WESTERN ISLES NHS BOARD

Review of Community Nursing

April 2015

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1. VISION

Community Nursing will:

A EVOLVE TO MEET THE CHALLENGES OF ISLAND HEALTH NEEDS, DEMOGRAPHY AND ECONOMY,

- Be flexible and responsive to the population’s health and well being needs
- Develop services that are appropriate and sustainable within geographical locations/island wide

B BE APPROPRIATE AND RESPONSIVE TO THE CHANGING NEEDS OF PATIENTS

- Enable more people to sustain and improve their health
- Develop our person-centred approach

C BE PROACTIVE (NOT REACTIVE), ANTICIPATE NEED AND PREVENT ILLNESS

- Evolve and respond to support new ways of working, mapped to a career framework model
- Increase the range and roles of community nursing

D BE AT THE CENTRE OF THE DELIVERY OF COORDINATED JOINT SERVICES

- Support appropriate local and timely access to other services and agencies
- Develop a coordinating role within multi-disciplinary teams
1.1 Introduction.

This review re-evaluates community nursing services in the Western Isles five years on from Professor Wilson and Ms Donald’s recommendations of 2009. The rapidly evolving landscape of delivering health services “closer to home” requires us to re-examine our current position and plan for a service that is safe, equitable, and clinically effective.

The review aims to address the future of Adult services separately from Children’s services recognising that the implications of delivering on the legislation required within the Children and Young People (Scotland) Act 2014 will require significant, wide-ranging and dedicated planning for effective delivery.

The review process included input from a wide range of stakeholders including Community Nursing Staff, AHP’s, Staff side representation and CNES colleagues.

1.2 Background

Community nursing in Scotland is at a crossroads. The community nursing workforce is ageing rapidly, with 30 percent of our nurses reaching retirement age within ten years. In the Western Isles over 60 per cent of our workforce is above 50 years of age. Demand for community health services is expected to increase. The Western Isles has a rapidly ageing population with complex health needs. There is a greater emphasis on long-term prevention and early years interventions, and a drive to provide more care at home, all of which, require a greater proportion of health care and support to be delivered in the community. A sustainable and vibrant nursing profession working with communities is key to the future of healthcare delivery. At the same time, the needs of patients and families are changing as they become increasingly active participants in their own care or the care of loved ones. With this comes a need to ensure that all health services are planned and delivered with the needs of users, rather than providers, in mind. It also requires a move to re-focus all healthcare services on the enablement of patients and carers. Nurses are key to ensuring this culture change is successfully delivered.
**Meeting the 20:20 vision**

Central to the Scottish Government’s 2020 vision for achieving sustainable quality in healthcare is enabling everyone to live longer healthier lives at home or in homely settings and delivering a healthcare system in which:

- health and social care are integrated
- there is a focus on prevention, anticipation and supported self-management
- care is person centred and provided to the highest standard of quality and safety
- care is provided in the community unless hospital treatment is required
- people get back to their home or community as soon as appropriate with minimal risk of re-admission

The Public Bodies (Joint Working) (Scotland) Act 2014 sets out the policy and procedures for integrated services to improve the wellbeing of people in the Western Isles. The aim is to better support those who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. In addition the act seeks to develop further the provision of preventative and anticipatory approaches.

District nursing services have much to offer in realising this vision and responding to the challenges associated with caring for an ageing population, improving Scotland’s public health record and improving quality within an economic climate which demands savings and efficiency. New approaches and models of care delivery are being tested. However, new ways of working are highlighting the need for a wider range of skills and knowledge across district nursing teams, from appropriately prepared and supervised health care support workers and assistant practitioners to registered nurses working from level 5 through to advanced practice.

We wish to enhance our learning and implement the findings from the work of Modernising Nursing in the Community, to ensure that nurses in the community can continue to provide high quality, safe, and patient-centred services across all of Scotland.
In our vision, all community nurses are core members of integrated multi-professional teams that bring together health services to deliver safe, high-quality, person-centred care. Barriers which currently limit joint working – whether between nursing professionals, or between nurses and other health and social care professionals – will have been reduced, so that patients, families, and carers experience a seamless journey through any community service in which nurses play a part.

To achieve this, in our vision we see community nursing as an integral part of locally defined community health teams, in partnership with all sections of the community, around locally assessed profiles of community health need. Nurses are empowered to take leadership roles within these teams, and have access to the resources required to provide the very best services to the people of their local community.

2. Description of workforce and current service provision

There are 85 community nurses employed by NHS Western Isles, 24 within specialist roles and 61 within geographical teams. Five Community nursing teams exist within NHS WI, they are geographically based and aligned with GP practices. Each team is led by a band 7 SCN and consists of a skill mix of band 6 and 5 registered nurses and band 3 HCA’s. An aspect of midwifery cover is also provided in South, West teams, which accounts for some of Band 6 work. Health Visitors and Public Health nurses are line managed by the Senior Charge Nurses. This also accounts for the larger proportion of band 6’s within each community nursing team.

