



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government

**WELSH ASSEMBLY GOVERNMENT**

**A COMMUNITY NURSING STRATEGY FOR WALES**

**CONSULTATION DOCUMENT**

**FEBRUARY 2009**

## **A Consultation on the development of a Community Nursing Strategy for Wales**

**Audience:** This document is relevant to all those who have an interest in the provision of community nursing services.

**Contents:** This document seeks views on the 43 recommendations of the proposed community nursing strategy which was developed by a Ministerial Task and Finish Group chaired by the Royal College of Nursing.

**Action required:** The consultation period will end on 19<sup>th</sup> June 2009 and responses should be received by that date.

The Welsh Assembly Government intends to publish responses to this document in full on its website. Normally, the name and address (or part of the address) of the author are published along with the response. If you do not wish to be identified as the author of your response please state this expressly in your response.

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## **Foreword by the Minister for Health and Social Services**

One of my key priorities is the development of a primary care led National Health Service. A key component of this is to ensure that all people in Wales are able to access community nursing services that both promote good health and provide nursing care for those who need it.

Community and primary care nurses are central to meeting the range of population health needs from promoting health and preventing ill health to dealing with increasingly more complex needs through to end of life care. I want community nurses to be able to use the full range of their skills in improving healthy lifestyles and well being, in providing nursing care and treatment in the community, and in preventing and delaying the onset and early deterioration of chronic conditions. Community nurses have a huge role to play in reducing the impact of chronic conditions on secondary care and care homes and in increasing self management and independence through encouraging and facilitating the participation of those with chronic conditions.

This strategy describes how to make this happen. It refers to all nurses, midwives and specialist community public health nurses who work in a community setting including those who work in mental health and learning disability.

I am grateful to the Royal College of Nursing for chairing the Task and Finish Group to develop this strategy. Recommendations for action are made to the Welsh Assembly Government, health organisations and other relevant bodies in order to ensure the provision of an equitable and effective community nursing service across Wales and promote its development into a world class service.

The strategy does not stand alone and its recommendations should be viewed in the context of existing and emerging Welsh Assembly Government strategies and policies, reconfiguration of the National Health Service and the developing Primary and Community Services Strategic Delivery Programme.

Some recommendations, particularly those relating to primary care, joint working between NHS organisations and local authorities, public health nursing and a new model for community nursing, will lead to much debate. To allow for full discussion of the recommendations and the issues raised I have decided to extend the consultation period to sixteen weeks. I want to encourage all those who have an interest in the provision of community nursing services to respond to the consultation.

The recommendations will impact on Welsh Assembly Government policies and the government will respond once the consultation period has ended and the responses have been considered.

I would like to thank all participants for their hard work in writing this document. I appreciate their continuing commitment to developing a world class community nursing service for Wales.

Edwina Hart AM MBE  
Minister for Health and Social Services

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## Recommendations

	Recommendation	Responsible Body	Timescale
1	<p><b>Implementing the Community Nursing Strategy</b> The Welsh Assembly Government will establish a Community Nursing Strategy Implementation Group to report progress against the recommendations to the Minister.</p>	<b>Welsh Assembly Government</b>	From 2009
2	<p><b>Implementing the Community Nursing Strategy</b> Within each health organisation, the Executive Nurse Director will be responsible for the implementation of the national Community Nursing Strategy and the health organisation will ensure that the Executive Nursing Director is fully involved in the development of partnership arrangements with other bodies. Service users and carers will be involved in the production of these plans. Plans will need to comply with organisations' Welsh Language Schemes and provide bilingual services in accordance with local needs. Regular updates will be given on progress against the recommendations to the Implementation Group and the health organisation Board.</p>	<b>NHS Health Organisations</b>	From 2009
3	<p><b>Implementing the Community Nursing Strategy</b> The Community Nursing Strategy Implementation Group will, as part of its work plan, ensure that other relevant strategic developments in health policy and implementation are cognisant of this strategy and incorporate its recommendations accordingly.</p>	<b>Welsh Assembly Government</b>	From 2009
4	<p><b>Health Organisation Community Nursing Strategies</b> Within each health organisation the Executive Nurse Director will be responsible for the creation of a localised Community Nursing Strategy to ensure the right skill mix to deliver optimal patient care. This will incorporate the nature of services to be provided (including bilingual services and services for vulnerable groups such as asylum seekers and homeless people) and a review of the skills base and workforce plans.</p> <p>The workforce plans will be an operational document, outlining the current and projected numbers and Agenda for Change banding of the registered nursing and Health Care Support Worker (HCSW) posts. The workforce plans will form part of the organisational workforce submission to the national workforce planning process and will be publicly available.</p>	<b>NHS Health Organisations</b>	From September 2009

5	<p><b>A New Model for Community Nursing: Local Community Nursing Teams</b></p> <p>The regional community nursing strategy will work towards the development of locality based community nursing teams (as described in Chapter 4).</p>	<p><b>NHS Health Organisations</b></p>	<p>From September 2009</p>
6	<p><b>Unified Assessment Process</b></p> <p>The Welsh Assembly Government will review the Unified Assessment Process to ensure it is person centred, nationally consistent and enables all the appropriate professionals and agencies to make a positive contribution through a unified assessment and care planning process to achieve positive outcomes for the service user.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From September 2009</p>
7	<p><b>Case Managers and Care Co-ordination</b></p> <p>Every patient will have an identified case manager. That case manager will have the responsibility for care co-ordination. Within the field of Learning Disability there is a specific need for health organisations to ensure that nurses remain working as nurse clinicians as opposed to undertaking purely care management roles within the unified assessment process.</p>	<p><b>NHS Health Organisations</b></p>	<p>From September 2009</p>
8	<p><b>A Children's Community Nursing Service</b></p> <p>The need for children's community nurses and the provision of professional networks to underpin these must be central to the development of the health organisation Community Nursing Strategies. There will be an increase in the number of training places and an increase in the number of posts for qualified community children's nurses. The Welsh Assembly Government should monitor the evolution of children's community nursing and promote its development.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	<p>From 2009</p>
9	<p><b>Recruitment and Retention</b></p> <p>Specific recruitment and retention strategies for mental health and midwifery which also outline the career structure should be developed to address particular national challenges in these fields.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From September 2009</p>
10	<p><b>Continuous Professional Development</b></p> <p>The Community Nursing Strategies of the health organisations will identify the priorities for continuous professional development (CPD) in that area. The Welsh Assembly Government and NHS organisations will work together to introduce paid protected time for CPD for community nurses identifying and maintaining a separate and exclusive budget for this purpose.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	<p>From 2009</p>

11	<p><b>Primary Care</b></p> <p>The Welsh Assembly Government will consider as part of its primary care policy how best to enable a strategic approach to the delivery of patient care by practice nurses. This work should include consideration of the option of direct employment of <i>all</i> practice nurses and address the need for a career framework, workforce development and consistent high quality clinical standards of care.</p>	<p><b>Welsh Assembly Government</b></p>	From 2009
12	<p><b>Primary Care</b></p> <p>Direct employment of practice nurses and nurse practitioners will be considered by NHS organisations as an option to supplement existing General Practitioner services and provide primary care health services that can not be provided by the independent contractor model.</p>	<p><b>NHS Health Organisations</b></p>	From 2009
13	<p><b>Practice Nurse Education</b></p> <p>Funding for practice nurse education will be removed from the GP “global sum” and administered by the health organisation with clear guidelines for use based on strategic policy. An audit mechanism and framework for monitoring levels of practice nurse education will be developed for use by the health organisations.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	From 2010
14	<p><b>Prescribing</b></p> <p>The Welsh Assembly Government and health organisations will increase the number of independent non-medical prescribers in the community workforce.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	From 2009
15	<p><b>Advanced Nursing Practice</b></p> <p>Health organisations will show evidence of assessment of need and subsequent development of community nurses as generalist and specialist advanced practitioners where appropriate, able to assess, diagnose, investigate and interpret results and prescribe medication.</p>	<p><b>NHS Health Organisations</b></p>	From 2009
16	<p><b>Nurse and Midwife Consultants</b></p> <p>Health organisations will develop the consultant nurse role with especial regard to the interface between primary and secondary care.</p>	<p><b>NHS Health Organisations and Higher Education Institutions</b></p>	From 2009
17	<p><b>Community Hospitals</b></p> <p>Health organisations will develop nurse-led beds, overseen by advanced nurse practitioners, in community facilities and enable the utilisation of step up/step down beds.</p>	<p><b>NHS health organisations</b></p>	From 2009

18	<p><b>Specialist Nurses</b> Health organisations will consider the need for specialist nurses to be part of the Local Community Nursing Teams e.g. as in palliative care teams.</p> <p>There will also be provision where needed of outpatient nurse-led clinics held in community settings where specialist nurses with advanced skills can see patients, have access to rapid diagnostics and referral rights and are independent prescribers.</p>	<b>NHS health organisations</b>	From 2009
19	<p><b>Development of Specialist Community Public Health Nursing</b> The Chief Nursing Officer will, in collaboration with professional groups, publish a further paper outlining the renewed focus on the Health Visitor's role and the implications of this for the education curriculum.</p>	<b>Chief Nursing Officer</b>	From 2009
20	<p><b>Nursing and Public Health</b> The Chief Nursing Officer will, in collaboration with professional groups, review the public health aspects of nursing roles within Wales to understand better the scope of this activity.</p>	<b>Chief Nursing Officer</b>	From 2009
21	<p><b>Development of the Healthcare Support Worker</b> The regional community nursing strategies will specify the roles of the HCSW and work towards the development of a generic model. The numbers, role and qualifications of HCSWs employed by the NHS health organisation will be provided to the Welsh Assembly Government. The Welsh Assembly Government will promote the uptake of education in this sector.</p>	<b>Welsh Assembly Government and NHS Health Organisations</b>	From 2009
22	<p><b>Research</b> The Welsh Assembly Government will invest in the funding of research that will develop the evidence base for community nursing interventions, evaluation methods and the appropriate numbers and skill mix for workforce planning.</p>	<b>Welsh Assembly Government</b>	From 2009
23	<p><b>Multi-disciplinary Assessment and Diagnostic Services</b> Health Organisations will develop access to fast track multi-disciplinary and multi-agency assessment in community settings to reduce hospital admissions. They will also develop access to fast track diagnostic services and increase the provision and use of near patient testing to provide timely and accurate diagnoses.</p>	<b>NHS Health Organisations</b>	From September 2009

24	<p><b>Independent Sector Skills</b></p> <p>Health organisations will, through their service commissioning processes, promote the skills development of staff in the independent sector to enable them to care for their clients' needs in this setting rather than admission to hospital.</p>	<p><b>NHS Health Organisations</b></p>	<p>From 2010</p>
25	<p><b>Palliative Care</b></p> <p>The Community Nursing Strategy Task and Finish Group endorses the recommendations of the Palliative Care Report and urges their implementation without delay.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
26	<p><b>Discharge Process</b></p> <p>Discharge planning needs to be undertaken as soon as possible after admission, working alongside community colleagues to ensure discharge can happen as soon as appropriate, with simple seamless systems in place to support the discharge process, for example, to access special equipment.</p>	<p><b>NHS Health Organisations</b></p>	<p>From 2009</p>
27	<p><b>Student Nurses and Midwives</b></p> <p>The Welsh Assembly Government and health organisations will take steps to increase the numbers of clinical practice placements and mentors (including non-NHS mentors) to adequately support practice learning and assess clinical competence of those undertaking specialist and advanced practice courses.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	<p>From 2009</p>
28	<p><b>Occupational Health</b></p> <p>The Community Nursing Strategy Task and Finish Group urges the Welsh Assembly Government to consider and endorse the recommendations of the Task and Finish Group on Occupational Health.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	<p>From 2010</p>
29	<p><b>Section 33 – Joint Planning and Pooled Budgets</b></p> <p>The Welsh Assembly Government will direct NHS health organisations and Local Authorities into Section 33 agreements to facilitate a coherent model of joint planning, pooled budgets and joint management of service delivery (For clarity please note that Welsh Ministers do not have statutory powers to direct Local Authorities in respect of section 33 arrangements)</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2010</p>
30	<p><b>Midwifery – Access</b></p> <p>The Welsh Assembly Government and health organisations will work together to develop suitable publicly accessible facilities to enable midwives to be the first point of contact for pregnant women.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	<p>From 2010</p>

31	<p><b>Midwifery – Service Redesign</b> The Welsh Assembly Government will in collaboration with the Chief Nursing Officer, other professional groups and health organisations radically review and redesign the provision of maternity care.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
32	<p><b>Maternity Support Worker</b> The Chief Nursing Officer will in collaboration with professional groups publish a further paper outlining the role and development of the maternity support worker.</p>	<p><b>Chief Nursing Officer</b></p>	<p>From 2009</p>
33	<p><b>Neonatal Care Provision</b> The neonatal standards implemented and clinical networks established.</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	<p>From 2009</p>
34	<p><b>Psychological and Social Therapies</b> Increasing numbers of nurses will be trained in psychological and social therapies and access improved to these services across all parts of Wales</p>	<p><b>Welsh Assembly Government and NHS Health Organisations</b></p>	<p>From 2009</p>
35	<p><b>Assessment of Information Technology (IT) Systems</b> The principles set out in Chapter 8 will be used as a framework to assess the suitability of IT systems to deliver person centric care.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
36	<p><b>Informing Healthcare National Architecture</b> The choice of systems to support the community nursing strategy will be determined by the national architecture structure led by Informing Healthcare.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
37	<p><b>Individual Health Record</b> The Welsh Assembly Government will facilitate the introduction of the Individual Health Record to the NHS in Wales as a matter of urgency.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
38	<p><b>Informing Healthcare’s Welsh Clinical Communications Gateway</b> The Welsh Assembly Government will support an evaluation of the use of the Welsh Clinical Communications Gateway as a vehicle for exchanging clinical information within health settings and between health and social care organisations.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009 - 2011</p>

39	<p><b>IT Mobile Devices</b></p> <p>The Welsh Assembly Government will invest in safe and effective mobile technology devices, that have been tested for reliability and sustainability to support clinicians to deliver effective community care.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
40	<p><b>IT Education</b></p> <p>The Welsh Assembly Government will work with the Nursing and Midwifery Council (NMC) and higher education institutions (HEIs) to establish an educational programme to prepare nurses for new ways of working that will be supported by the use of IT..</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
41	<p><b>Scottish Community Census</b></p> <p>The Welsh Assembly Government will review the Scottish Community Census to assess its applicability in the Welsh context.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
42	<p><b>Pre-registration Education</b></p> <p>The Welsh Assembly Government will work with the NMC and higher education institutions to develop modifications to pre-registration nursing and midwifery programmes in line with service re-design.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>
43	<p><b>Modernising SPQ programmes</b></p> <p>The Welsh Assembly Government will work with the NMC and higher education Institutions to modernise the community SPQ programm, and develop flexible modules that prepare nurses for specialist and advanced roles in the community.</p>	<p><b>Welsh Assembly Government</b></p>	<p>From 2009</p>

## **Introduction: A Vision for Community Nursing Services in Wales**

Since the publication of the Wanless Report in Wales in 2003<sup>1</sup> there has been public recognition of the need to refocus our health service. We will achieve the most from our spending by preventing ill health and maintaining good health. Policy and practice are already signalling a move to a primary care led NHS with a focus on services in the community. The most recent publications, the Community Services Framework and *Designed to Improve Health and the Management of Chronic Conditions in Wales*<sup>2</sup> clearly identify the actions needed to reform service delivery.

This refocusing will strengthen community services to support the care of individuals in, or close to, their own homes. Where appropriate, secondary care services will be transferred to the community and patients with ongoing complex care needs will be cared for at home. It will rely on the enhancement of self and supported care as part of increasing public health and well-being and the avoidance of unnecessary hospital admissions.

This strategy provides the nursing response to this policy both in terms of the development of the profession and in the strategic deployment of the workforce within the health service.

The strategic document *Designed to Realise our Potential*<sup>3</sup> refreshes the strategy for nursing in Wales, acknowledging the considerable changes within the National Health Service (NHS) in Wales over recent years and highlighting the need for nursing to be flexible, adaptable and knowledgeable and “will need to achieve a balance between generic and specialist skills at the point of need while delivering holistic, seamless care”(p.13) Describing the key purpose of nursing, midwifery and specialist community public health nursing as the well being and care of patients in different contexts and at differing levels of need, the strategic aims were restated as:

- Improving the environment of care
- Ensuring a high quality service for all
- Encouraging independent and reflective practice
- Developing existing and new career pathways

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<sup>1</sup> Welsh Assembly Government (2003) Review of Health and Social Care in Wales. Welsh Assembly Government, Cardiff

<sup>2</sup> Welsh Assembly Government (2007) *Designed to Improve Health and the Management of Chronic Conditions in Wales. An Integrated Model and Framework*. Welsh Assembly Government, Cardiff

<sup>3</sup> Welsh Assembly Government (2008) *Designed to Realise our Potential: A “beliefs and actions” statement for nurses, midwives and SCPHNs in Wales for 2008 and beyond*. Welsh Assembly Government, Cardiff

- Demonstrating the value of nurses, midwives and specialist community public health nurses (SCPHN)

Each of these aims highlights the wide ranging strategic approach needed to ensure a nursing workforce that makes a positive difference to the patient experience.

### **The Vision for Community Nursing**

Successful community nursing will require a new model centred on the development of Local Community Nursing Teams, as described in chapter 4. These will comprise knowledgeable and competent practitioners across a range of specialties and grades, working together to deliver the care for the community in which they work, with particular reference to case mix, managed clinical networks and patient pathways. This will include building partnerships across statutory, voluntary and independent sectors, for example, with healthcare and social care staff employed by independent practitioners, those engaged in occupational healthcare in local industry, school health, personal social services and social justice and regeneration.

While each team will be unique to the health and social care needs of their particular community they will all however, encompass core professional competencies required to deliver care in the community and degrees of specialist skills across the range of the nursing professions as appropriate. Modernisation of the workforce is likely to require the development and introduction of new roles, new ways of working and new ways of delivering education and training. Roles should be built up from the competencies required to deliver care rather than based on the assumption that current role structures will be perpetuated.

Teams will need to take account of the linguistic and cultural needs of their communities and be able to provide bilingual services in line with the Welsh language Act and local needs. This will be especially important when developing plans for community nursing services for children, the elderly, those with a learning disability and mental health services.

Training and development for community nursing will span the career pathway from novice to expert, enabling newly qualified staff to work to the level of their ability as well as enabling the migration of staff from secondary to primary care, under the direction of a highly experienced team leader, themselves working towards Consultant level.

An increasing amount of education and training will be delivered through multi-disciplinary/multi-agency frameworks and will be based on a flexible, modular system allowing individual staff to build their own portfolio of competencies related to their employment.

Individual practitioners as well as their managers/mentors will become skilled at demonstrating the benefits of nursing intervention and quality outcomes, generating further opportunities for research and evaluation. They will be skilled at determining how health informatics and technology can assist in the delivery and monitoring of healthcare, so as to shape the development of new solutions, including signposting service users to acquire knowledge about their own lifestyle and health.

The Community Nursing Strategy has been written based on this vision. Its aim is to describe and make recommendations for a service that can provide holistic, seamless care with a nursing workforce that is flexible, adaptable and knowledgeable and able to achieve a balance between generic and specialist skills at the point of need.

Across Wales there are many good examples of innovative community nursing services. Excellent examples can be seen of Local Health Board (LHB) initiatives that have enabled a structured, supportive development of the local practice nursing service. Rhondda Cynon Taf (RCT) Teaching Local Health Board (tLHB), Caerphilly tLHB<sup>4</sup> and Merthyr LHB have developed initiatives in recognition of a need for both service development and retention and recruitment of primary care clinicians in order to revitalise primary care services in these areas. In addition to meeting a broad chronic conditions management agenda RCT tLHB, for example, provides “locum” cover for practice nurses and GPs, provides salaried practice nurses and GPs, directly manages practices where there are difficulties replacing retiring GPs and provides education for local practice nurses and GPs.

