Delivering Care
Phase 3
District Nursing

A Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

Department of Health

HSC Health and Social Care

Introduction

Delivering Care aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

Phase 3 of this work focuses on District Nursing.

This summary paper is intended to provide an update on progress to date for Steering Group and Working Group members regarding the District Nursing capacity requirements, taking account of evidence available, benchmarking, key drivers and influencing factors.

It is recognised that workforce planning processes include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPI's) for safe, effective, person-centred care. This work has been developed in the context of the principles of Quadruple Aim, which combines a focus on population health and wellbeing, safety, quality and experience, cost and value with experience of care givers.

Context

A District Nurse is a registered nurse with a graduate level education possessing a specialist practitioner qualification recordable with the Nursing and Midwifery Council. The District Nurse leads a District Nursing team comprised of registered Nurses and Healthcare Assistants. The District Nurse is considered a lone worker who works autonomously and has a central and decisive role in the assessment, planning and delivery of care and treatment at home within community care settings (QNI 2009). Simultaneously the role also requires that the District Nurse works collaboratively and in partnership with statutory and non-statutory colleagues to co-ordinate care. They may work within Integrated Care Teams (Nurses, Social Workers and Allied Health Professionals).

The District Nurse has named responsibility for a designated population (caseload) in a GP Practice. The District Nursing service is mainly domiciliary based, providing a wide range of nursing interventions primarily for frail older people, people living with long term conditions, those who are palliative and end of life, and disabled adults. They play a key role in supporting independence, managing long term conditions and preventing and treating acute illnesses (King's Fund 2016).

In June 2014 a regional workshop was held with District Nursing staff to define the activities of the District Nursing service that needed to be factored into a workforce model. The 3 main components were divided into:

- Daytime
- Evening; and
- Night Service

In order to find a way forward to measure like-with-like across Trusts, it was agreed to define what 'core' District Nursing team activities would fall within each of the three specified units of time. It was also agreed that where a service did not currently exist within a Trust, e.g. night service, then broad activity was defined within each of the three areas (**Appendix 1**). The most distinct variance relates to blood transfusion management (not provided in SHSCT or BHSCT). Some Trusts run a separate infusion service that administer blood transfusions, platelets, intravenous/subcutaneous therapy and administer IV medication therapies.

District Nursing Funded Clinical Establishment

A regional summary of funded clinical Whole Time Equivalent (WTE) by Agenda for Change (AfC) banding for each HSC Trust is provided in **Table 1.** This summary table includes core daytime teams, and other teams within the District Nursing service, such as Rapid Response/Hospital Diversion and Evening service.

Belfast HSC Trust and South Eastern HSC Trust provide a night time service but related staffing has not been included in the Table below to enable some regional comparisons to be made. The remaining three Trusts do not currently provide a night time District Nursing service.

A number of investments have been processed in each Local Commissioning Group in the last two years, resulting in an increase of almost 70 WTE.

Table 1: Health and Social Care (HSC) Trust funded WTE by AfC Band (July 2016)

AfC Band	HSCT Trust WTE day and evening teams (night excluded)					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
7	0	35.40	2	0	33.4	**70.8**
6	59.61	4	42.99	59.11	2.53	**168.24**
5	114.66	164.60	128	122.92	129.63	**659.81**
3	44.49	62.32	30.42	24.53	27.82	**189.58**
2	0	0	6.13	0	0	**6.13**
Total	**218.76**	**266.32**	**209.54**	**206.56**	**193.38**	**1094.56**

Evidence

A literature review was carried out as part of the Phase 3 framework to ascertain the evidence base for District Nursing workforce planning. Thompson and McIlfactrick (University of Ulster, 2014) indicated that community nursing staffing levels are typically outlined either as a population ratio or through caseloads, i.e. the number of patients per District Nurse. They state that defining staffing levels in this way can be difficult as none of the parameters used are fixed.

The Queen's Nursing Institute review (QNI, 2014), commissioned by NHS England, reviewed workforce planning within District Nursing across the UK. The review identified a significant gap in the availability of workforce tools that enable and support strategic workforce planning. The review made a number of recommendations, including the need to develop a tool that provides operational and strategic information, a tool that is clinically driven and built in to existing systems and includes agreed standards of core activities.

QNI has just published a report *Understanding Safe Caseloads in the District Nursing Service (Sept 2016)* which describes the elements to be considered when planning safe caseloads.

