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District Nursing All-Wales Review

Betsi Cadwaladr University Health Board

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The team who delivered the work comprised Mandy Townsend, Sara Utley, Kate Febry, Gabrielle Smith and Tracey Davies.

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Summary report

Summary

1. District nurses are a major provider of care in the community. They play a crucial role within the primary and community health care team, visiting and providing care to patients in the community and their own homes. District nurses also have a role working with patients and their relatives to help them manage their condition and treatment, avoiding unnecessary admission or readmission to hospital.
2. A district nurse's patient caseload can have a wide age range with a considerable mix of health problems, including those who are terminally ill. The largest numbers of patients are the elderly and frail. For the foreseeable future, demand for district nursing services is likely to increase because of the growing elderly population, shorter hospital stays and the move to treat more patients, often with complex care needs, in the community rather than in hospital. Across Betsi Cadwaladr University Health Board (the Health Board), the number of people aged 85 and over is expected to more than double by 2036¹ while there are increasing numbers of older people living with one or more chronic conditions.
3. The Welsh Government's chronic conditions management model², its primary and community care strategies^{3,4} both in 2010 and in 2014, signal the need to rebalance services on a whole-system basis and to provide more care in community settings. The Welsh Government's refreshed vision is for an integrated multidisciplinary team focusing on coordinating community services across geographical localities for individuals with complex health and social care needs.
4. Our previous work on chronic conditions⁵ found that:
 - few health boards have a good understanding of the capacity or capability of their community workforce, making it difficult to target training and development in order to achieve a shift in care towards the community;
 - some health boards have restructured district nursing services to provide the capacity needed to 'shift' care into the community and provide care coordination; and
 - community services for the most vulnerable patients could be better coordinated as many of these services, including district nursing, provide the same or similar care for this cohort of patients.

¹ Welsh Government, Local Authority Population Projections for Wales, 2011-based Variant Projections (SDR 165/2013), 2013

² Welsh Government, *Designed to Improve Health and Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action*, 2007

³ Welsh Government, *Setting the Direction: Primary and Community Services Strategic Delivery Programme*, 2010

⁴ Welsh Government, *Our plan for a primary care service for Wales up to March 2018*, 2014

⁵ Auditor General for Wales, *The Management of Chronic Conditions in Wales – An Update*, March 2014

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5. If these challenges are to be met, delivery of care in the community requires an appropriately coordinated, resourced and skilled workforce that is effectively deployed. With increasing demand on services and continuing financial constraints, health boards need to understand how the district nursing service is used and where it fits in the overall development of community services.
 6. Currently, the district nursing service is comprised of approximately 406 nursing staff. District nursing staff are organised into 50 teams across 14 localities with individual teams each caring for approximately 255 patients at the time of our audit. The teams generally operate between 8am and 8pm with some cover for late evening services in parts of the Health Board, and enhanced care teams providing care outside these hours for patients on the caseload.
 7. The Auditor General has carried out an all-Wales review of district nursing services based upon the collection of detailed information from all health boards. The review, carried out between March 2014 and August 2014, sought to answer the question: 'Is the Health Board planning and utilising its district nursing resources effectively as part of its wider approach to delivering care in the community?' [Appendix 1](#) sets out our audit approach.

Our main findings

8. The main conclusion from the review is that the Health Board does not have a clear strategy for its district nursing service; it has a limited understanding of demand, a lack of assurance that staff are effectively deployed and an inability to monitor and report on performance, quality and safety, which means that the potential to help shift the balance of care towards the community is unknown.
9. The table below summarises our main findings. The detailed evidence underpinning these findings is set out in [Appendix 2](#) in the form of a presentation that was given to the Assistant Director of Nursing and the Associate Chief of Staff (Nursing) for Primary Care and the Community and Specialist Medicine Clinical Programme Group on 30 October 2014. The datasets underpinning the audit findings will be shared with the Health Board.

Part 1 – The Health Board does not yet have clear plans for its district nursing service and is not clear as to how the service will support broader aims to shift the balance of care away from hospitals into the community

The district nursing service has a clear vision; however, this has not been formally adopted by the Health Board nor agreed with partners and stakeholders:

- *Healthcare in North Wales is Changing* includes a high-level aspiration to treat more patients closer to home, with an intention and a direction of travel to roll out enhanced care across all localities, but there is a lack of clarity about how district nursing will support this aspiration;
- the district nursing service developed a draft community nursing strategy in 2013, which provides more clarity at the service level, but this requires integration into wider Health Board strategic plans;
- there is no approved three-year plan which means intentions at health board level to shift care into the community and the implications of this on community services are not well articulated; and
- poor information on demand for community services hampers the service's ability to plan service changes.

In 2013, a draft specification for the district nursing service was developed without the involvement of key stakeholders and the Health Board has yet to formally agree it:

- in 2013, the Senior Nursing and Midwifery Group, Community and Specialist Medicine Clinical Programme Group senior nurses and locality matrons developed a district nursing service specification although wider stakeholders were not involved in its development;
- the Health Board has yet to approve the specification nor has the Health Board used the specification to inform any plans for district nursing services;
- district nursing teams are not actively involved in helping to plan or reshape the service to support the rebalancing of care towards the community; and
- there is a perception that external stakeholders are unwilling to agree to modernise the service, because the wider impact on these stakeholders is unknown.

Outside locality management structures, lines of accountability for the district nursing service are long and complex:

- locality management structures are consistent, with locality matrons providing operational management of local district nursing teams while the locality matrons report to the CPG's Area Clinical Lead Nurse; and
- lines of accountability to the Board are long and complex, which means that the district nursing service receives little oversight or scrutiny by the Board, although this will change under the proposed new organisational structure.

Part 2 – A limited understanding of demand makes it difficult for the Health Board to assess whether workforce numbers and skills are sufficient

Demand for district nursing services is managed locally by teams and not strategically by the Health Board:

- the draft district nursing specification contains high-level referral guidance, but there is no evidence this has been shared with referrers;
- different referral criteria are in use across localities;
- there is no system for regularly monitoring the number and reason for referrals or their appropriateness; and
- there is no standard referral form or checklist, which results in poor-quality referral information.

The Health Board does not know if it has the right number and skill mix of district nursing staff to meet demand:

- The number of district nursing staff available for the population of registered patients compares favourably with the average for Wales.
- Numbers of staff are not compared with current or future demand, and grade mix is reviewed against a Health Board profile when vacancies arise at a team or locality level.
- The district nursing workforce has reduced by eight per cent since 2011 as part of the Health Board's cost improvement plans with reductions across most pay grades. Consequently, the grade mix is largely unchanged.
- Healthcare support workers make up one-fifth of the district nursing workforce, which is higher than the Wales average but this varies across teams within and between counties.
- Just over half the district nursing teams have support from clerical staff and the Health Board is one of only two to include clerical staff within the teams.

