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District Nursing: Update on Progress – **Aneurin Bevan University Health Board**

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

The person who delivered the work was Gabrielle Smith.

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Summary report

Introduction

1 District nursing staff play a crucial role within the primary and community health care team, providing the core universal element of adult community nursing care. District nursing staff provide skilled nursing care, advice and support to patients and their families 24 hours a day, seven days a week. They also use their judgement about how and when to involve other professionals in providing care and to orchestrate them to meet patients' needs. This care supports patients and their families manage their health, to avoid unnecessary hospital admissions, enable early discharge and maintain independence for as long as possible.

2 The growing elderly population coupled with shorter hospital stays and the move to treat more patients, often with multiple complex care needs, in the community means that district nursing services require an appropriately co-ordinated, resourced, skilled and effectively deployed workforce.

3 Our 2014 report on District Nursing Services concluded that there was unexplained variation in resourcing and workload, as well as weaknesses in information systems, making it difficult to assess performance, capacity and demand. We made 12 recommendations related to clarifying the role and purpose of the service, influencing and managing the growing demand on care in the community, improving staff deployment to better match demand, and to strengthen performance monitoring and management.

4 Our follow-up report in 2015 found that work was underway to address our recommendations but was incomplete. The Health Board was taking steps to improve the district nursing service as part of wider community service provision, but it still had to define the remit and workforce requirements. Understanding service demand remained a challenge and unexplained variation in the deployment and distribution of resources meant that the Health Board could not take assurance that staff were effectively deployed. Meanwhile, the Health Board was continuing to develop a bespoke system to address information needs in the short to medium term.

5 In 2015, there was no guidance on safe staffing levels in the community, no standardised tools to assess workload or patient dependency and no community care information system. The following year, the Nurse Staffing Levels (Wales) Act 2016 was enacted (the Act). The Act introduces a general, overarching duty 'to have regard to providing sufficient nurses to allow them time to care for patients sensitively' irrespective of care setting. In the same year, the Wales Community Care Information System (WCCIS) was procured nationally to give health and social care staff the digital tools they need to work more effectively together but roll out is not yet widespread. And finally, in 2017, the Welsh Government issued Interim District Nurse Guiding Staffing Principles to ensure a consistent approach for district nurse workforce planning.

6 We undertook a high-level assessment of the Health Board's progress to address our recommendations between March and July 2019. In undertaking this work, we:

- asked the Health Board to complete a self-assessment of progress;
- reviewed documentary evidence to support the self-assessment, as well as board and committee papers; and
- interviewed several officers to discuss progress, current issues and future challenges.

7 A summary of our findings is set out in the following section with more detailed information provided in Appendix 1.

Our findings

8 Our overall conclusion is that **the Health Board has largely addressed our recommendations for improving the management of district nursing services.**

9 In summary, the status of progress against each of the previous recommendations is set out in Exhibit 1.

Exhibit 1: status of 2015 recommendations

Total number of recommendations	Implemented	Ongoing action	No action	Superseded
12	10	2	0	0

Source: Wales Audit Office

10 We found that the Health Board has largely addressed our recommendations because:

- there has been continued progress with integration of community nursing services, including district nursing;
- the purpose and remit of the district nursing service have been clarified and the service specification is regularly reviewed in collaboration with key stakeholders;
- referral criteria and processes have been agreed in collaboration with key stakeholders;
- caseloads are reviewed weekly and work to better match resources to current and future demand is ongoing;
- it remains an active contributor to the national nurse staffing programme to develop an evidence-based workforce planning tool based on patient need;
- there is good compliance with the interim district nurse staffing principles; and

- the introduction of the scheduling tool enables performance monitoring against a set of locally agreed indicators and benchmarking with peers.