In 2015 an electronic workforce tool was developed in NI based on the work of Dr Keith Hurst, who had acted as an expert advisor to the Working Group. Analysis of the data collection is ongoing.

The electronic Caseload Analysis Tool (eCAT) allows for some local demand management and regional trend analysis over time.

The Buurtzorg Nederland (home care provider) Model is also being explored, following a study visit in May 2016. This Model was founded in the Netherlands in 2006/07; Buurtzorg is a unique District Nursing system which has garnered international acclaim for being entirely nurse-led and cost effective.

Understanding Quality in District Nursing Services (King's Fund 2016) has identified evidence of a growing gap between capacity and demand in district nursing services creating pressures which can impact on the quality and safety of patient care and results in increasing task focused approaches and missed opportunities for prevention.

Key Drivers

In the development for this model, a range of strategic and operational drivers have been considered. These key drivers that will have a significant impact on the future District Nursing service include:

1. The DoH District Nursing framework currently being developed. The vision is to have a District Nursing Service that is provided 24 hours a day 7 days a week throughout Northern Ireland, and will be underpinned by the principles of person-centred care, integration, efficiency and expertise

2. Quality care - In addition to the Quality 2020 strategy the King's Fund (2016) sets out a framework for the components of good care for older people receiving a District Nursing service and identifies 3 characteristics of good care; caring for the whole person, continuity of care, and the personal manner of staff.

3. Population health - Increased focus on enabling health promotion, prevention and self-management. The "*Making Life Better" NI* Public Health framework (DHSSPS 2013) seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision of Northern Ireland where all people are enabled and supported in achieving their full health and wellbeing potential and to reduce inequalities in health.

4. Care enabling technologies - Building on the "Regional eHealth and Care Strategy" (DHSSPS 2015). It is imperative that there are systems and processes to support timely and consistent sharing of patient information, with real time access to all relevant health and social care information for district nurses and all other relevant care providers to enable them to work effectively and safely with their patients. This will be achieved through the development and implementation of an electronic record in common for all citizens in NI over the next 5 - 10 years.
5. Palliative care - The Regional Palliative Care Programme recognises that the District Nurse will typically be the keyworker and key elements of this role include identification, co-ordination and contact and delivering care and support.
6. A commissioning priority for Unscheduled Care in 2016/17 is to have effective, integrated arrangements, organised around the needs of individual patients, in place in community settings to provide care for people at home, avoiding the need for hospital attendance/ admission and to support safe and effective discharge.
7. Increasing Demand - Due to the rapidly changing health and social care landscape increasing numbers of people with multiple and complex conditions are being cared for at home, which includes people living in deprivation and those living to a very old age.

   There has been an increase of some 120,000 District Nursing contacts between 2010/11 and 2014/15, equating to an increase of 10%.
8. Demography - The population of NI is increasing, and within this overall increase the size of the older population is increasing more quickly. **Table 2** illustrates the current and projected population by Trust area.

Table 2: Populations and percentage calculations across the HSC Trusts

Trust	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Population (all ages) (NINIS 2014)	351554	469051	352301	369391	298201	1,840498
% Total population	19.1%	25.5%	19.1%	20.1%	16.2%	100%
Population > 65 years (NINIS 2014)	53728	76845	60977	51556	42810	285916
% population > 65	15.3%	16.4%	17.3%	14%	14.4%	15.5%
% population projected change from 2014-2024 for > 65 years (NINIS 2014)	14.1%	26.2%	28.8%	29.8%	30.7%	25.8%
Projected population all ages (2024.)	364,281	486,877	371,577	408,410	307,570	1,938,175

The Northern HSC Trust has the greatest population, and South Eastern HSC Trust has the greatest percentage population > 65 years.

If the population change is projected to 2024 for those >65 years, the Western HSC Trust followed closely by Southern HSC Trust and South Eastern HSC Trust have the greatest increase.

The focus on the population > 65 is significant as District Nursing caseload analysis data (March 2015) indicates that 82.5% of patients on the caseload were in this age range.

