

<p style="text-align: center;">Social Care and Sport Committee Review of DN services ABMU Overview Assessment</p>
--

ABMU Headline figures

Team Configuration:

From the 1st April 2019 within the new Health Board, Neath Port Talbot & Swansea will have 22 district nursing teams. All the teams are led by a DN Team Leader with a specialist DN qualification (SPQ). All teams are predominately made up of registered nurses. The average skill-mix split for all 22 teams is 74%(qualified staff) 26% (non qualified staff).

DN Contacts:

The number of contacts (estimate) for Neath Port Talbot & Swansea for the year 17/18 is 391,500.

DN Vacancies:

The total number of District Nursing vacancies within the new Health Board (Neath Port Talbot & Swansea) are:

Band 7 - 2 WTE

Band 6 - 1 WTE

Band 5 - 10.5 WTE

Band 3 - 1.5 WTE

Total = 15 WTE

- **Do we have a clear picture of the district nursing/community nursing workforce in Wales?**

The DN service operates on a Health Board-wide footprint under one Service Specification. The service provides short, medium and long term interventions for patients who need nursing services and health care at home. The District Nurse undertakes the care Coordinator role for the majority of patients being cared for within the home setting. There is collaborative working for short term interventions from separate community nursing services such as Acute Clinical teams and support from Disease specific specialist professionals from both community and secondary care depending on the clinical need.

The quarterly submissions for the DN CNO Principles is providing a clear picture of the DN workforce. The pilot phase of an Escalation Process for District Nursing is also helping to clarify workforce resources. Community Nursing services not covered by and separate to the DN Principles are not so clearly defined, these nursing groups include; Acute Clinical Teams, Wound Care teams and Continence Services.

- **Do we have a clear picture on the level of need for community nursing services (including future need)?**

The Three Year Network Cluster Plans and Primary Care IMTPs incorporate an assessment and planning mechanism to determine needs at a Cluster and Health Board Level, the assessment and needs presented in each of the plans are not specific enough to identify the key areas where community nursing services can be deployed and redesigned to meet those needs.

- **Do we have the evidence base to support effective workforce planning?**

For the District Nursing Workforce, a clear understanding of the workforce is emerging through the CNO Principles. The service is using the workforce information to understand the deficits and to begin planning to redesign and shape district nursing workforce in order to comply with the Eight Principles.

There are numerous capacity and demand tools which have been implemented, however there is a paucity of evidence around the validity of tools and the effectiveness by which they match workforce to workload. The All Wales District Nurse Workload and Workforce Group is supporting ongoing collaborative testing of acuity tools.

ABM has utilised skill mix where appropriate to match workload and workforce as well as implementing efficient mobilised IT systems which deliver efficiency benefits in terms of time.

Ongoing issues with the training and retention of Advanced Nurse Practitioners due to sustainability of Primary Care, once qualified ANPs are leaving the community workforce to take up employment with General Practice and acute hospital settings due to attainability of higher grades.

Ongoing issues with the ability to support the required numbers of DN SPQ students due to inability to backfill permanently, despite funding from WEDS. There are lost opportunities in not being able to support direct entrants to the SPQ as this would decrease internal pressures and expand the talent pool into community nursing from the acute settings.

There are opportunities to expand and development the nursing workforce and skill mix with the development of a Band 4 HCSW role.

Workforce planning has traditionally been driven by available resources. The Three Year Network Cluster Plans which incorporate a public health approach to population assessment, now present the opportunity for future workforce planning to be based on local and regional population needs.

There are opportunities within the new pre-registration nurse training to ensure newly qualified nurses can take up post in community services upon qualifying with the necessary skills for community practice; e.g. supplementary prescribing.

- **Whether there is clear strategy, at national and local levels, about the future direction for district nurse-led community nursing services.**

The Community Nursing Strategy for Wales 2009 started to articulate the direction required for community nursing services, this has been superseded by a Health Board Nursing and Midwifery Strategy 2017. This high level strategy has little specific direction for the community nursing workforce as a whole.

The CNO Principles have clear direction for district nursing in that the service should be aligned with the Clusters. The Cluster plans have started to incorporate nursing requirements. However, community nursing representatives need to become more integral to the needs assessment and planning mechanisms for each neighbourhood cluster to ensure all opportunities to engage and direct the DN workforce are supported.

- **How well aligned is this with the development of the primary care cluster model for example, and with the vision for health and care services set out in A Healthier Wales.**

It is widely acknowledged that community nursing is a fundamental aspect of the primary care team and is key to supporting the implementation of the key themes of the Quadruple Aim in a Healthier Wales.

- Improved population health and wellbeing;
- Better quality and more accessible health and social care services;
- Higher value health and social care; and
- A motivated and sustainable health and social care workforce.

The skill sets to deliver on the agenda of keeping people out of hospital during acute illness and supporting them to return home early after illness are wider than traditional community nursing training courses such as the DN SPQ. In an attempt to address deficits in the workforce, varying specialist nursing roles have developed e.g. Chronic Condition Nurses and Advanced Nurse Practitioners.

This has led to a disintegration and fragmentation of community nursing services and the development of hyper specialist roles which can, on occasions result in multiple nursing teams caring for patients or condition specific nursing leading to confusion for patients and key stakeholders. The multiple teams also compete against once other for scarce resources in an already stretched pool of specialist staff.

The new registrant programme will future proof the workforce as nurses will qualify with advanced skills and will be ready to work in a generalist community nursing role on qualifying. What is required in terms of further or specialist training can be aligned to local cluster plans and Health Board IMTPs and directed/supported in terms of local population needs assessment.

- **How effectively community nursing teams are able to work with a range of professionals and agencies (including primary and secondary care services, social care services, and the voluntary sector) to deliver seamless, person-**

centred care. Integration, IT systems, co-location, mobilisation, loss of relationships

With the ICF investment teams of Local Authority and Health staff became co located and function in an integrated management structure. The advantages of delivering on the “what matters to me” objective were obvious as patient focussed outcomes were able to be agreed. However, the integration of the Public Sector Services has come at a cost and that was the loss of synergy with the Primary Care Sector and the deterioration of previously strong professional relationships. The community nursing service is a clinical facing professional nursing service and the CNO Principles and Cluster Plans provide new opportunities to refocus the professional working relationships with Cluster teams in their broadest sense.

WCCIS will give opportunities for an integrated health and social care system, however, the system has limited interface with the GP systems. GPs are responsible for 85% of patient referrals for the DN service, thus further work is required to bring the two clinical facing professional services together. The recent mobilisation of the community nursing workforce gives rise to exciting opportunities for community nursing staff to remotely access the GP patient record which will support improved communication and partnership working for the local population.