The Health Board relies on district nurse leaders to ensure staff are appropriately skilled but appraisal and training records held centrally are unreliable and present corporate and operational risks:

- the Health Board relies on professional judgement at a team level to identify the skills needed to deliver a safe and effective district nursing service;
- team leaders told us that they have appraised and reviewed the personal development plans of all their staff in the last 12 months but records held centrally show that only a third of staff have had an appraisal and PDR review within the last 12 months;
- the Health Board recognises that information on compliance with statutory and mandatory training held centrally is incomplete and differs to that held by local teams, which means it is difficult to assess overall compliance;
- it is difficult for staff to access paid protected time for continuing professional development due to workload pressures;
- the Health Board has draft Clinical Supervision guidelines, which have been out to consultation but require ratification by the Strategic Nursing and Midwifery Committee, in the interim several team leaders have put systems in place to ensure their staff have access to monthly supervision;
- typically, from the evidence gathered during the audit, district nursing staff are making use of the skills for which they have received training; and
- the proportion of registered district nursing staff who hold a specialist practitioner qualification compares well with the Wales average but there are big differences between teams.

Part 3 – The Health Board cannot take assurance that its district nursing staff are effectively deployed

There is unexplained variation in the way district nursing teams are deployed:

- there are ad hoc systems in place to deploy staff according to need at a team level but these systems do not support flexibility at a locality or county level;
- the proportion of time spent on direct patient care is the same as the Wales average;
- but, there are differences in the proportion of time spent on direct patient care across counties, localities and teams;
- overall, travel time accounts for less than a fifth of the time spent on patient-related activity but this varies across localities;
- however, average travel time per patient contact varies twofold between localities with similar levels of rurality;
- the proportion of time that staff spend with patients and in non-patient-related activity varies across and within grades, although there does not appear to be a clear rationale for this variation;
- the grade mix of staff deployed across the week appears cost effective with Band 7 staff deployed primarily during weekdays, reducing additional Agenda for Change allowances; and
- a small proportion of time is spent on 'wasted' journeys where patients are not at home.

Service provision is based on historic patterns of staffing rather than assessment of caseload need:

- Workloads, measured as numbers of patients per district nurse, varied threefold between district nursing teams and it is unclear whether the variation reflects patient need or historical staffing allocations.
- The district nursing service undertook 15,691 contacts with patients during the reference week; an average of 44.5 per WTE member of staff but there is significant unexplained variations between teams.
- At the time of the audit, just over half of the district nursing staff worked in excess of their contracted hours.

Caseload holders manage their own caseloads but there is no systematic review mechanism in place across the Health Board:

- caseload holders review caseloads to manage their workloads, but do not have standardised tools to help them in this task;
- staff report that patients get discharged when treatment is finished or care is no longer required, but there may be scope to discharge through regular systematic review as practice varies across teams;
- caseloads generally never close but keep stretching to accommodate more patients;
- some patients are visited at home but are not necessarily 'housebound'; and
- some patients remain on the caseload for a long time.

The Health Board relies on local contacts and informal mechanisms to minimise duplication of care:

- The Health Board has a policy whereby district nurses become the case manager, but this is not uniform with district nursing teams coordinating or case managing services for only three-fifths of the patients on the caseload.
- There is integrated working at team level with other health and social care professionals to identify the needs of the patients on individual caseloads. But:
 - there has been limited progress towards addressing duplication and overlap with GPs or practice nurses; and
 - communication channels between district nurses and other primary and social care professionals rely on local contacts and knowledge.

Part 4 – The Health Board is currently unable to systematically assess, monitor and report on the performance, quality and safety of its district nursing service and has only informal mechanisms to identify and share good practice

The Health Board is developing key performance indicators to routinely assess, monitor and report on district nursing services, but current information is patchy and ad hoc:

- The Health Board is in the process of defining what information it needs to monitor demand, performance and quality of its district nursing services; in the future, the all-Wales Fundamentals of Care audit, soon to be rolled out to district nursing services, will provide some information.
- The Health Board uses one-off exercises to enable it to assess and monitor demand for services and performance and the quality of its district nursing service, but more systematic methods would better inform day-to-day management.
- There are some mechanisms in place to seek patient and user experience feedback to assess the quality of the district nursing service.
- Information is too poor to effectively support service improvements.

Senior district nurses actively participate in the All Wales District Nursing Forum, but there are no effective mechanisms in place to identify and share good or innovative practice across the Health Board:

- senior district nurses actively participate in the All Wales District Nursing Forum;
- there are no formal mechanisms for sharing learning or good practice within the Health Board's community services;
- although sharing good practice is part of the locality matron role, this is not happening in practice due to workload pressure; and
- district nurses are aware of developments within and outside the Health Board through their own endeavours rather than through a health board-wide system to ensure all district nurses are kept up to date.

Recommendations

Strategy and planning

- R1 The role of the district nursing service needs to be clearly articulated. Drawing on the findings from this review, the Health Board should work with district nursing staff and other key stakeholders to agree the role and responsibilities of the district nursing service within the wider provision of community nursing services by:
- agreeing where care will be provided and defining 'housebound' so that patients are treated in the most appropriate care setting for their needs, while ensuring service efficiency;
 - agreeing what care or services will or will not be provided, such as annual venepuncture or 'checks';
 - raising awareness with potential referrers of what the district nursing service can offer;
 - publicising the purpose of the district nursing service with potential users; and
 - considering whether there are opportunities to integrate separate community nursing teams into one team.

- R2 The district nursing service needs to integrate its strategy and plans with the rest of the Health Board, and gain formal recognition and approval of these plans. The Health Board must ensure that planning support to the proposed area management teams enables district nursing service's involvement in planning for future services.

Resources to meet demand

- R2 The district nursing caseload stretches to accommodate new patients and the number of visits is potentially unlimited. The Health Board working with its district nursing teams should:
- agree a threshold at which point the caseload might be closed to new referrals;
 - develop escalation procedures when the threshold is likely to be breached; and
 - consider whether care delivered to patients seen infrequently is needed or whether these patients can be safely discharged from the caseload or their care provided by other professionals.
- R3 Not all referrals to the district nursing service are appropriate and the quality of referral information is sometimes poor. The Health Board should:
- use the referral criteria it has drafted and communicate these to referrers;
 - develop a clear checklist of information required from referrers to support the new Integrated Assessment documentation; and
 - regularly audit compliance with the criteria and checklist of information and target education on those who refer inappropriately or provide poor information.

Effective deployment

- R4 There were big differences in how district nursing staff spend their working day. To support effective deployment of its district nursing resource, the Health Board needs to:
- monitor grade-mix by comparing the work done with activities expected by the grade of nurse;
 - examine the variation in non-patient activity and consider whether there are opportunities to free up time for direct patient care;
 - explore the true extent of excess hours working; and
 - examine the differences between teams in the types of care interventions, such as venepuncture, to determine whether existing resources could be used differently.

- R5 There were big differences in how team leaders spent their time. The Health Board should agree mechanisms to allow team leaders protected time from operational duties to proactively manage caseloads, supervise and support staff, and lead their teams.