11 In undertaking this assessment of progress, we identified no new risks in relation to district nursing services.

Appendix 1

Progress made by the Health Board to address recommendations identified in our previous reports on the District Nursing Service

Exhibit 2: assessment of progress

Recommendation	Status[1]	Summary of progress
Service aims and objectives		
In 2015, we concluded that the Health Board had a clear vision for delivering more care in the community but had yet to define the remit of the district nursing service within a new integrated community nursing service, while progress in updating the service specification had been slower than anticipated. To effectively meet the growing demand on care in the community and support more streamlined and integrated care delivery, we recommended that the Health Board should:		
R1a Work with all key stakeholders to determine and clarify the role and responsibilities of the district nursing services within wider community service provision. As part of this process, it should take the opportunity to agree how care in the community can be streamlined and better integrated, including defining and agreeing who is best placed to act as the patient's care co-ordinator and to deliver specific care needs.		1. The Community and Primary Care Division is working towards a Place Based Model of Care as part of Clinical Futures, the Health Board's strategy to modernise primary, community and acute services. Integrating community nursing services is a part of the place-based approach and is a key action in the Health Board's 2019-20 integrated medium-term plan. The aim is to move from a single-handed uni-professional approach to a multi-professional approach where health and social care staff work collaboratively to provide care closer to home. 2. The District Nursing Service is a key part of the placed-based approach and integration between District Nursing and Community Resource Teams continues. The Health Board has co-located district nursing and social care teams aligned to the Neighbourhood Care Networks (NCN) in Blaenau Gwent and Monmouthshire.

[1] Green indicates that the recommendation has been achieved; Amber indicates ongoing action to address the recommendation; Red indicates that insufficient or no progress has been made; and Blue indicates that the recommendation was superseded.

Recommendation	Status[1]	Summary of progress
Service aims and objectives		
In 2015, we concluded that the Health Board had a clear vision for delivering more care in the community but had yet to define the remit of the district nursing service within a new integrated community nursing service, while progress in updating the service specification had been slower than anticipated. To effectively meet the growing demand on care in the community and support more streamlined and integrated care delivery, we recommended that the Health Board should:		
R1a Work with all key stakeholders to determine and clarify the role and responsibilities of the district nursing services within wider community service provision. As part of this process, it should take the opportunity to agree how care in the community can be streamlined and better integrated, including defining and agreeing who is best placed to act as the patient's care co-ordinator and to deliver specific care needs.		3. Work, led by the Division's Head of Nursing, is underway to integrate other community nursing services starting with the Rapid Response, Chronic Conditions and Care at Home Teams. The aim is to ensure fewer handoffs between professional staff working in the same geographical area and with many of the same skills. 4. The Health Board is also one of three health boards to receive funding from the Welsh Government in 2018 to pilot neighbourhood nursing principles based on the Buurtzorg model of care[2]. The Newport East teams is testing these principles to determine the longer-term model for integrated community nursing. The pilot project concludes in 2020 and the team is working with the value-based healthcare team to develop outcome measures.

[2] The Buurtzorg model of care was developed by a social enterprise in the Netherlands. It involves small teams of self-managing nursing staff. These teams provide a range of personal, social and clinical care to individuals in their own homes in a specific neighbourhood. The teams work with the individual and their informal carers to access resources available in their social networks and neighbourhood to support them to be more independent.

Recommendation	Status[3]	Summary of progress
Service aims and objectives		
In 2015, we concluded that the Health Board had a clear vision for delivering more care in the community but had yet to define the remit of the district nursing service within a new integrated community nursing service, while progress in updating the service specification had been slower than anticipated. To effectively meet the growing demand on care in the community and support more streamlined and integrated care delivery, we recommended that the Health Board should:		
R1b Update and re-launch the district nursing specification to all key stakeholders and within the specification, clearly signpost where other community services may be more appropriate and ensuring that these other community service specifications are up to date.		5. A revised service specification – the Community Nursing Service Specification – was implemented in 2016-17 following engagement with key stakeholders, such as NCNs and Local Medical Committees (LMCs). The specification sets out a simple pathway and referral response times. It also clarifies service aims and objectives, the range of clinical care provided including acting as care co-ordinator for continuing healthcare assessments, clarity around appropriate and inappropriate referrals, who can refer and discharge arrangements. 6. At the time of our fieldwork, the specification was subject to review to ensure it remained up to date. The Division's Head of Nursing, with support from senior nurses and team leaders, is undertaking the review with proposed changes to be discussed with the NCNs and LMC. We would expect any future specification to reflect changes brought about by the integration of community nursing teams. Depending upon timing, the Health Board plans to use learning from the neighbourhood nursing pilot to inform revisions to the service specification. Any revisions to the specification also need to reflect the move to operating 24 hours a day, seven days a week.

