Department of Health
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HEALTH AND WELLBEING 2026
DELIVERING TOGETHER

Neighbourhood District Nursing Interim Report

December 2020

HSC Public Health Agency

Contents

Foreword

I am delighted that this interim evaluation report "***Neighbourhood District Nursing"*** demonstrates the effective contribution of district nurses and their teams within the Neighbourhood District Nursing prototype and the excellent work being undertaken by district nursing across Northern Ireland. District nurses are central to the rebuilding of the Health and Social Care (HSC) system following the Pandemic.

The District Nursing Framework 2018-2026 describes the way forward for delivery of the district nursing service in Northern Ireland. One key outcome was to develop and test a community nurse-led model of care to ensure a population health focus where district nurses lead the assessment, planning and co-ordination of care in self-organised teams.

The Neighbourhood District Nursing prototype developed through coproduction and tested in each HSC Trust demonstrates benefits for people who use the service, staff and the wider HSC system. District nursing teams have been supported to play their full part in transformation of our services, both as individual practitioners and as exemplars of collective leadership.

It is imperative that we spread and scale this model in conjunction with the planned roll-out of Primary Care MDTs and include the model as a key driver in Phase 3 District Nursing Delivering Care Project.

The district nursing service has been and will continue to be central to primary and community health and social care services. They play a significant role in enabling people to remain at home where clients want to be cared for.

We need to continue to support and empower district nursing teams to lead the delivery of high quality, safe and effective person centered care.

I would like to thank every single member of staff who works in the Neighbourhood District Nursing prototypes for the tremendous contribution they make in supporting people at home where they want to be.

I wish to acknowledge the work undertaken to date by the Public Health Agency, Health and Social Care Board, Health and Social Care Trusts, Queens Nursing Institute, Service Users, AgeNI, RCN, Staff side organisations and GPs who contributed to the development, testing and evaluation of the Neighbourhood District Nursing model.

PROFESSOR CHARLOTTE MCARDLE
Chief Nursing Officer

EXECUTIVE SUMMARY

Policy context

Health and Wellbeing 2026: Delivering Together (DoH 2016)[1] details the 10 year approach to transforming health and social care (HSC) in Northern Ireland (NI). This was the response to the report produced by an Expert Panel led by Professor Bengoa tasked with considering the best configuration of health and social care services in NI[2]. More recently and following a period without devolved government the New Decade New Approach agreement (2020)[3] identified significant changes and investment in almost every sector across NI. One priority is to deliver on the HSC reforms set out in the earlier reports which include further rollout of primary care multi-disciplinary teams (MDTs).

Primary care is the bedrock of HSC and MDTs, including district nursing, are the future model. The central role of primary health care for achieving health and well-being for all, at all ages is recognised by the World Health Organisation (WHO). They state that 'primary health care can cover the majority of a person's health needs throughout their life including prevention, treatment, rehabilitation and palliative care'[4].

The Department of Health District Nursing Framework 2018-2026 (DoH 2018)[5] outlines the strategic direction for provision of district nursing services in NI and advocates that district nurses will be instrumental in population health management.

[1] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[2] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf
[4] https://www.who.int/news-room/fact-sheets/detail/primary-health-care
[5] DH (2018) A District Nursing Framework 2018- 2026 24 Hour District Nursing Care No Matter where You Live www.health-ni.gov.uk

The Nursing and Midwifery Task Group (DoH 2020)[6] highlights significant transformation of nursing and midwifery services is essential to the stability and sustainability of the NI HSC system. Three themes were identified;

Theme 1: Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes

Theme 2: Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice

Theme 3: Doing the right things in the most effective way and working in partnership

Covid-19 has brought new and unprecedented challenges to the HSC system, and the rebuilding strategic framework[7] provides an analysis of the impact. It also sets out the approach to restoring services as quickly as possible, taking into account examples of innovative approaches to service delivery developed in response to the pandemic. District nursing has experienced severe disruption and increased service demand. During the pandemic, MDTs including district nursing have emerged as an essential part of the primary care response, delivering essential support to vulnerable people at a time of extreme need in the community.

Neighbourhood District Nursing Model

The Neighbourhood District Nursing (NDN) model was commissioned as a transformation project by the Public Health Agency in 2019 on behalf of the Department of Health. The NDN model builds on local and international evidence and supports the transformation required to reform

[6] https://www.health-ni.gov.uk/publications/nursing-and-midwifery-task-group-nmtg-report-and-recommendations
[7] https://www.health-ni.gov.uk/sites/default/files/publications/health/rebuilding-hsc.pdf

the NI District Nursing service. An outcomes-based approach using quadruple aim methodology has been embedded throughout.

Five district nursing teams, one in each HSC Trust, started to test the model in stages in June-July 2019. Enhancement to existing district nursing teams meant that 43 WTE Staff in post, representing almost 4% of the district nursing workforce aligned to 3% of the GP population, tested the model.

In Quarter 3 2019/20 the combined NDN caseloads of the five teams had a 'total caseload' of 1293 patients/clients. Of this the 'working caseload'[8] consisted of 819 patients/clients, which regionally represents approximately 6% of the district nursing 'working caseload' across NI[9]. This interim evaluation report details the findings from the five prototype teams which demonstrate;

- the benefit of using a structured, proactive population health and public health based approach

- effective education and supportive interventions enabling patient self-management and promoting independence

- a highly rated service by patients, families and carers

- coproduction and collaborative team approach that empowers staff

[8] The working caseload is defined within district nursing as those cases (number of patients) seen monthly or more frequently.
[9] based on eCAT Regional Event Report for District Nursing April 2019

- coaching model that supported collaborative working and critical thinking

- efficient use of the district nursing resource

As the process of rebuilding HSC services develops it will be essential to scale up and spread the NDN model in line with the primary care MDT roll out plan, with a view to having all district nursing teams operating this model within 5 years.

Methods

A range of evaluation methods were co designed to address the NDN objectives and reflect the Quadruple Aim (see figure 1). They included;

1. Pre-test questionnaire survey using SurveyMonkey® June 19
2. IHI Quality Improvement palliative care project (one team) Oct 19
3. People measurement survey (staff thermometer) to capture staff experience using SurveyMonkey® Phase 1 Dec 19
4. 10,000 More Voices Survey to capture the patient experience Jan 20
5. Outcomes Based Accountability (OBA) scorecard quarterly returns
6. Queens Nursing Institute (QNI) Team Transformational Leadership programme evaluation, which included written evaluations, online questionnaires and prototype practice visits Jan 20
7. Completion of a population health profile by each NDN team and presentation of the findings and future directions

Figure 1 – Evaluation methods to reflect Quadruple Aim

Results

The results presented are initial findings and demonstrate the growth within teams through participation in this project. Results would need to be substantiated by a longitudinal study. Value has been demonstrated, particularly the qualitative benefits for patients and staff.

All teams carried out a structured population health needs assessment that helped inform improvement plans, which include

- a diabetes self-management SQE project
- palliative care – a QI project has improved communication between hospital based specialist palliative care services and
- hypertension by participation in local health living Momenta programme

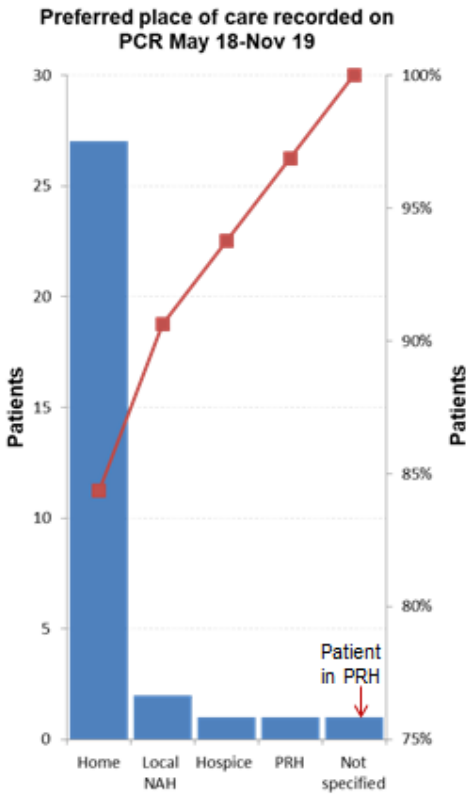
The OBA monitoring return for Q3 2019/20 shows favorable comparisons with the April 2019 electronic caseload analysis tool (eCAT) regional event report for district nursing. The NDN average working caseload by WTE was 17 compared with the regional figure of 13.