However, there are also challenges that require solutions. A plethora of nurses, therapists and social care workers, voluntary and independent sector staff are presently involved in community nursing services, moving across traditional boundaries between secondary and primary care environments. There is currently no central co-ordination of these services, which often results in lack of co-ordination of services to patients and duplication of effort.

Over the last year there has been a welcome increase in the number of community training places for nurses. A modular approach is being taken to allow a range of nurses seeking employment within the community setting, to develop skills appropriate to their role at an appropriate pace. This is essential to developing the flexible and skilled workforce required for the future. Equally essential, however, is that there are enough nursing staff overall employed in the community to deliver safe and effective care. For a variety of reasons, there has been a steady decline in the number of specialist qualified skilled nurses working in the community since 1999 and local workforce planning in NHS organisations have only recently been fully integrated into planning for service delivery. This Community Nursing Strategy is an essential tool to help achieve the world class healthcare services that the public expects.

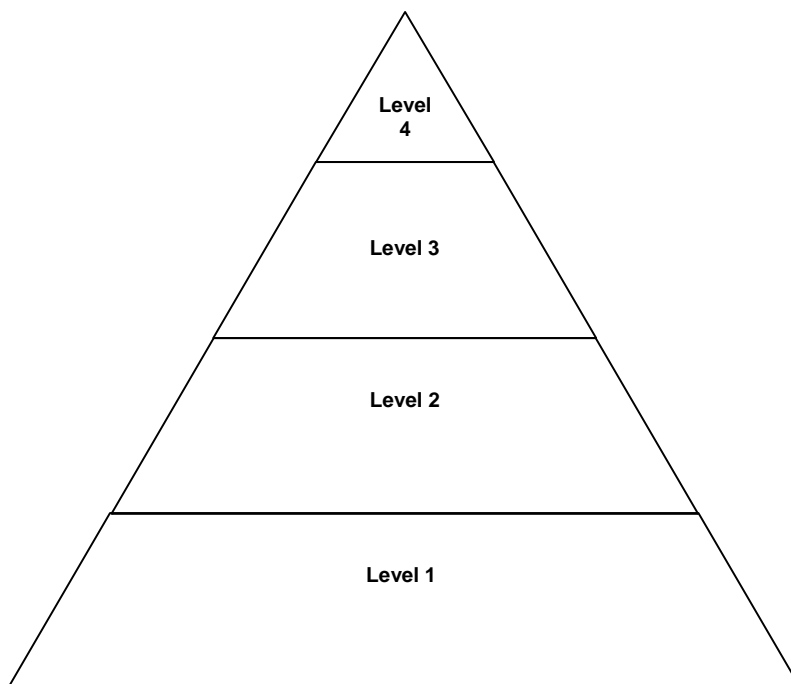
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<sup>4</sup> [www.wales.nhs.uk/tlhb](http://www.wales.nhs.uk/tlhb)

## The Way Forward

With the emphasis on self-management and personal responsibility, the strategy responds to the needs of communities and individuals. The conceptual framework from which this strategy was developed can be represented as the Pyramid of Patient Need (Figure 1) set out below. This was first developed in Child and Adolescent Mental Health and was also used in developing the Welsh Assembly Government's Framework for the Management of Chronic Conditions in Wales<sup>5</sup>.

**Figure 1: Pyramid of Patient Need**



- Level One - predominantly relates to ill health prevention in primary care and health promotion
- Level Two – the patient and nurse participating in active healthcare
- Level Three - medium and high risk management
- Level Four - case managed services

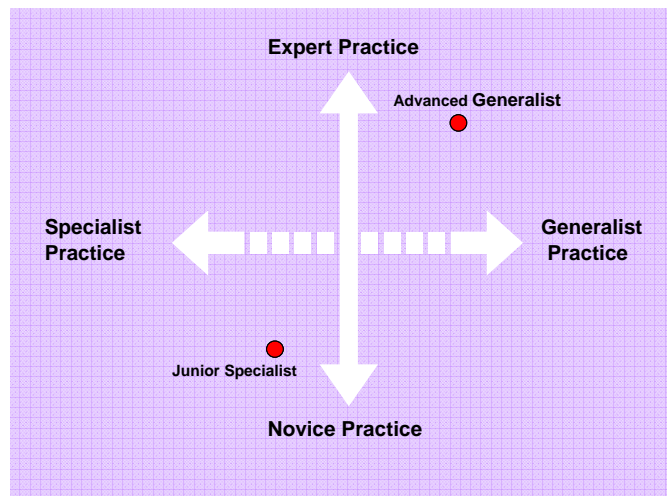
It is important to stress that the diagram is represented as a pyramid because as the complexity of patient need increases the numbers of patients requiring that level of care typically diminishes. It is not intended to demonstrate a professional hierarchy. Instead the professional interrelationships between expert and novice,

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<sup>5</sup> Welsh Assembly Government (2007) Designed to Improve Health and the Management of Chronic Conditions in Wales. An Integrated Model and Framework. Welsh Assembly Government, Cardiff

specialist and generalist (where one can have a junior specialist or an advanced generalist nurse) can be seen in the diagram of the square base of the pyramid (Figure 2)<sup>6</sup> which shows the relationship between specialist and advanced practice. In this instance, it signifies the professional diversity running through each level of patient need. This concept is the foundation of *Modernising Nursing Careers*<sup>7</sup>.

**Figure 2: Base of the Pyramid**



An illustrative patient story begins each chapter. Using the four levels of patient need, chapters 1 to 4 describe the contribution that nursing can make at each level and how the service should develop to enable this. Some nursing services will of course need to move with the patient through the levels of care. In chapters 5 to 8 the Pyramid of Need has been adapted to describe levels of care and make recommendations related to:

- Midwifery
- Mental health and learning disability
- Education
- e-Health

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<sup>6</sup> Scottish Government (2008) Supporting the Development of Advanced Nursing Practice; A toolkit approach. Scottish Government, Scotland

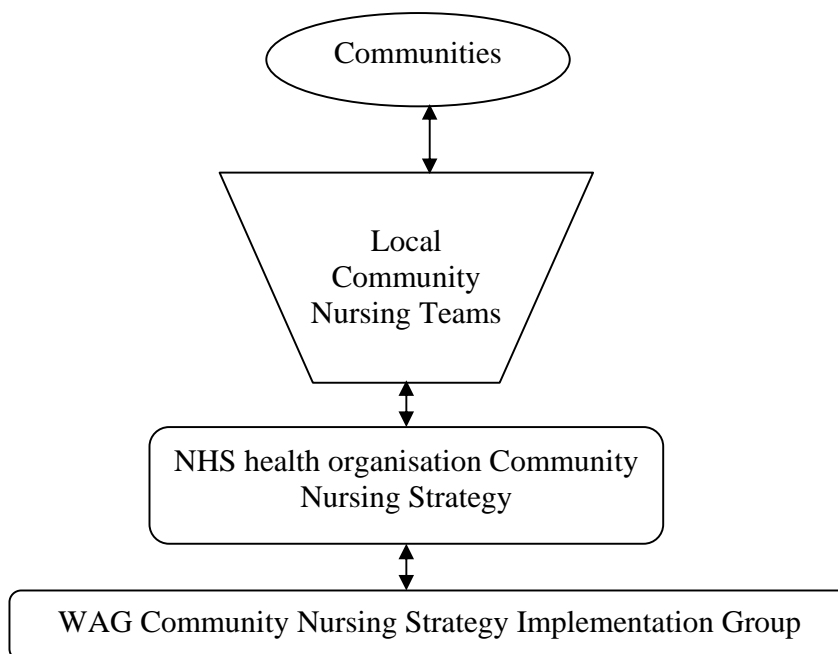
<sup>7</sup> Department of Health (2006) *Modernising Nursing Careers: setting the direction*. Department of Health, London

## Conclusion

There are 43 recommendations for the development of community nursing. These have been designed for implementation over a 5 year period ending in 2014 to coincide with the end of the third period of the Designed for Life strategic plan and progress will be audited during this period.

Figure 3 illustrates the community nursing planning structure as proposed by this strategy and outlined in recommendations 1 to 5.

**Figure 3: The Community Nursing Planning Structure**



The nursing workforce is the largest group of health professionals employed by the NHS and consideration of its role is essential to the success of any health service strategy or delivery plan. This strategy does not stand in isolation and is written in the context of the current reconfiguration of the NHS and current and emerging Welsh Assembly Government strategies and policies including the developing Primary and Community Services Strategic Delivery Programme.

## Chapter One

### Community Nursing at Level One of Patient Need

#### Using a Toothbrush Bus in School

The Toothbrush Bus is a specially-made washable toy that carries a toothbrush for each child bearing his or her name.

Parts of Wales currently have amongst the highest dental disease levels in Europe. The Welsh Assembly Government's Child Oral Health Improvement Programme *Designed to Smile*, (WHC (2008) 008) is aimed at tackling oral health inequalities in Wales and uses the Toothbrush Bus as one of its tools.

Several children in one South Wales community had never seen a toothbrush and never cleaned their teeth. A project was set up by a local health visiting team in partnership with the Community Dental Service, the LHB, the Local Authority and the National Public Health Service. The project started with home visits when babies were 7 – 9 months of age and then at 20 –24 months of age.

Dental packs and advice were given at each visit and a questionnaire used to evaluate the impact. For the children identified with poor dental hygiene, working in partnership with local schools, a project taking a Toothbrush Bus into schools has reaped huge benefits.

The children think it is fun to have the buses, their oral hygiene has improved and through a simple project, long term benefits are possible.

## Background

Level 1 of patient need predominantly relates to ill health prevention in primary care and health promotion. One definition of health promotion and primary prevention is: *“What we should do is look at the world about us and make important decisions. It then becomes possible, in some cases more than others, to prevent predictable problems, to protect existing states of health and healthy functioning and to promote desired goals and objectives for some of the population of people. This is the core meaning of primary prevention and health promotion.”*<sup>8</sup>

Healthcare in Wales is changing to focus intensively on public health issues, health inequalities and social inclusion. Reducing obesity and smoking related deaths in the population are but two examples of such intentions while illness prevention and managing long term conditions such as diabetes, supporting self care and providing services in the community environment all continue to be important drivers for achieving high levels of health and wellbeing across the total population.

The provision of the right care in the right place at the right time, and the associated risks of such provision, set within the wider context of the social and community settings of everyday life, are an integral part of the strategic direction for Wales and the local responses identified within the Health, Social Care and Wellbeing Strategies.

Individuals need the skills and support to manage their conditions within their local communities. Integral to this are health improvement interventions, early identification and appropriate treatment and support. These require a strong infrastructure to promote healthy lifestyles across communities to include the promotion of healthy eating, exercise, smoking cessation, weight management, moderate drinking, social inclusion and a healthy environment including work places and homes.

The Welsh Assembly Government has developed a range of National Service Frameworks, for example, dealing with cardiac disease<sup>9</sup>, diabetes<sup>10</sup> and renal disease<sup>11</sup>, to provide strategic direction and supportive frameworks for all action. They aim to ensure that services are planned, organised and delivered in response to patients’ needs thereby improving the quality of care.

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<sup>8</sup> Thomas P. Gullotta, Martin Bloom (2003) Encyclopaedia of Primary Prevention and Health Promotion. Springer, London

<sup>9</sup> Welsh Assembly Government (2008) The Cardiac Disease National Service Framework for Wales. Welsh Assembly Government, Cardiff

<sup>10</sup> Welsh Assembly Government (2003) National Service Framework for Diabetes in Wales Delivery Strategy. Welsh Assembly Government, Cardiff

<sup>11</sup> Welsh Assembly Government (2007) Designed to Tackle Renal Disease in Wales: A Policy Statement and National Service Framework. Welsh Assembly Government, Cardiff

The Strategy for Older People in Wales<sup>12</sup> and the National Service Framework for Older People<sup>13</sup> clearly outline the rights of the older person in relation to meeting their full potential and preventing harm. There is also a growing awareness that older people are vulnerable to abuse and building on this further, the Dignity and Respect in Care Programme<sup>14</sup> responds to gaps in how the elderly are treated based on concerns raised by organizations such as Age Concern and Help the Aged.

The National Service Framework for Children, Young People and Maternity Services<sup>15</sup> sets out the quality of services that children, young people and their families have a right to expect and receive in Wales.

Other key components of primary prevention and health promotion are the promotion of a shared responsibility to maintain health and well being, and where appropriate, early diagnosis through screening.

Community nursing has a long tradition of providing expert care to individuals, families and communities in their homes, workplaces, schools and GP surgeries. Everyone will at some time during their life receive care from a community nurse particularly through services that help people stay healthy through surveillance and prevention initiatives.

Community children's nurses (CCN) care for children with complex needs with the aim of reducing admissions into hospital and ensuring parents can continue to care for their child and the rest of their family at home. They provide a skilled nursing resource and assess, plan and implement care to meet the needs of the child, young person and their family holistically. While this role can predominantly be seen as fitting within Level 3 of patient need i.e. high risk management, CCNs also play a part in primary prevention and health promotion. Current practice includes:-

- Providing care in all settings in the community
- Enhancing the quality of life
- Providing health promotion for the whole family
- Empowering parents and increasing their confidence in caring for their child at home

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<sup>12</sup> Welsh Assembly Government (2003) The Strategy for Older People in Wales 2008-2013. Welsh Assembly Government, Cardiff

<sup>13</sup> Welsh Assembly Government (2006) The National Service Framework for Older People in Wales. Welsh Assembly Government, Cardiff

<sup>14</sup> Welsh Assembly Government (2007) Dignity and Respect in Care Programme for Wales. Welsh Assembly Government, Cardiff

<sup>15</sup> Welsh Assembly Government (2005) The National Service Framework for Children, Young People and Maternity Services. Welsh Assembly Government, Cardiff

District nurses play a critical role in primary care as they visit people in their own homes providing care for patients and supporting family members. Current practice includes:

- Health education and health promotion advice such as continence and smoking cessation
- Vaccinations and the provision of information
- Participation in immunisation programmes for older people
- Encouraging people to participate in regular screening programmes.
- Involvement with local older peoples forums providing support and information
- Proactive health surveillance and wellness programmes

The role of the Health Visitor/SCPHN is early identification of health needs, prevention of ill health and health promotion. Current practice includes:

- Providing a universal home visiting service for all families with children under the age of 5 years
- Providing and supporting a universal child health surveillance programme
- Safeguarding children up to school entry age through collaboration with social services.
- Identifying and tackling public health issues including immunisations, obesity, smoking cessation, breast feeding, accident prevention and oral health.
- Supporting the capacity for improving parenting skills
- Having a working knowledge of the local population and their health needs e.g. teenage pregnancy, employment, domestic violence, substance abuse.
- Promoting and supporting infant and family mental health
- In some areas there is a health visiting service working with the elderly supporting and promoting the well being.
- Flying start has increased the Health Visiting service in some deprived areas enabling intensive home visiting by health visitors to support families to improve outcomes and life chances for children.
- Working with vulnerable groups such as Gypsies and Travellers, Asylum seekers and refugees.

In many areas Health Care Support Workers (HCSW) have been encouraged to undertake further training to gain their NVQ level3, in order to undertake various roles delegated by the registered nurse to include supporting the monitoring of chronic conditions. The generic worker project based on patient specific competencies has also been adopted within Wales. Another key area for the HCSW is increased knowledge and skills in nutrition and the nationally accredited course at Level 2 in Community Food and Nutrition Skills.

Nurses working in the independent sector have a major role in maintaining the health and well being of people in the workplace and residential homes. The important aspect is the provision of independent local support to community groups and individuals through accessible public information and advocacy, the promotion and development of citizen participation, and specific project developments. Developing greater collaboration within this sector is likely to play a key role in improving community health and well being in the future.

Occupational Health nurses provide specialist advice relating to the promotion of health at work and protecting the health of the employees from risk. Current practice includes:

- Pre employment health assessment and interviews
- Providing an effective health screening programme to include audiometry, lung function and vision
- Health education and surveillance
- Planned education programmes such as smoking cessation

Practice nurses have a key role to play in primary prevention and health promotion. Their role embraces these as part of the QoF targets for the GMS contract. Current practice includes:-

- Participating in vaccination programmes
- Involvement in national screening programmes
- Raising awareness and signposting to smoking cessation and the National Exercise Referral Scheme
- Involvement in sexual health programmes particularly in raising Chlamydia awareness
- Participation in family planning clinics
- Participation in healthy hearts' initiatives and exercise advice

The school nursing (SN/ Specialist Community Public Health Nurse School Nursing) role is predominantly public health nursing as school nurses play a key role in promoting the health and wellbeing of school aged children. School nurses are best placed to link agencies, communities and groups to ensure locally developed services are provided to promote this ideal. Most NHS Trusts in Wales now have school nursing teams with many SN's accessing the Specialist Community Public Health Practitioner academic route in University. Current practice includes:-

- Safeguarding the health and welfare of children
- Identifying vulnerable children, attending child protection case conferences.
- Acting as a confidante
- Health promotion
- Extended child and family support

- Identifying children with additional needs
- Responding to outbreaks of infectious disease and the successful implementation of hand washing schemes as part of the Healthy School Scheme.
- Child health surveillance
- Discussion on transition to adult life
- Disease prevention and health promotion

An example of working in partnership is the support afforded to colleagues in education providing Sex and Relationships Education (SRE) in line with government and WAG policy.

## **Key Issues**

### Primary Prevention and Health Promotion

Primary prevention and health promotion are enablers to keeping people healthy and independent. To be successful the health promotion agenda should be focused throughout the life cycle from pregnancy through to death and needs to be owned by the public. Nurses, allied health professionals and other health promotion workers need to work together with the public in order to provide programmes that achieve the best health outcomes. It is about an integrated and well co-ordinated approach, the development and expansion of roles within existing services based on local health improvement targets.

There is already a wealth of best practice that details the positive impact of nursing interventions on the primary prevention and health promotion agenda, for example, in the area of nutrition.

However, there is an overreliance in some areas of practice on the medical model of health. It is recommended that there is investment in interagency education and training, including the nursing profession, to (re)connect the conceptual framework of health promotion and public health to practice.

One example of a potential benefit from this approach has been the development of a Men's Health Specialist Nurse. A health promotion approach is important in men's health as many men's health problems are preventable and related to factors such as lifestyle, health risk behaviour and poor health care service utilisation. The further development of the role of the Men's Health Specialist Nurse will provide a multifaceted approach including health education for community groups, development of health promotion resources and population based health assessment in a clinic situation and in the workplace.

There is also a real opportunity with the current NHS restructure to bring health promotion into mainstream care especially if primary and community care work as one seamless service.

There is a considerable challenge in keeping nurses informed and updated regarding various programmes available in their locality in order to be able to signpost people appropriately. Efficient communication streams for sharing public health and health promotion issues should be developed and updated information made available locally. Nurses should also be skilled and competent to recognise needs requiring prevention, intervention or health promotion. Nurses working closely in communities are best placed to identify trends and they should be able to inform strategy and service development.

### SCPHN Health Visiting

The profession of Health Visiting needs to adapt and respond to changing needs and aspirations. The aim should be to tackle the underlying causes of ill health rather than only responding to the consequences. There should be the capacity to take a population perspective and understand health need across a whole population, rather than only responding to individual needs. Work should be planned on the basis of local priorities, and the development of partnerships with others to plan services and meet locally agreed targets. It will also be important to find appropriate methods of evaluation to demonstrate effectiveness and the best use of resources.

England reviewed its health visiting service in 2007<sup>16</sup><sup>17</sup> and revised the Child Health Promotion Programme<sup>18</sup> resulting in a focus mainly on progressive universalism to young children and their families. Currently, health visitors in Wales focus mainly on the health of young children and their families and consideration needs to be given as to whether the service should extend beyond this and develop into a fully integrated service providing early intervention, prevention and health promotion for individuals, communities and populations within a public health context.