<table>
<thead>
<tr>
<th></th>
<th>Band 3</th>
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<th>Band 6</th>
<th>Band 7</th>
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The following chart displays the proportion of bandings within the core adult service community nursing establishment

**Profile**
Findings from local workforce assessments reveal the older age profile of community nurses. The majority of staff are in the 50 or older age categories.

Further the assessment revealed that the largest proportion of band 5’s are aged between 50-54. The higher level bandings (6-8) are mainly within the 50+ age grouping. The majority of band 6’s displayed throughout the age groups are mainly composed of specialist nurses. Conversely it revealed the older age profile of district nurses with a community nursing qualification at band 6 and 7 (age 50 >) and the larger number of staff with no specialist qualification at band 5 (age < 50)
Collectively across NHS WI a significant amount of community nursing patient contacts are for “prescribed tasks” including wound dressings, venepuncture etc resulting in very little proactive active work such as anticipatory care.

The workload tool reveals that 48% of time within an average day is spent on direct patient activity which includes 11% of travel to and from patient’s homes. A further 9% is spent planning caseload activity including case conferences, communications on patient status and situational awareness.
Examination of local district nurse activity demonstrated different and changing work practices across geographical teams. Interestingly the proportion of proactive work increased in the more rural geographical areas. The East team which covers Stornoway and surrounding areas and which serves the largest practice population displays the largest proportion of routine reactive patient contact.
The chart below examines who (unqualified or qualified nurses) does what (by levels of complexity). For example, are the unqualified nurses doing a proportionally greater level of lower complexity work? Almost half of the level 1 and 2 (the least complex) is carried out by qualified staff. More appropriately almost all work at level 3 and 4 (most complex) is carried out by suitably qualified personnel.

More time is required on higher level complex care with approximately ¾ of an hour spent with level 4 patients as opposed to half an hour on lower complex care.
2.1 Workforce suitability

In order that our current workforce is sustainable and can meet the pressures of service delivery we require to consider the following;

• Community nursing does not work in isolation but fully integrates with existing work practices
• Every effort should be made to streamline practice – stop duplication
• Provide a 24 hour service that is fit for purpose
• Improve access to care and treatment
• Support and implement improvement programmes
• Develop, retain and protect staff and invest in skill mix
• Consult service users at planning stage

2.2 Considerations and Recommendations

There is a disproportionate amount of time spent by qualified staff on lower complexity tasks. Consideration should be given to the appropriate skill mix within community nursing teams, to enable qualified staff to focus upon anticipatory care and case management. (appendix 1)
The average time spent on complexity level 1 to 3 does not vary significantly. This would indicate that teams should review the patterns of working and establish if time could be reallocated.

The rural and remote nature of the work and the distances travelled to patients can mean that qualified staff are utilised on lower complexity tasks in an effort to work more efficiently. Teams should review to ensure the most appropriate staff are utilised across the caseload where possible.

Primarily the Community Nursing service is aimed at patients who are housebound. It is recognised that patients should not be disadvantaged by their remote and rural location. However, strict referral criteria are now developed that encourage self-management and ownership of health needs. Community Nurses should work jointly with GP practices, AHP’s and patients to agree an individual assessment and plan of care. The purpose is to minimise unnecessary home visits and will include an assessment of the need for local clinics to increase efficiency.
3. Health Needs and Workload Projections

The analytic tools for projecting condition specific estimates that include sophisticated tracking of disease profiles or anticipated advances in treatment were not available. Two straightforward methods utilising existing data sources were therefore used to estimate future workloads. Condition specific SPARRA risks and current workload information were projected utilising anticipated demographic changes over the next twenty two years up to the year 2037. It is noted that this methodology is limited but nonetheless provides a guide to the anticipated workload. The workload is estimated to increase by half over the next 12 years and by almost double by the year 2037

**SPARRA: All Risk**

<table>
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<tr>
<th>Condition</th>
<th>2014</th>
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<th>2022</th>
<th>2027</th>
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<td>Atrial fibrillation</td>
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<td>413</td>
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<td>47</td>
<td>52</td>
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<td>COPD</td>
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<td>124</td>
<td>140</td>
<td>164</td>
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<tr>
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<td>125</td>
<td>145</td>
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<td>Diabetes</td>
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<tr>
<td>Renal failure</td>
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<td>126</td>
<td>146</td>
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<td>TOTAL</td>
<td>2455</td>
<td>2735</td>
<td>3134</td>
<td>3629</td>
<td>4061</td>
<td>4465</td>
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Projected total number of people on the Scottish Patients at Risk of Readmission and Admission (SPARRA) register aged 75+ years

Projected number of face-to-face contacts by Community Nurses
3.1 Nursing Roles

Roles and function

The RCN defines the fundamental role of district nursing to be:

“The planning, provision and evaluation of appropriate programmes of nursing care, particularly for people discharged from hospital and patients with complex needs; long term conditions, those who have a disability, are frail or at the end of life” (April 2013)

Three care domains for the effective delivery of district nursing services have been identified as;

- Acute care at home
- Complex care at home
- End of life care at home

These care domains depict the complex challenge of care provision in the community and the corresponding skills and infrastructure required to deliver care effectively and efficiently particularly in a rural setting.

