



Department of
Health

An Roinn Sláinte

Mánnystrie O Poustie

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A District Nursing Framework 2018-2026

24 Hour District Nursing Care No Matter Where You Live







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‘I believe this Framework sets the way forward for all of us to work together to deliver a world class district nursing service.’

Acknowledgement



I would like to thank all of those who were involved in the development of A District Nursing Framework 2018-2026. I believe this Framework sets the way forward for all of us to work together to deliver a world class district nursing service. I am confident that the implementation of the Framework will have a valuable impact on delivering safe and effective person centred care by district nurses and their teams in community settings, in line with the overall ambitions of Health and Wellbeing 2026: Delivering Together.

I would like to acknowledge the work undertaken by The Queen’s Nursing Institute, Ulster University, Public Health Agency and Health and Social Care Trusts (HSCT) in contributing to this framework. I would also like to thank the Royal College of Nursing for facilitating a workshop with front line district nurses to enable them to contribute to the development of this Framework. I am also enormously grateful to all the General Practitioners (GPs), Members of Legislative Assembly (MLAs) and Voluntary and Statutory Agencies who responded to the consultation process and whose comments have strengthened the development of the framework.

In addition, it is important to acknowledge the role played by all those who commented on the various drafts of the Framework. I am very grateful for the help of all involved in bringing this document to publication.

A handwritten signature in black ink that reads "Charlotte McArdle".

Professor Charlotte McArdle
Chief Nursing Officer



Foreword



The district nursing service is well respected and a highly valued part of the Northern Ireland Health and Social Care system. The District Nursing Framework 2018-2026 paves the way for developing a world class district nursing service that is available twenty four hours a day, seven days a week. Whilst this will happen over time as resources become available, all patients, no matter where their location, should have the same excellent healthcare experience. Patients and their carers must have equal opportunity to access a regional standard of service and be enabled to play an active part in co-producing their care plans and in co-designing their services. This Framework enables district nurses to grasp the transformational agenda of the ambitions in Health and Wellbeing 2026: Delivering Together, and to play a central role in its delivery. The Framework should be regarded as a roadmap for commissioning, managing and partnering with district nursing services as well as for district nurses themselves.

Transformation will require collective leadership, access to new technologies and a skilled workforce aligned to support new service models. The district nursing workforce must not only be at the leading edge of clinical practice but they must also lead innovation. Feedback from staff, patients and carers is critical to improving services and the use of improvement methodologies must become an everyday skill; standardising and removing variation to improve efficiency; improving existing systems to achieve better performance and innovating and changing existing systems to improve outcomes for the benefit of patients. I would like to take this opportunity to thank all the district nursing teams for their contribution to this work and to wish them well on delivering this transformational agenda.

Mr Richard Pengelly
Permanent Secretary

‘All patients no matter where their location must have the same excellent healthcare experience.’

Context

Over the past few years, there have been five reviews and reforms of health and social care in Northern Ireland (Transforming your Care (2011), The Right Time, The Right Place (2014), Review of HSC Structures (2015), Systems not Structures (2016) and Health and Wellbeing 2026 (2016)).

A Framework is essentially a supporting structure and as such this Framework should be viewed as the roadmap for the district nursing service in Northern Ireland.

Northern Ireland has embarked on an unprecedented programme of change as identified in Health and Wellbeing 2026: Delivering Together (DoH 2016). This highlights the challenges presented by an ageing population with an increase in complex co-morbidity resulting in rising demand and widening health inequalities. These demands are putting increased reliance on district nursing, as we see a continuing shift of care from hospital to community settings. Patients, their families and carers are rightly demanding improvements in the quality of care alongside a requirement to commit to co-production of care plans and co-design of services. Staff are central to delivery of a quality healthcare experience and it is an acknowledged fact that they cannot deliver a good healthcare experience without having a good working experience themselves.