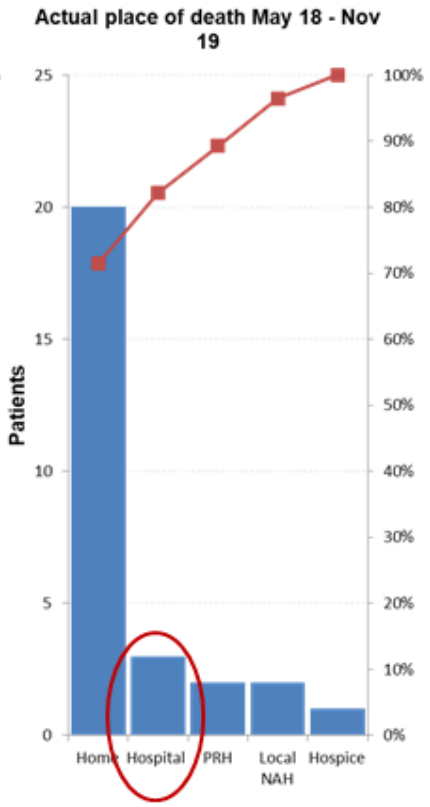
In terms of ‘is anyone better off’, regionally in quarter 3 (19/20);

- 59 patients were supported to self-manage in the areas of diabetes, continence, medicines and weight management
- partnership working with a range of community and voluntary groups was evidenced. The pre-test staff survey had shown two thirds of respondents were ‘not satisfied’ or ‘slightly satisfied’ with partnership working and cited lack of knowledge, time and lack of staffing as the main barriers
- An average of 91% patients who were in the palliative stage of their illness and whose preferred place of care was known were supported to fulfil their wishes.

Ballycastle and Cushendall NDN team participated in an IHI QI palliative care project and focused on identifying all patients in the palliative stage of their illness and with consent adding their details to the palliative care register (PCR) including their preferred place of care. Improvements demonstrated that by December 2019, 80% of patients identified in the palliative stage of their illness were informed about the PCR, consent obtained and details including preferred place of care were recorded. Outcomes measures are shown on figure 2.

Figure 2 –Ballycastle and Cushendall Palliative Care QI project outcome results





Outcome measures

Pareto charts have been used to display outcome measures

89% (n=25) of patients who were on the PCR died in their preferred place of care – Goal was 90%

11% (n=3) of patients died in an acute hospital which was NOT their preferred place of care. This has not occurred since April 19.

18% (n=5) patients died in hospital (non acute and acute hospital combined). The NI average in 2018 was 48% (NISRA).

Whilst this quality improvement project was primarily focused on improving the patient experience there was also an indirect cost impact.
In 2014/15 the average number of days a person stayed in hospital prior to death (with a palliative care diagnosis) in this particular HSC Trust area was 18.6 days. Current costs are £698 per bed day for Palliative Care, acknowledging that costs vary between non-acute and acute settings and by speciality. There average cost for a district nursing contact in 18/19 was £41.05[10]

With regards to patient experience 83% of the twenty-nine responses to the 'My Experience of Care with the District Nursing Team' 10,000 More

[10] https://www.health-ni.gov.uk/publications/community-services-indicators

Voices survey rated their experience of NDN as strongly positive. Three themes were identified in the 10,000 More Voices survey as important to patients, relative and carers;

- Continuity of staff resulted in a better patient experience and enhanced the quality of care
- Care delivered in the home had a positive impact upon health and wellbeing of the patient and relative
- Whilst work demands were evident, the majority of patients highlighted that this did not impact on the quality of their experience

One patient said;

> *'Being involved in my care and making decisions about myself and my care is important to me… helps me at home and the nurses know me well and can respond to my needs'*

A people measurement survey was used to capture staff experience. Analysis of this phase 1 benchmarking survey, based on the responses from 29 staff, showed an engagement score of 4.39 out of 5.0 which compares favourably with HSCNI and the National Health Service (NHS) engagement levels from 2017. This survey also asked staff to rate the coaching role using a slider scale of 0-100; the coaching role was rated positively at 71.07.

One staff member said;

> *'I feel that NDN has improved patient care and outcomes. Having extra time to spend with patients, I have been able to identify opportunities for social prescribing which have been well received, as well as time to liaise with colleagues and patients to*

co-produce more effective treatment/care plans. Whilst the self-managing team aspect can be challenging at times, I feel well supported and the 'coach approach' encourages ownership and collaborative working.

Evaluation of the QNI Team Transformational Leadership Programme identified a high degree of congruence between the education programme three key themes (developing self, working within a self-managed team and understanding the new model of service delivery) and the participant's assessment of the efficacy of the course.

Conclusion

The NDN model is being spread to other district nursing teams as part of the new model for Primary Care MDTs set out by the Department of Health[11]. Initial findings successfully demonstrate positive patient experience and staff engagement; further work will be undertaken to evaluate the economic impact and population health benefits. It is clear that the Team Transformational Leadership programme has impacted positively on learning and development and can show immediate outcomes in practice with the introduction of the NDN model.

Recommendations

1. Consider an independent longitudinal study of the NDN model to inform and offer independent credibility to this innovative and pioneering work in Northern Ireland

2. Develop a spread and scale plan using Quality Improvement methodology

[11] https://www.health-ni.gov.uk/articles/primary-care-multi-disciplinary-teams-mdts

3. Population health is a key component of the NDN model and community profiling and health needs assessment, including health improvement plans, need to be included in District Nursing education programmes and become integral to district nursing practice

4. Further test Delivering Care Phase 3 staffing recommendations with more teams

5. Continue to build on the progress made to establish self-organised teams and create co-design space for district nursing leaders and managers.

6. To continue to provide role clarity and role definitions for staff not involved in the prototype as the model and framework is more widely introduced across the system

7. The coaching role has been fundamental in this transformational change. The coaches supported the wider operational planning, delivery and evaluation of the model. Coaching should continue to be supported within District Nursing

8. To continue to apply the principles of economic assessment and demonstrating value of Neighbourhood District Nursing in order to build a case for scale and spread of the model.

9. Review the evaluation methods utilised to date to ensure they are fit for purpose and meet the needs of the new model. Tools such as the 10,000 More Voices and People Measurement survey should be reviewed and updated accordingly. It will also be necessary to

determine how these evaluation methods can be integrated into the wider MDT independent evaluation.

10. The Neighbourhood District Nursing Delivering Together Framework has been an invaluable tool and has provided guidance to clinical staff, managers and QNI Team Transformational Leadership programme lead. This framework review should coincide with planned rollout of the NDN model.

11. Options for future delivery of the Team Transformational Leadership programme need to be explored. Due to Covid-19 restrictions Project ECHO will be used as means of delivering part of the programme supported by the Coaches.

12. Explore technology options that could be introduced to support a public health approach to care delivery and supports proactive and predictive health care management.