Benchmarking

A benchmarking of District Nursing staffing levels as a population ratio in NI is presented in **Table 3**, which details the HSC funded establishment WTE by population size (total population and additionally > 65 years population). The District nursing ratio reflects the composition of the total District Nursing Team. This includes:

- District Nurses with specialist qualification
- Community Staff Nurses
- Non registered Health Care Assistant

Table 3: HSC funded establishment WTE by population size

Trust	Total WTE	Population (all ages) (NINIS 2014)	Population > 65 years (NINIS 2014)	Ratio of WTE per 10,000 head of population	Ratio of WTE per 10,000 head of population >65 years
BHSCT	218.76	351554	53728	6.2	40.7
SEHSCT	209.54	352301	60977	5.9	34.4
NHSCT	266.32	469051	76845	5.7	34.7
SHSCT	206.56	369391	51556	5.6	40.1
WHSCT	193.38	298201	42810	6.5	45.2

Simple analysis indicates:

- The HSC Trust District Nursing ratio of WTE per 10,000 head of population ranges from 5.6 – 6.5 (NI average 5.9)
- The ratio of WTE per 10,000 head of population >65 years ranges from 34.4 - 45.2 (NI average 38.0)
- Western HSC Trust has the highest ratio of District Nurses per 10,000 population over 65 years
- South Eastern HSC Trust has the lowest ratio of District Nurses per 10,000 population over 65 years.

The RCN survey of District Nurses and Community Nurses which was undertaken in 2013 in England (King's College London 2014) found that for the average population size of just over 5,000 people there were 10.9 WTE (7.8 WTE were registered). The authors of the RCN report highlight that a large number of participants did not know the population size (67%) and the variation in responses led to uncertainty regarding how the question was answered, and so did not use the population data in the analysis.

The NHS National Community Services Benchmarking report (2015) provided outturn data for 2014/15 from 70 community services (no NI submissions) which indicates a mean of 52.4 (range 60.1 - 40.3) WTE per 100k population. This includes clinical and non-clinical Community/District Nursing Service and Community Matrons. Integrated Care Teams were excluded as it was not possible to distinguish the District Nursing WTE from the other professions. The report highlighted a mean average waiting time of 8.8 days for the District Nursing Service and 12.2 days for Community Matrons.

The Buurtzorg Nederland Model (one of the home care providers) consists of small self-managing teams. There are now approximately 850 teams employing a total of 10,000 nurses. Each team has a maximum of 12 staff who work in a neighbourhood of 10 – 20,000 population providing co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients.

In June 2016 a question was posed to District Nursing Leads in each HSC Trust to ascertain professional judgement about what a District Nursing team size should look like for a 10 - 20,000 population. Whilst not a scientific approach and cognisant that other teams such as infusional services, etc had not been included for a day and evening service (not night time service), the range was 5.75 - 7.50 WTE for a 10,000 population.

It has been difficult to benchmark against other District Nursing teams within and outside NI as the configuration of the service varies considerably in terms of structure and workload activity.

Staffing Model

In order for the District Nursing service to have sufficient capacity to address future service demands and implement key drivers, it is recommended that a range of 8 - 10 WTE which will incorporate appropriate skill mix is needed for a 10,000 population.

Influencing Factors

Workforce planning for nursing staff is both complex and diverse. The application of processes or approaches to gauge the number of individuals required with the right level of competence to provide the appropriate level of care for a particular client group can be a challenge. As part of the Delivering Care framework, a number of factors that impact on the opportunity to deploy staff to provide safe and effective person-centred care have been identified and will be considered to agree the final staffing model for each District Nursing team in each HSC Trust.

Workforce

- Optimal rostering of staff for day, evening and night time to deliver safe and effective care will require deployment of appropriate skill mix availability within the nursing workforce to match the variations in the workload.
- Annual review of the availability of District Nursing Specialist Practice Qualification education programme placements, and teacher practitioner requirements.
- Percentage supervisory role of the District Nurse team leader to be agreed.

- Skill mix for a day, evening and night time service (excluding infusional teams) should be 80% registered and 20% non-registered staff. It is acknowledged while non-registered staff provide a vital services both in hospital and community they are limited to the patients they can care for in their own home often due to patient complexity and clinical need.
- Management of recruitment factoring in demographics of the workforce.
- Management of planned and unplanned absence (24%).

Environment and support

Integrated Care Partnerships (ICPs) are a key element of Transforming Your Care and a new way of working for the health service in NI to transform how care is delivered. There are 17 ICPs serving local populations of approximately 100,000 people. The District Nursing WTE required per 10,000 population will be determined at ICP population level, and local influencing factors that will need to be considered to differentiate between ICPs are outlined below:

- The geographical location of the teams - rural/urban.
- Population profile - this will include demography, deprivation and disease risk factors.
- Geography - the geographical location of the teams will have an impact as it may affect travel times required between patient visits, other appointments and meetings. Geographical location may also impact on the feasibility to provide ambulatory care service in clinic settings, and cause reduced access to technology.