With regard to young children and their families the focus of health visitors will continue to be early intervention, prevention and health promotion for young children and families. Priorities in which health visitors will play a lead will include:

- Preventing social exclusion in children and families
- Reducing inequalities
- Tackling the key public health priorities in particular obesity, smoking, alcohol, drugs, accident prevention and oral health
- Promoting infant, child and family mental health

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<sup>16</sup> Department of Health (2007). Facing the Future. A review of the role of health visitors. Department of Health, London

<sup>17</sup> Department of Health (2007). The government response to Facing the Future: a review of the role of health visitors. Department of Health, London

<sup>18</sup> Department of Health and department for children, schools and families (2008). The Child Health Promotion Programme. Pregnancy and the first five years of life. Update of Standard One (incorporating Standard Two) of the National Service Framework for Children, Young People and Maternity Services (2004). Department of Health, London

- Supporting the capacity for better parenting
- Improving pregnancy outcomes,
- Monitoring and surveillance of child health and development.
- Safeguarding children, addressing domestic violence, supporting parental relationships and fathers in their parenting role.
- To assess, identify and engage those children and families with additional needs and risk factors
- To build healthy communities for children and families by working with local people and other sectors
- To lead a multi-skilled team
- Safeguarding, risk assessment and management
- To work in partnership with maternity and school health provision

The key component of the health visitor role is public health but there needs to be new leadership and redirection for the service with the redesign of teams and uniformity across Wales. With the introduction of a new population centered public health, the health visiting role will be critical to the successful implementation of the model. In this new role the health visitor will:

- Take a population perspective: the flexibility of the role (with no caseload) will allow the health visitor to develop an overview of community health
- Develop grass roots partnerships and engage in a cycle of public health action that identifies local need, gathers evidence of what works, implements public health interventions and evaluates outcomes
- Work with family centered and older person centered teams acting as both a resource and a facilitator to develop a public health approach that responds to local need and national strategies
- Feed information up from grass roots to a strategic level as sharing live information about local communities can serve to inform and strengthen Health Social Care and Well Being Strategies.

The role of health visitors with older people is less well developed

A public health partnership model outlines a systematic approach to health visiting that builds on the essential work undertaken with individuals and families and broadens the scope of public health action.

### Family Nurse

The Welsh Assembly Government is currently consulting on the development of a family nurse service<sup>19</sup> which will involve the development and integration of the current school nursing service with other child and family focused nursing roles. The future school nursing team will support the core surveillance programme and

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<sup>19</sup> Welsh Assembly Government (2008) The development of a family nurse service for Wales. Welsh Assembly Government, Cardiff

work in partnership with education, partners and families to ensure that the health promotion agenda is delivered to this group.

#### Health Care Support Workers

Over the next few years it will become increasingly important for the NHS to work successfully with local government to develop the role of the HCSW to ensure that this role can support the healthcare professional more effectively thereby releasing their capacity to be more proactive and responsive. It will also be important to work with staff employed by local authorities to develop their skills in caring as too often people can be excluded from respite or day care because staff lack the confidence to manage risk appropriately.

HCSWs in the community are an underutilised resource whose roles could be developed to support all professionals in primary prevention and health promotion. There are clear examples of best practice already identified, particularly within the areas of nutrition and management of chronic conditions, but this could be developed further. One example is the excellent work of dental nurses who in some areas go into schools to provide health education on oral hygiene and smoking cessation. This is an area that could be expanded to further utilise and develop the role of the HCSW.

HCSWs should share the same vision as registered healthcare professionals regarding primary prevention and health promotion. It is crucial they understand the key messages and are able to highlight relevant issues to the patient and the healthcare professional. HCSWs will be crucial in promoting the self-management agenda but will need to understand and gain confidence in it themselves firstly. Delegation to HCSWs must of course be managed by nurses, midwives and SCPHNs in ways that best meet the needs of the individual patient/client.

#### Teamwork and Partnership Working

There is duplication of roles in the current healthcare system and this strategy recognises the need to reconfigure services to ensure 'joined up' ways of working and to release resources.

Nurses, midwives and SCPHNs will work in partnerships with other healthcare professionals and/or agencies to promote the best interests and welfare of their patients/clients. Innovative partnerships across acute and community services will be based on patient/client needs and evidence will demonstrate the contribution of these partnerships to enhancing healthcare outcomes. Community nurses should be involved in community developments and encouraged to attend locality based activities and meetings for example with key partners such as the police, leisure centres and housing.

### Performance Monitoring and Evaluation

A key issue is the ability to measure and evidence tangible outcomes. Suitable measurement tools are required to demonstrate how promotion and primary prevention impact upon long term health and wellbeing. Evaluation and audit tools will identify care given by nurses, midwives and SCPHNs and report on its quality and contribution to the patient/client experience and healthcare outcomes. Nurses, midwives and SCPHNs will be able to provide evidence of how they contribute to the achievement of quality standards. Patient/client evaluations will be used by nurses, midwives and SCPHNs to inform quality monitoring and planned improvement of services. It is recognised that research is required in this area to ensure a robust evidence based approach.

There is also the need for key performance indicators and a strong information management infrastructure at a regional and national level.

### Research and Evidence-based Practice

The nursing profession also has a responsibility to contribute to the knowledge generation that underpins their practice in the sphere of public health. At a certain level of experience the nurse should be able to provide evidence of how they are contributing to the research agenda and/or the development of clinical practice. Innovative partnerships between education, the health service and research should be developed, based on patient/client needs, which can provide evidence demonstrating the contribution of such initiatives to enhancing healthcare outcomes.

### **Conclusion**

At Level 1 of patient need nurses, midwives and SCPHNs will enable patients/clients to participate in decisions about their care and will work with them to promote healthy lifestyles and self-management of health, illness and/or disability. New roles will be created, based on care pathways or patient/client 'journeys'. Transferable skills will be essential to appointment to these roles and post holders may work across professional boundaries and across all care settings. Evidence will show how these new roles enhance healthcare outcomes for patients/clients and job satisfaction for staff.

## Chapter Two

### Community Nursing at Level Two of Patient Need

#### Mr. Jones' Story

Mr Jones is a 42 year old man who has had asthma for many years. He works as a policeman and enjoys coaching the local youth rugby team in his spare time. He is married with three teenage children, two of whom have also had asthma since childhood.

Mr Jones's GP surgery holds an asthma clinic where he is able to access twice yearly appointments to have support for managing his asthma. This enables him to proceed with his life with the minimum of interference from his condition.

One of the GPs and a practice nurse have specialist training in asthma care which means that Mr Jones can access appropriate care within his locality. He is also able to directly contact the GP or practice nurse for any urgent advice.

At a typical visit Mr Jones will have lung function tests undertaken. A review of his asthma control over the previous 6 months will occur, followed by a discussion about any aspects of his condition that may concern him.

Any medication changes can be made by either the GP or the practice nurse, who is qualified as a nurse prescriber.

A written self-management plan, which is reviewed annually, has been agreed by Mr Jones and the practice nurse, helping him to confidently cope with any changes in his condition that may require him to make any alterations to his medication. As an example, if the weather is cold and he feels short of breath while running around on the rugby field, he knows how to cope with this so that he is comfortable enough to continue rather than avoid the activity.

The practice nurse can take a holistic view of Mr Jones' health and may discuss lifestyle factors, such as exercise, diet, alcohol and smoking. In addition, working as a member of the multi-disciplinary team it is possible to liaise with other agencies, such as social services, for any housing issues; and occupational health colleagues for workplace based considerations. The practice is able to offer preventative measures which may help avoid worsening of his asthma such as influenza and pneumococcal vaccinations.

## Defining Level Two

For the purposes of this strategy Level 2 of patient need is defined as: *The level of patient need which requires a patient and nursing partnership to empower the patient to be an active participant in their health care.*

Table 1 indicates the current professional groups of nurses, with respective employers, who are thought to contribute to Level 2 of patient need:

**Table 1: Nursing Groups contributing to Level 2 of Patient Need and their Employers**

<b>Employer</b>	<b>Nursing groups contributing to Level 2</b>
<b>NHS Trusts</b>	District Nurses School Nurses Health Visitors Case Managers (Long term conditions) Nurse Practitioners Consultant Nurses Supplementary/Independent Prescribers Intermediate Care Nurses, including Day Hospital, Rapid Response, Reablement and Community Rehabilitation Nurses Community Children's Nurses Learning Disability Nurses Mental Health Nurses HCSWs (HCSWs) Health Visiting
<b>LHBs</b>	Practice Nurses Case Managers (Long term conditions) Nurse Practitioners Out of Hours Nurses Public Health Nurses HCSWs
<b>General Practitioners - GPs (independent contractors)</b>	Practice Nurses Nurse Practitioners Supplementary/Independent Prescribers HCSWs
<b>Social Services</b>	Nurse Assessors Community Reablement Nurses Support Workers
<b>Independent Sector</b>	Nursing and Residential Home Nurses HCSWs Out of Hours Nurses Agency Nurses
<b>Voluntary Sector</b>	Funded posts, direct or via NHS Trust
<b>Industry/Workplace</b>	Occupational Health Nurses
<b>NHS Direct</b>	Nurses

At this level a nurse will contribute nursing knowledge and skill to help the patient adapt to or prevent a furthering of their condition or level of need and possibly assist with a return to wellbeing. The underpinning aim of nursing is towards patient empowerment and independence.

Nursing intervention may occur, for example, in chronic disease management, in secondary prevention of complications or in supporting a parent to care for a child in the home. The specific needs of patients with learning difficulties or mental health problems will be addressed within a separate chapter, though may be touched upon here in recognition of the multifactoral aspects of health care provision. All age groups are included within this chapter, acknowledging the breadth of nursing care provided to children, adolescents and adults within the community setting.

### **Introduction to the current service**

The workforce is largely based on traditional models of community nursing, though many innovative new roles have been introduced in recent years in managing long term conditions, where excellent models of nursing are being demonstrated and where health and social services co-exist.

When more than one organisation is involved in care delivery there can be problems in communication and integration of roles leading to service overlap or gaps in continuity of care across the range of patient needs. For example, a patient being seen for a long term condition by a secondary care specialist nurse, a district nurse and a practice nurse. Another problem relates to the differing definitions of “urgent need” between health and social care organisations which, whilst the debate over responsibility for individual patients’ care packages occurs, often leaves the patient suffering a lack of any care. This is a particular issue for children who enter the “transition” stage to adult services.

The variety of employers of community nurses contributing at Level 2 can also result in restrictions relating to shared strategic planning and resourcing of nursing services.

It is recognised that some nurses contributing to Level 2 of the Pyramid of Need also contribute at Level 1, for example in primary prevention and screening roles within general practice; at Level 3, where specialist knowledge is used to manage a higher level of patient risk by practice nurses and district nurses; and at Level 4, for example where district nurses offer palliative care. This recognition supports the need for ongoing discussion about the roles of generalist versus specialist roles whilst also discussing the “novice to expert” continuum within any nursing role and the resultant need for educational preparation of nurses and HCSWs.

## **General Practice Based Nursing Services**

Nurses working in general practice comprise a large proportion of the community nursing workforce and contribute greatly to patient interventions at Level 2 as well as other levels of care.

Nursing in general practice involves first contact care, public health and management of long term conditions.

It has been estimated that 90% of a GP practice population will visit their GP at least once every 3 years; this level of patient contact across all age ranges and populations also applies to practice nurses.

The significance and variety of practice nursing roles has increased as primary care services expand and the management of long term conditions shifts away from secondary care. Practice nurses frequently take a lead role in the Quality and Outcomes Framework (QOF) component of general practice, which is largely related to the management of long term conditions.

GP services are contracted at a national level by the Welsh Assembly Government to provide national health primary care services to the people of Wales. It is important that the employment status of practice nurses (who are employed by GPs as independent contractors) does not prevent NHS strategic planning for the deployment of this workforce or its development as an integral part of the community nursing workforce.

Many general practice nurses are due to retire in the next 10 years. There is a clear need to plan more strategically for the recruitment and development of practice nurse teams throughout Wales.

Excellent examples can be seen of LHB initiatives that have enabled a structured, supportive development of the local practice nursing service. Rhondda Cynon Taf Teaching Local Health Board (RCT tLHB), Caerphilly tLHB and Merthyr LHB have developed initiatives in recognition of a need for both service development and retention and recruitment of primary care clinicians in order to revitalise primary care services in these areas. In addition to meeting a broad chronic conditions management agenda RCT tLHB, for example, provides “locum” cover for practice nurses and GPs; provides salaried practice nurses and GPs; directly manages practices where there are difficulties replacing retiring GPs; and, provides education for local practice nurses and GPs.<sup>20</sup>

The establishment of “Well Being Centres” is a commitment of the Welsh Assembly Government<sup>21</sup>. The initiative has been developed from the experience

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<sup>20</sup> [www.wales.nhs.uk/tlhb](http://www.wales.nhs.uk/tlhb)

<sup>21</sup>Welsh Assembly Government (2007) One Wales: a progressive agenda for the government of Wales. Welsh Assembly Government, Cardiff

of England of “Walk in Centres” which offer a nurse-led, no appointment service, sometimes being combined with a GP service. In view of the varied role that many practice nurses undertake it is clear that this group of nurses could offer many of the skills required for services such as minor illness and injuries treatment, assessment by nurses with advanced skills, and health promotion and advice.

The Working in Practice Partnership (WiPP) general practice nursing (GPN) initiative was set up in 2004 by the NHS in England to support general practice with capacity building resources and strategies. It aimed to develop a range of core principles best practice guides, toolkits and frameworks to create capacity and support the general practice nurse and their employers. After two years in development, it is said to be helping to improve standards across England and diminish anomalies in roles, skills and remuneration in practice nursing. Nursing within general practice in Wales lacks any formal recognition of varying levels of responsibility.

The Working in Partnership Programme (WiPP)<sup>22</sup> outlines a career framework for practice nursing that fits in with a general nursing career framework endorsed by the Modernising Nursing Careers initiative<sup>23</sup>, identifying practice nursing as spanning the wide range of roles including nurse partner, nurse consultant, advanced practitioner, specialist practitioner, senior practice nurse, practice nurse, and HCSW. Currently it is possible to find examples of the more senior roles within selected practices, though these are developed according to individual GP employers’ decisions rather than necessarily according to factors strategically identified for patient populations.

It is recognised that the practice nursing workforce is ageing<sup>24</sup>, though there are no centrally held, current data available to determine the number of practice nurses in Wales or to provide any further information concerning anticipated retirement. The 2007 Royal College of Nursing (RCN) Labour Market Survey showed 19% of the hospital nursing workforce as aged over 50 in contrast to 29% of the community workforce.

In 2005 the GMS contract in Wales was amended, removing the requirement for GPs to report on the number of their employees. The lack of centrally held practice nurse and HCSW data prevents a strategic approach to educational preparation of the future practice nurse workforce and to the strategic employment of this professional group. This requirement must be reinstated.

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<sup>22</sup> [www.rcn.org.uk/development/general\\_practice\\_nurse\\_toolkit](http://www.rcn.org.uk/development/general_practice_nurse_toolkit)

<sup>23</sup> Welsh Assembly Government (2006) Modernising Nursing Careers: setting the direction. Welsh Assembly Government, Cardiff

<sup>24</sup> Royal College of Nursing (2007) Nurse workforce planning in the UK. A report for the Royal College of Nursing. Royal College of Nursing, London

GPs have reported difficulties in recruiting suitably qualified and experienced nurses to vacant practice nurse posts. This is due, in part, to a lack of central funding for pre-registration student nurse clinical placements in general practice.

One proposed example of a tLHB solution to this problem is to provide funding to GP practices so that student nurses can be placed within and supported in GP placements. In return, the local University will undertake to provide mentorship training to the practice nurses, so that they can meet the 50:50 commitment to the theory:practice split in providing “sign off” verification of a student’s achievement of competence.

Central funding of clinical placements for pre and post registration students is necessary if general practice is to become a career choice for nurses. In England, the recent Darzi report <sup>25</sup> has indicated an intention to “rebase the historical funding arrangements for clinical placements ... to secure the required number of high quality placements, including innovative placements in new settings”.

It has been noted that practice nurse education activity has reduced since funding for staff development became part of the GP/nGMS global sum; and concerns are that there will be a resultant decrease in knowledge and skills needed to deliver an increasingly diverse service to patients in general practice, particularly in chronic conditions management.

Anglesey LHB in collaboration with Skills for Health is mapping and auditing the skills and competences for chronic conditions management across health and social care. They are also working with the local education providers to develop training from the outcome of the skills audit.

### **Home Based Nursing Services**

The range of services provided by district nursing teams is extensive, demonstrating how district nurses have adapted to meeting patient need following changes directed by, for example, the NHS and Community Care Act 1990. These services are discussed in Chapter 4.

### **Case Management for Long Term Conditions**

The role of the “case manager” is increasingly being introduced across Wales and is based upon its successful application in England where the role is known as the ‘community matron’.

The case manager is focused on the management of people with long term conditions, the aim being that “one person acts as both provider and procurer of

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<sup>25</sup> Department of Health (2008) A high quality workforce: NHS Next Stage review. Department of Health, London

care; taking responsibility for ensuring all health and social care needs are met, so that the patient's condition stays as stable as possible and wellbeing is increased<sup>26</sup>. Examples of patient groups who are supported in this way include those with single chronic conditions; those with multiple conditions; and, those with frequent emergency hospital admissions.

The case manager usually has a district nurse or practice nurse background and a prescribing qualification and can take a “bird’s eye” responsibility for the patient during the entire health and social care journey handing over responsibility for continuity of care to other health and social care professionals when appropriate.

### **Intermediate Care**

Aimed primarily but not exclusively at older people, intermediate care services aim to preserve and promote the independence of patients living in their own homes where they would otherwise face hospital or long term care.

Examples of intermediate care health services (which include reablement or rehabilitation nurse, district nurse, practice nurse or specialist nurse involvement) in Torfaen Local Authority include; a one stop chest pain clinic; a heart failure clinic; and a podiatry led diabetes foot assessment clinic.

Examples of intermediate care social services include; the provision of “step-up/step-down” beds within residential care; day activity services; a support and monitoring service for patients with dementia; and, occupational therapy at home. There is further discussion of these services in Chapter 4.

The identification of an individual’s needs is essential to identify the outcomes necessary for that person to manage their own care or work in collaboration with nurses or social services to promote and maintain independence.

Assessment of patient need is based on the principles of a unified assessment<sup>27</sup> in recognition of the contributions of both health and social services towards patient care. Unified Assessment is the standardised framework for sharing assessment information across health and social care organisations. Nursing is a specialist assessment within this context.

However, there are difficulties in the implementation of the unified assessment which often result in the patient suffering a lack of care. These difficulties are due to differing professional languages and cultures and to organisational differences between health and social care services in the development of modern data systems.

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<sup>26</sup>[http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH\\_4134132](http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_4134132)

<sup>27</sup> Welsh Assembly Government (2002) Creating a Unified and Fair System for Assessing and Managing Care. Welsh Assembly Government, Cardiff

## **Child and Adolescent Nursing Services**

The recent consultation document “The Development of a Family Nurse Service for Wales”<sup>28</sup> recognises that school nurses should be seen clearly as a valued part of the primary care system, and that this is the only professional group whose remit is entirely focused on meeting the health needs of school-aged children, young people and their families.

There is a lack of specialist community children’s nurses in Wales so that district nurses increasingly deal with the needs of children as well as adults. The RCN recommends that for an average sized district with a child population of 50,000 a minimum of 20 WTE community children's nurses are required to provide a holistic community children's nursing service in addition to any child specific continuing care investment.

A seamless transfer and transition from child to adult health care services should be the goal of the health service<sup>29</sup>. This is increasingly important as more chronically ill children survive into young adulthood. Currently children can find themselves abruptly transferred to adult services at 16 or 18 years of age, depending on whether they are still in full time education; staying in the paediatric area longer than is appropriate; or leaving clinical supervision altogether, either voluntarily or by default. An appropriately qualified nursing workforce would assist adolescent patients through their health journey, across sectors and levels of need.

## **The Workplace**

Occupational health nurses (OHN) are well placed to address Level 2 patient needs across the working age span, from 16 to retirement, within the workplace.

The role of the occupational health nurse is highlighted in the report “Working for a Healthier Tomorrow”<sup>30</sup>. The report describes the need for practitioners to address a wider remit and embrace closer working with public health, general practice and vocational rehabilitation in meeting the needs of all working age people. This should be underpinned by clear workforce plans, clear standards of practice and formal accreditation of all providers.