Introduction

Health and Wellbeing 2026: Delivering Together (DoH 2016)[12] details the 10 year approach to transforming health and social care (HSC) in Northern Ireland (NI). This was the response to the report produced by an Expert Panel led by Professor Bengoa tasked with considering the best configuration of health and social care services in NI[13]. More recently and following a period without devolved government the New Decade New Approach agreement (2020)[14] identified significant changes and investment in almost every sector across NI. One priority is to deliver on the HSC reforms set out in the earlier reports which include further rollout of primary care multi-disciplinary teams (MDTs).

Primary care is the bedrock of HSC, and MDTs, including district nursing, is the future model. The central role of primary health care for achieving health and well-being for all, at all ages is recognised by the World Health Organisation. They state that 'primary health care can cover the majority of a person's health needs throughout their life including prevention, treatment, rehabilitation and palliative care'[15].

The Department of Health (DoH) District Nursing Framework 2018-2026 (DoH 2018)[16] outlines the strategic direction for provision of district nursing services in NI and advocates that district nurses will be instrumental in population health management.

[12] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[13] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report
[14] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf
[15] https://www.who.int/news-room/fact-sheets/detail/primary-health-care
[16] DH (2018) A District Nursing Framework 2018- 2026 24 Hour District Nursing Care No Matter where You Live www.health-ni.gov.uk

The Nursing and Midwifery Task Group (DOH 2020)[17] highlights that significant transformation of nursing and midwifery services is essential to the stability and sustainability of the NI HSC system. Three themes were identified;

Theme 1: Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes

Theme 2: Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice

Theme 3: Doing the right things in the most effective way and working in partnership

Covid-19 has brought new and unprecedented challenges to the HSC system, and the rebuilding strategic framework[18] provides an analysis of the impact (DOH 2020). It also sets out the approach to restoring services as quickly as possible, taking into account examples of innovative approaches to service delivery, developed in response to the pandemic. District nursing has experienced severe disruption and increased service demand. During the pandemic, MDTs including district nursing have emerged as an essential part of the primary care response, delivering essential support to vulnerable people at a time of extreme need in the community.

Throughout the United Kingdom community nursing service is under tremendous pressure due to workplace shortages, a rising older population and reduced length of hospital stays resulting in more complex patients

[17] https://www.health-ni.gov.uk/publications/nursing-and-midwifery-task-group-nmtg-report-and-recommendations
[18] https://www.health-ni.gov.uk/sites/default/files/publications/health/rebuilding-hsc.pdf

being cared for at home, highlighted by RCN 2013[19] and Ball et al 2014[20]. The Kings Fund (2016)[21] presented the growing gap between capacity and demand creating pressures that are compromising quality of care and resulting in an increasingly task-focused approach to care.

The NI Executive has committed to building capacity in primary care through ongoing rollout of Primary Care MDTs and this includes enhancing the District Nursing workforce. The Delivering Care[22] (PHA 2017) policy framework aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialties.

The Delivering Care project Phase 3[23] made District Nursing staffing recommendations in order to ensure sufficient capacity to address future service demands and implement key drivers. These key drivers include providing quality care, population health, palliative care keyworker role and function, unscheduled care, increasing demand and demographic challenges.

The Neighbourhood District Nursing (NDN) model builds on local and international evidence and supports the transformation required to reform NI community nursing services. An outcomes-based approach using

[19] Royal College of Nursing May 2013. Moving care to the community: an international perspective (RCN) London.

[20] Ball, J, Philippou J, Pike, G & Sethi, J (June 2014) Survey of district and community nurses in 2013. Report to the Royal College of Nursing. Kings College. London

[21] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quality_district_nursing_aug_2016.pdf

[22] https://www.publichealth.hscni.net/directorates/nursing-and-allied-health-professions/nursing/delivering-care

[23] https://www.publichealth.hscni.net/sites/default/files/3.Delivering%20Care%20Summary%20Paper_Phase%203%20DN.pdf

quadruple aim methodology (Figure 1) has been adopted to implement the District Nursing Framework and to evaluate the NDN model.

Figure 1 – Quadruple Aim

The NDN model aims to improve safety, quality and experience by developing a 'one team' approach, provided by a 24 hour Neighbourhood District Nursing team within a designated community and aligned to the GP Practice, with the ethos of home being the best and first place of care. To do this, the team work in partnership with patients, carers and their families, General Practitioners, and other health and social care professionals as part of a wider multidisciplinary team.

The objectives are to;

- Test a new model of District nursing linked to Primary Care MDTs
  Promote a new public health model for District Nursing
- Improve patient care through proactive management of population health
- Develop self-organised teams under a collective leadership model
- Test a coaching model for district nursing
- Reduce bureaucracy and maximise the use of technology in care
- Test Delivering Care staffing recommendations in District Nursing

Five District Nursing teams, one in each HSC Trust, started to test the model in stages in June-July 2019.

Developing the Model

Following approval of the initial proposal by the NI Department of Health a multi-professional, multi-agency steering group was established to provide direction and oversight. A separate working group was also set up focusing on recruitment, education, evaluation, communication and operational issues.

A collective leadership approach was used applied at all stages of this project. The HSC Collective Leadership Strategy (DoH 2017)[24] was referenced in order to help improve the health and wellbeing of people by harnessing strengths and working collaboratively and effectively across traditional boundaries as one system.

As part of the learning from similar UK models, a workshop was held to co-produce a NDN Delivering Together Framework to provide guidance and set parameters for staff testing the model (see appendix 1). The four principles of the DoH District Nursing Framework (DoH 2018) were adhered to;

- person centred;
- expert;
- efficient and effective and;
- integrated and population based around general practice.

[24] DH and HSC (2017) HSC Collective leadership Strategy Health and Wellbeing 2026: Delivering Together

In addition, the Queen's Nursing Institute (QNI) provided significant support through the Team Transformational Leadership Programme. The programme was developed by the QNI in collaboration with the senior nursing leadership in Northern Ireland. The overall aim was to prepare participants to work in the new transformed health service environment, to develop as excellent leaders and role models in order to deliver world-class person-centred care in the community. The indicative content and underpinning theory of the programme focused on developing participants to be fully engaged with the NDN Teams Delivering Together Framework. The themes of the programme were:

- The 'WHY' of Neighbourhood Nursing Teams – humanistic approaches to leadership
- The 'WHEN' of Neighbourhood Nursing Teams – focussed primarily on the model
- The 'HOW' of Neighbourhood Nursing Teams – focussed on the whole team approach to care

Population Health Approach

One objective of the Neighbourhood District Nursing model is to improve patient care through proactive management of population health and take account of the Making Life Better 2013 -2023 strategy (DOH 2014)[25].

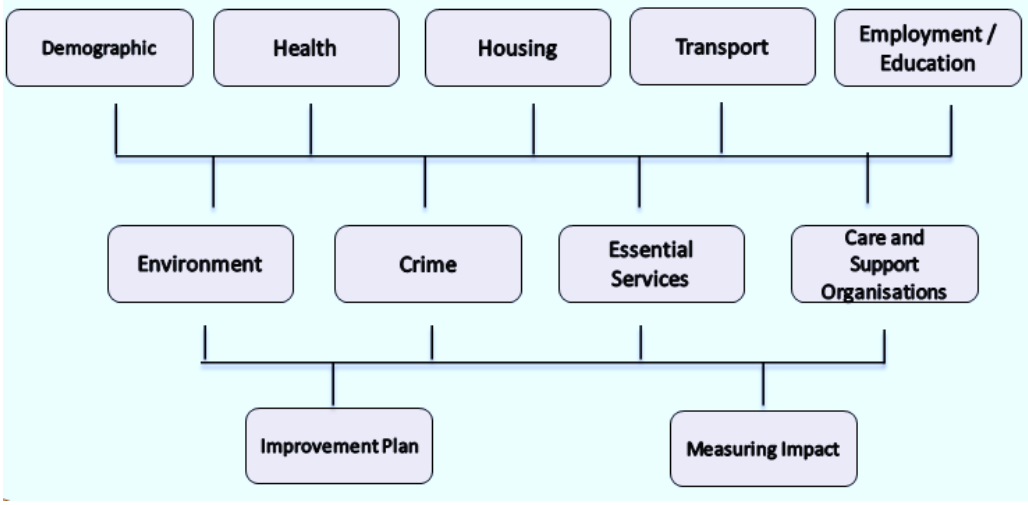
The QNI developed a bespoke template which enabled each NDN team to undertake a structured population health needs assessment in their geographical area. This template included a comprehensive picture of local health needs by combining data about health status and behaviours and access to clinical care and services. Paying particular attention to the

[25] https://www.publichealth.hscni.net/about-us/making-life-better

social determinants of health and economic factors, a local community health profile with the development of a health needs assessment and the application of a community health improvement plan based on nursing need was devised.