Matching resources to the caseload

- R6 Workload varies between teams. The Health Board should use the all-Wales dependency tool when it becomes available to monitor and review the case mix between teams compared with team resources.

Monitoring and improving services

- R7 There is currently limited information about the quality and safety and overall performance of the district nursing service. The Health Board should:
- Rapidly progress its work to agree performance measures, including information on the quality and safety of the services, such as compliance with appraisals and statutory and mandatory training, service user experience, patient outcomes, service costs and the contribution of district nursing in shifting care from acute to community settings.
 - Develop a comprehensive approach of reporting these measures to the Board at least biannually.
 - Ensure a fit-for-purpose Community Information System is rapidly adopted, which is able to produce information on efficiency and performance of district nursing services; the collection of appropriate quality metrics; and the production of a dashboard at team, locality, county or area and Health Board level.
 - Develop local forums for district nurses to share learning and good practice at Health Board and area or locality levels.
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- R8 Compliance with both the appraisal and the personal development plan review process and statutory and mandatory training is poor and corporate systems to monitor compliance are inadequate. The Health Board should:
- work with local managers to consistently identify and record the statutory and mandatory training each member of staff needs and its required frequency so that compliance rates can be calculated accurately; and
 - agree a consistent format for collecting data locally on compliance and the mechanism to feed this information in centrally.

Appendix 1

Audit approach

The audit asked the question: 'Is the Health Board planning and utilising its district nursing resources effectively as part of its wider approach to delivering care in the community?'

In particular, we examined whether:

- there is a clear strategy for the delivery of district nursing service;
- there are adequate district nursing resources to meet demand;
- district nursing resources are effectively deployed; and
- there are effective arrangements to monitor the quality and performance of district nursing services.

We carried out a number of audit activities between March and July 2014 to answer these questions. Each audit activity, described in the table below, was conducted in successive weeks to minimise the impact of one activity upon another.

Audit activities	Purpose
1. Team survey	<p>We asked individual team leaders to complete a short questionnaire survey about their respective teams. The survey sought information on workforce numbers, types of care activities staff were trained to deliver and whether these skills were being utilised, numbers of staff with specialist practitioner qualifications, participation in clinical supervision, and protected time for training.</p> <p>We received 50 completed surveys – 46 from district nursing teams, two from the enhanced care teams and two from the chronic conditions teams in the central area.</p>
2. Individual workload diary	<p>We asked all nursing staff, working as a part of a district nursing team at the time of the audit, to keep a seven-day activity diary between 31 March and 5 April 2014. The diary captured the amount of time individual nursing staff spent on different types of activity, and the number and location of patient contacts.</p> <p>We received 494 completed diaries for the reference week from staff working as members of staff for the district nursing service, the enhanced care service and the chronic conditions teams. These staff included bank staff, third-year pre-registration students and post-registration students.</p>

Audit activities	Purpose
<p>3. Prospective survey of referrals to the service</p>	<p>We asked district nursing teams to complete a short questionnaire survey about each referral the team received between 6 April and 12 April 2014. The survey sought information on the number and nature of the referrals made to district nursing services, including the quality of the referral information and the perceived appropriateness of referrals received by the district nursing teams. Each team completed a questionnaire survey for each new referral received that resulted in a face-to-face visit or a telephone call.</p> <p>We received 1,144 completed surveys from district nursing teams.</p>
<p>4. Caseload survey</p>	<p>Team leaders were asked to complete a survey questionnaire about each 'active' patient, that is, any patient for whom the district nursing team had visited, or had been in contact with, during the previous six months and for whom another visit was planned. Team leaders could undertake the review anytime between 13 April and 26 April 2014. We sought information about the composition of the caseload, in particular the following factors:</p> <ul style="list-style-type: none"> • age and gender; • whether the patient is considered housebound; • types of care interventions; • frequency of visits; • length of time on the caseload; • whether nursing care is needed out of hours; and • whether the patient receives care or support from other community health care services, specialist nurses, social services and unpaid carers. <p>We received 12,510 completed surveys (including 145 responses for the enhanced care teams and CCM teams). One team was unable to complete the exercise due to staff shortages.</p>
<p>5. Health board survey</p>	<p>We asked the Health Board to complete a short questionnaire survey, which sought information about the model of provision for district nursing services, trends in workforce numbers and service expenditure, information on compliance with the appraisal and performance review process and statutory and mandatory training and arrangements for performance management, including aspects of quality and safety.</p>
<p>6. Workshops with team leaders and managers</p>	<p>We shared the findings from the data collection exercises with team leaders and locality matrons at a feedback workshop held at the end of July. This workshop provided an opportunity for team leaders to comment on the validity of the findings.</p>

Audit activities	Purpose
7. Workshop with senior nurse management team and executive directors	We met with the Assistant Director of Nursing and the Associate Chief of Staff (Nursing) for Primary care, Community and Specialist Medicine Clinical Programme Group at the end of October to share our initial conclusions based on the audit findings.

Appendix 2

Presentation of key findings

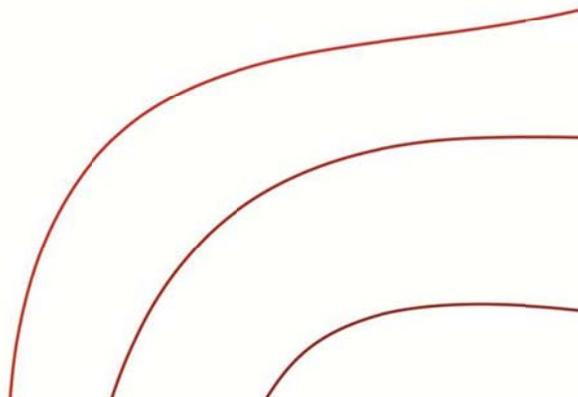
The data presented in this appendix is for the district nursing service. We shared the survey findings for the district nursing teams with the Health Board as part of our initial feedback.



October 2014

District Nursing Review

Betsi Cadwaladr University Health Board



Aim of today

- Provide a very brief overview of background and approach
- To share and discuss our findings and early conclusions
- To discuss next steps

District Nursing Review

Slide 2

Background

- District nurses are a major provider of healthcare delivered in patients homes.
- The demand for district nursing services is likely to rise in Betsi Cadwaladr University Health Board.
 - The population aged 85 and older is forecast to more than double by 2036.
 - There are pockets of deprivation and rurality that impact on demand for services.
 - There are increasing numbers of older people living with one or more chronic conditions.
- Our previous national report on chronic conditions found that:
 - Few health boards had a good understanding of the capacity or capability of their community workforce, making it difficult to target training and development in order to achieve a shift in care towards the community;
 - Some health boards had restructured district nursing services to provide the capacity needed to 'shift' care into the community and provide care coordination; and
 - Community services for the most vulnerable patients could be better coordinated as many of these services, including district nursing, provide the same or similar service for this cohort of patients.
- Delivery of care closer to home requires an appropriately resourced and skilled community workforce that is effectively deployed.
- With increasing demand and continuing financial constraints, health boards need to understand how the district nursing service is used and where it fits in the overall development of community services.