It is recognised that occupational health needs to be brought into the mainstream of health care provision<sup>31</sup> if holistic patient care is to be a reality. At present

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<sup>28</sup> Welsh Assembly Government (2008) The development of a family nurse service for Wales. Welsh Assembly Government, Cardiff

<sup>29</sup> Royal College of Nursing (2004) Adolescent transition care. Guidance for nursing staff. Royal College of Nursing, London

<sup>30</sup> Department of Health (2008) Working for a healthier tomorrow. Dame Carol Black's Review of the health of Britain's working age population. The Stationery Office, London

<sup>31</sup> Department of Health (2008) Working for a healthier tomorrow, Dame Carol Black's Review of the health of Britain's working age population. The Stationery Office, London

occupational health is not seen as being part of the “main stream” of health provision for patients so that fragmentation of care occurs and the best use of resources to help people remain in and return to employment is not facilitated.

An integrated approach including general practice, occupational health and rehabilitative services such as occupational therapy and psychiatry would enable the patient to receive care in the environment of their choice for a variety of needs including rehabilitation or chronic conditions management for example. OHNs are additional members of the community nursing team and therefore part of a skill mix assessment.

However OHNs are currently employed within the public or private sector as part of human resources management. OHNs report that this employment relationship towards the employer adversely affects their relationship with their clients and can affect take up of services.

It is suggested that, in order for occupational health to become embedded within the wider NHS system for the benefit of patients, that OHNs are employed by the new NHS health organisations to work within the local workplaces, be part of the GP team and have a liaison role with all other sectors offering support for people seeking health services related to their work.

Education opportunities for OHNs are increasing within Wales, with courses being offered at the University of Glamorgan, for example. However, there is no national strategic guidance for education and training for OHNs, neither is the uptake consistent across Wales and employing organisations. Leadership roles within occupational health are few in number and it is felt that this group should be developed in line with other nursing groups as part of a post registration career framework, enabling nurse consultant level posts to assist the strategic review and development of nursing for the working age population.

### **Independent and Supplementary Prescribing**

The most important impacts of nurse prescribing are improved services and better access to services offered to patients and clients. The patient has improved access to and advice about their medicines and this enables more effective use of the skills of nurses.

There have been some great successes in the implementation of both supplementary and independent prescribing within the community setting, including district nurses, practice nurses, nurse practitioners and long term conditions nurses. This is recognised as a contributory factor in developing advanced nursing roles that support patients through Level 2, where management of long term conditions is increasingly the responsibility of nurses.

208 nurses in Wales have so far become independent prescribers and approximately 150 training places will be made available to nurses by the Welsh Assembly Government in the year 2008/9.

However, there has been no attempt to strategically promote the uptake of these places to particular sectors of the nursing population, for example, where a nursing role is predominantly in chronic or long term conditions management. Moreover practice nurses in particular are unable to access this course without the support of the employing GP for funding, study leave, mentorship and funding of the backfilled post.

It can be seen that there are a number of important issues relating to the practice nurse workforce that impact on the ability to ensure a consistent approach to patient care across Wales. The capacity to strategically address workforce planning, recruitment and retention, and, training and education for practice nurses is compromised by the employment of practice nurses by GPs as independent contractors. One option would be NHS employment of practice nurses, in line with other community nurses such as district nurses. There would be advantages and disadvantages to this but the option is worthy of serious consideration and could be well timed within the context of NHS reconfiguration focused on primary care based health care delivery.

### **Public Health and Screening Services**

As the emphasis within the NHS is increasingly placed on health promotion and disease prevention, using public health data and population based needs assessment to inform services, the role of nurses in new public health roles is growing. For example, screening services for breast cancer, cervical cancer and bowel cancer involve nurses who use their knowledge and skills to undertake clinical tests such as “cervical smears” whilst supporting the patient through invasive procedures and possible subsequent health promotion or follow-up treatment. Table 2 illustrates the range of public health nursing roles within public health organisations

It is perhaps surprising that many nurses working in these important new public health roles do not align themselves to the 3<sup>rd</sup> part of the NMC register for specialist community public health nurses.

This would appear to necessitate a review of public health nursing within Wales, to ensure that the nursing workforce is clearly identified, prepared and supported in line with the needs of patients and the NHS generally.

**Table 2: Public Health Nursing Roles within Public Health Organisations**

<b>Public Health Organisations</b>	<b>Public Health Nursing Roles</b>
National Public Health Service (NPHS)	Health Protection, includes infection control, vaccinations and immunisations, environmental health
	Child Protection, working with vulnerable children
	Health Promotion, includes smoking cessation, healthy lifestyle
	LHB activities, includes cardiac rehabilitation
Screening Services	All National screening programmes, such as cervical, breast and bowel screening.
Welsh Blood Service	All static and mobile blood collection units

### **Proposed New Model for Community Nursing**

This report has drawn fresh attention to the large number of different nursing groups working for patients requiring Level 2 nurse support close to their home and/or place of work. It also highlights that these nursing groups frequently work in separation from each other and that more could be done to utilise effort and expertise in a co-ordinated way. Chapter 4 of this Strategy outlines the proposed new model of Local Community Nursing Teams to address these issues.

The new NHS structures will have major implications for the alignment of governance and management responsibilities of community nursing. However, detail is as yet unknown about the management of community services or the administration of the GP budget in the new NHS health organisations. Figure 4 represents our proposals regarding community and primary care nursing within the new health organisations.

In order to facilitate a strategic integration of practice nursing and occupational nursing into community nursing it is recommended here that a specific Primary/Community Care Directorate of the new Health Organisations manages these nursing services.

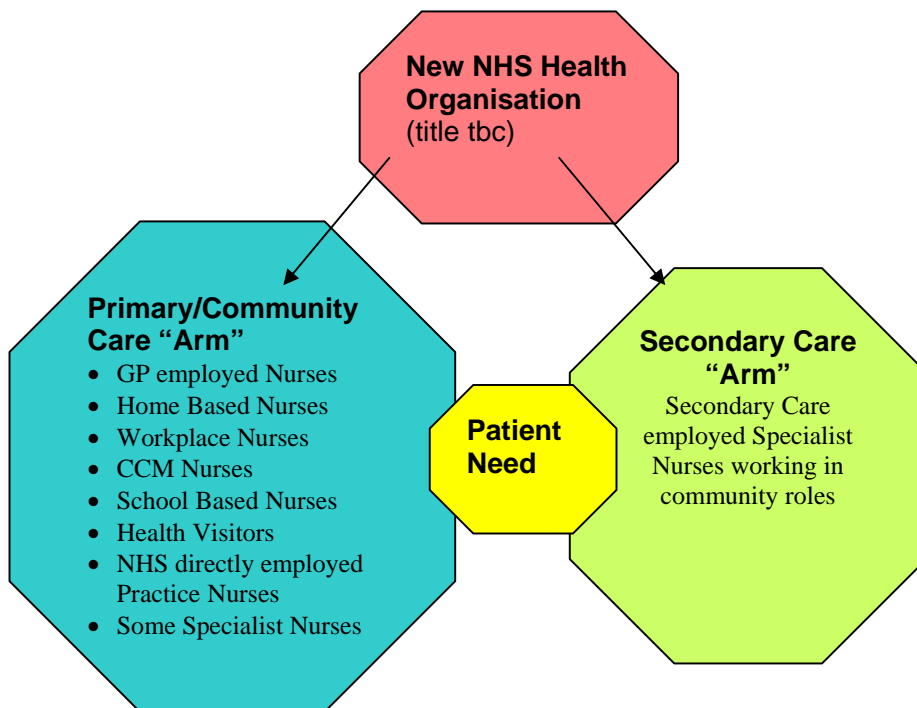
In addition, in order to facilitate true integration of nursing services it is proposed that school nursing and the traditional community nursing (home based) services

such as district nursing are managed within this Primary/Community Care Directorate and also those specialist nurses e.g. diabetic facilitators who are employed in the community. Health visitors could also be managed within this directorate.

Due to the base of the secondary care employed nurses usually being within the hospital consultant team, it is desirable that the work undertaken by such nurses, often with a “specialist” focus, should be integrated and co-ordinated alongside the nurses employed directly for work in community roles.

Funding streams need to be clearly agreed between the 2 “arms” of the new Health Organisation to ensure that patient need is able to be met in a co-ordinated way by nursing teams rather than continue with current separate arrangements and the resultant inability to work in a truly collaborative and integrated way.

**Figure 4: Community and Primary Care Nursing within the New Health Organisations**



## Chapter Three

### Community Nursing at Level Three of Patient Need

#### Mr. Griffiths Story

Mr Griffiths is a 65 year old diagnosed with Motor Neuron Disease with rapid onset. His needs have increased and his family needed support so he has been admitted to the hospice as his current package of care is not adequate.

A case conference is held and a care package is put together to increase the input from the specialist nurses and to provide four visits from carers each day. Equipment is provided at home i.e. a hoist and Marie Curie nurses and agency nurses provide four nights of nursing care.

A district nurse has overall responsibility for care coordination, with the responsibility to visit daily to assist with care, monitor symptoms, support family dynamics and coordinate the care. She is also responsible for liaising with the GP and accessing members of the care team as and when required.

The package of care enables Mr. Griffiths to be cared for at home, surrounded by his family, who are also given support and advice to help them as his condition deteriorates.

## Background

Level 3 has been defined as medium/high risk management including intermediate care services, network based services, outreach clinics and specialist nurses. In comparison, Level 4 care is defined as case managed services, continuing and palliative care

It is inevitable that there will be some blurring and cross over across each level of care need, as the patient journey and subsequent needs over time may move into different levels. The interventions within different levels may reduce the likelihood of moving into a higher level of care need or facilitate a quicker return to a lower level of care need. However the overarching vision for Level 3 care is that:

- No patient stays in an acute hospital setting any longer than is necessary to manage and treat their acute needs.
- There are no boundaries, either implicit or explicit, during the patient journey through acute services, community services, primary care services and the independent sector and between different levels of need. Care and the level of expertise that is required follow the patient in order that care can be delivered as close to the patients' home as is safe to do so.
- Community care is seen as the 'norm' with time spent receiving care in an acute setting kept as short as it is safe to do so.

Community nursing, including community adult, mental health, learning disability, paediatric nursing and midwifery, which contributes to Level 3 medium/high risk management, includes many innovative service and role developments. However community nursing at Level 3 is still predominantly based around the traditional model of community/district nursing.

Practice nursing has also seen development in recent years with the introduction of nurse practitioners with advanced skills who manage their own caseloads and thus are able to provide a valuable contribution to the care of Level 3 high risk patients. However, practice nurses, with few exceptions at present, are employed by GPs whose business is independently contracted to the NHS. This has resulted in a lack of strategic thought by the NHS to the best deployment of the skills of practice nurses and the co-ordination of the healthcare services they provide.

Specialist nursing roles provide invaluable expertise to the care of patients and their role is highly valued by patients and colleagues alike. However these roles have developed in Wales (as across the United Kingdom) in an unco-ordinated way. Many such roles were established in an acute setting, supporting medical consultants. More recently they have begun to outreach into the community setting when resources allow and there is now an expectation that they will

contribute to chronic conditions management and the philosophy of provision of safe care as close as possible to home.

Network based services continue to develop across Wales, for example the innovative community Heart Failure service model in North West Wales which consists of GPs with special interests (GPwSI) and heart failure community based specialist nurses. Based in primary care, both specialist nurses also work closely with secondary care and network with the regional heart failure teams. There are a small number of specialist renal nurses based in each dialysis unit who have a substantial community role. Home therapies, satellite dialysis and anaemia management are examples of the developed and developing role. Other specialist nurse roles, such as cardiac rehabilitation nurses and arrhythmia nurses work across the primary and secondary care sector as well as other agencies in the community, although currently these services are often secondary care led.

All of these developments require a strategic overview to ensure they are sustainable and that the maximum benefit can be extrapolated and deployed across Wales. The risks of continuing with ad hoc development are confusion, unsustainability, duplication of roles and the failure to recognise the importance of including the community setting in education programmes.

Providing care in the community often requires the input of more than one service, profession or organisation. Where more than one organisation, or indeed different parts of an organisation, are involved in care delivery, there can be challenges with communication and integration of roles. Potentially this can lead to service overlap or gaps in continuity of care across the range of patient needs. One example of role overlap would be a patient with diabetes who is seen by a specialist nurse, a district nurse and a practice nurse.

Nurses also work in many other community care settings, for example NHS community hospitals, independent nursing homes and prisons. Too often in these settings people requiring Level 3 medium/high risk nursing care are currently being referred to secondary care as presently there may not be the skills or resources to provide such care in the home environment. However, addressing the need for additional skills or nursing posts in these settings should become a priority for the new health organisations to ensure that people are cared for in their home environment rather than moved unnecessarily into secondary care.

School nurses and health visitors also contribute to care in the community. Whilst their contribution may mainly be to Level 1 and 2 care, they are in a position to prevent service users from moving into Level 3 care needs. Also there may be occasions when they are caring for Level 3 needs which may not necessarily be physical. For example, in safeguarding or with psychological needs considerable work is undertaken by health visitors and/or school nurses to prevent escalation to Level 4 needs and to encourage a return to Levels 2 and 1 care.

Community paediatric services vary across the country and have developed in different ways. Children's nursing is a distinct area of nursing, with generalist and specialist roles within it. There is an urgent need for the new health organisations to consider the need to create specific children's community nursing posts and to promote community training to children's nurses.

Providing Level 3 patient care in the community setting is made difficult and frustrating for the healthcare professional by boundaries (both perceived or real) between health and social services. The most common example is a patient spending an extended length of stay in secondary care with discharge delayed whilst the professionals wait for a care planning meeting. These delays can also be due to lengthy and complicated processes in relation to securing funding for nursing care or continuing care which is often related to poor understanding and/or disagreement about patients needs. These processes, involving NHS Trusts, LHBs and social services can compound, delay and complicate transfer of care. Review of patients who have existing care packages can also be a complex and lengthy process and delay discharge from secondary care.

Whilst there are specific difficulties with discharge from secondary care of those requiring continuing care, overall both the numbers of patients seen in the community and the complexity and acuity of their needs are rising. Health technology, disease understanding and treatments continue to develop changing the way in which patients are cared for. Where once surgical cases required several days' admission into secondary care, increasingly surgical interventions are developing and leading to faster discharge from hospital with care required to be delivered in the community.

Intermediate care services are developing across Wales. These are predominantly multi-disciplinary teams. An example of the mission statement of an intermediate care team is '*A person centred service which will provide intervention for individuals, in order to improve and maximise their independence, therefore enabling individuals to remain in their own homes whenever possible and promoting their health and well-being. Intermediate Care aims to reduce admissions to hospital, residential or nursing home settings and where admission is unavoidable, facilitates early discharge from hospital/care facility.*'<sup>32</sup>

The concept of intermediate care has existed for many years, but the health services have only very recently begun developing services in this field primarily in response to new innovations and pressures upon existing services, which have challenged traditional thinking and established models of care. Consequently, these services have appeared under a number of different names and a variety of formats all with broadly similar objectives. The potential for confusion prompted the National Assembly for Wales to set out a standard definition of

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<sup>32</sup> Conwy Intermediate Care Team. Unpublished internal document

Intermediate Care<sup>33</sup>. Intermediate care was defined as services that meet all the following criteria:

- are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care;
- are provided on the basis of a comprehensive assessment, (as defined within the Unified Assessment and Care Management system), resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery. The initial assessment should identify the appropriate clinician with managerial responsibility and the most appropriate care co-ordinator;
- have a planned outcome of maximising independence and typically enabling patient/users to resume living at home. This approach will be dependent upon the development and implementation of joint, multi-agency service access criteria;
- are usually time-limited, often no longer than six weeks and frequently as little as 1-2 weeks or less; and
- involve cross-professional working and agencies working in partnership, with a single assessment framework, single service access criteria, single professional records and shared protocols.

### **Key Issues**

The key issues identified in order to deliver nursing care at Level 3 of patient need include:

#### Access to services

Increasing patient access to certain services such as multi-disciplinary assessment or diagnostic services.

This requires investment in community nursing services to ensure they are available seven days a week and 24 hours a day. The services will be further refined in the recommended regional Community Nursing Strategies, depending on patient need. Out of Hours GP services will need to link in with community nursing services.

Access to fast track multi-disciplinary specialist and advanced assessment should be available in community settings, to include an element of out of hours

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<sup>33</sup> National Assembly for Wales (2002) WHC (2002) 128 NAFWC 43/02. National Assembly for Wales, Cardiff:

service, to be defined according to patient need, in order to reduce hospital admissions.

Access to fast track diagnostic services should be developed with an increase in the provision and use of near patient testing to provide timely and accurate diagnoses. This should also include an element of out of hours' service, to be defined according to patient need in each region. For example it may not be necessary or an effective use of resources to provide a 24 hour service, however it may be that a 16 hour a day, 7 days a week service is necessary.

### Knowledge and Skills

There is a need for the new health organisations and the Government to identify the skills base required across Wales, for example, supplementary/independent prescribing, assessment and triage skills, recognising that there may be core skills and skills related to local need and population.

Implementation of non medical prescribing, both supplementary and independent, within community settings, including district nurses, practice nurses, nurse practitioners and chronic conditions management nurses can contribute to nurses managing patients and preventing them moving into Level 3 care needs.

Continuous professional development will be required to ensure a strong base for generic nursing care to realise a flexible, competent workforce to meet local needs. This may include developing more advanced practitioners working either as specialists (e.g. diabetes) or generalists and practitioners with special interest programmes. Nurses in community hospitals are able to safely manage patients who are ventilated thereby freeing up valuable intensive care resources. They have become skilled in delivering intravenous therapies and blood transfusions to divert work away from in-patient settings to care closer to home.

There is work ongoing in North Wales, "Designed for Competence", in conjunction with Skills for Health which is undertaking the identification of competencies relating to patient need with specific reference to chronic conditions. The generic health and social care worker, trialled in North Wales, is an example of removing the health and social care boundaries. Joint budgets should be considered as this role develops.

### Teamwork and networking

Network based services need to continue to develop in order to provide specialist support across Wales using models, for example, such as the heart failure nurses in North Wales who are part of a team including GPwSI, community nurses and practice nurses and based in the community.

An excellent example of best practice in multi-disciplinary team working and extended skills would be the nephrology teams developed across Wales. This type of practice could be mirrored in many other services with staff working in

primary and secondary care breaking down barriers as understanding of the roles of others improves. Development of accommodation in the community would facilitate the development of fast track clinics and outreach services.

### Discharge Planning

Discharge planning needs to be undertaken as soon as possible after admission, working alongside community colleagues to ensure discharge can happen as soon as appropriate, with simple seamless systems in place to support the discharge process, for example, to access special equipment.

### **Conclusion**

It is clear that the current community nursing service is excellent with many examples of innovative practice. However there are also examples of barriers to achieving the goal of enabling patients to access and receive care as close to their home as it is safe to do so. Development of community nursing services has been inconsistent across Wales. Community nurses have the willingness and enthusiasm to support the development of services to enable patients requiring Level 3 care to be managed in the community.

The health needs of the community and the delivery of health care are changing. In the past, people requiring a high level of care would automatically be cared for in a hospital setting but as services and roles develop this is not now the case. Nurses are in an ideal position to drive this change.

Development of community services will need investment and must be pump primed to ensure a smooth transition to a fully developed service, ensuring no adverse impact on patient care. This investment will see a return as the need for secondary care services is reduced as a result but this will only happen when the service is developed.

Enhancing and advancing nursing practice in the community will reduce the need to access secondary services.

## Chapter Four

### Community Nursing at Level Four of Patient Need

#### Paul's Story

Paul is a 36 year old gentleman who has a degenerative muscle disease that was diagnosed while he was a child. Paul's physical health has gradually deteriorated and he is reliant on others for all his daily care needs.

Paul has received health and social care services as a child and now as an adult. He is invasively ventilated and receives regular daily input from community nurses for general care and complex invasive procedures to maintain his health and well being.

Paul lives with his family who support his care, they receive regular respite at home from trained community support staff.

On occasion Paul needs to access the local intermediate care services for active physiotherapy and intravenous medication treatment for acute chest problems.