Modern Nursing in Community (2012) identified the following examples of clinical skills required by district nurses in the future;

- Advanced clinical assessment skills including history taking, physical examination skills and cognitive assessment.
- Critical thinking and decision making.
- Case management.
- Acute care skills eg IV antibiotics therapy, rehydration therapy.
- Palliative and end of life care.
- Anticipatory care
- Utilising technology to enhance care
- Non medical prescribing
- Motivational interviewing.
- Protection of vulnerable adults.

Staff development/training

In remote and rural areas, the skills and qualifications of the nurses reflect the more autonomous and multifaceted nature of the role and rather than the SPQ DN, some nurses have alternative or additional qualifications.
There is a wide variation in the range of skills and qualifications of district nurses that are additional to the SPQ DN. In some areas, some of the DNs are non-medical prescribers, or have undertaken advanced practice modules, some have completed long term conditions programmes or courses such as Minor injury and Illness.

Skill mix in district nursing teams has developed to some extent in all areas, developing leadership, mentorship and supervision skills is felt to be essential particularly for DNs who had been working in teams with very little if any skill mix for a number of years.

Health care support workers play an important role in most DN teams and undertake a variety of clinical tasks. Examples include Band 3 support workers undertaking phlebotomy, simple wound dressings and administering insulin in specific circumstances.

In addition to care managed within district nursing teams, a number of innovative services and models of care are identified in which nurses usually with additional qualifications and higher level skills played a key role in enabling people to stay at home and avoid unnecessary hospital admission. These new models reflect the increasing complexity of care at home and the nursing skills required were reported to be a combination of skills associated with district nursing and those of nurses working in acute settings. In some cases, specialist practitioner qualified district nurses were employed within these roles and in others nurses with other qualifications and experience. From consultation it was apparent that the care of older adults should be the focus of district nursing services and the increasing number of older people with multiple co-morbidities and long term conditions, polypharmacy and complex social care needs emphasised the importance of district nurses’ case management and specialised clinical skills. Discussions highlighted the need for DNs to proactively manage care by promoting health, anticipating health needs, enabling and supporting self-care and providing support and supervision to the well elderly.

Consideration was given to the delivery of district nursing services to enable a consistent service 24 hours a day and 7 days a week. They recognised the need for effective management and leadership skills for the DN caseload holder and the team leader resulting
from increased skill mix, the responsibility to manage 24 hour care, the complexity of care delivered and the increasing range of staff requiring appropriate support and supervision.

There are band 5 “link” nurses who have developed skills and competencies within a specific aspect of care such as tissue viability or diabetes. This enables personal and professional development and strengthened the expertise available within the district nursing team. New initiatives and service models appear likely to increase the need for well-prepared staff nurses and more continuing professional development opportunities to support them.

A number of skills were discussed in relation to the role of district nursing in an integrated adult health and social care service. There was general agreement that district nurses should have the skills to lead and facilitate change, be able to negotiate effectively, be confident and assertive and be able to promote and facilitate synergy between agencies. The Kaiser Permanente triangle model has been used in other Board’s to assist joint working between community nursing, secondary care, social care and third sector organisations.

Table 1 summarises the skills that were identified during a national scoping exercise, as part of Modernising Nursing in Community, which were felt to be essential for district nursing to meet the needs of increasingly complex caseloads. There was general consensus that the skills required of the DN of the future were more characteristic of advanced practice. However, it was also acknowledged that in some areas including remote and rural areas, these are the skills that district nurses require today. The Career and Development Framework for District Nursing (NES 2011) was referred to within discussions and the four central pillars of practice described in the Advanced Practice toolkit were utilised as a framework to categorise skills and competencies during the scoping exercise.
Table 1 Examples of skills required by District Nurses identified in the scoping exercise

| Clinical skills | Advanced clinical assessment skills including history taking, physical examination skills, cognitive assessment  
|                 | Critical thinking and decision making  
|                 | Case management  
|                 | Acute care skills such as rehydration therapy, intravenous antibiotic therapy, care of central venous catheters, parental and enteral feeding  
|                 | Skills in the care and support of people with dementia and their families  
|                 | Palliative care and end of life care  
|                 | Anticipatory care  
|                 | Utilising technology to enhance care  
|                 | Nurse Independent Prescribing  
|                 | Motivational interviewing  
|                 | Protection of vulnerable adults  
| Facilitation of learning | Clinical supervision, coaching and mentorship, assessment, team building and empowerment  
|                         | Teaching skills to enable effective educational communication with colleagues, patients and carers  
|                         | Reflective skills to enable personal and professional development and to facilitate reflection for colleagues  
|                         | Education to enable vision regarding the utilisation of tele-care and tele-health to enhance care  
| Leadership | Ability to lead and manage change  
|            | Lead and manage the district nursing, multidisciplinary and multi-agency team  
|            | Manage the case load and delegate appropriately  
|            | Risk management  
|            | Manage and lead quality improvement and patient safety  
|            | Resource management  
|            | Use a range of skills related to eHealth  
|            | Ability to measure effectiveness of care  
| Evidence, research and development | Knowledge regarding sources of evidence  
|                         | Ability to generate, manage and utilise data  
|                         | Ability to critically examine research and its application to clinical practice and to facilitate and participate in research and its dissemination where appropriate.  

