nursing services and wider community services
	• Consulted with professional organisations and educational organisations
	• Tested scope and with district nurses in a number of areas
	
	Communication
	
	• Twitter
	• DN Blog
	• CNO Bulletin
	• DH District Nursing webpage
	
	Good practice
	
	• Collected good practice
	• Developed a peer review process

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