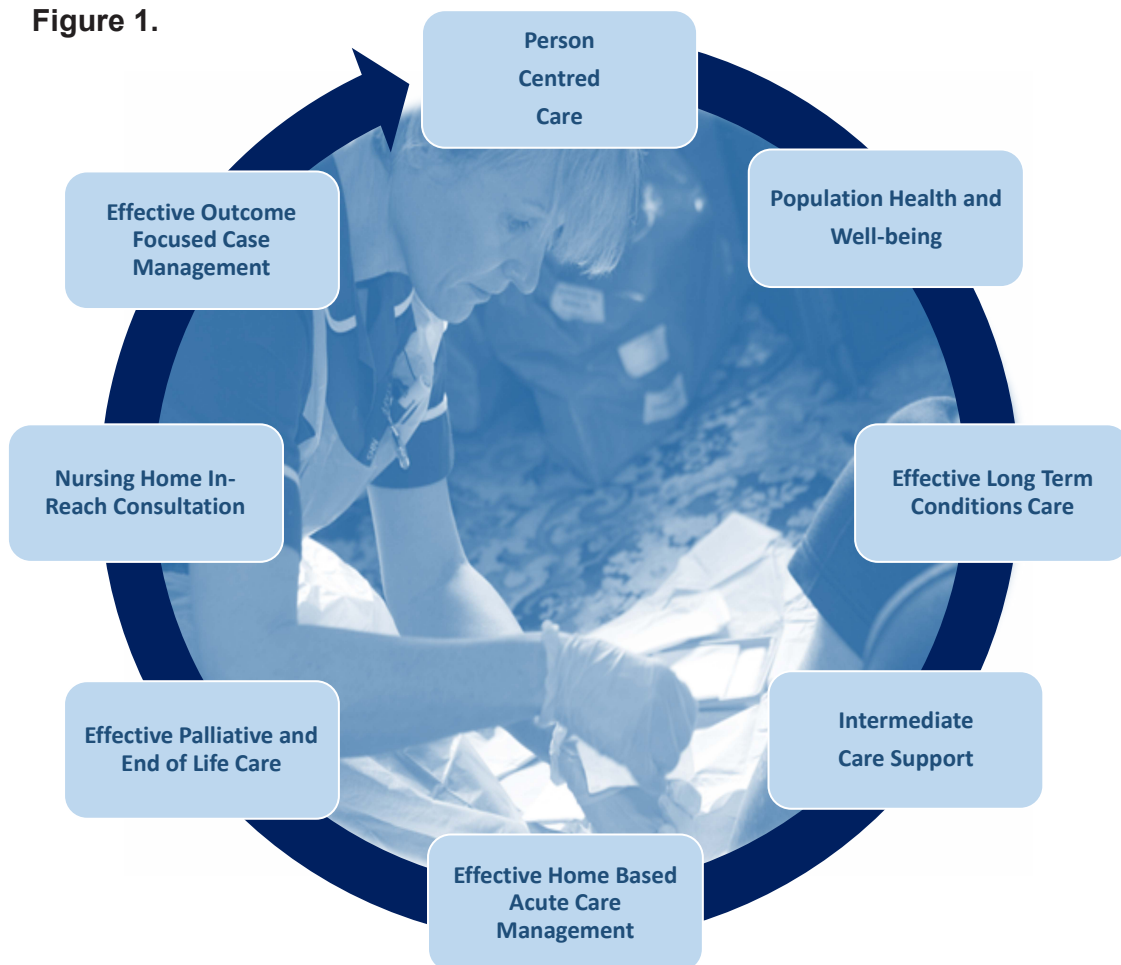
These challenges will require a transformation in the way services are delivered and in the way the system is organised. There will be a move away from the focus on ill health to a model of prevention and self care that is based on maintaining the health of the population which must be personalised, preventative, participative and predictive.



Introduction

The district nursing service is an essential part of the health and social care system, and often makes the difference between people being able to stay at home rather than being admitted to hospital or nursing home care. The district nursing team assesses care needs and delivers a wide range of nursing interventions to people in their own homes or close to their home. They play a key role in supporting independence, managing long term conditions, providing palliative and end of life care and preventing and treating acute illnesses. Figure 1 outlines these key roles.

Figure 1.



‘Increasingly, care and treatment (including care in the last days of life) is being delivered in settings outside hospitals and closer to, or in the home.’

The title district nurse and community nurse are often used interchangeably, however they are distinctly different and it is important to define exactly what their titles mean.

A district nurse is a registered nurse with a graduate level education possessing a district nursing specialist practitioner qualification recordable with the Nursing and Midwifery Council (NMC). The specialist practitioner qualification focuses on a range of topics including: case management; clinical assessment skills; care co-ordination; autonomous decision making, enhanced clinical skills; population health; leadership and team management.

A community nurse is a registered nurse working in the community within the district nursing team.

Health and Social Care services are evolving in response to both the changing profile and changing needs of the population. To succeed, the district nursing service needs to be at the forefront of these changes. Despite the changing demographics, Northern Ireland does not have a fully regional twenty four hour district nursing service. Increasingly care and treatment (including care in the last days of life) is being delivered in settings outside of hospitals and closer to or in the home.

In order to meet these changing needs and to make Health and Wellbeing 2026: Delivering Together (DoH 2016) a reality, the district nursing service must provide a twenty four hour a day, seven day a week service. This district nursing framework will provide the strategic direction for the district nursing service for the next ten years and will enable the service to meet this challenge by ensuring that they have the right technological support which will enhance their practice and not distract them from delivering care. A critical element to the success of this Framework will be to ensure that the introduction of any new models or developments are assessed appropriately before introduction to ensure their impact on the workforce is properly understood.