[3] Green indicates that the recommendation has been achieved; Amber indicates ongoing action to address the recommendation; Red indicates that insufficient or no progress has been made; and Blue indicates that the recommendation was superseded.

Recommendation	Status[1]	Summary of progress
Referral management		
In 2015, the Health Board had not updated and re-launched the referral criteria for district nursing services. Although district nursing staff believed that referral information was adequate, some basic information was missing, and some teams were more proactive in managing demand and challenging referrals received. To effectively meet the growing demand on care in the community and improve referrers' understanding of the correct service for the user, we recommended that the Health Board should:		
R3a Update and re-launch the criteria for referrals and communicate these to all referrers. R3b Draw on the prompt card to develop a checklist of information to act as a standard referral pro forma to be used across all Health Board areas and use the information generated to target those that refer inappropriately. R3c Work in partnership with GPs to understand the variation between how some GP practices use the district nursing service and determine whether district nurses are the most appropriate resource to deliver those needs.		7. As part of the service specification discussions, the referral process and referral criteria were agreed with the NCNs and LMC and provided an opportunity to explore variation in referrals between GP practices. The specification sets out examples of inappropriate referrals with the expectation that staff signpost referrers to more appropriate community services. Referrals are triaged by a registered nurse within each team, helping to ensure the relevant information is provided at the point of referral. 8. In 2015, Newport district nursing teams were testing the use of the Frailty Service portal to log referrals and manage their caseloads, but the trial was discontinued because it was not in keeping with the referral process set out in the revised service specification. The Health Board intends to pilot electronic GP referrals to Blaenau Gwent district nursing teams when the Welsh Community Care Information System (WCCIS) is eventually implemented.

Recommendation	Status[1]	Summary of progress
Deploying staff to meet demand		
In 2015, we concluded that there was unexplained variation in the deployment and distribution of resources, which meant that the Health Board could not be assured that staff were effectively deployed and matched to the caseload. It was difficult to assess whether there was enough capacity despite increasing numbers of staff and, at that time, caseloads never closed but stretched to absorb new patients. Information about the number of patients on the caseload was not readily accessible, the size of caseloads relative to numbers of staff varied and some teams were more effective at discharging patients. There was no standardised patient dependency tool in use and the Health Board was awaiting the development of a national tool. To support effective deployment of the district nursing resource, we recommended that the Health Board should:		
R2a Agree mechanisms to allow Band 7 team leaders protected time from operational duties to proactively manage the caseload, supervise and support staff and lead the team.		9. In September 2017, the NHS Wales Chief Nursing Officer (CNO) issued Interim District Nurse Guiding Staffing Principles to ensure a consistent approach for district nurse workforce planning. The CNO assesses compliance with these principles every six months and information submitted by the Health Board for March 2019 shows good compliance in particular: • all district nursing teams are coterminous with the cluster footprint and teams are predominantly made up of registered nursing staff; 12% of district nursing staff are healthcare support workers; • all district nursing team leaders and their deputies have a specialist practitioner qualification in district nursing; • team leaders spend on average 60% of their time on case management, well in excess of the 20% minimum specified; • team leaders spend on average 27% of their time undertaking supervisory activities, again in excess of the 20% minimum specified; • all teams have access to 15 hours of administration support each week with the Health Board only one of two where this is the case; and • the principles advise that staffing levels should be no greater than 15 staff or 12 whole time equivalents (WTE) to promote continuity of care; just over half the Health Board's 23 teams have a complement in excess of 12 WTE within each cluster.