Paul is reviewed regularly by his general practitioner, who accesses support from the consultant led specialist team when appropriate to Paul's needs.

## Background

The definition of Level 4 for the purposes of this strategy refers to case managed services, patients (adults and children) who require regular essential input from statutory and non statutory providers of care to ensure they can meet their daily living needs. These include patients with palliative care and life limiting disease and patients deemed to be requiring continuing NHS funded health care.

These patients may be supported in many different health care settings from their own homes, supported care environment or independent nursing home to name a few.

Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments<sup>34</sup>.

Continuing NHS healthcare and NHS-funded nursing care is provided over an extended period of time to meet physical or mental health needs that have arisen as a result of disability, an accident or illness. The care can be provided in a variety of settings including a hospital, nursing home, hospice or the patient's own home.

District nurses and community nurses have a pivotal role in providing care to patients in their own homes as part of the end of life care and continuing healthcare workforce. It is clear that this workforce will require the essential knowledge, skills and attitudes to continue to fulfill their roles effectively.

A plethora of nurses, therapists and social care workers, voluntary and independent sector staff is presently involved in community case managed services, moving across traditional boundaries between secondary and primary care environments. There is currently no central co-ordination of these services, which often results in duplication of effort and lack of co-ordination of services to patients, with patients not knowing who or how these staff groups relate to one another.

There has been considerable change in the statutory community nursing services over the last 10 to 15 years. The Community Care Act (1990)<sup>35</sup> placed greater focus on social care provision for individuals' basic needs. The Act also led to the introduction of charges for social care services that often resulted in barriers

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<sup>34</sup> National Council for Palliative Care: [www.ncpc.org.uk](http://www.ncpc.org.uk)

<sup>35</sup> HMSO (1990) National Health Service and Community Care Act. Her Majesty's Stationery Office, London

between social care and health care and reduced service flexibility. In 1995 the Department of Health issued guidance on continuing health care<sup>36</sup>. Patients assessed as eligible for health led care now have their basic care needs met by the NHS a service that is free at point of contact.

The Welsh Assembly Government has also placed more emphasis on acute hospitals reducing the time patients wait for hospital inpatient and outpatient care and reducing overall length of stay for hospital care. The whole system aims to be more efficient and responsive to patients' needs. It was recognised that prolonged length of hospital stay potentially caused increased complications for patients whereas prompt discharge to their own home environment was seen as beneficial. Core community services saw a change in demand for follow up care and had to reactively respond and up skill staff to meet the demand. Some community specialist services (such as continence and wound care teams) have been developed as part of the core community services but recently disease specific services have also begun to emerge following the development of the Welsh Assembly Government's Chronic Conditions Management policies.<sup>3738</sup>

There has been a significant increase in specialist nurses outreaching into the community from acute hospitals for patients with complex needs as a direct result of policy change<sup>39</sup> and the lack of specialist knowledge within the core services. However, these services have not always dovetailed with existing generic core community services with specialist nurses setting up discrete separate services. Some of these specialist nurses, although experienced in their specialist area, often do not meet the current standard expected for specialist practice<sup>40</sup> nor have experience of working within the community setting.

Educational background and preparation for nurses working within the community is varied with the traditional community nursing workforce working towards the NMC specialist practice standard - district nurses, health visitors, practice nurses, children's nurses and more recently school nurses. Many of these staff have undertaken additional education and training to Master's level, undertaking autonomous advanced practice roles within the community setting. Nurse practitioner roles have been developed within general practice and as part

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<sup>36</sup> Department of Health (1995) NHS responsibilities for meeting continuing health care needs. HSG(95)8. LAC(95)5. HMSO, London

<sup>37</sup> Welsh Assembly Government/National Public Health Service for Wales (2006) International Overview of the Evidence on Effective Service Models in Chronic Disease Management. Welsh Assembly Government, Cardiff

<sup>38</sup> Welsh Assembly Government (2007) Designed to Improve Health and the Management of Chronic Conditions in Wales. An Integrated Model and Framework. Welsh Assembly Government, Cardiff

<sup>39</sup> Welsh Assembly Government (2003) Review of Health and Social Care in Wales. Welsh Assembly Government, Cardiff

<sup>40</sup> Nursing and Midwifery Council (2001) Standards for Specialist Education and Practice. Nursing and Midwifery Council, London

of generic and intermediate care services, chronic conditions management, tissue viability and continence services.

Currently, within Wales, there are significant operational differences in the availability of generalist and specialist services for patients with complex care needs within the community. Only Cardiff and Vale, Merthyr Tydfil, Swansea, Neath, Port Talbot and Carmarthen operate 24 hour generic district nursing services. The rest of the geographical areas within Wales generally have 9-5 day services with some evening cover for palliative care (predominantly voluntary sector) and continuing health care. Other nursing groups working within the community generally work office hours between the hours of 9-5, Monday - Friday.

Chronic condition management nurses (CCM) have been developed within certain areas of Wales, to look specifically at preventing complications from long term disease or help provide support and advice to those patients with chronic conditions to promote independence and further disease progression. Some CCM posts who have a different role to specialist nurses have been developed from within existing generic district nursing services as enhanced and developed roles (North and North West Wales, Abertawe Bro Morgannwg East Division, Pembrokeshire/Hywel Dda) and others as part of separate initiatives of LHB development (Abertawe Bro Morgannwg West Division, Cardiff and Vale, Gwent). This has been directly related to the policy drivers outlined in 'Designed for Life'<sup>41</sup> and the Chronic Conditions Management Framework<sup>42</sup>.

Following Wanless<sup>43</sup> there has also been a development of intermediate care services within the community aiming to prevent unnecessary hospital admissions or facilitating rapid discharge based on Designed for Life principles of providing patients with alternatives to traditional hospital care in their own community. These services have been developed as part of existing community services, developing and enhancing nursing and therapy roles to provide more acute skills such as intravenous therapies/ antibiotics and blood transfusions and advanced roles such as insertion of lines and cannula and clinical assessment skills (Cardiff and Vale, Carmarthen, Neath Port Talbot, Gwent, North West Wales).

Health visiting (SCPHN) services within community have generally been focused on caring for and supporting mothers following birth until the child is 5 years old and are seen as an integral part of the primary health care team. Their health

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<sup>41</sup> Welsh Assembly Government (2005). Designed for Life Creating World Class Health and Social Care for Wales in the 21<sup>st</sup> Century. Welsh Assembly Government, Cardiff

<sup>42</sup> Welsh Assembly Government (2007) Designed to Improve Health and the Management of Chronic Conditions in Wales. An Integrated Model and Framework. Welsh Assembly Government, Cardiff

<sup>43</sup> Welsh Assembly Government (2003) Review of Health and Social Care in Wales. Welsh Assembly Government, Cardiff

promotion role and disease prevention expertise have been utilised in some areas within chronic conditions management (Level 1 and Level 2 of patient need). However the work of health visitors, school nurses and Looked After Children's nurses in child protection and with mothers with physical health problems should be recognised as a Level 4 activity due to the significant health and social implications on the family as a unit and the potential impact on the need for services.

The NHS is also working with the HCSW workforce to develop and enhance training and skills. HCSW are inputting into health packages for case managed care and intermediate care also working as part of a team to deliver direct care. Examples of this would be for patients with invasive ventilation, reablement and intermediate care services, also family health workers within health visiting focusing on parenting support. have led to HCSWs becoming generic workers who work across traditional boundaries – enhancing their nursing, social care and therapeutic/reablement skills.

The last 10 years has seen an increasing need for specific children's nursing services in the community who can support children up to 18/19 years of age. However, these services are not consistently available across Wales with generic adult services usually being used to respond to the needs of all age groups. There is an urgent need therefore to develop this workforce.

School nurses within the community mainly focus on primary health promotion and disease prevention (Level 1 and 2 of patient need) however they also have a role with case managed children with complex care within the special schools linking in with multi-agency children's services or working with core generic adult services to support families to provide individualised care for this group of children.

## **Key Issues**

### Workforce

There is a need to develop an evidence based workforce maximising the efficiency and utilisation of existing resources between health and social care acknowledging both the gaps and duplication of effort that exists in the system between primary care (including GP services) acute care and statutory community services which prevent and constrain patients from receiving the right care at the right time in the right place.

There is a need to understand the change in demand for community based services and ensure appropriate staff resources are developed and available based on population-based need which is nationally agreed

There is a need to understand the impact of the development of outreach services and the growing number of specialist services within the community on

core generic services. There needs to be clarity of roles and clear consistent planning needs to be in place for any future development to prevent further duplication and devaluing and fragmentation of core generic service provision.

#### Access to services

There is a need to develop equitable services across Wales that are accessible 24 hrs a day 7 days a week that support robust community based responses for health and social care need.

The demand for continuing healthcare and palliative care within the community far out stretches the available resources within the system as it is currently set up. Individual patients should have clear expectations of what services they are able to access when they have complex care needs and delays in the system should be at a minimum when individuals choose for their care to take place within community.

#### Partnership Working

Financial conflict between health and social care providers needs to be resolved with pooling of budgets and the establishment of clear partnership working.

Statutory and non statutory organisations providing care within the community should undertake standard education and training that is recognised and credited to the European standard that meets professional regulations and enables staff to work together across organisational boundaries – protection of vulnerable adult training (POVA) and child protection is an example of training in partnership which is effective and client centred.

There is a need to review the local enhanced services currently being supported through GMS to see if there are opportunities to reduce duplication with NHS provision and to ensure the availability of flexible multi-professional blended education to support practice based learning.

#### Monitoring and Measuring Performance

There is currently very little data available within health and social care communities across Wales to determine where resources are being spent and whether value for money is being achieved. The development of robust data and performance measures need to be established and are vitally important which dovetail with existing primary care and acute data sources that will lead to better understanding of the patient's whole journey.

#### Information Technology

IT infrastructure needs to be resolved to proactively plan to support the patient pathway across traditional boundaries with additional investment for equipment and telecare/health and accessing medication for the last days of life.

## Conclusion

Community nursing services have in recent years flexibly adapted and changed to the needs of the patient and this change should be celebrated. However for the future we need co-ordinated services to maximise the efficient use of resources in a climate of population, social change and high service demand.

There are good examples within mental health services within Wales of how integrated services can offer patients seamless multi-agency, multi professional services. These services have excellent engagement of the voluntary sector that can guide the strategy development for general services for the future. There would be a need for strong team leadership- case/care co-ordination and a robust governance framework to allow staff to function safely within accepted guidelines. An excellent example of this would be the “Gold Standards Framework; A programme for community palliative care”<sup>44</sup>.

Work is already in place within the Abertawe Bro Morgannwg University NHS Trust ‘Delivering Integrated Services Project’ that has established a community engagement approach for chronic disease management which engages with all multi-agency services looking to co-ordinate a local response for the local population. This work can inform this strategy development in engaging all relevant stakeholders including voluntary sectors partners.

Modernising nursing careers<sup>45</sup> and the advance practice tool kit<sup>46</sup> are key enablers for developing future nursing roles and reducing duplication of effort between services. Many nurses within the community are already working at Advanced level with the need to develop their roles further to Nurse Consultant level. Specialist nurses need to be developed and focused around specific population need and a review of the many disease specific specialist nurses needs to be undertaken focusing on common disease groups within populations such as respiratory/COPD, Diabetes, Nephrology and Palliative care.

## Proposed Community Nursing Model

Figure 5 represents the current model of community nursing with many different nurses working in the community providing care at all four levels of patient need. At times nurses from different specialties work together to benefit patients but often they work separately. More could be done to co-ordinate services by ensuring they work as a team.

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<sup>44</sup> The Gold Standards Framework :[www.goldstandardsframework.nhs.uk](http://www.goldstandardsframework.nhs.uk)

<sup>45</sup> Department of Health (2006) Modernising Nursing Careers: setting the direction. Department of Health, London

<sup>46</sup> Scottish Government (2008) Supporting the Development of Advanced Nursing Practice; A toolkit approach. Scottish Government, Scotland

The central recommendation of this strategy is for the development of Local Community Nursing Teams to provide care at all four levels of patient need. The proposed community nursing model is shown in Figure 6 representing a continuum of care from acute into primary care and centralised at the integrated community team closest to where people live. This team approach will address the current lack of co-ordination and duplication of effort.

A Local Community Nursing Team would be led by a designated care/case co-ordinator collating and managing the provision of the range of services which are sensitive to the needs of individual patients to enable them to maintain and maximise their health and independence. These teams could include nurses with a special interest relevant to local community health needs.

This concept of an integrated nursing team is to build a team of nurses from different disciplines working flexibly together, supporting colleagues, maximising their skills and focusing on the health needs of the population. The composition of Local Community Nursing Teams will depend on the health needs of the population. For instance, these teams could include nurses with a special interest relevant to specific needs e.g. cardiac rehabilitation or diabetes.

Teams will work closely with GP practices establishing links with the local community to access support from pharmacy, dentistry and optometry; with acute consultant led specialist services and their nurse consultant/specialist nurses e.g. ventilation/respiratory medicine, critical care/respiratory medicine and other population-based specialist services. They will work alongside a range of therapists, including physiotherapists, occupational therapists, podiatrists and speech and language therapists. It will be essential that they build active partnerships across statutory, voluntary and independent sectors.

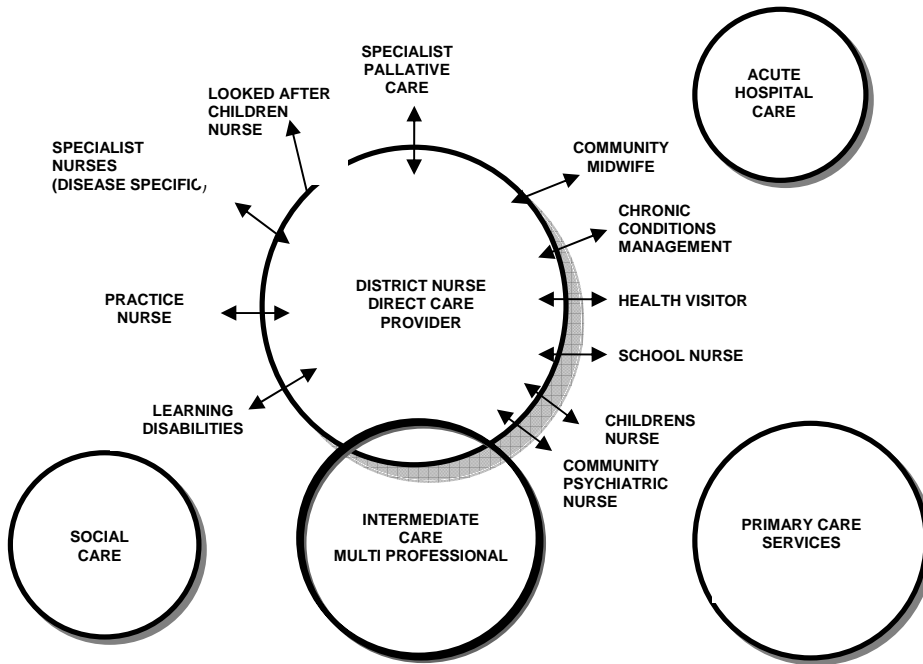
Local Community Nursing Teams will need to be:

- Clinically up to date and trained to national standards for each professional group.
- Educationally prepared to work within the community setting
- Educated to specialise in population-based disease-related issues e.g. diabetes education for populations where diabetes is of high incidence
- Providers of direct care covering a wide range of skills – a generic workforce

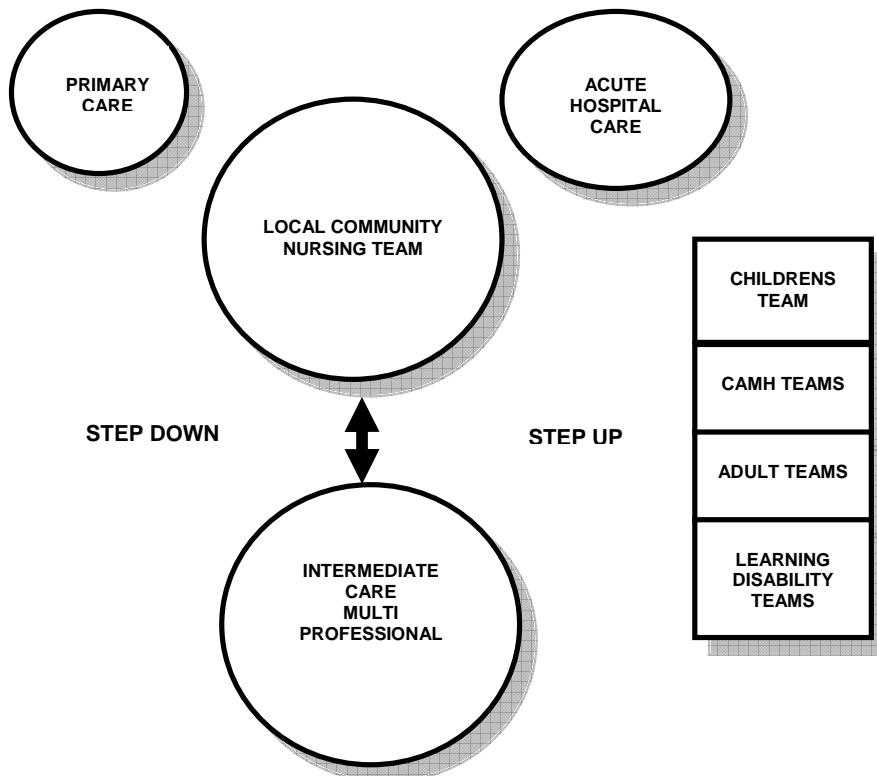
They will require a range of essential skills and expertise including:

- Clinical assessment skills
- Population assessment skills
- Prescribing (all levels - appropriate to case mix of patients)
- Reablement expertise

**Figure 5: Current Community Nursing Model**



**Figure 6: Proposed Community Nursing Model**



The boxes at the side of the diagram are examples of local multi-professional teams that should be developed to support the vision. Child and adolescent mental health service (CAMHS) and learning disability teams are already in place. Adult, children's and intermediate care teams need to be developed consistently across Wales.

## Chapter Five

### Midwifery

#### Precious' story

Precious is a 17 year old asylum seeker who arrived in Wales when she was 10 weeks pregnant. She is initially seen by a midwife at 12 weeks who confirms the pregnancy and undertakes the booking history. The midwife refers her for an ultrasound scan to confirm dates and to detect any major fetal abnormalities. During the 20 week anomaly scan a fetal abnormality is detected and Precious is referred to the fetal medicine unit. After extensive tests the fetus is found to be normal and she returns to midwife led care.

The midwife remains the lead professional and sees Precious at each antenatal consultation.

Precious is booked for induction of labour at 42 weeks and is admitted to the Consultant led unit. Her labour progresses very slowly and she eventually requires an emergency caesarean section for fetal compromise. Following the birth of the baby Precious suffers a catastrophic haemorrhage resulting in a hysterectomy.

Due to the massive blood loss and resulting disseminated intravascular coagulation she requires transfer to ITU where she stays for 3 days. She and the baby make a good physical recovery and both are discharged to the care of the midwife.

## **Background**

Using the Pyramid of Need (Figure 1) the four levels of need will be defined in relation to maternity care.

### **Level 1: Primary Prevention and Health Promotion**

Within maternity care this includes antenatal care, health promotion, antenatal screening and antenatal education.

The importance of health promotion pre pregnancy cannot be underestimated and it is important that the midwives are up to date with current thinking and evidence in order to provide appropriate advice should women contact them before embarking on a pregnancy.

When women believe they may be pregnant they contact a midwife directly or their GP. The majority of care they receive in the antenatal period is provided by a midwife as the lead professional. Some women will have care provided by their GP in conjunction with a midwife. In addition to this package of care some women may be referred for obstetric care.

During the antenatal period women will receive health promotion/public health advice from their midwife. Advice and support may be accessed from a number of different health care providers who will work alongside the midwifery team. Examples include smoking cessation, dieticians, Flying Start, substance misuse midwives and safe guarding children teams. Women particularly in their first pregnancy and those with special needs will be seen by their health visitor who can offer additional support thus ensuring that long term relationships are developed.