District Nursing Review

Slide 3

Audit approach

Is the Health Board planning and utilising its district nursing resources effectively as part of its wider approach to delivering care in the community?

- Is there a clear strategic approach?
- Are there adequate resources to meet demand?
- Are staff effectively deployed?
- Are there effective arrangements to monitor and improve services?

- **Local data collection to answer these questions.**
 - general information survey (50 teams, including enhanced care and chronic conditions team and evening service)
 - diary exercise (494);
 - caseload review (12,510);
 - referral survey (1,144); and
 - health board survey.

District Nursing Review

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Key messages

The Health Board does not have a clear strategy for its district nursing service; it has a limited understanding of demand, a lack of assurance that staff are effectively deployed and an inability to monitor and report on performance, quality and safety, which means that the potential to help shift the balance of care towards the community is unknown.

- The Health Board does not yet have clear plans for its district nursing service and is not clear as to how the service will support broader aims to shift the balance of care away from hospitals into the community.
- A limited understanding of demand makes it difficult for the Health Board to assess whether workforce numbers and skills are sufficient.
- The Health Board cannot take assurance that its district nursing staff are effectively deployed.
- The Health Board is currently unable to systematically assess, monitor and report on the performance, quality and safety of its district nursing service and has only informal mechanisms to identify and share good practice.

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The Health Board does not yet have clear plans for its district nursing service and is not clear as to how the service will support broader aims to shift the balance of care away from hospitals into the community.

The district nursing service has a clear vision, however this has not been formally adopted by the Health Board nor agreed with partners and stakeholders.

- *Healthcare in North Wales is Changing* includes a high level aspiration to treat more patients closer to home, with an intention and a direction of travel to roll out enhanced care across all localities. But
 - no other detail on community nursing services; or
 - how all of the community services will fit together
- The district nursing service developed a draft community nursing strategy in 2013, which provides more clarity at the service level, but this requires integration into wider Health Board strategic plans.
- There is no approved three year plan which means intentions at whole health board level to shift care into the community and the implications of this on community services are not well articulated
- Poor information on demand for community services hampers the service's ability to plan service changes

Operational planning

In 2013, a draft specification for the district nursing service was developed without the involvement of key stakeholders and the Health Board has yet to formally agree it

- In 2013, the Senior Nursing and Midwifery Group, Community and Specialist Medicine Clinical Programme Group senior nurses and Locality Matrons developed a district nursing service specification although wider stakeholders were not involved in its development.
- The Health Board has yet to approve the specification nor has the Health Board used the specification to inform any plans for district nursing services.
 - The draft specification sets out the type of skills required across district nursing teams but lacks any detail on how gaps in resources will be filled.
 - The draft specification also sets out referral guidelines as well as the types of care patients could receive.
- District nursing teams are not actively involved in helping to plan or reshape the service to support the rebalancing of care towards the community.
 - Instead, teams perceive that they are simply "*expected to pick up the pieces when patients are discharged into the community*".
- There is a perception that external stakeholders are unwilling to agree to modernise the service, because the wider impact on these stakeholders is unknown

District Nursing Review

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Lines of accountability

Outside locality management structures, lines of accountability for the district nursing service are long and complex.

- Locality management structures are consistent, with Locality Matrons providing operational management of local district nursing teams while the Locality Matrons report to the CPG's Area Clinical Lead Nurse.
- Lines of accountability to the Board are long and complex, which means that the district nursing service receives little oversight or scrutiny by the Board.
 - Lines of accountability are likely to change in the near future with the implementation of a new organisational structure
 - the area-based structure will shorten the management chain and place District nurses closer to the Board

District Nursing Review

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A limited understanding of demand makes it difficult for the Health Board to assess whether workforce numbers and skills are sufficient.

The Health Board does not understand demand for its district nursing service.

- Limited information about current levels of demand mean assumptions have been made at a Health Board level about the capacity that the district nursing service has to absorb more patients.
- Caseloads are not systematically reviewed at a Health Board level so there is little understanding outside individual teams or localities about the numbers and needs of patients on the caseload.
- The information systems used by district nursing teams vary between and within localities.
- In common with other health boards in Wales, there is no standard measure in place to assess patients' dependency or acuity against available resources.

Understanding demand

Caseload findings:

- There are 12,510 'active' patients i.e. patients seen within the last six months, across 49 caseloads
 - 85% of patients are aged 65 years and over; 38% of patients are 85 years or older
 - 40% of patients receive a weekly or more frequent visit, 8% receive a fortnightly visit, 20% receive monthly visits, 19% receive visits every 2 to 3 months, 7% receive visits 4 to 6 monthly and 5% receive visits once a year
 - 5% of patients have nursing needs outside core hours
 - 51% of patients receive support from an unpaid carer
- Three-fifths (62%) of patients are considered to be 'housebound' but this varies between teams (range 8% to 94%) with some teams visiting patients at home because these patients do not have transport that would enable them to attend a surgery or clinic.
- Most patients receive a single-handed visit in their own home.
- Patients receiving a 'one-off visit' are not always captured on the caseload, which means that overall demand may be underestimated.
- More than one-third (35%) of patients have been on the caseload for more than 2 years but there are variations between teams.
- Nearly half (49%) the patients receive one care intervention typically for wound care, venepuncture and continence management and medication administration.

District Nursing Review

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Managing demand

Demand for district nursing services is managed locally by teams and not strategically by the Health Board.

- The draft district nursing specification contains high level referral guidance, but there is no evidence this has been shared with referrers.
- Different referral criteria are in use across localities.
- There is no system for regularly monitoring the number and reason for referrals or their appropriateness.
- There is no standard referral form or checklist, which results in poor quality referral information.

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Referral survey findings:

- In the week of the audit (April 2014), 1,144 referrals were received. Of these referrals:
 - 99% were received during core hours
 - 38% were for patients known to the DN service
 - Few (1%) were received at the weekend with the peak on Monday and Tuesday
 - 50% of referrals were received from GPs and 23% received from ward staff
 - 6% were perceived to prevent hospital admission/attendance and 23% perceived to support earlier discharge
- Three-fifths (63%) of patients were seen the same the referral was received with a further fifth (22%) seen the next day but there are big differences between localities.
- Two-fifths (42%) of referrals resulted in on-going care after the first visit; 25% of referrals resulted in an one-off visit and for 33% of referrals ongoing care had yet to be agreed.
- Nearly all (96%) referrals were deemed appropriate.
- Four-fifths of referrals (80%) were considered to provide adequate information but basic information was missing.
- Three-quarters of referrals were for wound management, venepuncture and ear care.

District Nursing Review

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Three-quarters of referrals were for wound management, venepuncture and ear care.