Recommendation	Status[1]	Summary of progress
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R2b Use the audit findings to identify opportunities to match resources to workload, examine variation in non-patient activity and determine whether existing resources could be used differently to support common care interventions like venepuncture.		10. In 2015, the Health Board's Community IT Implementation Group was developing a caseload management system to match resources to the caseload as efficiently as possible. The group successfully implemented the scheduling tool across all 23 district nursing teams in 2016, to safely and efficiently allocate patients across a seven-day period for the given skill mix at team level. Scheduling clerks were appointed to all teams in order to oversee the management of the tool, which has freed up nursing time to provide care. The scheduling tool enables teams to assess whether they have enough capacity to allocate calls/visits safely. The Health Board is also looking to learn from Cwm Taf Morgannwg University Health Board's implementation of a commercial scheduling system called Malinko. 11. Where there are gaps in resourcing, teams will look to change visit frequency to manage pressures. The Health Board is currently working with the NHS Wales Delivery Unit to develop an escalation framework of triggers and responses for primary and community care services, including district nursing. The framework will ensure a consistent response across all teams when managing increasing operational pressures.

Recommendation	Status[1]	Summary of progress
Deploying staff to meet demand		
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R2b Use the audit findings to identify opportunities to match resources to workload, examine variation in non-patient activity and determine whether existing resources could be used differently to support common care interventions like venepuncture.		12. In 2015, district nursing caseloads were cleansed on a monthly basis. The introduction of the scheduling tool means that caseloads are now cleansed weekly by looking specifically at the frequency of visits. The district nursing dashboard shows that 25% of patients are discharged each month and the median length of time on the caseload is just under 3 months compared with 4.7 months in 2016[4]. 13. Our previous audit work found that there were on average 30 patients per WTE staff with workloads varying two to three-fold between teams. The district nursing dashboard shows that at the end of March 2019 there were fewer patients per WTE staff (24.5 patients per WTE) but the level of variation is unchanged. All resources, not just those for the District Nursing service, are being reviewed as part of planning for the place-based model of care. Meanwhile, the Health Board's analysis of caseload information shows that teams with more staff had the lowest reported patient safety concerns and good quality metrics.

[4] Primary Care and Community Services Division IMTP 2017-18 to 2019-20

Recommendation	Status[1]	Summary of progress
Deploying staff to meet demand		
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R2b Use the audit findings to identify opportunities to match resources to workload, examine variation in non-patient activity and determine whether existing resources could be used differently to support common care interventions like venepuncture.		14. The CNO's office has indicated that the Health Board has the richest skill mix amongst district nursing services across Wales but fewer registered nurses for the population aged 65 and older (one registered nurse for every 460 people) compared with the Wales average (one registered nurse for every 415 people). The Health Board has indicated that this variation will be addressed as part of its place-based model of care based on a better understanding of demand and the resources needed to meet it. 15. Demand is currently determined by the current or predicted population aged 65 or older. The Health Board recognises that further work is needed to understand future demand based on population need in order to deploy resources effectively and equitably. The Health Board is developing a caseload analysis tool to refine analysis of demand based on caseload details, such as the nature of the activity and time spent, not just the number of patients. The caseload analysis tool is being tested as part of the neighbourhood nursing pilot in Newport. Early indications showed: • variation in the type of demand or approaches to one-off appointments; • caseload size was not a direct indication of demand for visits with teams with smaller caseloads assessed as requiring more face-to-face time with patients each week; • opportunities for healthcare support workers to undertake specific tasks on behalf of registered nurses; and • opportunities to reduce demand by supporting patients to self-care.