The patient and their carers need to be at the centre of all that is proposed in this Framework, with the core multi-disciplinary team built around them and aligned with General Practice as illustrated in Figure 2.



Figure 2. The Primary Care Core Team



District nurses will be aligned with GP practices and maintain a population health focus, embedded in HSCTs.

‘District nursing will deliver world class care to patients, twenty four hours per day, 7 days per week and 365 days per year.’

Developing the Framework

This Framework has been co-produced and developed after extensive engagement with all key stakeholders and a comprehensive review of policy directions (see appendix 1) including Programme for Government (PfG).

Four principles underpinning the district nursing service were agreed within the Framework and are outlined in Figure 3. Care will be:

- Person Centred;
- Efficient and Effective;
- Expert; and
- Integrated and population based around General Practice.

The District Nursing Framework

‘District nursing will be an innovative, collaborative and transformed service, which will deliver world class care to patients, twenty four hours per day, seven days per week no matter where the patient lives.’

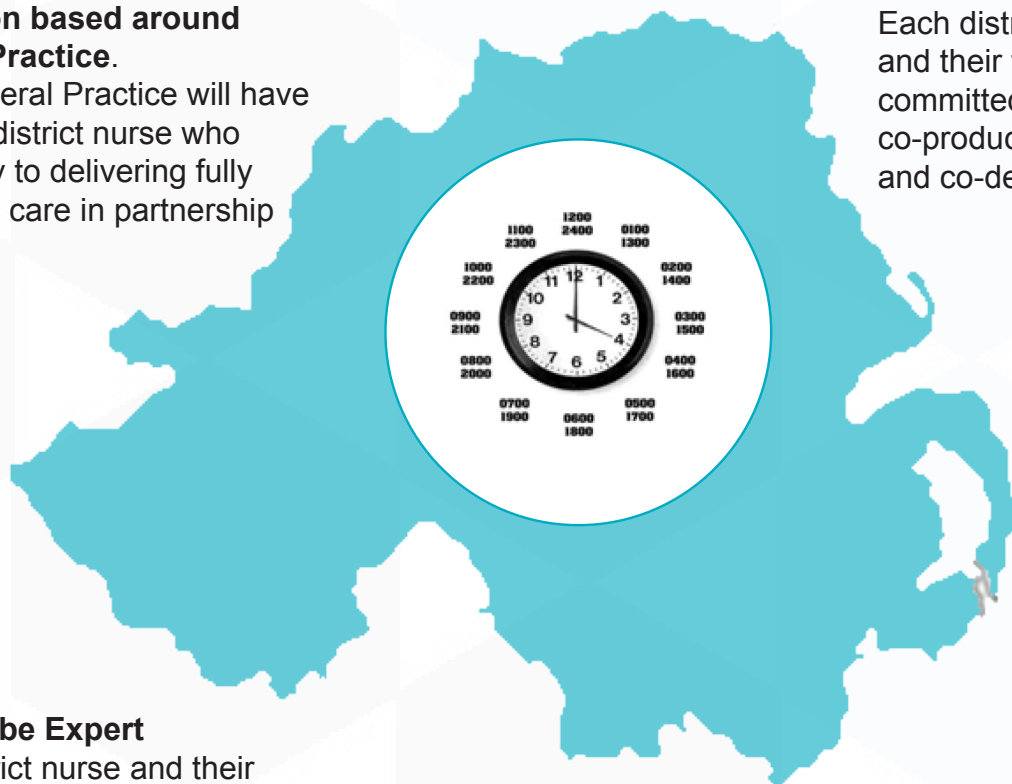
Figure 3.

Care will be integrated and population based around General Practice.

Each General Practice will have a named district nurse who will be key to delivering fully integrated care in partnership with GPs.

Care will be Person Centred

Each district nurse and their team will be committed to developing co-produced care plans and co-designed services.



Care will be Expert

Each district nurse and their team will have the resources and expertise to deliver a world class service and will be committed to their own continuous professional development.