Figure 2 outlines the various components that helped inform an improvement plan and measuring impact.

Figure 2 - Population Health Needs Assessment Components



The teams have completed a local health needs assessment and identified priority areas. For example, in Newcastle the team is focusing on

- a diabetes self-management SQE project;
- palliative care – a QI project has improved communication between hospital based specialist palliative care services and;
- hypertension by participation in local health living Momenta programme

Competing demands of Covid-19 has temporarily delayed progress on the health improvement plans.

Methods

A range of evaluation methods were co designed to address the NDN objectives and reflect the Quadruple Aim (see figure 3). They included;

- Pre-test questionnaire survey using SurveyMonkey® June 19
- IHI Quality Improvement palliative care project (one team) Oct 19
- People measurement survey to capture staff experience using SurveyMonkey® Phase 1 Dec 19
- 10,000More Voices Survey to capture patient experience Jan 20
- Outcomes Based Accountability (OBA) scorecard quarterly returns
- Queen's Nursing Institute (QNI) Team Transformational Leadership Programme evaluation, which included written evaluations, online questionnaires and prototype practice visits Jan 20
- Completion of a population health profile by each NDN team and presentation of the findings and future directions

Figure 3 –Evaluation methods to reflect Quadruple Aim

A regional working group was established with representation from Coaches, District Nursing Managers, Human Resources, Data Analytics and Service Users. This group met regularly to develop the tools and ensure a regional standardised approach.

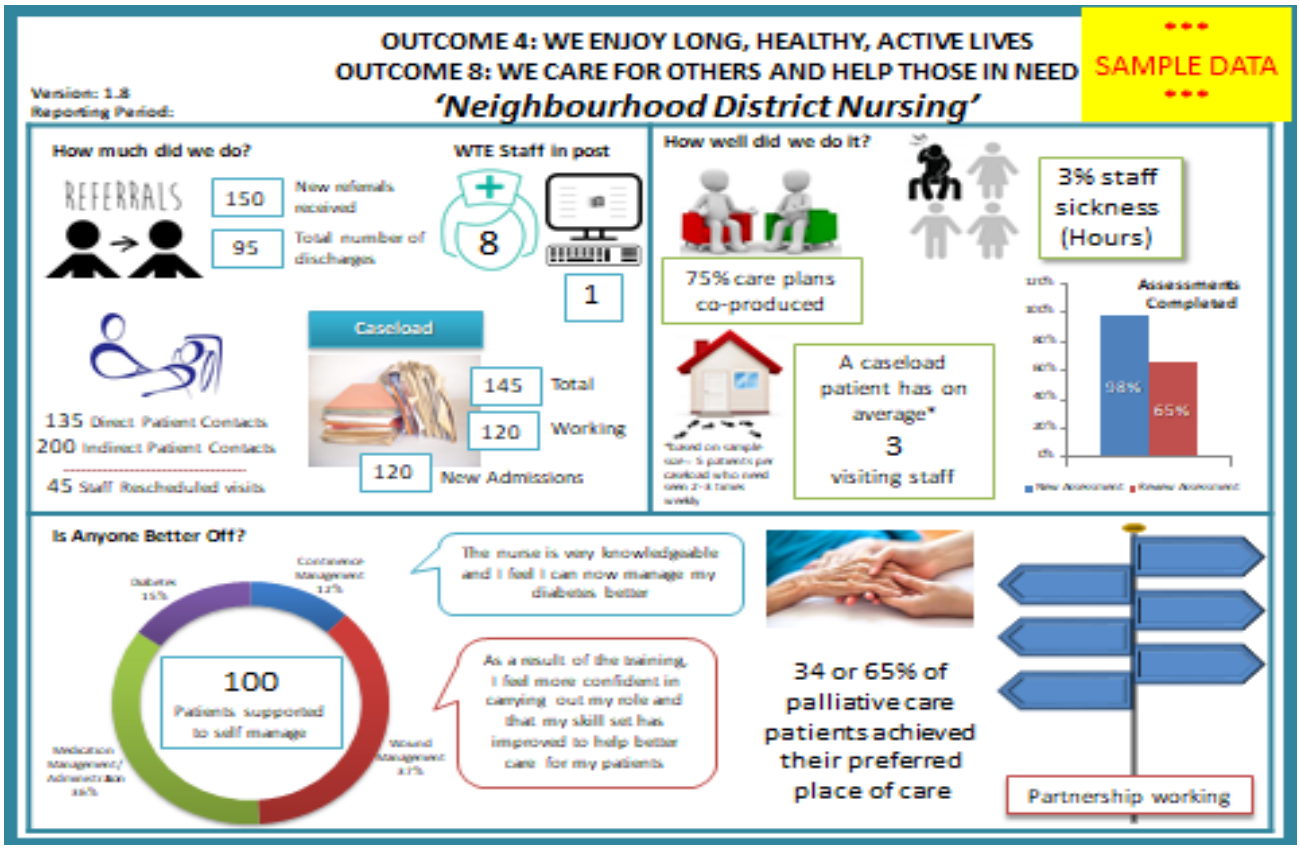
Findings

Outcomes Based Accountability (OBA)

A regionally agreed OBA scorecard (figure 4) was co-designed and a number of measures with operational definitions were agreed to reflect;

- How much did we do?
- How well did we do it?
- Is anyone better off?

Figure 4 - OBA Scorecard



The first plan, do, study, act (PDSA) scorecard testing period was reported in Quarter (Q) 3 (Feb 2020). As part of the rebuilding after Covid-19 the score card will be reviewed taking account of cost benefit analysis in addition to patient and staff benefits and organisational opportunities for development. Data has shown that;

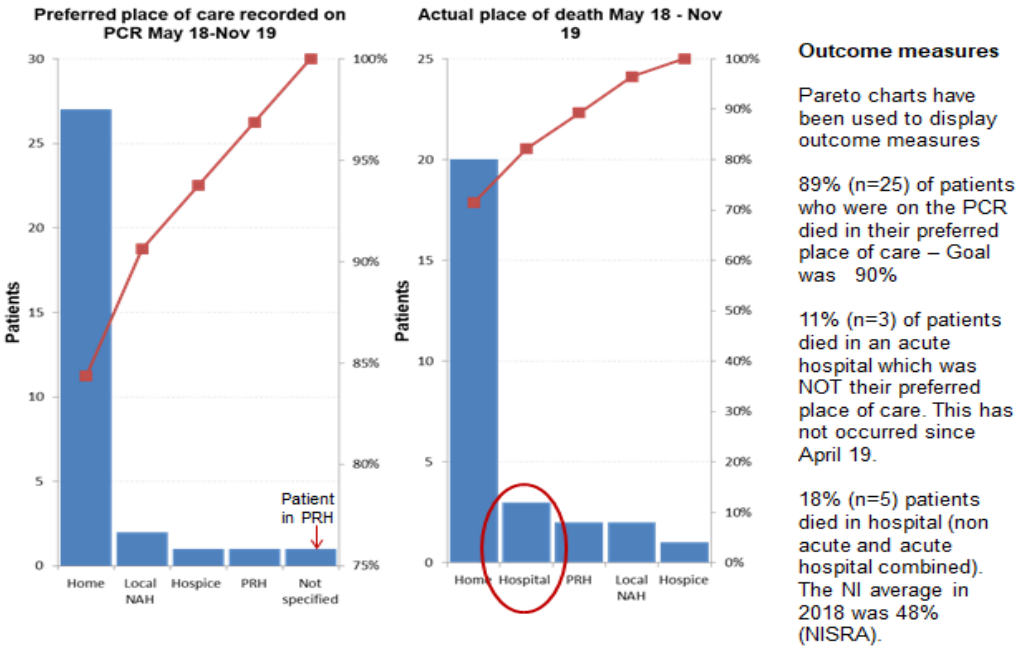
The OBA monitoring return for Q3 2019/20 shows favourable comparisons with the April 2019 electronic caseload analysis tool (eCAT) regional event report for district nursing. The NDN average working caseload by WTE was 17 compared with the regional figure of 13.
In terms of 'is anyone better off', regionally in Q3 (19/20);