Reason for referral	Proportion of referrals
Wound management	34%
Venepuncture	30%
Ear care	10%
Contenance management	6%
Other e.g. advice, acute illness, end of life care	5%
District nursing assessment	5%
Administering medications, including intravenously	4%
Monitoring e.g. blood pressure	4%
End of life care	1%
Support or advice for patients & carers	1%
Continuing healthcare assessment	1%
Acute illness	1%

District Nursing Review

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Managing demand

Referral information about new patients is considered adequate but basic information is missing.

Did the referral information for new patients include...	
the urgency of the referral?	59%
the medical history or diagnosis?	51%
whether the patient lives alone?	26%
whether equipment or dressings would be required?	22%
whether the patient has a carer?	18%
whether other health professionals are involved in the patient's care?	16%
how you would gain access to the patient's home?	12%
whether social services are involved in the patient's care?	8%
whether voluntary services are involved in the patient's care?	4%

District Nursing Review

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Available resources to meet demand

The Health Board does not know if it has the right number and skill mix of district nursing staff to meet demand.

- The number of district nursing staff available for the population of registered patients compares favourably with the average for Wales at 2.8 WTE district nursing staff per 1,000 population aged 65 or older.
- Numbers of staff are not compared with current or future demand, and grade mix is reviewed against a Health Board profile when vacancies arise at a team or locality level.
 - A long replacement process means some staff are working longer hours and the use of temporary staff is increasing.
- The district nursing workforce has reduced by 8% since 2011 as part of the Health Board's cost improvement plans with reductions across most pay grades. Consequently, the grade mix is largely unchanged.
 - At the time of the audit, the vacancy rate was 4% compared with 5% across Wales (ranging from 2% to 9%).
 - Between the end of 2010-11 and 2012-13, expenditure on pay for permanent district nursing staff reduced by 8% while pay for temporary staff increased by 57%; by 2013-14 pay costs had increased for permanent staff and reduced for temporary staff.

District Nursing Review

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Available resources to meet demand

Continued

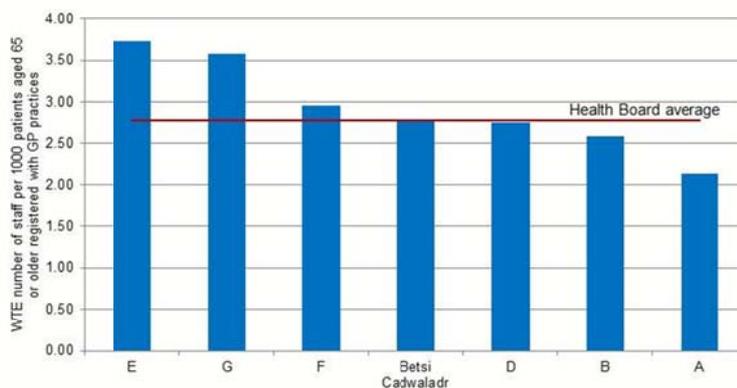
- Healthcare support workers make up one-fifth of the district nursing workforce, which is higher than the Wales average but this varies across teams within and between counties.
 - Across Wales, healthcare support workers make up 17% of the district nursing workforce but ranges from 11% to 22%.
- Just over half the district nursing teams have support from 'admin' and clerical staff and the Health Board is one of only two to include 'admin' and clerical staff within the teams.

District Nursing Review

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Available resources to meet demand

The number of district nursing staff available for the population of registered patients aged 65 or older is the same as the Wales average.



District Nursing Review

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Available resources to meet demand

The number of district nursing staff reduced by 8% between 2011 and 2013.

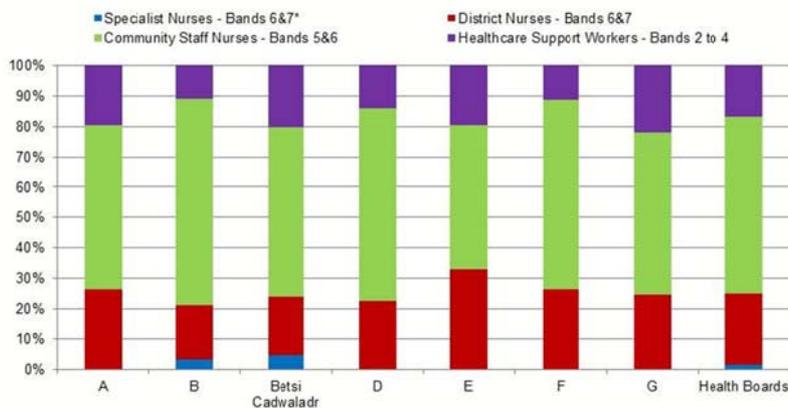
Pay grade	Whole-time equivalent number of district nursing staff at 30 th September:		
	2011	2012	2013
District Nurse – Band 7	81.2	71.8	69.8
District Nurse – Band 6	58.4	55.9	57.1
Community staff nurse – Band 5	221.2	213.7	203.7
Healthcare support workers - Band 3	67.7	60.0	64.5
Healthcare support workers - Band 2	2.8	2.8	1.8
Betsi Cadwaladr	431.3	404.1	397.0

District Nursing Review

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Available resources to meet demand

The proportion (20%) of healthcare support workers is one of the highest in Wales.

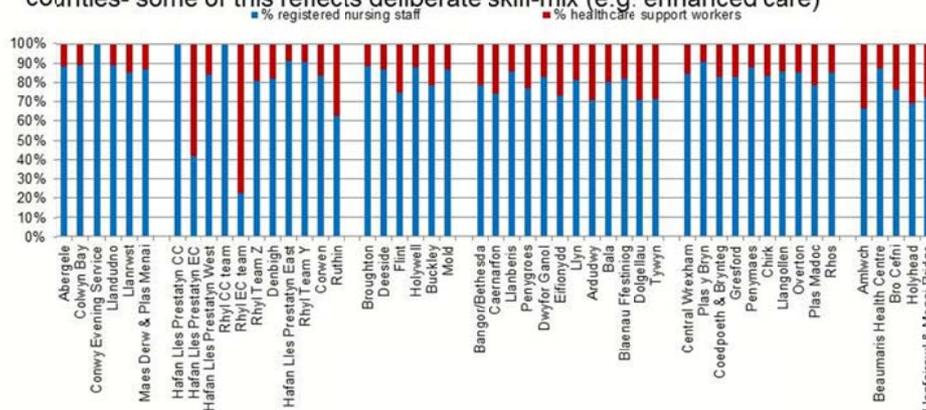


District Nursing Review

Slide 21

Available resources to meet demand

The proportion of healthcare support workers varies between teams and counties- some of this reflects deliberate skill-mix (e.g. enhanced care)



District Nursing Review

Slide 22

Equipping staff with skills to provide services

The Health Board relies on district nurse leaders to ensure staff are appropriately skilled but appraisal and training records held centrally are unreliable and present corporate and operational risks.