Care will be Efficient and Effective

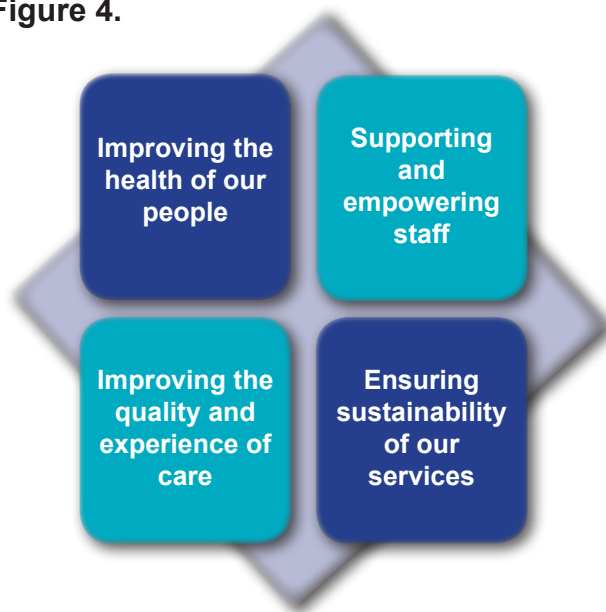
Patients will get the right evidence based safe, dignified, compassionate quality care, which delivers the right outcomes delivered by the right person with the right skill set.



Programme for Government (PfG) and Outcomes Based Accountability for District Nursing Services

Health and Wellbeing 2026: Delivering Together's ambition is to enable patients, their carers and their families to lead long, healthy and active lives, and this is one of the outcomes in the NI Executive's Draft Programme for Government. The ambition is underpinned by four key aims (quadruple aim) outlined in Figure 4:

Figure 4.



It is within this context that district nurses will work in partnership with patients, carers, families and their communities to achieve better health and wellbeing outcomes. District nurses will be instrumental in:

- 1. Population Health Management:** This means the district nurse will use patient level information (data) to proactively anticipate and manage people's needs in order to prevent ill health, reduce clinical risk and promote health and well-being.
- 2. Improving people's experience of care:** This means the district nurse will facilitate person centred care by partnering (co-producing) with patients in the development of care plans.
- 3. Improving clinical and care outcomes:** This means the district nurses will utilise and fully implement evidence in their practice, and will routinely record clinical and care outcomes.

‘Teams who have a good working experience, will be able to deliver a good healthcare experience to their patients.’

Figure 5.



4. Optimizing health and care resources. This means the district nurse will be a reflective practitioner and seek to use quality improvement approaches to improve care pathways, and to ensure resources are used to enable the most effective outcome for the people they care for.

5. Supporting and empowering staff. The leadership of nursing will proactively support the development of the district nursing roles including the enhancement of their clinical skills to meet the needs of their respective populations. Through the development of a Neighbourhood District Nursing Model, district nursing teams will be empowered and resourced to manage and direct patient care for the populations they serve.

In translating the quadruple aim into practice, an outcome based accountability approach has been adopted for the four principles in the district nursing framework. A number of improvement priorities, actions and indicators of success have been identified for each of the four principles. This approach will be adopted for the district nursing service as it encourages a population health focus. District nurses make an important contribution to the promotion of health and the prevention of ill health in the general population.

District nurses support and enable people to exercise choice and take control of their own health decisions and behaviours. They must also be able to acknowledge the demands of their practice on their own health and wellbeing, engaging in self-care and accessing support when required for themselves and their team. There is a growing evidence base acknowledging that teams who have a good working experience will be able to deliver a good healthcare experience to their patients.

Greater integration of health and social care services is occurring across Northern Ireland, requiring registered nurses to negotiate health and social care boundaries, support and manage the care of people with a range of care needs and play a proactive role in multi-disciplinary teams and inter-agency working. They must show equal regard for identifying and meeting mental, physical and cognitive challenges and behavioural needs and liaise with mental health and learning disability teams as required. They must also demonstrate cultural awareness and sensitivity in order to prioritise person centred nursing care.

To make delivering of this Framework a reality, district nurses must be supported through the development of a bespoke leadership programme to enhance their ability to influence the current transformational agenda. By strengthening their leadership skills, their business planning abilities and their influencing skills, the programme will enable them to become more innovative and entrepreneurial.

Details on the evaluation systems to be used in respect of particular policies and programmes will be included in the Implementation Plan which will follow the launch of this Framework.



Outcomes for Delivering Person Centred Care (PCC)