- 59 patients were supported to self-manage in the areas of diabetes, continence, medicines and weight management.

- Partnership working with a range of community and voluntary groups was evidenced. The pre-test staff survey had shown two thirds of respondents were not satisfied or slightly satisfied with partnership working and cited lack of knowledge, time and lack of staffing as the main barriers.
- An average of 91% patients who were in the palliative stage of their illness and whose preferred place of care was known were supported to fulfil their wishes.

Ballycastle and Cushendall NDN team participated in an IHI QI palliative care project and focused on identifying all patients in the palliative stage of their illness and with consent, adding their details to the palliative care register (PCR) including their preferred place of care. Improvements demonstrated that by December 2019, 80% of patients identified as being in the palliative stage of their illness were informed about the PCR, consent obtained and details including preferred place of care were recorded. Outcomes measures are shown on figure 5.

Figure 5 –Ballycastle Palliative Care project outcome results

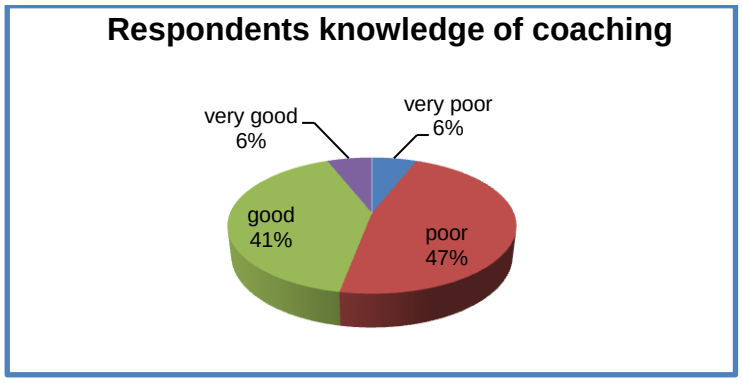


Whilst this quality improvement project was primarily focused on improving the patient experience there was also an indirect cost impact.
In 2014/15 the average number of days a person stayed in hospital prior to death (with a palliative care diagnosis) in this particular HSC Trust area was 18.6 days. Current costs are £698 per bed day for Palliative Care, acknowledging that costs vary between non-acute and acute settings and by speciality. There average cost for a district nursing contact in 18/19 was £41.05[26]

Coaching model

Another objective of the NDN prototype was to test the coaching model for district nursing. Coaching is a collaborative relationship, undertaken between a skilled facilitator (coach) and a willing individual (client). It is time limited and focused and uses conversation to help clients (individuals or groups) achieve their goals' (Williamson 2009)[27]. Knowledge of coaching was assessed in the NDN Pre-test Prototype staff survey carried out in June 2019. Thirty-two respondents indicated that their knowledge of coaching in Health and Social Care was either very poor/poor (53%) or good/very good (47%) (see Figure 6).

Figure 6- Respondents knowledge of coaching



[26] https://www.health-ni.gov.uk/publications/community-services-indicators
[27] http://www.donnerwheeler.com/documents/STTICoaching.pdf

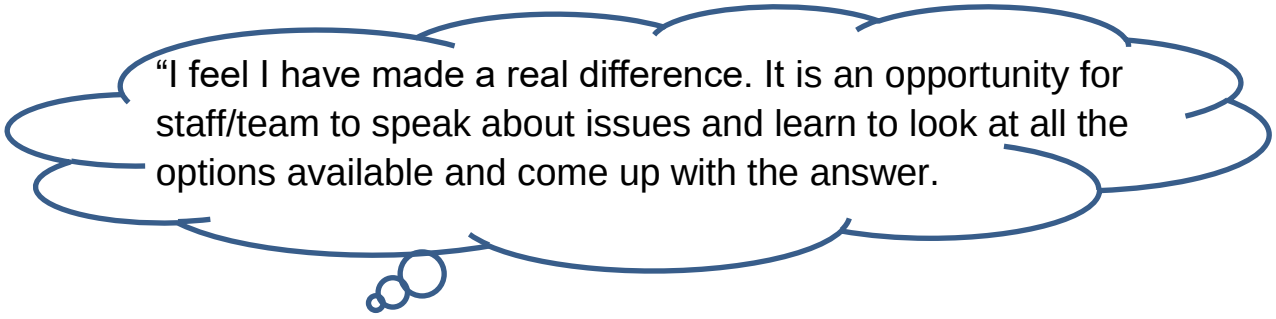
As part of the model the prototype teams were allocated a coach to assist them with the changes they needed to make in order to deliver the new model of district nursing services. The main role of the coach was to focus on individual and personal development, team working and the ability of the team to work as a cohesive group in order to deliver the organisational vision to transform the District Nursing Service, both initially and into the future. Two of the five coaches had previous coaching experience, however all were supported to undertake an Institute of Leadership and Management (ILM) Level 5 Coaching qualification, developed and delivered by the HSC Leadership Centre.

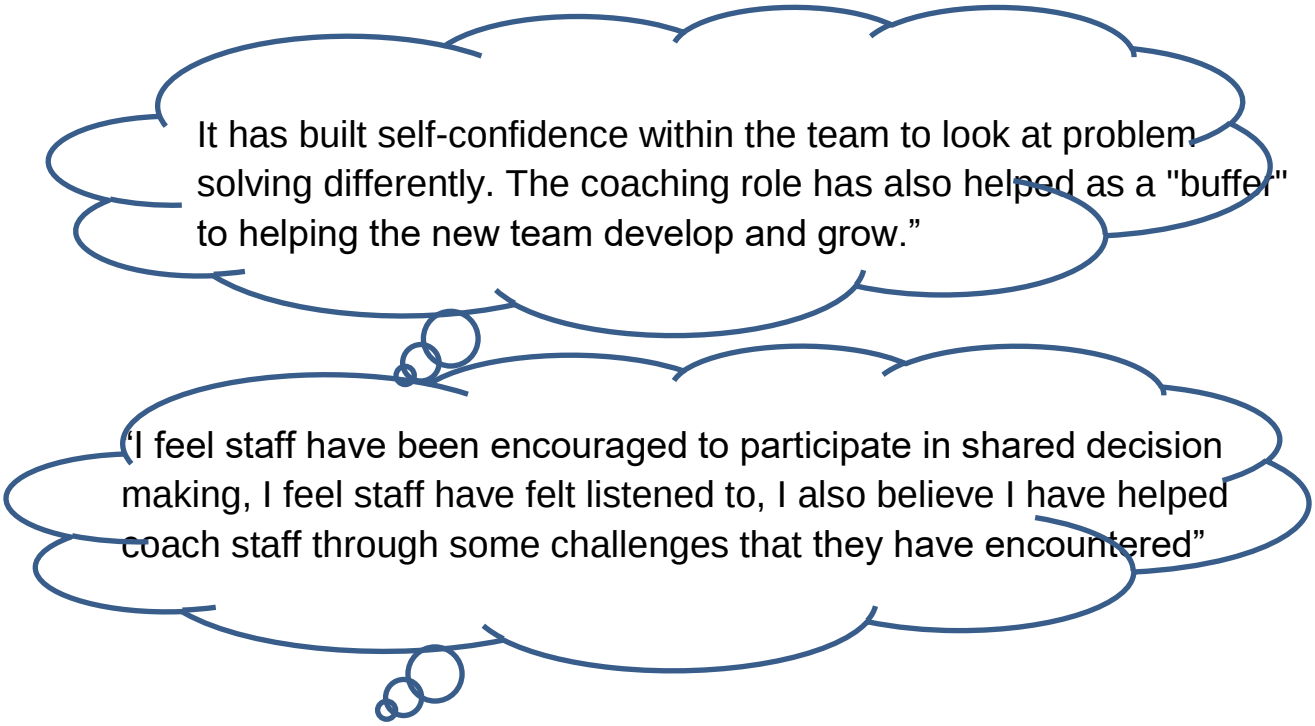
The QNI Programme Lead also met with the coaches prior to the Team Transformational Leadership Programme at a pre-workshop which helped articulate the vision the programme and model and determine individual needs around their role.