CUCN- Community Unscheduled care Nurses

The CUCN team have evolved from a community night nursing service, piloting a rotational day/night service and an Enhanced Health Care at home service to currently supporting the NHS 24 OOH service in Lewis and Harris. The team are trained in advanced clinical assessment, management of common presentations and minor injuries; they are also non
medical prescribers. They currently cover a twilight shift and an overnight shift based at WI hospital.

The main functions of this role are;

- Support the OOH service working closely with the on call GP.
- Provide care out of hours to patients at end of life who wish to remain at home.
- Delivery of the OPIAAT service.
- Ongoing nursing care and delivery of treatment plans OOH.

Consideration and Recommendations

Consideration should be given to full utilisation of the CUCN specialist skills set. Some skills may be transferable across other nurse practitioner fields i.e. ENP, CSN, this would lend itself to a more flexible, sustainable nurse practitioner workforce.

Equally these skills may be utilised effectively as part of frailty assessment multidisciplinary team.

Twilight shifts are essential for the continuous provision of care to patients in their own homes, however a suitably developed skill mix approach should be considered to deliver routine care OOH.

A local needs assessment in Uists and Barra should be carried out to establish numbers and frequency of unscheduled care nursing requirements in order to inform local delivery models. The ongoing skills development of staff in Uists and Barra Hospital should be included in the analysis.

Outpatient Intravenous Antibiotics and Alternative Therapies (OPIAAT)

OPIAAT was set up in 2012 to identify and plan the requirements to deliver a safe and effective way to deliver IV antibiotics to patients in primary care – initially for cellulitis.

In line with the aims of the Quality Strategy and Shifting the Balance of Care the service now provides the infrastructure to allow patients to be treated in a location suitable to them in the community without the inconvenience and costs associated with hospital admission. In
addition, the project has strengthened the links between community and secondary care staff to the benefit of patient.

The service has evolved significantly and is mainly managed by the CUCN team with increasing input from the community nursing service. Recent service change to incorporate a twilight shift has considerably strengthened the provision of this service. A database is currently being developed which will report on activity.

**Considerations and Recommendations**

Some secondary care/outpatient work lends itself to primary care. This includes managing patients with heart failure to receive intravenous diuretics at home or expansion of OPIAAT service to include delivery of other infusions such as iron, immunoglobulin.

Future planning for expansion of these services should consider the implications on community staffing.

**OPAC**

**Implications of OPAC and Comprehensive Geriatric Assessment**

The standards for the care of older people in hospital will enhance collaborative working across primary and secondary care. This person-centred approach focuses on personal goals and personal outcomes for patients within a model of service provision that focuses on the assets, strengths, and aspirations of each individual.

Older people who are frail or who have cognitive impairment are at particular risk of healthcare-associated harm. Older people frequently have complex healthcare needs as a result of a higher prevalence of multimorbidity, physical and cognitive impairment. On first presenting to hospital care (including A&E, unscheduled care, elective admission and pre-assessment clinics) it is important to identify all the current health problems that are contributing to their presentation and to identify those at increased risk of healthcare associated harm. Patient safety is intrinsically linked to effective patient flow. This is especially true for frail older people. Following appropriate assessment decisions must be made as to whether further inpatient care is necessary, or whether care could be provided
in the person’s home or a community setting. This decision must balance the risks and benefits of hospital care and of care at home.

**Consideration and Recommendations**

Pathways for patients presenting with frailty require to be formulated.

Resources are required to develop and establishing community based multidisciplinary teams including nurses with appropriate assessment skills to meet OPAC recommendations.

Assessment should identify opportunities to deliver care in community settings where clinically appropriate and flows should exist to allow care to be transitioned to these teams.

**Buurtzorg (Neighbourhood) Integrated Community Based care for Better Outcomes**

Buurtzorg Nederland is an organization in which district nurses and district healthcare workers themselves have overall authority. Every team is responsible for its own clientele and is in close contact with GP’s and families. The teams are also responsible for their own finances. Teams of highly-trained nurses self manage their locality evidencing that the commitment of highly-trained personnel is much more effective and yields better care, as a result of which organizations can operate up to thirty percent more cheaply. The benefits are that patients become less dependent quicker and self management is promoted, families and the wider community take more responsibility for caring and supporting, hospital admission rates have decreased, satisfaction rates with patients and staff are improved.

Consideration should be given to exploring the options of piloting this method of care within local community teams.

**Specialist Nurses Overview**

Specialist Nurse Services comprise of suitably qualified nurses who have a condition specific focus. Across the Western Isles the range of specialist services include; Macmillan Nurse team, Diabetes, team, Cardiac team and individual practitioners specialising in Parkinson’s,
Multiple Sclerosis, Stroke and Tissue Viability /Continence. The Respiratory Nurse specialist is managed under secondary care.