- The Health Board relies on professional judgement at a team level to identify the skills needed to deliver a safe and effective district nursing service.
 - Training needs assessments and skills deficits are identified informally
- Team leaders told us that they have appraised and reviewed the personal development plans of all their staff in the last 12 months but records held centrally show that only a third of staff have had an appraisal and PDR review within the last 12 months.
- The Health Board recognises that information on compliance with statutory and mandatory training held centrally is incomplete and differs to that held by local teams, which means it is difficult to assess overall compliance.
- It is difficult for staff to access paid protected time for continuing professional development due to workload pressures.
 - 7 of the 50 teams indicated that they never had access to paid protected time

District Nursing Review

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Equipping staff with skills to provide services

Continued ...

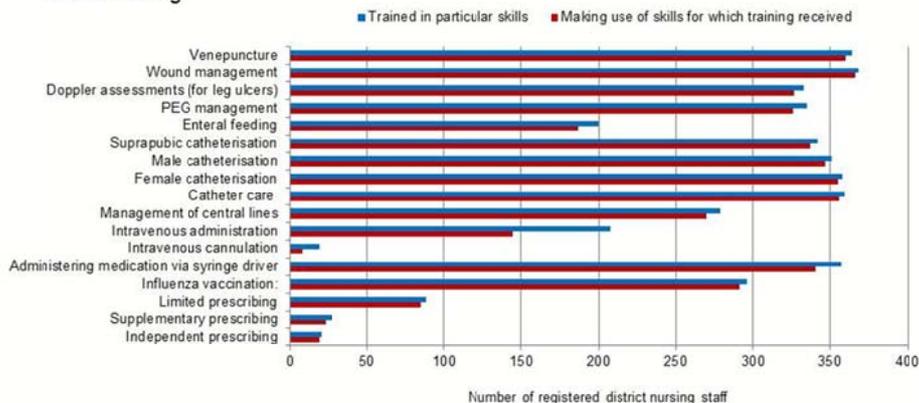
- The Health Board has draft Clinical Supervision guidelines, which have been out to consultation but require ratification by the Strategic Nursing and Midwifery Committee, in the interim several team leaders have put systems in place to ensure their staff have access to monthly supervision.
- Typically, from the evidence gathered during the audit, district nursing staff are making use of the skills for which they have received training.
- The proportion of registered district nursing staff who hold a specialist practitioner qualification compares well with the Wales average but there are big differences between teams.
 - The proportion of registered district nursing staff holding a SPQ varies from 0% to 100% across teams; 7 teams indicated that no team members held a SPQ;
 - Across Wales, one-quarter (26%) of registered district nursing staff hold a SPQ, ranging from 18% to 35%.
 - The time taken to train using the modular approach is long (upto three years) and backfill is an issue

District Nursing Review

Slide 24

Equipping staff with skills to provide services

Typically, registered district nursing staff are making use of the skills for which they have received training.



District Nursing Review

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The Health Board cannot take assurance that its district nursing staff are effectively deployed.

There is unexplained variation in the way district nursing teams are deployed.

- There are ad hoc systems in place to deploy staff according to need at a team level but these systems do not support flexibility at a locality or county level.
- The proportion of time spent on direct patient care is the same as the Wales average.
- But, there are differences in the proportion of time spent on direct patient care across counties, localities and teams.
- Overall, travel time accounts for less than a fifth of the time spent on patient related activity but this varies across localities.
 - Across Wales, travel time accounts for 18% of the time spent on patient related activity (range 17% to 22%).
- However, average travel time per patient contact varies two-fold between localities with similar levels of rurality.
 - Some teams manage travelling by planning non-urgent visits geographically close together on the same day.

Effective deployment

Continued ...

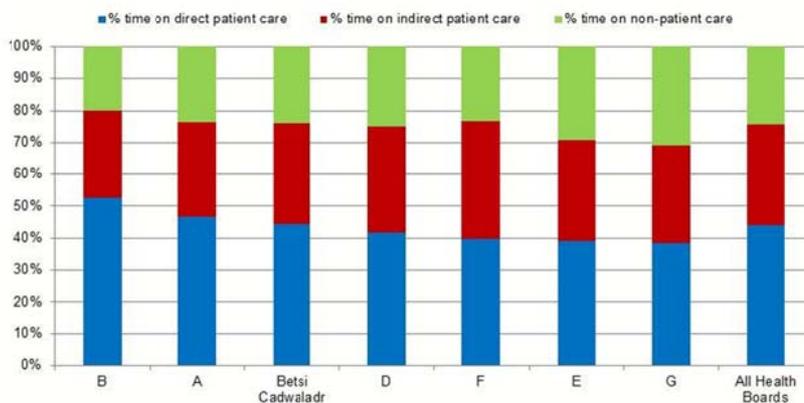
- The proportion of time that staff spend with patients and in non-patient related activity varies across and within grades, although there does not appear to be a clear rationale for this variation.
 - The proportion of time on direct patient care reduces with increasing seniority.
 - There are big differences in how time team leaders and caseload holders spend their time.
 - Some teams do not have administration and clerical support, which accounts for some of the time spent by staff on 'admin'.
- The grade mix of staff deployed across the week appears cost effective with Band 7 staff deployed primarily during weekdays, reducing additional Agenda for Change allowances.
- A small proportion of time is spent on 'wasted' journeys where patients are not at home.

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Effective deployment

Direct patient care accounts for 44% of staff time, which is the same as the Wales average.

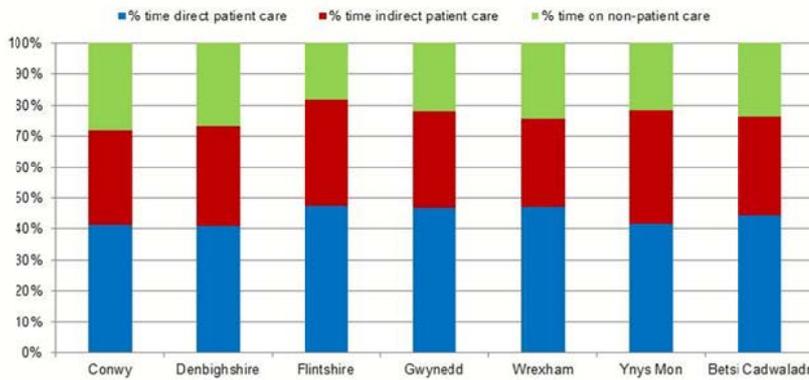


District Nursing Review

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Effective deployment

District nursing staff spend 44% of their time on direct patient care but there are small variations between counties.