In partnership with the Programme Lead *a Building Transformation Guidance* document was created that included a checklist of requirements to introduce the coaching role into the prototypes.

All coaches fully engaged with the ‘coaching workshops’ which were delivered by the QNI Programme Lead on the afternoons prior to each module starting and this proved to be very successful for both feedback, supervision and support as the transformational change was introduced.

Coaches Comments:





Results from the People Measurement and Analysis Phase 1 Benchmarking survey showed that the average score from 29 individual responses using a slider scale derived from the 0-100 scale was 71.07 to the question. One respondent wrote ‘I feel well supported and the 'coach approach' encourages ownership and collaborative working’.

The role of the coaches has been vital both in terms of the implementation of the model to the prototype teams and the facilitation of them ‘going live’ and making the transition to the new way of delivering high quality district nursing care. Consideration will need to be given to a sustainable model of coaching within District Nursing.

Staff Satisfaction

A People Measurement and Analysis Phase 1 Benchmarking survey was undertaken in order to measure the people impacts of the intervention. The project team utilised the engagement measurement methodology from the HSCNI employee survey. This methodology utilised nine questions in total which when analysed provides a single index measure of engagement out of a total of 5.0

The rationale for using this methodology is that it is reliable, standardised, has validity and allows for benchmarking against previous scores for HSC Trusts and Divisions as required. This method is repeatable and allows for an overall assessment of the impact on engagement levels and can also be used as a temperature gauge during the project to assess progress.

The survey was sent to 45 members of staff involved in NDN via email using Survey Monkey® in December 2019 and a 65% (n = 29 respondents) completion rate obtained. This was at a time of regional industrial action.

The overall engagement score for the 29 respondents was **4.39**

An additional four questions were included to explore specific areas of interest using a 0-100 slider scale; 0 representing strongly disagree and 100 being strongly agree. These questions were analysed using averages of the individual responses by question derived from the 0-100 scale (see table 1)

Table 1

Question	Average
Do you feel that the new NDN model has enhanced the primary care MDT working?	64.10
To what extent do you feel that your team is more self-managing as a result of the new NDN model?	65.24
The coaching approach supports me to think about changing the way the district nursing service is provided?	71.07
I feel that the new NDN model improves patient care because I have a better understanding of the local population health needs?	68.21

December 2019

Comments from respondents indicated staff satisfaction with the model, support from coach, effective team working and benefits for patients;

Respondents wrote;

> *'I feel that NDN has improved patient care and outcomes. Having extra time to spend with patients, I have been able to identify opportunities for social prescribing which have been well received, as well as time to liaise with colleagues and patients to co-produce more effective treatment/care plans. Whilst the self-managing team aspect can be challenging at times, I feel well supported and the 'coach approach' encourages ownership and collaborative working.*
>
> *'We have been short staffed and now have a new team, they are enthusiastic and developing their skills which will enhance the team to develop the neighbourhood nursing model further'.*

One District Nursing story has been provided in Appendix 2 which captures the fuller essence of the NDN model.

These initial results provide an indication of the current engagement levels across the whole project team across the five HSC Trusts. Overall the engagement scores compare favourably with HSCNI engagement levels and in comparison with the NHS engagement levels from 2017 and these are shown in table 2 below.

Table 2

	HSCNI 2015	HSCNI 2019	NHS 2017	NDN Dec-19
Engagement Score	3.72	3.78	3.78	4.39

Results for engagement levels are positive; however caution should be exercised in drawing statistical relevance given the low number in some

localities. The results as presented allow for an initial benchmark of current engagement levels for this project and against regional measures which range from 2015 to recent employee survey scores for the HSCNI

Results for the questions which addressed the extent to which the change has been beneficial using a sliding scale are also broadly positive with the most positive outcome from respondents being around the extent to which the coaching model supports staff to think about changing the way district nursing services are delivered. It is interesting to note that the results for the questions concerning culture around change performed less well than the other questions. Whilst the performance was still positive, it may be that further consideration should be given to the extent to which staff in this cohort feels that they can influence change within their focus of control.

These early phase results allow project leaders and coaches to assess relative efforts to date and amend focus/direction to ensure objectives are being achieved.

The plan was to re-run the survey every two months or at appropriate intervals before the end of the project and performance over time/trends against these people measures could be analysed. Due to the Covid-19 this was temporarily deferred.

Patient experience

Patient and client experience is a key element to the NDN model. The Public Health Agency in NI is undertaking an extensive programme with the aim of introducing a more patient and client focused approach to services and shaping future healthcare through 10,000 More Voices[28]. The questionnaire gives patients and clients the opportunity to highlight what is important to them regarding their experience and what matters to them. Survey information is recorded and the main themes are identified using SenseMaker®

The Regional Lead for 10,000 More Voices supported the development of a bespoke survey 'my experience of care with the district nursing team' which was piloted with the neighbourhood district nursing team and the questionnaire was designed to reflect the objectives of the model.

The questionnaires were completed in January 2020 with the help of facilitators who are trained in patient, client, and experience facilitation. They engaged with patients, relatives and carers either by home visit or telephone interview. Postal returns were also received and a small number completed using online ink.

Overall 83% from 29 stories received rated their experience of NDN as strongly positive; the remaining 17% were rated positive. Whilst this is encouraging the survey questionnaire will be reviewed to make sure the probing questions are sufficient to counter balance a concept called "gratitude bias". Gratitude bias is common in services whereby there is great need and the respondent's gratitude for the service influences them and reduces their ability to critique the care received.

[28] https://10000morevoices.hscni.net/about-us/

A number of themes were identified;

- Continuity of staff results in a better patient experience and enhances the quality of care; This also helped to build trust into the relationship between the patient/relative and the nurse

Respondent '…*Prior to this [hospital admission] he had a different district nurse to take bloods every four weeks before admission. Now he has the same nurse to take the bloods and he loves that. He loves the consistency. She never fails to ask if there is anything else worrying him or any other issues to be looked at*…'

Throughout the respondent's narrative there is a key theme of the nurse knowing the patient and understanding their complex needs.