Routine screening, including ultrasound, is offered to all pregnant women and support and advice regarding this will be provided by a midwife. If necessary the midwife will refer to a specialist obstetrician/fetal medicine consultant.

Antenatal education is offered to all women who may then access classes, or one to one advice from a midwife. Some women choose to access private antenatal education for example via the National Childbirth Trust.

### **Level 2: Population Management.**

For maternity this applies to women who fit into a low risk category and will receive their antenatal care within the community setting either at home, in the GP's surgery, in Birth Centres or, in the future, in resource centres.

All pregnant women are responsible for carrying their own pregnancy records which will go with them regardless of where care is provided. This ensures that

the relevant up to date information is always available to appropriate health care professionals.

At any point during the antenatal period a midwife may decide that a woman should be referred for an Obstetric opinion. This will be a decision which the midwife makes in relation to the woman's clinical condition. Following this referral many women will return to midwife led care.

Increasingly women choose to give birth in a Birth Centre or at home, supported by a team of midwives.

All women receive post natal care, based on need, initially in the birth setting and then at home. Drop-in centres are being developed so that women have a choice of where they receive post natal care from the midwife. There is close liaison between the midwife and the health visitor who will take over the care of the mother and baby at between 10 and 28 days.

### **Level 3: High Risk Management**

At any point in her pregnancy a woman may become high risk and will require referral to obstetric care. This may be because of an existing medical condition, i.e. Diabetes, or due to complications of pregnancy, either maternal or fetal. The seriousness of the condition will determine place of birth, for example, there may need to be neonatal services or paediatric surgical services on site.

All women with high risk pregnancies are advised to give birth in an obstetric unit but all of these women will be cared for by a midwife in conjunction with the obstetric team.

### **Level 4: High Dependency Care**

There are a small but increasing number of women with complex, medical conditions and social needs that require specialist care during their pregnancy, labour, birth and the post partum period. This specialist care is provided by a range of professionals and could include cardiologists, haematologists, physicians, radiologists, intensivists, psychiatrists and specialist midwives.

There is growing evidence from various national reports, for example the Confidential Enquiry into Maternal and Child Health (CEMACH), that some groups of women are more susceptible to major complications of pregnancy. And as concern grows in relation to the health of the general population, for example, increasing obesity levels, the drain on maternity services cannot be underestimated.

## **Services in Wales and the Policy Context**

Maternity services in Wales are provided by 7 NHS Trusts. Within these Trusts there are a variety of settings from stand alone midwife-led birth centres, alongside birth centres, consultant led units and tertiary referral units with fetal medicine facilities. Midwives work across all settings including community.

### **1. National Service Framework for Children Young People and Maternity Services<sup>47</sup>**

This framework, launched in September 2005 as a 10-year strategy, is the vehicle for delivering the Welsh Assembly Government's commitment to children and young people as set out in Children and Young People; Rights to Action<sup>48</sup>. It contains 3 standards for maternity the first of which states that Women and their partners are empowered to make informed choices throughout their pre-pregnancy and maternity care. Services are co-ordinated seamlessly between hospital and community and between agencies, to maximise the health and well-being of families.

### **2. "Realising the Potential" Briefing Paper 4: "Delivering the Future in Wales". A Framework for Realising the Potential of Midwives in Wales<sup>49</sup>**

Following extensive consultation with the nursing and midwifery profession, the Nursing Division of the Welsh Assembly Government published the Strategy for Nursing, Midwifery and Health Visiting, 'Realising the Potential' in July 1999.<sup>50</sup> The strategic goal of the paper was: 'to realise the full potential of nursing, midwifery and health visiting in order to meet, in collaboration with others, the future health needs of people in Wales'. In response to and in support of this paper, the Heads of Midwifery Advisory Group in Wales developed a midwifery briefing paper which sets out a number of aims which will assist in achieving their vision for the midwifery profession in the next decade. Aim one, improving the environment of care, states that Heads of Midwifery will work with others to maintain and develop a maternity service which is:

- Community orientated with a public health focus
- Integrated across community and acute services
- Offering home births
- Strengthening multidisciplinary partnerships

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<sup>47</sup> Welsh Assembly Government (2005) National Service Framework for Children Young People and Maternity Services. Welsh Assembly Government, Cardiff

<sup>48</sup> Welsh Assembly Government (2004) Children and Young People: Rights to Action.. Welsh Assembly Government, Cardiff

<sup>49</sup> Welsh Assembly Government (2002) "Realising the Potential" Briefing Paper 4: "Delivering the Future in Wales". A Framework for Realising the Potential of Midwives in Wales. Welsh Assembly Government, Cardiff

<sup>50</sup> National Assembly for Wales (1999) "Realising the Potential" A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales into the 21<sup>st</sup> Century. National Assembly for Wales, Cardiff

### **3. Safer Childbirth Service Standards<sup>51</sup>**

This report was commissioned following concerns from the CEMACH and its predecessor organisations the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) and the Confidential Enquiry into Maternal Deaths (CEMD) which indicated the need for a fresh look at the organisation of care in labour. The requirements of Standards for Better Health and the recommendations arising from investigations conducted by the Healthcare Commission added to the breadth of the report, which also incorporates the aspirations of UK maternity service policies. Whilst the report acknowledged that the central role of midwives as autonomous practitioners of normal labour and birth it also stated that the organisation of care in labour in all settings should be reviewed and, if necessary, changes implemented to reflect the recommendations in this report. The adoption and implementation of the staffing standards, facilities and governance structures outlined below should help to ensure the best outcome for women and their babies regardless of the birth setting.

### **4. Standards for Maternity Care<sup>52</sup>**

These were devised so that providers and planners of maternity care, as well as women and their families, could benefit from a single, comprehensive set of standards which would cover every step of the pathway of care from pre pregnancy through to the transition to infancy and parenthood. The thirty standards provide guidance on the development of equitable, high quality service standards across the UK and include the standard that all women are able to access midwives in their community, on a drop-in basis.

### **5. Midwifery 20:20**

In February 2007, the UK Chief Nursing Officers commissioned a paper looking at ways midwifery could positively contribute in the future to maternity care in the UK. A programme of work has now commenced which is due to be completed in 2010. Five key themes have been identified and working groups established: Maternity Care Pathways, which is being led by Wales, will focus on the journey of a woman and her family through the maternity service from conception to six weeks following birth. Mapping a woman's needs will enable the group to consider what care is required and who is best to give that care. The other themes are Workforce and Workload, Career Progression, Measuring Quality and Public Health.

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<sup>51</sup> Royal College of Obstetricians and Gynaecologists (2007) Safer Childbirth - Minimum Standards for the Organisation and Delivery of Care in Labour. Royal College of Obstetricians and Gynaecologists, London

<sup>52</sup> Royal College of Obstetricians and Gynaecologists (2008) Standards for Maternity Care. Maternity Audit Indicators. Royal College of Obstetricians and Gynaecologists, London

## **Key Issues**

Childbearing can be viewed as a process that occurs within a 12 month period, 9 months of pregnancy and three months of new baby care. It is essential during this period of time that continuity of care for all women is provided.

### User Involvement

Women are vulnerable whilst they are in the health system and whilst midwives can and do act as their advocates, many women will wish to participate in service design either because of a complaint or because of excellent service received. User involvement is key and must capture the thoughts and beliefs of these women during this important phase of their lives.

### Antenatal Care

Antenatal education is invaluable in ensuring that women are enabled to make choices and feel central to the care that is being provided. For many women this will be the first time they have been exposed to childbirth and babies. It is an opportunity to involve them in the health agenda for example, smoke cessation, obesity issues or simply appropriate child care and breastfeeding.

### Birth Centres

Birth Centres have proven to be effective ways of providing high quality appropriate care for women in their local communities. Further development and improvement in the existing birth centres is a key issue, together with accessible antenatal care in community settings.

Using the First point of contact framework, birth centres are one of the places where antenatal contact with a midwife could be made. Increasing the opportunity for early contact with a midwife, in a community setting, will ensure that women receive the right advice at the earliest possible opportunity, and that they are able to access that advice, support and care throughout their pregnancy.

Post natal care can also be provided in these centres, providing vital peer support, advice and information for those women who require it.

### Workforce

It is recognised that there are insufficient midwives to provide the standard of care that is required. Although the service is safe, it is not perfect and the development of maternity care assistants is vital to continually improve service delivery. This will need to be reflected in student midwife training so that new midwives are aware of the various resources they can utilise to support women in their care. It is essential that student midwives work with experienced midwives in all settings so that an overview of the work of a midwife is obtained. Long term workforce planning will need to include these new support staff so that an ideal number of qualified and other staff are commissioned.

Within any service a flexible and sustainable workforce is required. This includes the development of appropriate shift patterns and skill mix whilst maintaining high standards.

#### Multi-disciplinary working

There is a need to strengthen multidisciplinary working, with an emphasis on communication and the development collaborative care planning. This is particularly important for the care of vulnerable women.

#### Neonatal Care

The current provision of neonatal care is also worth further scrutiny and action to ensure that it also reaches a standard that is equitable across Wales and of a high standard.

### **Conclusion**

Midwifery is and will remain a woman focussed service which ensures that care is delivered in the most appropriate place by the appropriate professional. The maternity team will comprise of trained professionals and support staff who will ensure the woman receives high quality care.

## Chapter Six

### Learning Disability Nursing

#### Tom's Story

Tom was referred to the clinical nursing service from the community nurse care manager to assist a client who has Downs Syndrome and hypothyroidism, to attend the G.P. practice to have thyroid function test. Tom was phobic about venepuncture with a history of fear and refusal to undertake the procedure. Previous interventions by primary health care had resulted in non compliance due to previous experience where blood was unable to be obtained. Further attempts had been made at Tom's home which were also unsuccessful

#### **Interventions undertaken by the Learning Disability Nurse**

The Learning Disability Nurse(LDN) met with Tom and his family to ascertain Tom's fears in relation to the procedure. It was established that his greatest fear was in relation to the use of a tourniquet. Tom was reluctant to visit the surgery.

The LDN discussed ways of relieving Tom's anxiety and it was agreed tat she would visit Tom's home and used massage as a method of relaxation.

During massage the nurse introduced the tourniquet, and equipment used for venepuncture and they talked about the procedure at each session. The LDN practiced using the tourniquet on family members arm, then on Tom's arm.

The LDN then liaised with the primary care team and arranged introductory visits to the GP surgery and to the room where venepuncture would take place. She arranged with primary care for use of anaesthetic spray and developed a pictorial reference of each session, made and retained by client.

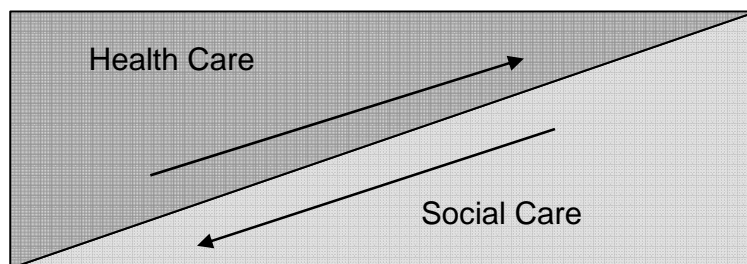
Tom attended the clinic, venepuncture was performed and thyroid function result obtained. The pictorial reference was retained by Tom for future reference. Tom stated that he felt more self confidence and the Primary Care Team were more aware of the support that the LDN can offer to clients with Learning Disability to help them achieve better health outcomes.

## Background

The Registered Nurse for People with Learning Disabilities (RNLD) is the only profession specifically trained to work with people who have learning disabilities. However, it is also a profession whose existence has been continuously challenged from its inception to the present day.

Various debates over the years regarding role definition have been fuelled by the consistent drive to distinguish between the concepts of health and social care, with particular reference to the implementation of the NHS and Community Care Act (1990).<sup>53</sup> Attempts to clarify such a distinction are largely artificial, given that people have a range of needs that transgress the health and social care spectrum, experiencing high or low levels of input in either dimension simultaneously as indicated below in a diagram taken from the Cullen Report.<sup>54</sup>

**Figure 7: The Health and Social Care Continuum**



RNLD nurses based within community settings as Community Nurses for People with Learning Disabilities (CNLDs) have led the way since the early 1970's in developing their skills within multi-disciplinary and multi-agency service models and have facilitated the development of policy and practice frameworks that have transcended organisational boundaries. The CNLD has not only survived, but has arguably strengthened its position in human services through a process of professional evolution that has responded positively to ever changing external drivers. That said, many challenges remain for the CNLD to respond to, to ensure the specialist and generic health needs of people with learning disabilities are effectively provided for.

The current multi-disciplinary/multi-agency framework of service delivery was rooted within the development of Community Learning Disability Teams in the early 1980's. Since that time, services have evolved considerably in terms of the size of the team and the range of professions and services based together. However, this metamorphosis has been inconsistent throughout Wales and human, professional and financial resources are

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<sup>53</sup> HMSO (1990) National Health Service and Community Care Act. Her Majesty's Stationery Office, London

<sup>54</sup> Cullen report (1991) Chief Nursing Officers of the U.K. Caring for people: mental handicap nursing. (PL/CNO (91) 5) Department of Health, London

inequitably dispersed throughout the different community teams. In addition, the roles and responsibilities of the CNLD lack clarity across many of the community teams, with nurses undertaking a range of clinical and care management roles that dilute the ability of the CNLD to meet the specialist health needs of people with learning disabilities. Nurses make excellent care managers and excellent specialist clinicians; however, they must not be expected to do both jobs at the same time.

The role of the CNLD has been under review by the All Wales Senior Nurses Advisory Group for the past eighteen months. This discussion has been prompted by recognition of the continued policy debate over what constitutes “Continued Health Care” and how the care co-ordinator’s role within the unified assessment process can be equitably performed by a range of community based healthcare professionals.

The role of the CNLD in Wales has developed incrementally, but differently, within different geographical regions and as such there has not been a nationally agreed model of service provision. It is also evident that many CNLDs are performing roles that should be undertaken by other community nurses and service providers. In this respect, one is looking at a profession that has been shaped by the consumer and the provider rather than the commissioner. The CNLD does provide a range of specialist clinical, facilitation and educational skills that are highly effective and valued. However, the extensive breadth of services provided by the CNLD which could be provided more appropriately by other community professionals, can dilute the quality of the specialist skills that need to be delivered to meet the specialist health needs of people with learning disabilities.

In terms of the future of the CNLD, the role must be that of a professional nurse clinician which focuses upon priority specialist health needs which can make the greatest impact in supporting people with a learning disability and their carers. This role is focused on four main strands of activity based upon a sound knowledge, skills and value base:

1. Direct Intervention e.g. working directly with a person, developing a health profile
2. Partnership working e.g. multi-disciplinary and multi-agency working
3. Education e.g. working with and providing information for service users, carers and generic services
4. Inclusion e.g. through collaboration with other service providers to facilitate the inclusion of people with learning disabilities in providing a full range of appropriate and effective interventions

The lack of accurate data and the subsequent lack of effective commissioning of appropriate services for people with complex health and behavioral needs, has arguably led to an escalation of their condition that often requires the provision of specialist healthcare services out of their local areas. Such provision is not only expensive in terms of financial resources but also in terms of the human and social cost and negative impact on the well-being of clients, families and carers.

It is imperative that specialist community health services, with a range of relevant skills, are commissioned and developed locally to meet the local needs of people with learning

disabilities and their carers and that they have the capacity to respond in a flexible and effective manner. The Welsh Assembly Government<sup>55</sup> proposed that specialist services need to be developed to provide specific specialist health skills in fields such as challenging behaviour, mental health, epilepsy, mobility and communication. This is consistent with the findings of a recent census of CLDN caseloads across Wales by the All Wales Senior Nurses Advisory Group, which identified the following areas of work activity as a priority:

1. Complex Physical and Medical Health Needs
2. Mental Health Needs
3. Epilepsy
4. Challenging Behaviour

Within the tiered approach to service delivery people present with the above needs and conditions at all four levels of care. However, it is the intensity and complexity of skills required to assess, plan and provide effective interventions that differentiates the specific specialist role, environmental location and function of the CNLD within the different levels of service delivery as indicated in Figure 8.

### **Complex Physical and Medical Health Needs**

People are living longer at both ends of the age spectrum and are presenting service providers with an increasing range of highly specialised needs that require specialist skills. In terms of the complexity of physical and medical health needs these are reflected by the following conditions and issues that services are challenged with such as chronic disease management, dysphagia, communication problems, sensory impairments, specific syndrome-related health needs, transition from childhood to adulthood etc.

Key roles of the CLDN will be to:

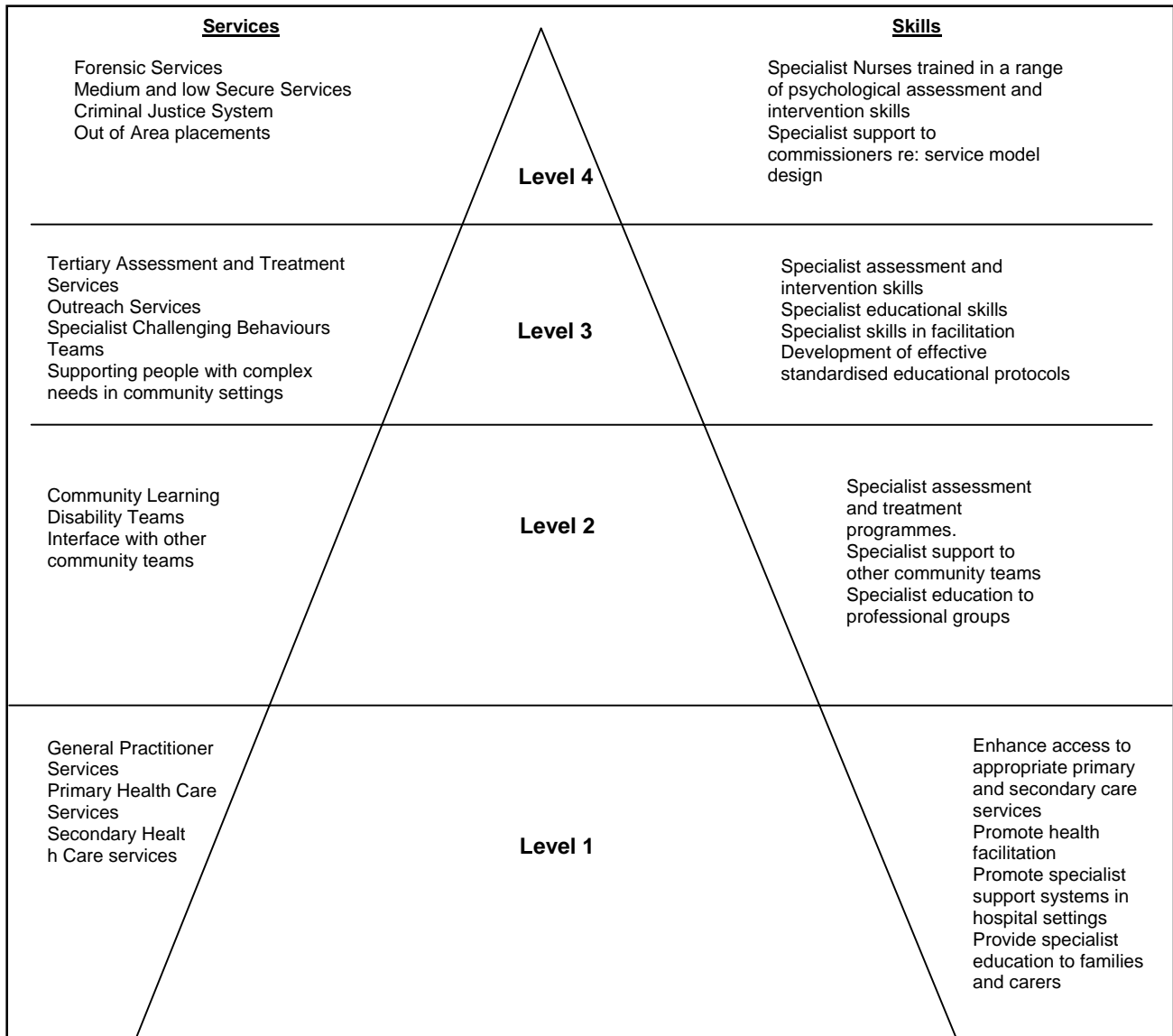
- Develop health profiles for individuals
- Provide specialist nursing assessments
- Develop Specialist Education Protocols and Operational Systems (i.e. Traffic Light Systems, Hand Held Health Records) within the primary and secondary care services
- Provide a consistent quality of specialist support, education and training to service users, carers and care providers
- Develop and implement effective communication strategies with clients and carers
- Provide clinical co-ordination and health facilitation for clients and carers with primary and secondary health service providers
- Facilitate the provision of appropriately skilled respite care services
- Create an evidence base for service planning
- Liaise with GPs and practice nurses regarding annual health checks