What needs to happen	How we will make it happen	How we will know it has happened
<p>The needs and experiences of patients, families and carers are at the heart of district nursing. Ensure timely access to an equitable service regardless of location.</p>	<p>In partnership with patient's values and beliefs, the district nurse and their team will co-produce patient's healthcare plans and work in partnership to co-design new services to ensure an excellent healthcare experience</p> <p>Staff and patients/families/carers will have access to feedback platform.</p>	<p>100% of care plans will be co produced and agreed with patients and their carers.</p> <p>District nursing patients will score highly on all satisfaction surveys.</p> <p>The district nurse will respond quickly and constructively to all feedback to improve their services.</p>
<p>District nurses will support individuals, their families and carers to self manage their condition (where appropriate) to enable them to stay at home whether they need urgent care, 24 hour care, palliative and end of life care or long term conditions care.</p>	<p>For patients assessed as appropriate Acute Care at Home* services will be available to provide an alternative pathway to admission to hospital; subject to resources.</p> <p>The key worker role will be fully implemented within the district nursing service.</p>	<p>100% of patients assessed as appropriate for Acute Care at Home will be cared for at home by March 2019.</p> <p>The district nurse will be the key worker for palliative and end of life care</p>
<p>People, communities and partners in care understand the role, function and design of the service.</p> <p>District nurses will adopt a Make Every Contact Count (MECC) approach.</p>	<p>The role of the district nurse will be clearly articulated, defined and profiled. Their services will be divided into the following areas of practice: Acute Care at Home; care associated with long term conditions*; palliative and end of life care*; population health and well being* (MECC).</p> <p>New ways of working will be developed to improve discharge planning mechanisms to ensure integration between hospital, GPs and community teams.</p>	<p>Referral mechanisms will be streamlined to ensure 100% of patients have timely access to all areas of practice.</p> <p>100% of patients referred to the district nursing service will experience no avoidable delays.</p>

* See Glossary

‘District nurses will deliver services that are integrated, effective and efficient.’

Outcomes for Integration

What needs to happen	How we will make it happen	How we will know it has happened
<p>The district nursing service will be further integrated to meet the needs of the patients in their care.</p>	<p>District nurses will work as a member of the multi-disciplinary team in community settings recognising that the relationship between the GP and district nurse is central. This should include multi-agency working with wider community sector groups.</p>	<p>Integration will support improved patient centred interventions by ensuring care is delivered by the right person with the right skills at the right time.</p>
<p>The service will support the modernisation and reform of HSC Services within Northern Ireland.</p>	<p>Commissioners will invest in technology to ensure district nurses are supported to work in mobile ways and enable the use of technology enabled care such as remote monitoring and video consultation.</p> <p>District nurses will work closely with Commissioners and Information Technology directorates to specify their information and communication needs.</p> <p>A central referral system will be developed to support a local integrated model, to reduce inefficiency and facilitate timely responses to referrals, including referral feedback.</p> <p>District nursing teams will participate in Improvement Methodology training as part of an integrated community model of care.</p>	<p>100% of district nurses will have a mobile phone by Mar 2018.</p> <p>100% of district nurses will have access to NI Electronic Care Record by June 2018.</p> <p>All district nurses will be able to work remotely using mobile devices by 2019.</p> <p>District nurses will be provided with access to suitable devices to enable them to see and input patient’s information directly to the system at the point of care.</p> <p>Data required to support the full delivery and operational management of district nursing service will be available via digital information systems by 2021 dependent on the implementation of a regional integrated Health and Social Care record.</p> <p>20% of district nurses will have Quality Improvement training by March 2018 increasing by 20% points per year until complete.</p>
<p>District nurses will deliver services that are integrated, effective and efficient.</p>	<p>District nursing teams will be practice aligned to GPs, with the named district nurse acting as the link between general practice and broader integrated teams and there will be a named district nurse for each General Practice.</p>	<p>100% of practices will know who their district nurse is and will know how to contact them in a timely fashion and vice versa by March 2018.</p>



Outcomes for Efficient and Effective Care

What needs to happen	How we will make it happen	How we will know it has happened
The district nursing service will be underpinned by agreed robust governance arrangements.	Each district nurse team will develop a yearly Business Plan and Risk Register.	100% of district nurse teams will have a Business Plan and Risk Register.
Effectiveness and efficiency will be measurable and performance managed	<p>A series of Key Performance Indicators (KPI) and benchmarks will be developed across Northern Ireland and further afield.</p> <p>Regional assessment, admission and discharge criteria for the district nursing service will be updated and regionally agreed to reflect a transformed, innovative service that delivers care in a variety of community settings and clinics and which encompasses NISAT*</p> <p>A regional caseload weighting tool will be agreed.</p> <p>New community nurse-led models of care, similar to Buurtzorg* type models will be tested and developed to ensure a population health focus where district nurses lead the assessment, planning and co-ordination of care in self-managed nursing teams.</p>	<p>A regional district nurse KPI Group will be set up by March 2018 to identify and monitor KPIs and outcomes.</p> <p>Regional referral, assessment, admission and discharge criteria will be agreed by March 2018.</p> <p>A regional caseload weighting tool Task and Finish Group will be established and report by March 2019.</p> <p>A regional community nurse-led model of care prototype will be agreed regionally by March 2018.</p> <p>The prototype will be scaled and spread throughout each HSCT Trust by Dec 2020.</p>
<p>Workforce planning and skill mix will support safe and effective care</p> <p>*See Glossary</p>	<p>HSCTs will value their district nursing teams by offering career and clinical development pathways.</p> <p>Delivering Care Phase 3 will be fully implemented over the next 3 years pending resources becoming available.</p>	<p>Each district nursing team will develop an educational framework for implementation through *ECG</p> <p>Delivering Care KPIs will be monitored on a 6 monthly basis.</p>