Impact of other services

- Other relevant services provided within the ICP area, e.g. Specialist Teams (Diabetes, Respiratory), Enhanced/Acute Care at Home models, Palliative Care.
- The number of GP practices (and GP registered patients) within each ICP area.
- The number of Nursing Homes and Residential Units in each ICP area and the extent to which they rely on District Nursing services.
- In addition, the technology and support of admin staff impacts on the supportive infrastructure and ability to stream line care appropriately.

Activity

- Workload analysis using tools such as eCAT to measure complexity/patient dependency and acuity, depth and breadth of care. eCAT data will provide local caseload analysis which will enable HSC Trusts to effectively manage and deploy staff appropriately.
- Analysis of planned and unplanned activity, including unmet need and care left undone.
- Face-to-face direct contact with staff.
- 24 hour District Nursing service provision.

Professional regulatory activity

- Revalidation and time allocated to support nurses in their practice, supervision and preceptorship. This is incorporated into the PUAA of 24% for NI.

Monitoring

Compliance in delivering on agreed key performance indicators requires a sufficient nursing workforce to deliver safe and effective care. On occasions when nurse staffing may be outside the policy range, the Executive Director of Nursing must provide assurance about the capacity of the workforce to provide quality nursing care to patients, and efficient use of resources through internal and external professional and other assurance frameworks.

The testing of new models of District Nursing service provision should incorporate a triangulation approach allowing for professional judgement.

Implementation

As with the Delivering Care model, the final staffing for District Nursing teams in HSC Trusts will be agreed following a discussion with the Trust Workforce Lead, the Trust District Nursing Lead and the Commissioning Nurse Consultant.

Review

This Phase will be reviewed in October 2019.

Appendix 1- District Nursing Activities by Specified Period of Time

Holistic Person Centred Assessment, Care Planning, Implementation and Evaluation Support (Clinical) to Nursing Homes Clinical interventions e.g. B/P, monitoring urine, BM, pre-treatment bloods, Doppler. Education and support to carer's formal and informal- e.g. teaching g re-training feeding, admin of meds etc. Nursing Assessment and review including risk assessments, e.g. Braden, MUST, pain, bedrails. Health Promotion/ education. Nurse prescribing. Administration of medication including flu vaccinations and chemotherapy. IV & subcutaneous Infusion management. Wound management e.g. ulcers, simple wounds and complex wounds, including all ranges of interventions. Device management e.g. central lines, catheter, syringe pumps, abdominal catheters (ascites drainage), chest drains, tracheostomy, gastrostomy, PEG/enteral feeding tubes. Continence assessment/review (urine and bowel), including ostomy care. End of life care Equipment assessment, prescribing, risk assessment and review. Pressure ulcer prevention Manual handling Management of long term health conditions including support for patient self-management Blood transfusions management. Platelet infusion management Administration of IV medication Urgent response crisis Root cause activity Management of Safeguarding issues. Key worker role Staff supervision and delegation. Management of students.	Holistic Person Centred Assessment, Care Planning, Implementation and Evaluation IV and Subcutaneous Infusion Management Management of complex wound Device management e.g. central lines, catheter, syringe pumps, abdominal catheters (ascites drainage), chest drains, tracheostomy, gastrostomy, PEG/enteral feeding tubes. Continence management End of life care Manual handling Clinical interventions e.g. B/P, monitoring urine, BM, venepuncture. Support and supplementary education of carers, personal care. Response to urgent 'crisis' calls. Administration of medications. Pressure ulcer prevention/ repositioning. Administration of IV medication Nurse Prescribing	Holistic Person Centred Assessment, Care Planning, Implementation and Evaluation IV and Subcutaneous Infusion Management Management of complex wound Device management e.g. central lines, catheter, syringe pumps, abdominal catheters (ascites drainage), chest drains, tracheostomy, gastrostomy, PEG/enteral feeding tubes. Continence management End of life care Manual handling Clinical interventions e.g. B/P, monitoring urine, BM, venepuncture. Support and supplementary education of carers, personal care. Response to urgent 'crisis' calls. Administration of medications. Pressure ulcer prevention/ repositioning. Administration of IV medication