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R2b Use the audit findings to identify opportunities to match resources to workload, examine variation in non-patient activity and determine whether existing resources could be used differently to support common care interventions like venepuncture.		16. The Health Board is continuing to upskill healthcare support workers and is scoping potential competencies needed to support caseload management further. And the neighbourhood nursing pilot is testing revisions to skill mix using band 4 staff. 17. Our previous audit work found a large proportion of inappropriate referrals (40%) were for ambulant patients requiring venepuncture. Our analysis of the Health Board's data shows that 10% of district nursing face-to-face contacts were for venepuncture, which appears to be a significant improvement with more than half of these contacts undertaken by healthcare support workers.
R2c Undertake a longer-term examination of how much time is spent on Continuing Health Care (CHC) Assessment to inform future resource planning and deployment.		18. Our previous audit found big variations between teams in relation to the proportion of time spent on CHC assessments. We did not repeat our caseload census as part of our follow-up work. Our analysis of the Health Board's caseload data for 2018-19 shows that few patients (1.4%) on the caseload were receiving continuing healthcare.

Recommendation	Status[1]	Summary of progress
Deploying staff to meet demand		
In 2015, we concluded that there was unexplained variation in the deployment and distribution of resources, which meant that the Health Board could not be assured that staff were effectively deployed and matched to the caseload. It was difficult to assess whether there was enough capacity despite increasing numbers of staff and, at that time, caseloads never closed but stretched to absorb new patients. Information about the number of patients on the caseload was not readily accessible, the size of caseloads relative to numbers of staff varied and some teams were more effective at discharging patients. There was no standardised patient dependency tool in use and the Health Board was awaiting the development of a national tool. To support effective deployment of the district nursing resource, we recommended that the Health Board should:		
R4c Actively participate and influence the work of the all-Wales Community Nursing Acuity Tool.		19. The scheduling tool only captures the volume and duration of calls and does not have the functionality to determine patient acuity and dependency. Work continues at an all Wales basis to determine whether the Welsh Levels of Care[5] can be used for assessing complexity of need of patients on the caseload. The Health Board remains an active contributor to this work, which is part of the national nurse staffing programme to develop an evidence-based workforce planning tool for district nursing. As part of the national programme of work, the Health Board also participated in the all-Wales quality audit earlier in the year. In the meantime, the Health Board has piloted a patient complexity tool with a team in Newport and discussions are taking place to roll it out as an interim measure until an all-Wales tool becomes available.

[5] The Welsh Levels of Care tool provides the evidence based clinical guidance for staff to identify the levels of need for individual patients. It is used to calculate bi-annually nurse staffing levels on medical and surgical wards.

Recommendation	Status[1]	Summary of progress
Monitoring and reporting service performance		
In 2015, we found that the absence of information systems meant the Health Board was unable to assess demand and determine workforce requirements and to regularly review caseloads. There were also limitations in the way service quality was assessed and discrepancies in sources of workforce information. To strengthen performance monitoring and improve service management, we recommended that the Health Board should:		
R4a Use the findings of this review as the baseline and catalyst for effectively managing the service. R4b Develop a wider range of quality and safety measures that are routinely monitored, reported and acted upon. R4d Improve the quality of information by addressing and removing the differences that exist between the different sources of workforce information		20. In addition to matching resources to caseload visits and regular caseload review (see paragraph 9), the scheduling tool enables the district nursing service to monitor performance against a set of locally agreed performance indicators and to compare with peers, both locally and nationally as part of the NHS Benchmarking Network. 21. The district nursing dashboard, which is compiled on a standalone system, provides the senior management team and the team leaders with an accurate overview of the previous month's performance. The team dashboard is RAG rated highlighting at a glance those areas where improvement is needed. The broad range of data includes: • activity and demand eg caseload size, numbers of contacts and discharges; • quality and patient safety eg numbers of patients dying with an end of life care plan, those with pressure ulcers, uptake of flu vaccination for housebound patients but currently there are no patient experience measures; and • workforce and finance eg WTE numbers of staff in post, overall expenditure, bank and agency expenditure, levels of sickness absence and compliance with the appraisal process and statutory and mandatory training.

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