Implementation

This Framework is intended to provide the strategic direction for the provision of district nursing services in realising the ambitions identified within Health and Wellbeing 2026. District nurses must be central to the development of new care models, as they are critical partners in transforming the way services are delivered and the way the system is organised. The District Nursing Framework provides a roadmap to making those ambitions a reality.

The Public Health Agency will lead in taking forward the Implementation Plan to progress the objectives in this Framework within the overall transformation of the Health and Social Care system as set out in Health and Wellbeing 2026: Delivering Together. The Public Health Agency will work collaboratively with the DoH, Health and Social Care Trusts, Local Commissioning Groups (LCGs), the primary care core team and people who use the service.

Progress on the Implementation Plan will be monitored through DoH and the new transformation accountability arrangements. Some of these actions can be achieved relatively easily, others will take longer to achieve as they will require detailed planning. Implementation of the actions will also be subject to available resources against the background of competing priorities for new investment across health and social care.

‘Delivering Care aims to support the provision of high quality care through a Framework for determining staffing ranges across district nursing.’

Glossary

Acute Care at Home

This includes patients who require acute care, due to the onset or exacerbation of an illness for a short period of time, as well as sub-acute where the care falls between the continuum of acute care at home and rehabilitative long term care. This pattern of care is often necessary for only a short time (which may mean very intensive support).

Buurtzorg

Buurtzorg means ‘neighbourhood care’ and it is a model of home care/district nursing which was developed and is being delivered in the Netherlands. This model aims to simplify and humanise a health and social care system that has reduced relationships to tasks and become over complex. The model sets out to show that enabling and supporting well trained health professionals to build relationships with clients and the networks around them would lead to better care at lower cost.

Care Associated with Long Term Conditions

This is care provided to patients with a disease of long duration and generally slow progression. The patient is encouraged to play a central role in managing their long term condition.

Care Management/Case Management

Roles and interfaces between district nursing, care and case management should be examined to ensure clarity of roles and identify overlap or confusion. Some evidence suggests that merging the care/case management role might be appropriate in some Trusts. In relation to case management, models based on specialist areas of practice should be clear regarding the difference between case management and specialist nursing services (e.g. diabetes, COPD, respiratory care, heart failure, hospice at home, etc).

Delivering Care Phase 3 District Nursing

Delivering Care aims to support the provision of high quality care which is safe and effective through a Framework for determining staffing ranges across district nursing.

ECG – Education Commissioning Group

This group plans and allocates the funding to a range of education programmes including specialist practice. The DoH, the 5 HSCTs and the PHA are represented on the group.

Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is an approach to behaviour change that uses the millions of day to day interactions that organisations and people have with other people to support them in making positive choices and changes to their health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations, communities and populations. MECC maximises the opportunity within routine health and care interactions for a brief discussion on health and wellbeing factors to take place. Embedding MECC in all our practice has the



potential to make a significant impact on the health of our population.

NIPEC Development Pathway for Nursing Assistants

The Northern Ireland Practice and Education Council in partnership with a range of stakeholders developed the Nursing Assistant Development Pathway, which is designed to equip Nursing Assistants (Band 2) and Senior Nursing Assistants (Band 3) in HSCs with the necessary knowledge and skills and attributes to fulfil their role.

NISAT – Northern Ireland Single Assessment Tool

Designed to capture information for holistic, person centred assessment of the older person

Palliative and End of Life Care

Palliative and End of Life care is the active holistic care of a patient with advanced progressive illness.

Population Health and Wellbeing

Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.

Population health is affected by a wide range of influences across society and within communities. Improving population health is not just the responsibility of health and social care services, or of public health professionals. There is evidence that the social determinants of health (social, environmental and behavioural factors) contribute 60% in improving the health of populations.

Q2020 Attributes Framework

The Framework is designed to help organisations to build the capability and capacity of the workforce; and to support leadership for quality and improvement in health and social care (HSC). It aims to develop leadership skills at all levels to empower staff to take decisions leading to changes and improvement in service delivery. The Framework includes the attributes of the knowledge, skills and attributes that leaders working in health and social care will be expected to acquire. Level-1 training is applicable for everyone working in and/or in training in health and social care and it will be available for all to access and complete on the HSC E-Learning portal.