Respondent '...*Knowing things are confidential is very important, you don't want everybody to know, your health is very private, and I have loads of confidence in that way to*…'

Respondent '...*I know them now and I trust them, I know they will not hurt me. My leg is very sore but it feels a lot better when I get my dressings renewed. Sometimes they could be with me for an hour. I have to get my leg soaked for 15 mins; they time it to the second. When they remove my dressings it is a real mess. I feel upset when I see it; I would never show it to any of my family. I would only ever show it to the nurse*…"

Respondent"…*The nurses know me, know my normal; they can pick up on symptoms and identify problems quickly before it becomes a full-blown infection*…"

Where continuity of the team was not experienced, respondents highlighted frustrations around repeating information. "…*My only thoughts on what didn't go well and it is not really a criticism but more an*

observation was the variety of nurses in my wife's care. They are all excellent but can find ourselves repeating sometimes and would be nice to have continuity but know this isn't always possible in healthcare…"

- Care delivered in the home contributed to positive impact upon health & wellbeing of the patient and relative

With regards to promoting self-care and making good choices about health and wellbeing rather than just attending to the immediate needs responses were more diverse. A central cluster of 62% indicated the District Nursing Team supported the patient to meet immediate need, helped to make good choices about health & wellbeing and supported self-care at home; the latter is a focus of the Neighbourhood District Nursing Model.

Respondent '*Being involved in my care and making decisions about myself and my care is important to me… helps me at home and the nurses know me well and can respond to my needs'*

Respondent '*To listen to and answer my questions… that's important; the district nurse attends to my left leg three times every week. I look forward to them coming in as they provide me with good conversations; my questions are always answered very informatively. They are the fabric of this community and always go the extra mile for me'*

"… *I can relate to them and they relate to me … it's a very personal contact. I don't feel like I'm a bother or a nuisance. I know they know what they are doing and I believe what they say, sometimes they back it up with evidence. They inform me about what has happened, what is happening and what is going to happen. They prepare me and advise me at all times. I feel that they treat me as a person and not somebody who is sitting in a wheelchair…."*

"…*They advise me about how to do things, that makes it easier for me to care for Mum. They can pick up on things a lot quicker than me this gives me a lot of reassurance*…"

Positively 76% of respondents highlighted needs in relation to social wellbeing were identified and met. One respondent outlined how the District Nurse team supported them to engage with daily exercise to support healing '…*I know it is not always possible all the time but they try to call in the am, I like to go for a walk in the afternoon, they say it is conducive to healing*…'

- Work demands were evident however the majority of patients highlighted this did not impact on the experience.

"….*The nurses are very busy; they are run off their feet. They work non-stop they deserve a lot of credit*…"

"…*I know they are busy but they never appear rushed to me..."*

"…They come when I need them. They are busy so I work with them…"

"…As far as I am concerned all the professionals come in and take their time. It is not running in and running out..."

Changes in Action – based on Neighbourhood District Nursing Framework Domains (2019)

As part of the Team Transformational Leadership Programme, it was agreed that the QNI Programme Lead would visit the prototype teams to discuss progress within practice and to make a connection with the individuals whilst developing their leadership style. The prototype visits were extremely well organised by the coaches and hosted by the Trusts with an emphasis on meeting as many of the team members as possible to

get feedback on how the prototypes were progressing. Feedback from the visits and as part of the ongoing evaluation was captured under the five domains of the Neighbourhood District Nursing Framework.

1. Person-Centred Care

There were many examples of person-centred approaches to care illustrated. This ranged from improved assessment strategies and continuity of care to being less ‘task focussed’ and having a more holistic approach. Teams discussed a change in culture within the team and all members of the team felt able to input into decision making and co-production of care plans. Patient stories resonated throughout all the teams with high levels of patient and staff satisfaction with a palpable shift from reactive to proactive care delivery.

2. Integration

Experiences of access to technology and community systems varied enormously across the Trusts. There were many examples of poor connectivity in the more rural areas and whilst there had been efforts to improve this sometimes the changes had been slow to implement for various reasons. Where technology was working well with the implementation of iPads the teams had put them to excellent use, e.g. developing web pages of all the local community services to show patients in the home and one team had developed a newsletter.

The teams that were aligned and located with GP practices reported improved partnership working and connection with the wider multi-disciplinary team.

3. Efficient and Effective Care

There was a focus on community profiling to determine local population needs and this again varied within the Trusts and had some bearing on whether the Trust had employed a Data Quality Officer. This role was both administrative and to facilitate data management including the collection, collation, quality assure and data input.

All Trusts acknowledged the importance of the teams developing the 'community profile' as a way of taking ownership and understanding the social determinants of health.

All teams were working towards self-management however all acknowledged some challenges around employing staff and retaining them within the prototype.

4. Expert District Nursing Team

Within this domain some of the most prolific changes were observed in the leadership of the District Nurse team leader. Most teams had developed a collective sense of team through staff notice boards, team mission or purpose statements. They have embraced the importance of 'happy team means happy patients', with examples of staff satisfaction and a new way of working together. Most teams had developed new communication strategies including daily 'hub meetings', time management initiatives and caseload reviews. Some teams had explored the learning environment and developed new orientation and induction templates and welcome letters for all new staff and students.

The overall evaluation of the Team Transformational Leadership Programme identified a high degree of congruence between the

programmes three key themes of developing self, working within a self-managed team and understanding the new model of service delivery and the participant's assessment of the efficacy of the course in respect of these themes. It is clear that the programme has impacted positively on learning and development and can show immediate outcomes in practice with the introduction of the Neighbourhood District Nursing Framework. The visits to the five prototype sites have reinforced the move towards the delivery of high quality, safe and effective person-centred care promoting an innovative and collaborative transformed service which is twenty-four hours per day, seven days per week no matter where the patient lives.

Conclusion

The NDN model is being spread to other district nursing teams as part of the new model for Primary Care MDTs set out by the Department of Health[29]. Initial findings successfully demonstrate positive patient experience and staff engagement; further work will be undertaken to evaluate the economic impact and population health benefits. It is clear that the Team Transformational Leadership Programme has impacted positively on learning and development and can show immediate outcomes in practice with the introduction of the NDN model.

This report provides initial evaluation findings into the testing of the NDN model in NI. Due to Covid-19 some scheduled evaluations were paused and are now being reviewed as part of the re build after Covid-19.

[29] https://www.health-ni.gov.uk/articles/primary-care-multi-disciplinary-teams-mdts

Recommendations

1. Consider an independent longitudinal study of the NDN model to inform and offer independent credibility to this innovative and pioneering work in Northern Ireland

2. Develop a spread and scale plan using Quality Improvement methodology

3. Population health is a key component of the NDN model. Community profiling and health needs assessment, including health improvement plans, need to be included in District Nursing education programmes and become integral to district nursing practice

4. Further test Delivering Care Phase 3 staffing recommendations with more teams

5. Continue to build on the progress made to establish self-organised teams and create co-design space for district nursing leaders and managers.

6. To continue to provide role clarity and role definitions for staff not involved in the prototype as the model and framework is more widely introduced across the system

7. The coaching role has been fundamental in this transformational change. The coaches supported the wider operational planning, delivery and evaluation of the model. Coaching should continue to be supported within District Nursing

8. To continue to apply the principles of economic assessment and demonstrating value of Neighbourhood District Nursing in order to build a case for scale and spread of the model.

9. Review the evaluation methods utilised to date to ensure they are fit for purpose and meet the needs of the new model. Tools such as the 10,000 More Voices and People Measurement survey should be reviewed and updated accordingly. It will also be necessary to determine how these evaluation methods can be integrated into the wider MDT independent evaluation.

10. The Neighbourhood District Nursing Delivering Together Framework has been an invaluable tool and has provided guidance to clinical staff, managers and QNI Team Transformational Leadership programme lead. This framework review should coincide with planned rollout of the NDN model.

11. Options for future delivery of the Team Transformational Leadership programme need to be explored. Due to Covid-19 restrictions Project ECHO will be used as means of delivering part of the programme supported by the Coaches.