The strongest feature for all services is the commitment to enhancing the patient journey by holistic, person centred care. Advanced clinical assessments make available condition specific inputs in conjunction with holistic needs assessment and multidisciplinary working as standard.

Most of the nurse specialist services have been established with no medical consultant lead and all provide a service that would otherwise require access to a mainland provision. The respiratory nurse posts alone developed from a request to enhance the 2 day a month Consultant visit. Service Level Agreements in place for Diabetes, Stroke Liaison and MS provide limited access to a consultant, therefore all services manage patient care without clinical supervision. The individuals and teams provide treatment, care and advice at point of need with a strong focus on best practise based on up to date research.

Person centred care is specifically aimed at maximising wellbeing, promoting self care and supporting medication concordance. Person centred care also assists in supporting patient choice to remain at home. One factor that affects the ability of the individual to stay at home with specialist input can be a lack of home care provision. Nurse specialists need to remain focused on their area of work rather than meeting care needs that can be delivered by generic services.

Tiered activity starts with promotion of self care via verbal and written information and when required moves through into assistance to further inputs to manage more complex health needs. The range of activities includes proactive and preventative inputs with Anticipatory Care Plans agreed at the appropriate stage.

Many of the specialist nurse posts and functions operate within the primary care setting. This provides a vital link between GP’s, community nurses, AHP’s and the wider multi-disciplinary team and enables assessment and provision of services closer or indeed within patient’s homes.
Having the specialised knowledge of medication regimes, Non Medical Prescriber activity is high. This directly benefits the patient by reducing further assessments by a doctor. All services provide support for families, carers and other professionals in the format of individual advice on management, joint visits, education sessions and the majority of services have a formal education programme for care providers, nurses and doctors.

Community nursing services under Mental Health were not included since these are currently under review via a separate process.

**Considerations and recommendations:**
Specialist services should be community managed with a strong focus on promoting well being and home care via Anticipatory Care Plans.

Specialist nursing services do not routinely cross cover other specialist areas and should not be included in the 7 day working provision.

Education inputs to other professionals should be formalised and coordinated so that equity of access is facilitated and specialist time is not used for organisation of training events.

Provision to Uists and Barra should be efficient and needs led. Upskilling of generic community nurses with ring fenced education and clinical time is an appropriate alternative to a separate part time specialist post.

Investment in telehealth technology could be used to support people in their homes, and extend access to specialist services.
<table>
<thead>
<tr>
<th>Service</th>
<th>Banding(s)</th>
<th>Referrals open</th>
<th>Advice to non specialist</th>
<th>Training provided informal(I) formal(F)</th>
<th>MTD working</th>
<th>Care homes input</th>
<th>Person centred care</th>
<th>ACP</th>
<th>NMP</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>1 x 7 3 x 6</td>
<td>yes</td>
<td>yes</td>
<td>both</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>SLA</td>
</tr>
<tr>
<td>Heart RA, HF, CR *</td>
<td>1 x 7 4 x 6 (1 vacancy)</td>
<td>yes</td>
<td>yes</td>
<td>both</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>no</td>
</tr>
<tr>
<td>Macmillan</td>
<td>4.6 x7 (2 at 0.8 Uists)</td>
<td>yes</td>
<td>yes</td>
<td>both</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>Roxburgh house advise</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>1 x 6</td>
<td>yes</td>
<td>yes</td>
<td>both</td>
<td>yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>no</td>
</tr>
<tr>
<td>Continence Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MS</td>
<td>1 x 6</td>
<td>yes</td>
<td>yes</td>
<td>both</td>
<td>yes</td>
<td></td>
<td>v</td>
<td>yes</td>
<td>no</td>
<td>SLA</td>
</tr>
<tr>
<td>Parkinsons</td>
<td>1 x 6</td>
<td>yes</td>
<td>yes</td>
<td>informal</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>no</td>
</tr>
<tr>
<td>Stroke Liaison</td>
<td>1.1 x 6 (1 x 30hrs, 1 x 15hrs Uists)</td>
<td>yes</td>
<td>yes</td>
<td>informal</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>SLA</td>
</tr>
<tr>
<td>Respiratory</td>
<td>1 x 6 (1 x 30hrs, 1 x 7.5hrs Uists)</td>
<td>yes</td>
<td>yes</td>
<td>informal</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>2 days per month visit</td>
</tr>
</tbody>
</table>

* Rapid access chest pain, Heart failure, Cardiac rehabilitation
4. Children’s Services

Arrangements to support children’s services and the implementation of the Children and Young People (Scotland) Act 2014

Situation

There has been a rising awareness that the small health visiting workforce is finding it increasingly challenging to ensure the health, wellbeing and safety of the children of the Western Isles. There is Scottish Government recognition that the changes contained within the above Act will increase their workload and there is also pressure on management to ensure its implementation.

Recent discussions have explored the opportunities presented by job vacancies that will provide us with the knowledge, skills and competence to lead change and establish roles for health visiting and school nursing compliant with the legislation.