‘To be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care.’

Appendix 1 - Strategic and Policy Drivers and their Impact on District Nursing Services

The World Health Organisation defines health as: *“A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.”* WHO (1948).

District nurses are ideally placed, visiting hundreds of thousands of people’s homes every year, to have a major impact on the health not only of their patients and clients, but also on the health of the wider family circle i.e. population health. This Framework has been developed by drawing heavily on a number of key policies:

Quality 2020

The Q2020 Strategy was launched in November 2011 with its aim being that patients and their experiences remain at the heart of service design and delivery by defining quality improvement under three headings:

- Safety: Avoiding and preventing harm to patients and clients from the care, treatment and support that are intended to help them;
- Effectiveness: The degree to which each patient and client receives the right care (according to the scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome; and
- Patient and Client focus: All patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Q2020’s 10-year vision for the HSC is *“to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care”*.

Transforming Your Care (TYC)

The HSC Review Report ‘Transforming Your Care’ was published in December 2011 and proposes significant and major changes across all areas of Health and Social Care in Northern Ireland. It sets out 99 proposals, built around the needs of patients that will:

- increase patient choice;
- have more care delivered closer to home;
- increase patient involvement in care; and
- improve social care and support.



Making Life Better 2012 – 2023

The Vision of Making Life Better is that all people are enabled and supported in achieving their full health and wellbeing potential. Every contact needs to count to ensure that no opportunities are lost in relation to health promotion. District nursing is in people's homes and is ideally placed to enable and support patients to improve their health and wellbeing. Patient education, support for self management and maintenance of independence is a key role of the district nurse and this must remain a key focus of their work.

‘For the district nursing service, co-production and co-design of service must be at the heart of every interaction.’

Investing in Health: the WHO European Strategic Directions for Strengthening Nursing and Midwifery towards Health 2020

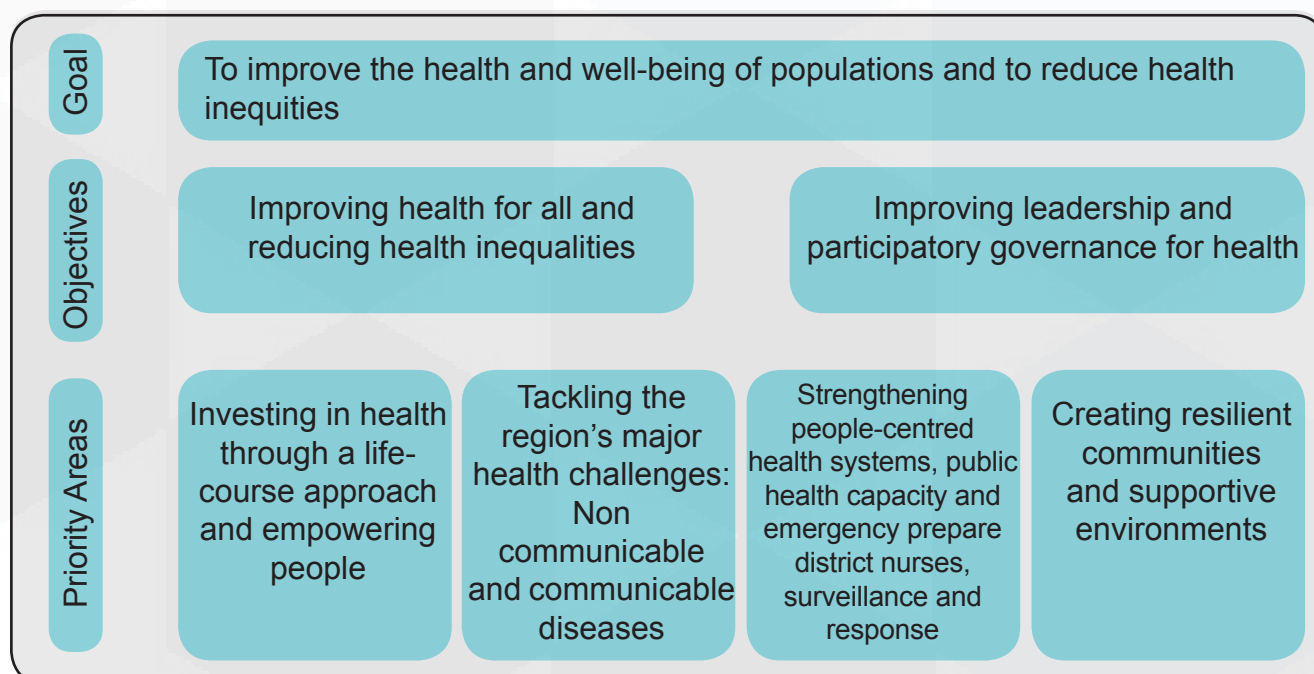
Investing in Health was published in 2015 and said that:

“... to ensure that the full potential of nursing and midwifery was realized, as service needs and population health demands change, so must the knowledge, skills and service delivery models employed by nurses and midwives.”