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<sup>55</sup> Welsh Assembly Government (2007) Statement on policy and practice for people with a learning disability. Section 7 (1) Local Authority Social Services Act 1970. Welsh Assembly Government, Cardiff

- Provide advice, support and consultation to other specialist healthcare services e.g. Palliative Care

**Figure 8: Learning Disability Nurses: Services and Skills**



The outcomes of such interventions include:

- Enhanced access to appropriate primary and secondary health care services
- Improved health outcomes for clients
- Reduced inappropriate admissions to acute services
- Improved advice and evidence for service planners on specialist service model development
- Increased awareness of learning disability issues by generic health staff leading to an improved “patient experience” and the effective and efficient use of scarce resources.
- Achievement of optimum health for individuals with learning disabilities

## **Mental Health Needs**

Mental health needs are recognised as being more prevalent among people with learning disabilities than the general population with evidence that a large proportion of such conditions go undiagnosed<sup>56</sup>. People with Learning Disabilities are vulnerable to the same range of mental health issues faced by the general population as well as additional issues that are condition specific i.e. early onset dementia in people with Downe`s Syndrome. However, it is often more difficult to recognize the manifestation of these needs and this requires the skilled interventions of specialist nursing staff in conjunction with other community professionals

Key roles of the CLDN will be to:

- Facilitate early recognition of changes in individual mental health
- Provide specialist support to generic mental health, GP and primary care services
- Administer specialist assessments and clinical screening based upon presenting condition to inform diagnosis (e.g. PASS-ADD (Psychiatric Assessment Schedule for Adults with a Development Disability)<sup>5758</sup>)
- Provide specialist input into clinical assessment, diagnosis, care planning, risk assessment, C.P.A. and Unified Assessment processes
- Provide direct clinical intervention (e.g. anger management, anxiety management)
- Facilitate access to acute mental health service where appropriate
- Educate service users carers and service providers
- Deliver education, and ensure administration and compliance with medication regimes is monitored and
- Ensure compliance with Mental Health Act legislation and procedures
- Assess, advise and support other agencies re mental capacity issues

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<sup>56</sup> National Patient Safety Agency (2004) Understanding the patient safety issues for people with a learning disability. National Patient Safety Agency, London

<sup>57</sup> The Moss, S.C., Prosser, H., Costello, H., Simpson, N., Patel, P., Rowe, S., Turner, S., and Hatton, C. (2002) PASS-ADD Checklist. ABS, Austin, Texas

<sup>58</sup> Reliability and validity of the PASS-ADD Checklist for detecting psychiatric disorders in adults with intellectual disability. Journal of Intellectual Disability Research 42 (2) 173-183.

The outcomes of such interventions should be:

- Optimum maintenance of individual mental health
- Improved support and quality of life for clients and carers
- Locally delivered services and appropriate use of scarce specialist inpatient services
- Improved knowledge base and communication for/with clients, carers and generic service providers
- Efficient and cost effective medication regimes
- Fulfillment of the requirements of the Adult Mental Health National Service Framework and Action Plan for Wales<sup>59</sup>

## **Epilepsy**

Epilepsy is more common in people with a learning disability than in the general population. About 30% of people (nearly one in three) who have a mild to moderate learning disability also have epilepsy<sup>60</sup> with people with severe/profound learning disabilities likely to present with more complex and uncontrolled seizure patterns.

Key roles of the CLDN will be to:

- Develop individual epilepsy profiles and management plans, including rescue protocols
- Monitor seizure patterns
- Assess risks
- Educate client, carer and service providers
- Facilitate nurse-led clinics
- Undertake Supplementary prescribing
- Liaise with specialist epilepsy services

The outcomes of such interventions will be:

- Improved management of the condition utilizing effective medication regimes
- Probable reduction in medication costs
- Efficient and effective use of resources
- Improved quality of life for clients and carers
- Improved knowledge base for clients and carers
- Facilitation of effective communication with GP and specialist consultants
- Reduction in the inappropriate use of emergency services and admissions to acute hospital beds

## **Challenging Behaviour**

People with learning disabilities whose behaviour challenges form an extremely diverse group which includes, for example, people with mild or borderline learning disability who

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<sup>59</sup> Welsh Assembly Government (2005) Adult Mental Health Services. Raising the Standard - The Revised Adult Mental Health National Service Framework and Action Plan for Wales. Welsh Assembly Government, Cardiff

<sup>60</sup> National Society for Epilepsy (2008) Information on epilepsy: epilepsy and Learning Disability - Information leaflet. National Society for Epilepsy, London

have come into contact with the criminal justice system as well as people with profound learning disability who may injure themselves<sup>61</sup>.

Key roles of the CLDN will be to:

- Administer specialist assessments e.g Adaptive behaviour Scale ABS-RC:2<sup>62</sup>
- Develop individual behaviour management plans based on specialist assessments
- Develop the knowledge, skills and value base of carers and service providers by utilizing specially designed educational protocols
- Liaise with other agencies e.g. psychiatry and the criminal justice system
- Facilitate effective risk management
- Provide education in Positive Behavioural Support

The outcomes of such interventions will be:

- Improved quality of life for clients and carers
- Improved knowledge, skills and value base for carers and service providers
- Provision of support for individuals within or as close to their own communities as possible
- Maintaining people within the appropriate level of service provision
- Appropriate use of scarce commissioning resources
- Reduction of use of high cost specialist services e.g. Assessment and Treatment Units and out of area placements

## **Key Issues**

### Professional Considerations

- The creation of outcome focused and evidence-based practice is essential to aid in effective service and workforce planning.
- There is no standardised approach to the level of education that CNLDs need to achieve in term of diploma, first degree, Master's Degree.
- There is a need to develop standardised specialist clinical and educational protocols to ensure a consistent quality of education is delivered to service users, families and carers across Wales.
- There is limited research within community services for people with learning disabilities, especially in relation to the role, function and outcomes achieved by the CNLD

### Commissioning

- There is a lack of commissioning intention for the development of lifelong services with many services identifying themselves as adult only. This denies access of children to relevant specialist skills and also prevents organizations

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<sup>61</sup>Department of Health (2007) Services for people with learning disability and challenging behaviour or mental health needs (Mansell Report) (revised edition) Department of Health, London

<sup>62</sup> Nihira, K., Leland, H., Lambert, N. (1993) ABS-RC:2 Adaptive Behaviour Scale – Residential and Community . Second Edition. The American Association on Mental Retardation,

and the nurse professionals in developing the additional specialist skills in working with children.

- There is increasing evidence that the demographic profile of people with learning disabilities is changing, with many people living to greater age than previously and with many presenting with complex medical health needs.
- Carers are ageing and carers' assessments are not consistently utilized to identify their needs
- There is a need to develop core areas of practice that meet the specialist health needs of people with learning disabilities and their carers.
- Unacceptable levels of clinical time are being spent on undertaking Continual Health Care assessments and having to justify these assessments on numerous occasions to commissioners.
- There is a lack of planned and emergency respite services for people with specialist needs in relation to their complex physical, mental health and challenging behaviour

### Service Provision

- There are variations in eligibility criteria by statutory bodies for vulnerable adults.
- Access criteria in some areas differs between health and local authority and can inhibit effective joint working
- There is a lack of effective joint working with community mental health teams, and CAMHS.
- There is a poor understanding of the CNLD role by other community nurses, and other community based health care professionals. There is a need to promote the specialist role of community RNLD with other professionals and in particular with primary and secondary health care teams and services.

### **Conclusion**

It is the ability to work across professional and organisational boundaries that is the strength of the CNLD, and identifies the CNLD as leading the modernisation agenda within the nursing profession by continuing to develop progressive and innovative roles that are flexible and responsive to individual need.

## Chapter Seven

### Mental Health Nursing

#### Peter's Story

Peter, a 17 year old student, living with his parents suddenly became withdrawn and started to neglect his personal needs. His parents worried that he might be using illicit drugs and, after much encouragement, Peter agreed to see his family doctor. His GP suspected mental health problems and referred Peter to his local first access/primary care liaison mental health service.

The initial nursing assessment concluded that Peter was beginning to experience significant mental health difficulties and a further referral to the local community mental health team (CMHT) was made. Unfortunately, before the CMHT was able to complete their assessment Peter broke down in a state of acute crisis resulting in him being assessed as a matter of urgency by the local crisis resolution and home treatment team (CRHTT). The assessment concluded that the severity of Peter's problems and his level of risk to himself warranted his admission to psychiatric hospital for a thorough assessment of his needs.

The only option available to the team at this time was to detain Peter under the Mental Health Act to an adult psychiatric admissions ward. After a period of three months in hospital, the CRHTT again became involved with a view to supporting Peter to make the transition back to his home. Members of the CRHTT and ward staff also opened discussions with the local CMHT for children and young people, and with the local working age adult CMHT, with a view to identifying which of the two community teams would assume responsibility for Peter's and his family's ongoing needs following hospital discharge. A formal aftercare planning meeting was convened, and under local care programme approach (CPA) arrangements a CMHT-based nurse was identified as Peter's care co-ordinator. Plans were made for Peter's discharge.

Peter, then, returned home to his family and community mental health nurses continued to work with him, delivering evidence-based psychosocial interventions together with individual and family problem-solving interventions. Peter's care co-ordinator also worked hard to educate Peter and his parents about his illness, and the types of care and treatment available.

After a year Peter again broke down, challenging his parents' ability to care for him. During subsequent re-assessment it was discovered that Peter had been using street drugs. Peter was referred to the local community drugs and alcohol service who worked collaboratively with the CMHT to address these issues. Peter then missed a number of appointments. His care co-ordinator received a frantic call from Peter's mother informing her that Peter was in police custody suspected of a violent offence.

Prior to his court appearance, Peter was assessed by a community nurse working in the local forensic service. The nurse was able to provide advice to the authorities over the care Peter needed. Peter was directed under the Mental Health Act for a further period of assessment and treatment in hospital. Following discharge to a hostel, Peter continued to receive care and treatment from members of a highly specialist forensic community team.

## Background

One in four of the population will experience mental health problems at some time in their lives. The prevalence of serious and enduring mental illnesses such as schizophrenia is approximately 1%. Many people with these conditions have complex health and social care needs which lead to further disadvantage, discrimination and vulnerability. They frequently need ongoing support with access to education, employment, quality housing and social inclusion. Specialised health care is required. This can take the form of psychological therapies to help with symptoms such as hearing voices and delusions, and assertive outreach services to enable inclusion and combat social withdrawal. Often people with serious mental health problems also require help in the form of medication, and in dealing with the unpleasant side-effects of this.

Unique amongst health care recipients, people who use mental health services may be legally detained and compelled to receive treatment and aftercare support. Changes to the Mental Health Act for England and Wales<sup>63</sup> mean that, in law, nurses are now able to assume overall responsibility for supervising the care of people receiving compulsory treatment and to make applications for the use of compulsory orders. This context of deprivation of liberty and forced treatment is important in helping shape how services should be provided, and how they are experienced by users. The UK has a long tradition of established social movements seeking to represent the views of mental health service users<sup>64</sup>. Although these movements have varied in rationale and purpose a common theme is that they seek to establish the central rights of service users to be listened to and to have their needs addressed. Many of these movements now combine political lobbying with the provision of residential, vocational and support services. Nurses and other professional workers in this field must engage with service users, their families and the movements representing them to provide care that demonstrates awareness of need and is sensitive to users' previous contacts with services.

Past<sup>65</sup> and present<sup>66</sup> policies in Wales have consistently promoted community-based services for people with mental health problems. Policy continues to emphasise the importance of partnership with recipients of services, and collaborative working across professional and agency boundaries. Most mental health nurses work in services led by health agencies though some (for example, nurses working with older people) work in services which are local authority-led.

In all settings, nurses qualified at the point of registration to work specifically in the mental health field play a vital role in the provision of effective, integrated community services. Most are based in interagency and interprofessional teams, which have provided dedicated services in Wales since the 1970s. In addition to nurses, CMHTs

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<sup>63</sup> Great Britain (2007) Mental Health Act 2007, Elizabeth II – Chapter 12. The Stationery Office, London

<sup>64</sup> Crossley, N. (1999) 'Fish, field, habitus and madness: the first wave mental health users' movement in Great Britain', *British Journal of Sociology*, 50, 4, 647-670.

<sup>65</sup> Welsh Office (1989) *Mental illness strategy for Wales*. Welsh Office, Cardiff

<sup>66</sup> Welsh Assembly Government (2005) *Raising the standard: the revised adult mental health national service framework and an action plan for Wales*. Welsh Assembly Government, Cardiff

typically bring together psychiatrists, social workers, psychologists, occupational therapists, support workers and others to provide locally accessible care to people living within defined geographical areas, or by reference to primary care practice boundaries.

CMHTs remain the cornerstone of community care in Wales. They serve as single points of entry for new referrals received from primary care and other sources and undertake initial screening, prioritisation of need and assessment. Nurses and other CMHT staff also provide ongoing, specialist, mental health services and act as co-ordinators of complex health and social care plans under care programme approach (CPA) arrangements<sup>67</sup>.

Community mental health nurses also work in teams serving specific groups, either with reference to stages of the lifespan or particular need. For example, nurses work in interprofessional community mental health teams for children and young people, older adults, people with substance misuse problems and people also in contact with the criminal justice system. Modernising Welsh policy has additionally led to the appearance of newer 'functional specialist' services. Examples include crisis resolution and home treatment teams, which provide an alternative to psychiatric hospital admission and support early hospital discharge<sup>68</sup>, and teams providing assertive outreach to people with severe mental illnesses<sup>69</sup>. Further guidance is expected for the provision of early intervention services (which aim to reduce the impact of psychosis on individuals at an early stage of their presentation), rehabilitative care, and primary care support.

Figure 9 illustrates the range of mental health nursing services provided across the four levels of patient need.

The nursing part of the NMC register is divided into fields of practice, of which mental health is one. Individual registration is achieved following completion of a three year programme, of which the final two-thirds are branch-specific. Whilst sharing the same professional regulatory body, nurses working in mental health settings have a history and set of working practices which are quite unlike those of their colleagues registered in the children's and adult nursing fields. In Wales these distinctions have been recognised through the production of a specific, national, mental health nursing strategy<sup>70</sup>

In their everyday practice, mental health nurses act as skilled assessors of health and social need, directly provide biopsychosocial care and fulfil roles as co-ordinators of

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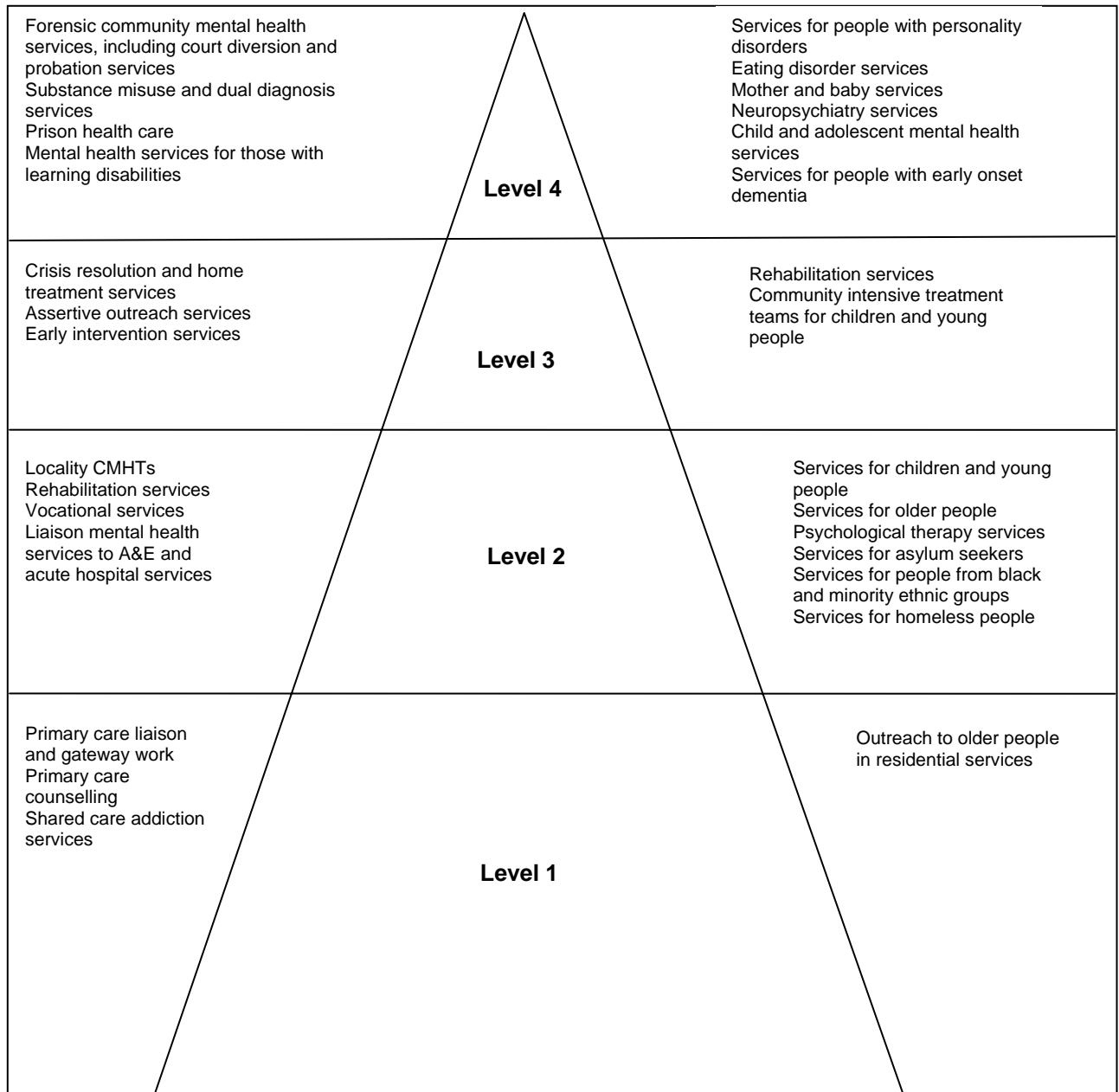
<sup>67</sup> Welsh Assembly Government (2003) Mental health policy guidance: the care programme approach for mental health service users, Cardiff, Welsh Assembly Government.

<sup>68</sup> Welsh Assembly Government (2005) Policy implementation guidance on the development of crisis resolution/home treatment (CR/HT) services in Wales, Cardiff, Welsh Assembly Government.

<sup>69</sup> National Public Health Service for Wales (2007) Assertive outreach in mental health services. Guidance to support delivery of SaFF Target 21 2007/2008, Cardiff, National Public Health Service for Wales

<sup>70</sup> National Assembly for Wales (2001) 'Realising the potential': a strategic framework for nursing, midwifery and health visiting in Wales into the 21st century. Briefing paper 2. 'Aspiration, action, achievement': a framework for realising the potential of mental health nursing in Wales. National Assembly for Wales, Cardiff

**Figure 9:  
Mental Health Nurses' Services across the Four Levels of Patient Need**



services. However specific post-registration preparation for mental health nursing in the community has never been mandatory. Optional post-qualifying courses for mental health nurses practising (or intending to practise) in community settings have been available since the early 1970s<sup>71</sup>. Since the mid-1990s the mental health field has been recognised as one of eight 'specialist practice' areas of community nursing, with

<sup>71</sup> White, E. (1990) 'The historical development of the educational preparation of CPNs', in Brooker, C. (ed.), *Community psychiatric nursing: a research perspective*, London, Chapman and Hall.

associated standards to be met by approved education programmes<sup>72</sup>. Welsh Assembly Government funded post-qualification courses designed to meet these standards are offered at Cardiff, Swansea and Bangor universities, with commissioning taking place on an annual basis.