The areas discussed include:

- strategic leadership of health visiting and school nursing
- operational management of health visiting service
- leadership for embedding GIRFEC in children’s services
- professional leadership for health visiting/school nursing

Background

The Children and Young People (Scotland) Act 2014 has already begun its implementation with the extension of Early Learning and Childcare provision from August 2014 and the introduction of free school lunches to primary 1-3 school children in January 2015.

The Act contains several areas that will require significant and wide-ranging planning for effective and timeous implementation. Most notable for the NHS are the aspects around embedding the Getting It Right for Every Child (GIRFEC) approach in law through implementation of the Named Person and Child’s Plan provisions, defining wellbeing, and reporting regularly on progress towards meeting the requirement of the UN Convention on the Rights of the Child. There are also provisions regarding adoption, children in care and kinship carers that will impact on NHS service provision.
Assessment
Recent staffing changes have provided an opportunity to reassess strategic leadership and management arrangements, and service provision in services that address health visiting and school nursing - the services most affected by the Act.

At present there are two suitable vacancies in the staffing establishment, one each in Public Health and health visiting.

Considerations and recommendations
The proposal is to utilise these posts to create a strategic leadership/ professional lead for GIRFEC based on the Public Health Practitioner role in Public Health and Health Strategy team, and a team leader/ operational manager for health visiting and school nursing, based in the community service. Funding is already in place for these posts. Their establishment is associated with the risk of failing to implement national legislation, the assessment of which will fall from 12 to 4 with the posts in place.

Operationally significant recent staffing changes have provided an opportunity to redevelop and increase resources for health visiting and support implementation of the Children’s Act. Concurrently a 6 week administrative scoping exercise concentrating on the 0-5 year caseload only has recommended the need for administrative support (see appendix 2).

The detailed examination of workload and staffing, based on identified future need relating to national legislation, reveals that the combined Health Visiting and School Nursing Team will require one additional WTE from 2016.

Proposed Measures Include:

- the use of GIRFEC funding to support HV training for 1 WTE from existing establishment in 2015 and continue to support the development of further HVs in 2016. (One staff nurse from existing establishment currently undertaking this training)
- Training of one Community Practice teacher (CPT) during 2015 (a necessary requirement to facilitate HV training locally)
- Provision of ‘long arm’ mentorship to support the CPT role
• The reconfiguration of skill mix within HV team to facilitate the use of HV time effectively (to focus on the statutory requirements of the Act)

• On going application of the caseload weighting tool, workload tool and professional judgement to inform practice requirements (appendix 3)

• Consideration of future school nursing staffing levels across the islands as a consequence of national guidance, to clearly differentiate between Health Visiting and School Nursing roles (appendix 4)

• Scoping exercise to assess administrative, information and information technology needs of the HV service. ( Completed March 2015)

• The creation of a coherent team structure for the health visiting and school nursing team that provides professional, strategic and operational leadership together creating a drive to implement GIRFEC across the organisation

Proposed Team Structure

• Band 7 Team lead for Health Visiting and School Nursing, this would encompass the CPT along with the leadership role. (Resources available through reorganisation of existing establishment)

• Ensure equitable spread of Health Visiting service across NHS Western Isles this will involve FTE Health Visitor in Barra supporting Uist caseload.

• Consider corporate (0-5) caseload for Lewis and Harris primarily based at Stornoway Health Centre but with named HV for each rural location ensuring equitable spread of complex cases between all Health Visitors.

• Consider using vacancy resources to employ administrative support thereby utilising Health Visitor time more effectively.

NB The proposal to assign a Team Lead for the HV service will have an impact on the Community SCN role in that they will no longer manage the HV’s within their locality, their job descriptions will be amended accordingly to emphasise the essential partnership and integration role.
5. Considerations and Recommendations for Delivery

5.1 Consultation and stakeholder’s vision
Stakeholders and staff groups were invited to offer their views on the delivery of future services in the context of the 20:20 vision and integrated working. They were asked to include their opinions and recommendations on how roles and services should evolve.

Five key areas for comment were identified namely: integrated multidisciplinary teams; unscheduled care; intermediate care; case management of patients; and specialist nurse roles.

Nine responses were received. The responses for each area are summarised below.

*Integrated multidisciplinary teams* – There was general agreement that multidisciplinary teams provided a basis for coordinated and improved communication, particularly in relation to the management and support of complex cases. Core membership included nursing (community and practice), home care, social work, occupational therapy, physiotherapy, community psychiatric nurses and general practitioners. Nursing staff acknowledged the need to work more closely with social care colleagues to improve efficiency and responsiveness as well as ensuring care standards are applied universally. Committed joint management of this process was essential. Frequency of meetings was important to ensure attendance. Weekly was recommended. To work effectively MDT’s needed to be robust and have a workable system for identifying those at risk, having a meaningful anticipatory care plan and a method of communicating effectively. Some AHP stakeholders identified problems in participating fully if MDT’s are frequent and geographically dispersed.