Evidence collated by WHO suggests that initiatives for service change that employ nurses and midwives with enhanced or advanced skills are addressing many serious issues, such as unclear or misaligned patient pathways, fragmented professional roles, compromised access and discontinuity of care and inadequate cross-sector work. A growing body of evidence shows these new models for services and nursing and midwifery practice are leading to cost effective, people-centred services with better patient outcomes. Education has significantly improved with the opportunity for continuing professional development that continues to build their knowledge and skills to ensure they remain fit for purpose.

Figure 6 summarises the WHO Strategic Directions for Strengthening Nursing and Midwifery (2015) and outlines their goal, objectives and priority areas.

Figure 6. Health 2020 Policy



Health and Wellbeing 2026 - Delivering Together

Health and Wellbeing 2026: Delivering Together is now our single road map for transforming services, which aspires to a new model of person-centred care focused on prevention, early intervention, supporting independence and wellbeing.



The future model of primary care is to be based on multi-disciplinary teams embedded around general practice. The district nurse will have a central role within this team.

All HSC staff will deliver on the concept of co-production. For the district nursing service co-production and co-design must be at the heart of every interaction.

Co-production will empower patients, service users and staff to:

- **design the system** as whole to ensure there is a focus on keeping the population well in the first place and ensuring that when people need support and help they receive safe and high quality care;
- work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact; and
- be partners in **the care they receive** with a focus on increased self-management and choice, especially for those with long term conditions.

Health and Wellbeing 2026 aims to liberate time for care by equipping the community based workforce with new technology that will increase the time spent with patients. Commissioners and district nursing managers must access this technology and make it available as a matter of extreme urgency. District nurses must embrace this technology in order to ensure best care, good communication and best value for their services. District nurses must position themselves to lead the way in the development of these new technologies and they must be enabled to do so. The challenges are immense and district nursing services must be empowered to meet them head on and this will require investment in their development through leadership programmes and improvement science methodologies. Many of the ambitions within *Health and Wellbeing 2026* are contained within the Strategic Priorities and actions in this document.

‘Staff wellbeing is an important prerequisite for positive patient experiences of care.’

Systems, Not Structures: Changing Health and Social Care (2016)

The Health and Social Care landscape is changing, in addition to a changing population demographic with increasing numbers of older people who often have more than one long term condition, care is becoming more complex and is increasingly being delivered either at home or closer to home.

There is an increasing requirement to ensure that every patient and carer has a good quality experience whilst meeting a requirement to manage a challenging financial climate. Quality 2020 defines quality under three main headings: Safety; Effectiveness and Patient and Client Focus, and is very closely aligned to the Institute for Healthcare Improvement (IHI) Framework. The IHI Triple Aim framework describes an approach to optimizing health system performance across three key dimensions:

- **Improving the patient experience of care (including quality and satisfaction);**
- **Improving the health of populations;**
- **and Reducing the per capita cost of health care.**

This has recently been updated to become the quadruple aim with staff health and wellbeing as the central component. There is an established evidence base demonstrating that staff well being, particularly within the context of local teams, is an important prerequisite for positive patient experiences of care (Powell et al 2014; Maben et al 2013; Raleigh et al 2009).



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‘I am very glad to have become a square peg in a square hole.’



Letter, July 1948

HOSPITAL VERSUS DISTRICT NURSING

Having recently left hospital life to take up District Nursing, I wish to put on record my thanks to the Queen's Nurses who have "shown me the ropes."

As a trained nurse in hospital, I did not get much time for actual nursing, as supervising the work, serving the meals, and doing rounds with doctors, office work, and telephone, took most of the time.

As there is such a scarcity of hospital beds, the work of the District Nurse is assuming more importance, and a greater demand is being made upon her services.

Although in many respects more arduous than hospital work, there are compensations in District Nursing that have a special appeal. There is closer individual contact with the patient, and the nurse is taken into the home as a friend, as well as a helper.

The nurses in the Queen's Home where I am staying say, "Once a District Nurse, always a District Nurse," and I am beginning to understand why, as many nurses are particularly suited to this type of nursing.

One loses that red tape, associated with all institutional life, on the District, and the healthy life, with its cycling or walking between cases, keeps one fit to do the work.

In fact, I am very glad to have become a square peg in a square hole.

- S.R.N, S.C.M.

Courtesy QNI, QN Magazine 1948