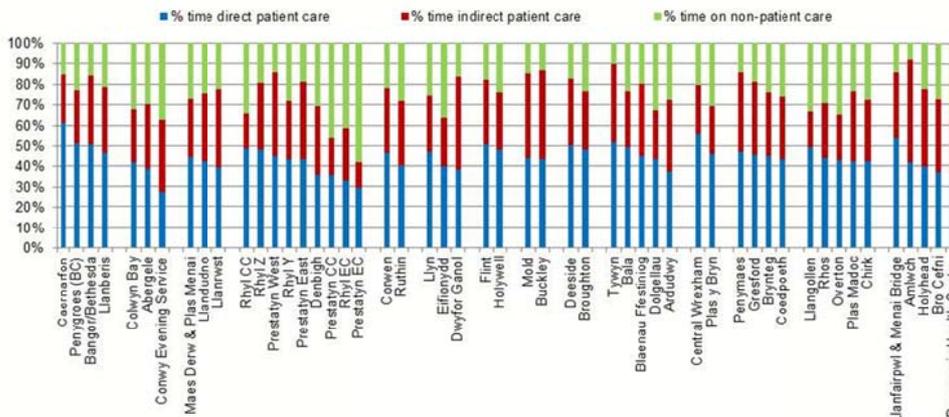


District Nursing Review

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Effective deployment

There are differences across teams and localities in the proportion of time spent with patients.

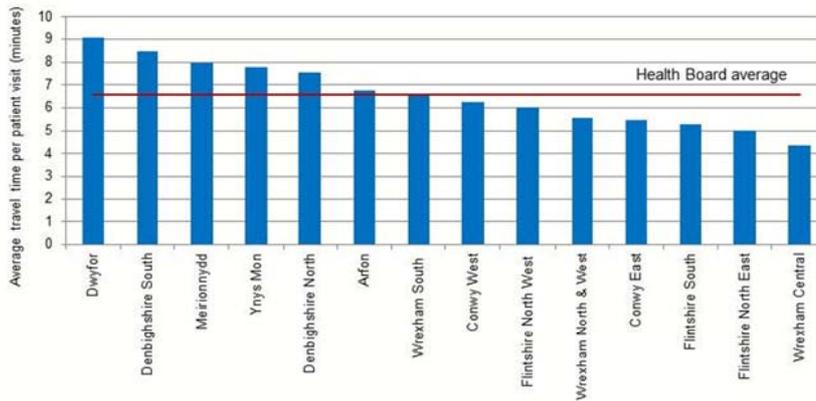


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Effective deployment

Average travel time per patient visit varies two-fold between localities.

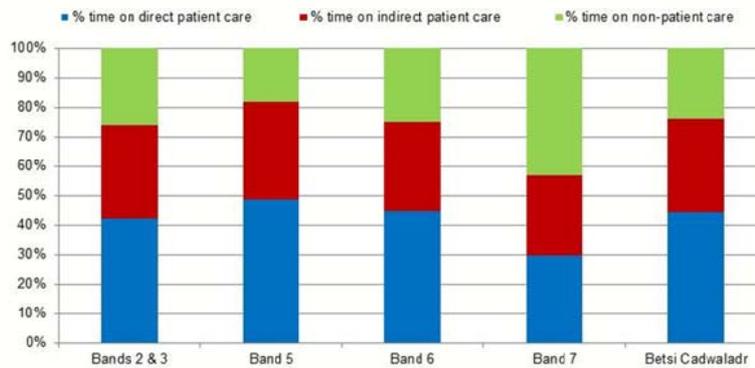


District Nursing Review

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Effective deployment

The proportion of time spent on direct patient care reduces with increasing seniority.

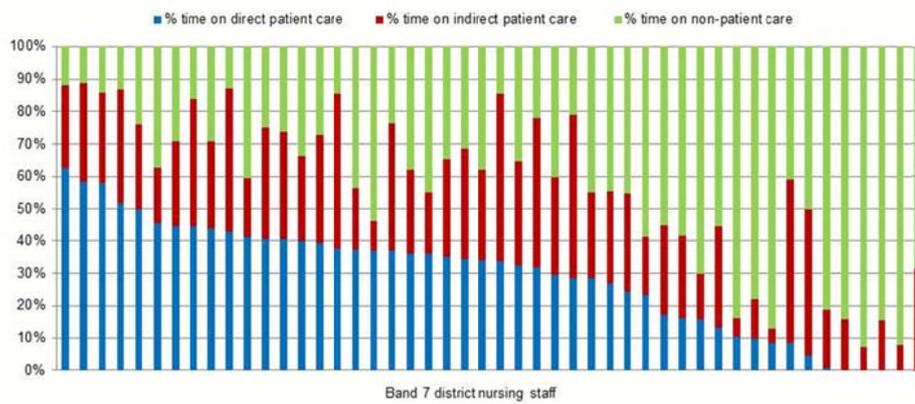


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Effective deployment

There are big differences in how team leaders (Band 7) spend their time.

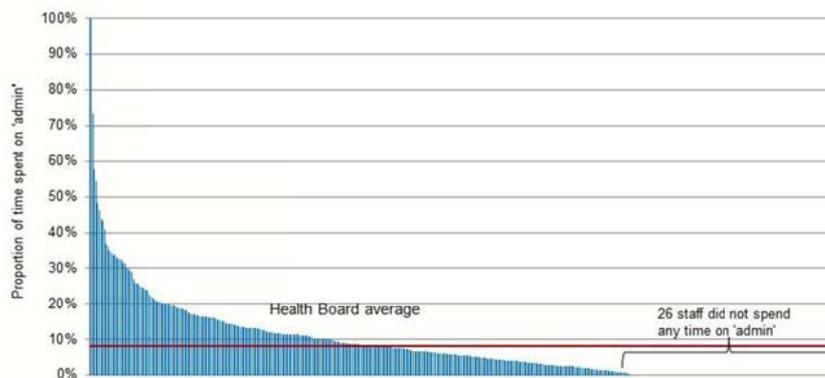


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Effective deployment

Not all teams have access to 'admin & clerical' support, which partially explains some of the time spent on 'admin'.



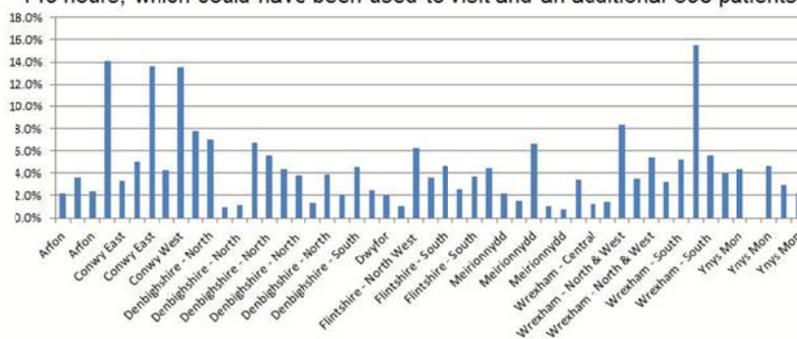
District Nursing Review

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Effective deployment

A small proportion of time is spent on 'wasted' journeys where patients are not at home

- 'No access' visits accounted for 4% of all contacts but was as high as 15% for some teams. Although 'no access visits' account for just 1% of staff time, this equates to 149 hours, which could have been used to visit an additional 398 patients



District Nursing Review

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Matching resources to the needs the caseload

Service provision is based on historic patterns of staffing rather than assessment of caseload need.