*Unscheduled care* – Community nursing staff were seen as essential to a ‘rapid response’ team that aimed to prevent admission to hospital or care home. Early identification and referral would improve the anticipatory nature of the service and enable identification of high risk patients who could be fast tracked to the team. Where patients are ‘off their feet’ quick access to moving and handling assessments. Resourcing and membership of team required consideration in terms of efficiency and effectiveness.
Intermediate care – Reablement approaches were seen as central to achieving objectives of intermediate care. The training, competencies and support to move from a reactive task orientated approach to a proactive reablement approach were recognised. This included knowledge and use of appropriate equipment and aids. However, the need to respond to existing ongoing needs and problems in an efficient manner should not be minimised to the detriment of patient care.

Case management of patients – The identification of appropriate case manager role for circumstances was highlighted. There was a view that case management was most appropriately provided by social work/home care with specialist input from other professionals when needed. However, the training and resources to undertake this role were essential, with dedicated time from caseload provision. Care Aims framework was recommended as an outcome based tool to identify community nursing, AHP and general practice responsibility and contribution.

Specialist nurse roles – The contribution of specialist nurses to patients, families, professionals and carers was acknowledged. Sustainability of single handed practitioners was identified as a risk. The role of specialists could extend to link/guide for teams ensuring regular, consistent communication. The skills and experience of specialist staff is particularly critical to effective functioning.

Other – Explicit role definition and communication to colleagues and patients would improve consistent practice across islands and increase opportunity for nursing staff to utilise and practice their skills.

Stakeholders discussed the value of rotating acute and community nurses between settings. This would aim to enable them to further develop an understanding of one another’s roles, to follow the patient’s journey and develop practitioner confidence and competence to work in a range of settings. Consideration should also be given in relation to the rotation of district nursing staff to different community teams, community hospitals and out of hours services. It was also noted that the success of a person’s discharge home could be assisted greatly, with a more consistent comprehensive portfolio of district nursing skills available within every locality.
6. Recommendations

The Board should consider the ability of the current workforce to meet the anticipated future demand. Recommendations are made below which include efficient workforce reorganisation and enhancing skills of staff. However, it is unlikely that the increasing need for community services will be met unless resources are identified to shift the balance of care.

- **Nursing Teams** – To meet the growing demand and make most efficient use of current resources we will invest in Band 3 and Band 6 development. As vacancies at Band 5 arise in teams the skill mix will be assessed and suitable appointments or upskilling made. This will include the appointment of integrated rural generic support workers where appropriate. This role will include a varied range of work across healthcare, social care and OT with a focus on rehabilitation. This will be informed through the development of the integrated strategic plan.

- We will invest in upskilling staff to obtain the District Nurse certificate/Specialist community qualification (nursing in the home)

- Line management of Health Visitors will be transferred to the new post of Health Visiting Team Lead and disaggregated from the role of SCN within geographical teams.

- Senior Charge Nurses will concentrate on adult services to be the clinical expert who will be accountable for case management and nursing activity within caseloads. This will include the overall management of anticipatory care plans. They will require to be involved in the planning of 24/7 community nursing including unscheduled and intermediate care services. The role will also encompass integrated working as developments take place on the integrated strategic plan.

- Band 6 role is enhanced to coordinate multi-agency meetings and case management of patients. Advanced assessment skills will be required to manage Long term conditions and frailty with the creation of geriatric community nurses.

- **Workload** – each team will audit activity to ensure appropriate nursing care for level of complexity and efficiency.
• The CUCN specialist skill set should be aligned with similar acute roles to provide support and fully utilise the nurse practitioner workforce. This will be particularly relevant to ongoing unscheduled care developments within the Uists and Barra.
• Frailty pathways are developed in conjunction with acute services.
• Resources will be sought to pilot innovative programmes of community care such as Buurtzog
• The value and challenges of single specialist nurse roles are acknowledged, therefore the education and training role will be formalised to enable improved coordination of anticipatory and self management plans.
• Explore alignment of District Nursing and Practice Nursing roles within Primary Care in order to ensure enhanced skill sets are utilised efficiently and effectively to provide equitable services to all patients. This could involve LTC management of housebound patients and potential for district nurse clinics in primary care.
• The Health Visiting and School Nursing service requires to be developed in line with the recommendations of the Children’s Act

The development and establishment of a modernised community nursing team that embeds in practice the 3 domains of; acute care at home, complex care at home and end of life care at home, will be greatly enhanced by the adoption of these recommendations. There remain two strands of work that will require more detailed analysis over the period up to April 2016 and will lead to further development. Firstly, the mapping and clear identification of a competency framework for all bands of nursing, will enable the necessary skills set to be more clearly defined as well as the associated training programme and monitoring system. Secondly, the further development of a person-centred approach that adopts a more seamless pathway for patients. This will involve looking in more detail at the potential benefits of closer working practices with primary and secondary care to include best use of existing staff skills, roles of all nurses and an exploration of the management of episodes of care in the most appropriate setting.
7. Appendices

Appendix 1 - Workforce requirements
Over the next 2 years, the incremental change to 2017, will lead to an anticipated 4% increase in workload. This will be absorbed into current workload by efficiencies in the system through extended benefits of the digital pen and Releasing Time to Care. During this period it will be necessary to put into practice an extensive period of planning, preparing and implementation of a training programme to adjust the skills mix. The balance of skills mix to provide a more effective and efficient team requires an increase of 3 band 6’s to ensure two band 6’s in larger teams and 4 band 3’s with the concomitant reduction of 7 band 5 posts.