12. Explore technology options that could be introduced to support a public health approach to care delivery and supports proactive and predictive health care management

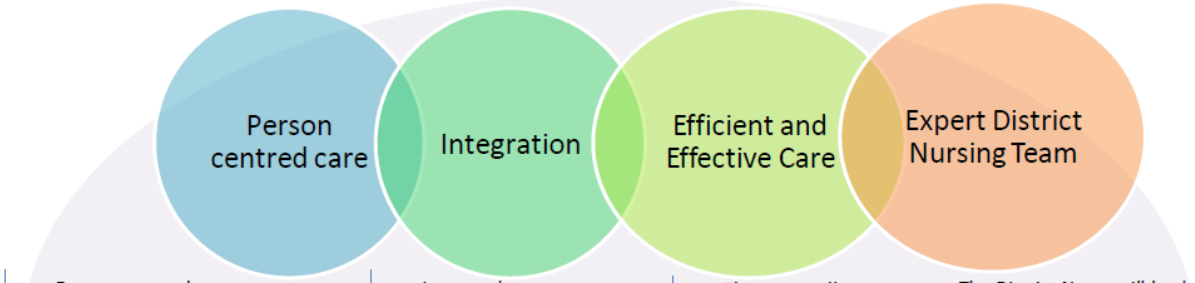
1

Appendix 1

NEIGHBOURHOOD DISTRICT NURSING TEAMS: DELIVERING TOGETHER
Framework

HSC Health and Social Care

To deliver a world class person centred Neighbourhood District Nursing service 24/7



Person centred care

- Every person has an assessment with a co produced care plan agreed by the person, family/nominated representative with consent as appropriate; shared with team and recorded in the patient held record.
- Aim to ensure every person has a positive experience of care.
- Embed a public health culture of self care/self management.
- Work with the local community and voluntary sector to signpost and for social prescribing.
- Proactive management of caseloads to ensure safe and effective nursing care.
- Continuity and consistent person centred care delivered by the same core team.

Integration

- Improved access to technology and community information systems.
- Information is streamlined and will support existing systems regionally.
- The team is GP aligned within a geographical area.
- Improve communication by ensuring the team is central to multi disciplinary person centred care.
- To connect and engage with GPs, the wider community and secondary care and voluntary multi disciplinary sectors.

Efficient and Effective Care

- The team will manage own budget.
- Implement Delivering Care staffing recommendations.
- Undertake active community profiling to determine local population needs.
- Continuous Quality Improvement should be the ethos of the team.

Expert District Nursing Team

- The District Nurse will lead the team, and team decisions are made taking account of collective leadership and the delegation framework.
- Communication is person centred and all team members contribute.
- Authorised to solve own issues knowing that the wider support and expertise is available when needed.
- Needs will be met safely and effectively.

Final 140119 v2. Review Jan 2020

Appendix 2 - A Community Nurses Story (collated by Marion Orr NDN Coach March 20)

This is an example of how a commonplace referral to district nursing, can become convoluted branching out in different directions like the branches of a tree.

One of my duties on a typical day is to check the computerised referral system several times mainly to deal with any red alert referrals which have to be accepted within a 4 hour timeframe and also routine referrals. This particular day a 'routine' referral came from the GP "*please call and assess wound, patient has no dressings*" was sitting in the inbox. There was no background information regarding the patient only a name and address.

I accepted the referral and immediately put on my 'detective' hat to delve further behind this referral, conscious of the patient's safety and also my own safety as a lone worker. Pre-assessment is very important as it provides a reliable picture before entering a home. I have found that this makes patients more relaxed and confident in me as a nurse and vice versa. Actually working in the local GP medical practice enables immediate access to the GP's computerised system and also face to face talks with the GP in the corridor or in the tea room at the end of surgery. I know the GPs and practice staff are confident of my professionalism and confidentially.

On this occasion gaining information proved more difficult. The patient had yet to register with the GP and consequently I was unable to access the patient's Health and Care number, the key to obtaining their recent medical history. However through my local intelligence of the area I established that the gentleman and his wife had recently moved to the area. The only option to complete a thorough assessment was to call out at the address, arguably to complete strangers. I told my colleagues where I was going and what time I planned to be back at but I felt fairly confident that there wasn't anything to compromise my safety as a lone worker. The area I work in is rural and everyone seems to know everyone else but I realise that my colleagues in town and city areas have more difficulties in this area.

When I arrived the door was immediately opened by the gentleman's wife and I was kindly invited into the house. My assessment skills as a community nurse really ignited. Using all my senses I was assessing the environment and at the same time gaining a verbal history and background from the patient. The therapeutic nurse patient relationship was being established. On observation I immediately recognised that the wound had opened up (known as dehiscence) and simultaneously I was also deciding on the most appropriate research based management of the wound. The small reserve of emergency dressings I carry in my nurse's bag was essential. I could only arrange a prescription for dressings once the patient was registered.

The assessment revealed that the gentleman was originally from another continent and had stayed in England for a few weeks until moving to Northern Ireland. Due to a medical condition he had recently undergone a right below knee amputation. My assessment was also 'investigative' in that I was able to trace the community team in England that had been attending him and over the telephone I was able to get a deeper insight into his nursing and medical history.

During the daily safety brief I discussed my findings with the District Nurse and the rest of the team. The gentleman had no furniture, heating or food in the home. The home was cold and empty. As he

was not from the area he did not know who to contact for oil, coal or even where the closest supermarket was. Mindful of this, some of colleagues took my allocated calls so that I would have time to go back to gentleman with a home file and signpost him and his wife to these basic need necessities that they obviously required. I also underscored the importance of registering with the GP in order to access prescriptions.

The next day when I called and noted that the home was warmer and there were now provisions in the house. I was satisfied that they were in a better position than the previous day. I was also able to discuss with the GP my findings and the most appropriate dressings. This has prompted me to obtain my nurse prescribing qualification so that I can prescribe a dressing in the person's home. Together with the patient and his wife a plan of care was produced and with the patient's consent I referred him to the TVN (Tissue Viability Nurse). I also obtained a wound swab, completed clinical observations and again liaised with the GP requesting antibiotics due to the increasing exudate, heat and pain the gentleman was experiencing.

The gentleman was scheduled for daily dressings and very quickly a bond was formed between the gentleman and the whole DN team. There was an excellent display of continuity of care as he knew us and we knew him. Continuity enables me to pick up very quickly when something is wrong with one of the patients however subtly. Gradually the number of visits began to reduce as the wound stabilised.

Gently I introduced self-management of the wound which enabled the gentleman and his wife to have a week-end away. I organised daily bags of dressing and taught his wife how to wash her hands and how to dress the wound until they returned.

Throughout the patient's journey with district nursing I and my colleagues made referrals to the occupational therapist, wheelchair service, tissue viability, and GP. There is a good level of communication between the integrated care team and it is rewarding to be able to update one another informally possibly over a coffee or formally at a team meeting. We all work together as a team with the same goal in mind, namely of providing a high level of quality care to the patient.

After a period of 4 months the gentleman was discharged as his wound had completely healed but I provided our contact details should he have any concerns. It was very rewarding to achieve success with the wound and also to receive praise and thanks from the gentleman for our dedication and care. I like to think that through his journey with myself and the district nursing team this gentleman and his wife are now involved in local community groups. Even though he is discharged from our service we still meet him in the village or surgery and get an update on his life. Currently he is waiting on the fitting of a prosthesis and intense physio regime to be able to walk, something he thought he would never be able to do. Additionally, he had recently become a grandfather and life couldn't be better.

This story demonstrates that when there is person centred care, continuity of care, good communication, teamwork and dedication, I and my district nursing colleagues can have a colossal impact on how care is delivered. On reflection this gentleman did receive a first class service and for this I am proud.