- Workloads, measured as numbers of patients per district nurse, varied threefold between district nursing teams and it is unclear whether the variation reflects patient need or historical staffing allocations.
- The district nursing service undertook 15,691 contacts with patients during the reference week; an average of 44.5 per WTE member of staff (very close to the Wales average of 43), but this varied significantly between teams from a high of 87.8 to a low of 27.0 in core day teams.
 - Most contacts (90%) took place during the week.
 - The average length of each patient contact was 22 minutes, but this varied between teams and localities.
 - Three-quarters (74%) of contacts took place in patients' homes, 9% in clinics and 11% by telephone.
 - Only a few (2%) contacts took place outside core hours (twilight).
 - 7% of contacts were double handed
 - A very small proportion (1.5%) of staff time was spent on activity related to continuing healthcare needs as expected as delivery is contracted out.
- At the time of the audit, just over half (52%) of the district nursing staff worked in excess of their contracted hours.
 - Staff, excluding pre and post-registration students and bank staff, worked anywhere from a few minutes up to 34 hours in excess of their contracted hours during the audit. Those working excessive hours worked part time.
 - The median excess hours worked was 2.4, the equivalent of an additional 7.8 WTE staff.

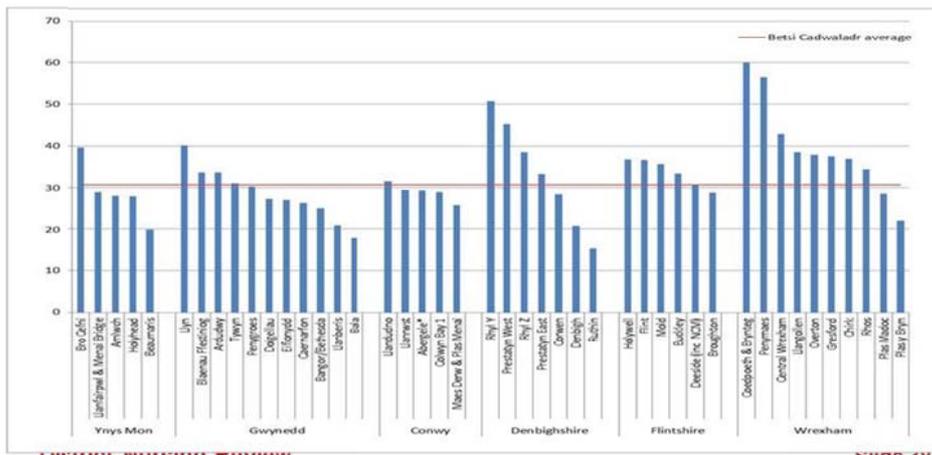
District Nursing Review

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Matching resources to the needs the caseload

There is marked variation in the number of active patients on the caseloads per WTE staff in post



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Local caseload management

Caseload holders manage their own caseloads but there is no systematic review mechanism in place across the Health Board.

- Caseholders review caseloads to manage their workloads, but do not have standardised tools to help them in this task.
- Staff report that patients get discharged when treatment is finished or care is no longer required, but there may be scope to discharge through regular systematic review as practice varies across teams
- Caseloads generally never close but keep stretching to accommodate more patients.
 - One team reported that the caseload had been closed in the last 18 months due to exceptional staffing pressures.
 - Staff describe caseloads as elastic and believe that some patients could be seen by other healthcare professionals.
 - Nearly three-fifths of the teams told us that there was a limit to the number of visits that could be made to individual patients in any one day during core daytime hours.
- Some patients are visited at home but are not necessarily 'housebound'.
- Some patients remain on the caseload for a long time.

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Care coordination

The Health Board relies on local contacts and informal mechanisms to minimise duplication of care.

- The Health Board has a policy whereby district nurses become the case manager, but this is not uniform with district nursing teams coordinating or case managing services for only three-fifths of the patients on the caseload.
 - 1 in 3 patients on the caseload receive care from other healthcare services or other specialist staff.
 - 40% of patients on the caseload receive care from social services, although for a small proportion of patients (9%), it is not known if support is provided by social services.
- There is integrated working at team level with other health and social care professionals to identify the needs of the patients on individual caseloads. But;
 - there has been limited progress towards addressing duplication and overlap with GPs or practice nurses.
 - communication channels between district nurses and other primary and social care professionals rely on local contacts and knowledge.

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Arrangements to monitor and improve services

The Health Board is currently unable to systematically assess, monitor and report on the performance, quality and safety of its district nursing service and has only informal mechanisms to identify and share good practice.

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Monitoring and reporting performance

The Health Board is developing key performance indicators to routinely assess, monitor and report on district nursing services, but current information is patchy and ad hoc.

- The Health Board is in the process of defining what information it needs to monitor demand, performance and the quality of its district nursing services.
 - No clear outcome measures have yet been identified and district nursing teams recognise that they are unable to demonstrate the impact of the service on patient outcomes.
 - But, district nurses are actively involved in developing community aspects of the all-Wales Fundamentals of Care audit, soon to be rolled out to district nursing services, will provide some information.
- The Health Board uses one-off exercises to enable it to effectively assess and monitor demand for services and performance and the quality of its district nursing service, but more systematic methods would better inform day-to-day management.
- There are some mechanisms in place to seek patient and user experience feedback to assess the quality of the district nursing service.
 - The Health Board has worked with the local community health council to seek patients' views.
- Information is too poor to effectively support service improvements.

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Identifying and sharing good practice

Senior district nurses actively participate in the All Wales District Nursing forum, but there are no effective mechanisms in place to identify and share good or innovative practice across the Health Board.

- Senior district nurses actively participate in the All Wales District Nursing forum.
- There are no formal mechanisms for sharing learning or good practice within the Health Board's community services.
 - Feedback workshops as part of the audit enabled team leaders to get together for the first time.
- Although sharing good practice is part of the Locality Matron role, this is not happening in practice due to workload pressure.
 - Note: the Locality Matrons have a wide remit, and are the only dedicated full-time member of the Locality Management teams, the GP-Clinical Directors and Managers are part-time.
- District nurses are aware of developments within and outside the health board through their own endeavours rather than through a Health Board wide system to ensure all district nurses are kept up to date.

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Recap on key messages

The Health Board does not have a clear strategy for its district nursing service; it has a limited understanding of demand, a lack of assurance that staff are effectively deployed and an inability to monitor and report on performance, quality and safety, which means that the potential to help shift the balance of care towards the community is unknown.

- The Health Board does not yet have clear plans for its district nursing service and is not clear as to how the service will support broader aims to shift the balance of care away from hospitals into the community.
- A limited understanding of demand makes it difficult for the Health Board to assess whether workforce numbers and skills are sufficient.
- The Health Board cannot take assurance that its district nursing staff are effectively deployed..
- The Health Board is currently unable to systematically assess, monitor and report on the performance, quality and safety of its district nursing service and has only informal mechanisms to identify and share good practice.

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Themes for our recommendations

There are number of themes for our recommendations

- Strategy and planning
- Resources to meet demand
- Effective deployment
- Matching resources to the caseload
- Monitoring and improving services

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