<table>
<thead>
<tr>
<th>Description</th>
<th>Projected costs/ savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Band 6 Nurses x 3</td>
<td>£ 115,776.00</td>
</tr>
<tr>
<td>Additional Band 3 HCA's x 4</td>
<td>£ 94,328.00</td>
</tr>
<tr>
<td><strong>Total staff costs</strong></td>
<td><strong>£ 210,104.00</strong></td>
</tr>
<tr>
<td>Reduction in Band 5 nurses x 7</td>
<td>£ 225,435.00</td>
</tr>
<tr>
<td><strong>Total staff savings</strong></td>
<td><strong>£ 225,435.00</strong></td>
</tr>
<tr>
<td><strong>Training costs for break even position</strong></td>
<td><strong>£ 15,331.00</strong></td>
</tr>
</tbody>
</table>

Costs re anticipated increase in workload:

<table>
<thead>
<tr>
<th>Description</th>
<th>Projected cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community nursing budgets 15/16</td>
<td>£ 3,307,000.00</td>
</tr>
<tr>
<td>23% increase in workload (27% less initial 4% met through efficiencies)</td>
<td>£ 761,000.00</td>
</tr>
</tbody>
</table>

Note: Above increase reflects anticipated position in 2022 excluding inflationary and incremental uplifts.
The review recognises that we require to invest in specific community nurse training in order to develop our community nursing workforce to deliver safe and high quality care to enable patients to remain at home for as long as possible.

Until recently the national and local requirement for appointment to a band 6 Community Nursing post was the Specialist Practitioner Qualification (SPQ). Given the profile and recruitment challenges reported in this review it is imperative to propose a sustainable option to run alongside the SPQ route.

This Development framework is an initial proposal and will require ongoing development to meet local needs along with taking cognisance of national recommendations. It is recognised that community nurses require to be competent and have knowledge of a patient’s condition, treatments and support systems, be able to assess and evaluate interventions and have the ability to co ordinate care services and manage ongoing care. Simultaneously they require to be confident and skilled in delivering care in complex situations demonstrating autonomy and leadership and forming collaborative relationships with patients, families and multiagency professionals.

The following two pathways aim to address the local requirements for the development of community nurses to band 6 posts and to increase the number from six to nine WTE over the next five years. This will be based on the development of current band 5 staff nurses and will be dependant on utilising band 6 vacancy when available with option 2 being cost neutral.
**Option 1 x 2 staff**

SPQ – RGU distance learning Post Grad diploma over two years gaining the NMC District Nurse qualification and RCN accreditation for advanced practice.

Current cost £4120 (Funded through NMAHP)

Modules covered;

- Research and Evidence to inform practice
- Key concepts of improving health and well being
- Specialist practice in District Nursing
- Advanced Contemporary District Nursing
- Clinical History taking, examination skills for advanced practice
- Clinical leadership
- Long term conditions management
- Leadership and advancing Specialist practice in District Nursing
- Non medical prescribing

**Option 2 x3 staff**

Academic modular Level 9 graduate certificate based programme and clinical practice option utilising current opportunities available through University of Stirling campus. This could include;

- Advanced Clinical Assessment SCQF level 9 – involve 3 weeks on campus. 40 credits. Current cost £1050.
- Non medical Prescribing SCQF level 9 delivered over 20 weeks with 8 days on campus. 40 credits. Current cost £1050.
- Mentorship, level 9, 5 days on campus, 20 credits. Current cost £440.
- Choice of modules; Supporting Self Care, Understanding and Assessing Pain, Assessing and Managing Symptoms in Palliative Care or equivalent i.e. LTC management, each 20 credits, running over 15 weeks. Current cost £440 each.

Leadership skills and clinical supervision would also be a requirement and would be accessed locally. Opportunities also exist through building a portfolio of evidence and utilising resources such as Effective Practitioner.
Recommendation - to seek support of the Practice Education Facilitator to establish a cohesive Option two model.

<table>
<thead>
<tr>
<th>Year</th>
<th>No of staff on SPQ 2 year programme</th>
<th>No of staff on Internal 2 year Development programme</th>
<th>No of band 5 Completed by end of year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Year One</td>
<td>3 Year One</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>1 Year Two</td>
<td>3 Year Two</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>1 Year One</td>
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<td>4 + 1 in development</td>
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<tr>
<td>4</td>
<td>1 Year Two</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td></td>
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</tr>
</tbody>
</table>

The above table gives an overview of the proposal to develop five nurses to band six level, utilising both options over the next five years, this would obviously also be dependant on recruiting to established band 6 vacant posts. This also takes account of two impending vacancies due to retirement and increasing the current band 6 establishment by three.

Decisions require to be made re ongoing funding after year 4 in consideration of workforce planning process and evolving service models.

Appraisal and identification of learning needs and skills gaps should be ongoing with band 5 and band 3 staff in line with local service needs and provision.