Alternative programmes (not linked to NMC community nursing standards, and therefore not eligible for funding from the Welsh Assembly Government non-medical training budget) also remain popular and for many observers are equal or more appropriate preparations for community work. Examples in the mental health field are psychosocial interventions (PSI) courses, which provide nurses and others with the skills to work effectively with people with serious mental illnesses and their families.

## **Key Issues**

### Research and Evidence-based Practice

Increasingly mental health nurses are required to engage in practice that is evidence-based and values-driven. However, the evidence for much health care practice is limited and nursing as a profession has traditionally had only limited success in securing research funding to improve this. There remains a need for a sustained effort in building research capacity and capability within the profession.

The fundamental reason for developing research capacity in community mental health nursing is to provide a better care experience for those in receipt of services. As community mental health care develops in evermore diverse ways it is essential that nurses have the evidence necessary to enable them to provide modern, user-informed and research based services. The focus on developing research capability has ensured that nurses are more conversant with research language, can better interpret research findings and can determine how and when to apply them to practice. Developing research capacity to enable community mental health nurses to research their practice, determine what works with who and when, understand the organisational and delivery contexts of mental health provision and develop new ways of working with services users and other disciplines remains an important and underdeveloped task. Opportunities to develop research capacity must include funding for clinical research careers, academic research fellowships, specific targeted funding streams to develop the evidence base in community mental health nursing as well as enhancing opportunities to engage in inter-disciplinary research.

### Perceptions of Mental Health Services

There is generally poor understanding by other professionals (including other community nurses) of the working practices, values and capabilities of nurses working in the community mental health field.

Mental health services have suffered from a lack of long-term investment, and remain vulnerable to NHS financial contingencies. There is also a perception in the field that other areas of health care are afforded higher priority<sup>73</sup>. Mental health nursing suffers

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<sup>72</sup> United Kingdom Central Council for Nursing Midwifery and Health Visiting (2001) Standards for specialist education and practice. UKCC, London

<sup>73</sup> Wales Audit Office (2005) Adult mental health services in Wales: a baseline review of service provision. Wales Audit Office, Cardiff

from low morale and high levels of occupational burnout<sup>74</sup> and associated difficulties in recruitment and retention.

### Organisation and Provision of Mental Health Care

Organising and providing mental health care in an effective manner is hindered by NHS and local authority interface challenges, including the lack of shared: funding cycles; organisational boundaries; integrated systems for leadership and management; information technologies; and mechanisms for organising the assessment and meeting of need<sup>75</sup>. The fragmented character of the system of mental health care, in which services are delivered by multiple agencies, teams and professional groups, challenges efforts to promote continuity<sup>76</sup>.

### Education and Training

To support future developments in services and practice, future education for community mental health care will need to be flexible and include non-classroom, e-learning, approaches. Future education programmes will also need to reflect the increasingly specialised, interprofessional and capability-based context in which community mental health nurses work. Community mental health nursing programmes should be delivered as much as possible in tandem with post qualification courses for other mental health professionals and these courses should be designed and informed by service user perspectives of care provision.

## **Conclusion**

People with mental health problems have rights which are equal to those of other members of society yet they remain amongst the most vulnerable and excluded sections of the community. Nurses specialising from the point of registration in the care of people with mental health problems aspire to provide values-based, evidence-informed and recovery-oriented services which meet complex health and social care needs in both community and institutional settings.

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<sup>74</sup> Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Jugessur, T., Fothergill, A. and Coyle, D. (2006) 'Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses', *Journal of Clinical Nursing*, 15, 8, 1007-1015.

<sup>75</sup> Hudson, B., Hardy, B., Henwood, M. and Wistow, G. (1999) 'In pursuit of inter-agency collaboration in the public sector: what is the contribution of theory and research?' *Public Management*, 1, 2, 235-260.

<sup>76</sup> Freeman, G., Weaver, T., Low, J., de Jonge, E. and Crawford, M. (2002) Promoting continuity of care for people with severe mental illness whose needs span primary, secondary and social care: a multi-method investigation of relevant mechanisms and contexts. National Coordinating Centre for NHS Service Delivery and Organisation RandD, London

## Chapter Eight

### e-Health

#### Bill's Story

More people are living with one or more long term conditions such as diabetes or dementia. One third of adults have at least one long term condition and two thirds of these are over 60. Often these same individuals are heavy users of health and social care services.

Bill Roberts is one of these people; he is 47 years old and has been diabetic for 30 years. He has suffered many of the complications that can occur as a consequence of his condition including:

- Damage to his kidneys so he needs dialysis three times a week
- Damage to his eyes so his vision is impaired
- Damage to the nerves in his legs resulting in poor sensation.

Bill also has high blood pressure and takes a number of medications each day. He spends a lot of time in and around hospitals. Apart from his attendance for dialysis treatment he attends multiple clinic appointments and is admitted 5-7 times a year. He knows that many of these admissions are because treatments have been started with the best intention but have often been informed by poor information.

Bill's paper case notes are enormous and are often in the wrong place or are too big for the key piece of information to be found. This situation results in questions like 'what did they say in the eye clinic?' 'how is your dialysis going?' or 'has anyone changed your tablets since we last saw you'. Patients are regularly asked similar questions – it is no surprise that they ask themselves 'surely they should know that without having to ask me?'

Ideally Bill would like to receive most of his care nearer to or actually at home. Supporting community nurses and other staff who work with patients in or near their homes is vital for people like Bill.

Informing Healthcare has played a leading role in defining the information and information technology that is needed to better care for people like Bill.

## Background

The Review of Health and Social Care in Wales (Wanless Report) stated unequivocally that increased ring-fenced, investment in Information Technology (IT) has to be made if improvements in the delivery of healthcare services are to be achieved. The current total Information and Communication Technology spend in NHS Wales is less than 1% of the NHS Wales annual budget, which Wanless recommended should be significantly increased.<sup>77</sup>

However, the technology systems (IT) alone are not enough: whatever the application, the single most important factor in realising the potential of eHealth is the people who use it.

The Information requirements necessary to support the delivery of the Community Nursing Strategy are inherently complex. Any emergent Information Technology (IT) systems needs to be considered in the context of existing electronic systems and services available in primary, community, secondary and tertiary health care environments and also social care and independent care environments.

It is also important to ensure that the content of the systems supports nursing practice and includes the data necessary to support both direct patient care (the “care and share” function) and the subsequent analysis of aggregated data for outcome identification, resource management, and policy development (the “measure and compare” function). Many information systems in current use are focused on administrative and medical information. Without the inclusion of nursing data (and that of other healthcare disciplines) the record of patient care is not comprehensive and the aggregated data is inadequate for secondary functions. Professional nurses and health care support staff working in the community need appropriate information services with the correct functionality to meet their direct requirement to treat patients / clients and to meet the management requirement for information in relation to the quality of healthcare service provision and performance and activity. The information service of choice should be governed by local need and the perceived benefits of both static and mobile systems and devices.

## Current Position

The prerequisites to enabling the delivery of technology supported healthcare involve; defining the clinical and business requirements including the design of the planned service, the process for the delivery of the service, and, critically, the preparation of the users. Research has shown that the single most important factor in realising the potential of Information Technology in healthcare is preparing the people who use it. Once these prerequisites have been met the information requirements, which must be person centric not organisationally focused can inform the acquisition of an appropriate technology system. The cornerstone of the approach described above is design informed by clinicians, the defining of standards and data sets must be informed by this process.

At present few systems in use adequately support or describe nursing practice. Systems which do include nursing tend to be hospital focused and do not take account of the much

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<sup>77</sup> Welsh Assembly Government (2003) Review of Health and Social Care in Wales. Welsh Assembly Government, Cardiff

wider range of patient problems that community nurses deal with nor of the environmental constraints under which community nurses have to work. Current (paper-based) documentation systems do not adequately support either the primary purpose of supporting integrated care or the secondary purpose of providing the evidence about nursing practice on which decisions about service planning or resource management could be based. The introduction of electronic health records provides an opportunity to overcome these problems – provided that decisions about systems are made early, and that nurses are educationally prepared to understand and use the required new ways of working.

Ensuring that nursing, midwifery and specialist community public health nursing has the opportunity to influence the design, development, testing and implementation of new technological methods to deliver improved care for patients and clients is a key principle of Informing Healthcare's strategic framework for engaging nurses in this change management agenda.

The information technology activities to support the delivery of care as identified within this strategy must be taken forward as part of the national technology architecture via a national infrastructure, this will provide better value for money and improved patient / client care.

## Key Issues

It is widely acknowledged by the nursing profession that within the current health and social care environment there are a number of constraints to the effective use of information technology to support the delivery of care. These constraints include:

- poor access to information technology systems
- the range of systems needed to address the effective management of available patient / client information
- the variability of staff skills and experience in the use of technology
- the need to ensure appropriate education and staff training

A literature review by Oroviogicoechea<sup>78</sup> showed that IT systems that are to be used by nurses must take account of issues such as attitude and culture as well as broader technological solutions for effective implementation to occur. Clark<sup>79</sup> and Hannah<sup>80</sup> amongst others have declared that nurses have to be at the forefront of informatics development and need both greater awareness and involvement to ensure the benefits to the nursing profession are fully realised.

Evidence suggests that involving nurses particularly those that are able to facilitate change can lead to transformations in the use of information and communication

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<sup>78</sup> Oroviogicoechea C, Elliott B, Watson R (2007) Review: evaluating information systems in nursing, *Journal of Clinical Nursing* 17: 567-575

<sup>79</sup> Clark J (2008) Embrace new technology or others will decide how we end up using it (letter). *Nursing Standard* 22(17): 32.

<sup>80</sup> Hannah K, Ball M, Edwards M (2008) *Introduction to Nursing Informatics*. (Third Edition) Springer Press, New York p2-10

technology<sup>81</sup> particularly as surveys from a number of countries have shown that frontline nurses are not necessarily confident or have the necessary skills in using information technology<sup>82</sup>.

Equally studies have shown that nurses do have a positive attitude towards learning to use technology<sup>83 84</sup>. The essential requirement to involve nurses in developments and use of information technology to support clinical care in the Welsh context is fully supported by senior nurses in Wales.

### **Use of Information Technology and e-health to support community nursing**

Utilising information technology to support the implementation of better and safer person centric care via the Community Nursing Strategy requires the following:

- Nurses having appropriate access to information
- Nurses that are adequately prepared to understand and use these systems
- Technology systems that support improved communication within and between health and social care organisations
- Appropriate and accurate analysis of data to improve service design and delivery

These requirements and the specific requirements of community nurses cannot be met immediately or indeed with one system.

In addition to the technical aspects necessary to deliver workable solutions for better and safer delivery of care for example network availability and security and Information Governance requirements, the importance of education (in addition to training), professional guidance, professional regulation, organisation and individual accountability and current pertinent legislation must not be underestimated.

The term e-Health covers all applications of Information Communication Technologies (ICT) in the delivery of healthcare including:

- Access to knowledge sources to ensure evidence based care and nurses' own continuing education and professional development;
- Patient and professional access to knowledge sources for patient information;
- Decision support systems;
- Communication and information sharing with patients and other care providers;
- Remote consultation between professionals (e.g. remote diagnosis) and between professional and patient (e.g. "virtual visiting");
- Transmission and electronic storage of images (e.g. X-rays, pictures of wounds);

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<sup>81</sup> Courtney K, Alexander G, Demiris G (2008) Information technology from novice to expert: implementation implications. *Journal of Nursing Management*; 16:692-699.

<sup>82</sup> Cole I, Kelsey A (2004) Computer and information literacy in post-qualifying education. *Nurse Education in Practice*, 4: 190-99

<sup>83</sup> Hillan E, McGuire M, Cooper M (1998) Computers in midwifery practice: a view from the labour ward. *Journal of Advanced Nursing* 27: 24-29.

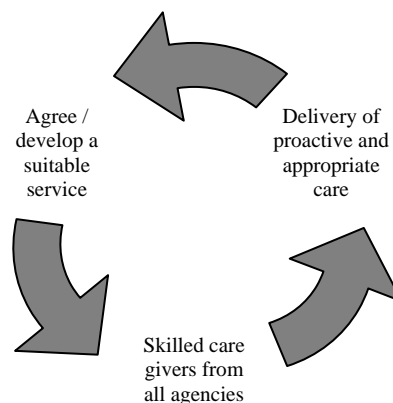
<sup>84</sup> Ward R, Moule P (2007) Supporting pre-registration students in practice: A review of current ICT use. *Nurse Education Today* 27: 60-67.

- Electronic patient records;
- Electronic administrative and business systems;
- Secondary analysis of aggregated patient data for planning and management purposes;
- Telecare (i.e. the delivery of healthcare to individuals within the home or wider community with the support of devices enabled by ICTs).

All of these applications are available now, although not all are yet available in Wales. All of them require new ways of working. While some nurses welcome these changes, others will see them as a threat to longstanding practices and professional values. For example, the use of e-Health requires changes in the management of the nurse-patient relationship. Both patients and nurses value the traditional face to face encounter which may now be replaced by a relationship managed remotely, or by the “intrusion” of a computer as a “third party” in the consultation. This requires the development of new communication skills, but it also requires that the ICT device is appropriate for the particular environment and that the professional is confident and comfortable with its use.

Current and suggested community nursing service configuration has been outlined in previous chapters, the purpose of this chapter is to advise how IT can support this service redesign. It is suggested that the emphasis on new ways of working should include the key elements illustrated in Figure 10.

**Figure 10: New Ways of Working**



New service models must recognise the need to provide community services that; increase safety for patients and the public, deploy staff with appropriate skills in the most effect and efficient way and in addition have a robust methodology for measuring and monitoring performance, e-Health (which includes all applications of ICT in health care) has enormous potential for achieving these aims.

Within the context of the current e-health position in Wales, necessary to support the community nursing strategy, some general principles have been identified and are presented as a framework to inform the solutions for the issues identified.

## **General Principles to address the e-health agenda in support of the community nursing strategy:**

1. There must be availability of and access to up to date, evidence based knowledge to support the delivery of modern health and social care services.
2. Nurses must have adequate access to technological systems and tools that support nursing practice and all relevant activities relating to their care of patients.
3. Nurses must have access to information about an individual persons care at the point of care.
4. Information about specific groups of the population must be available to inform appropriate service design.
5. Efficient and effective communication channels need developing between patients / clients and care givers and between professional groups that provide care.
6. The design of technical applications must include the availability of functions that support professional decision making and recording of the decisions.
7. Electronic patient records must support nursing practice, and must include all relevant nursing data, including the nursing assessments, the patient's nursing needs and problems, nursing decisions and interventions, and the results of nursing interventions, and must be structured in such a way that these elements can be easily identified and linked, for example in decision support systems.
8. Terminology used in electronic patient records must include relevant nursing concepts alongside those of other disciplines.
9. There must be appropriate levels of training and education for nurses at both pre and post registration in the application of information technology to support clinical practice.
10. The effect of interventions supported by technology in relation to the delivery of care and service improvements must be measured and monitored.

This next section of the chapter illustrates how the application of the principles supports the delivery of better and safer person centric care using IT.

### **Access to up to date, evidence based knowledge**

The efficient and effective collection, retrieval, analysis and communication of information will enable informed decisions to support treatment and care planning options and will provide the data necessary to support service planning and resource management. Knowledge management and the subsequent development of knowledge management tools will:

- provide the evidence upon which the care given can be informed
- support clinical audit;
- the evidence to support service planning and resource management, and
- assist with research and development activities.

In addition, signposting the general public to recognised web sites that provide evidenced based standardised information has the potential to enhance individualised patient / client centred care planning and to improve the self management of care.

The following initiatives support the availability of evidence based knowledge:

- e-library;
- Online clinical knowledge resource e.g. the Map of Medicine; and
- NHS Direct Wales Patient Portal, this is a public and patients' website which focuses on individuals and their dependents health and health service needs. The portal includes sections on; health information, Directories of services, links to other NHS websites and public health alerts.

### **Access to information about an individual persons care**

Supporting staff to undertake their day to day activities through the capture of real time standardised patient / client information, available to all nurses working in the community, should be the ultimate goal. Nurses need to be able to receive and record information at the point of care; for community nurses, the provision of appropriate devices such as laptops, mobile computers with touch screens/graphic tablet screens, or Personal Digital Assistants (PDAs) is essential. This functionality is already available to community nurses in some places.

Work has been undertaken in Wales to enable, with appropriate consent, an individuals GP health record to be available in emergency care settings. This initiative has been beneficial in providing safer patient / client care and is being rolled out across Wales in out of hours settings. The further development of this work includes the availability of the Individual Health Record in the Royal Gwent Hospital's Medical Assessment Unit. This pilot is being closely monitored and early indications suggest that nurses and doctors are seeing immediate benefits.

The importance of supporting the public to access GP services and to achieve a greater sense of ownership of their clinical record is fully appreciated by the National Programme (IHC). A pilot initiative, My Health on Line (MHoL) has been undertaken in Wales and the results of this work, in particular, in patient access to e-services, is being incorporated into a Business Plan to inform a potential national solution.

### **Access to information about specific groups of the population**

The ability to access accurate information about specific groups within the population and subsequently to introduce a more community focused service for patients / clients is a challenge for health and social care service providers.

Work is currently underway to develop a tool that will assist in the identification of people at risk of an emergency admission to hospital and those in need of additional packages of care. The Predictive Risk Stratification Model, known as Prism, will use existing population and health data to band the population according to the level of risk of emergency admission, this information will help to inform proactive care management.

### **The development of efficient and effective communication channels**

New and emerging plans for the redesign of services need to consider the linkages and impact of information technology to these services some examples of progress that has

been made in Wales to enhance communication channels are included in this section of the chapter.

NHS Wales' Digital All-Wales Network, dawn2, has provided an excellent foundation for Health over the past 7 years, where some aspirations of having a true multimedia network have already been realised. The new Public Sector Broadband aggregation initiative which brings information technology networks supporting health, education, local government and other local services in Wales together into a single network will enhance the delivery of services in Wales.

Managing the information available within and between health, social care, independent and voluntary sector organisations and other public sector organisations is fundamental to the creation of improved service design necessary to support the people of Wales.

The exchange of clinical information electronically, for example e-referrals and discharges is currently being evaluated in Wales. This initiative, the Welsh Clinical Communications Gateway Project (WCCG), which is based on the Scottish Care Information Gateway model, is currently being piloted. Early indications suggest that the WCCG has the potential to enable a more effective technical interface between health and social care.

Using e-mail as a communications tool has become an essential part of working practice for many working in the NHS. The national e-mail and directory service enables a single secure login to be created so that staff can access systems and services regardless of where they are working. The National Active Directory and E-mail exchange is being rolled out across Wales during 2008/2009.

The term telecare is used to refer to the use of devices in patients' normal environments (e.g. in their own homes, or on their bodies) for monitoring physiological or environmental signs to provide alerts (followed by appropriate intervention) to deviations from normal. The most common application is probably falls monitoring, but applications are rapidly expanding to include "smart" houses in which alerts are triggered by, for example, doors opening or changes in temperature. These applications have great potential for supporting independent living for elderly, infirm, or disabled people (including those suffering from dementia). In Wales telecare has been developed primarily within social services, but clearly has great potential for community nursing.

The use of assistive technology has been shown to improve the independence of patients and clients and these developments will be particularly important for those patients and clients living in remote areas.

Some examples of telecare initiatives currently available include:

- A six month trial, part of the European Commission funded project called 'Better Breathing' which involves patient with chronic obstructive pulmonary disease using telehealth equipment to measure their own vital signs and send results via a free- phone telephone line to a chronic disease management nursing team; and
- Video conferencing links are being used across Wales, specifically in Cancer care.

## **The provision of and access to technological systems and tools**

There are a number of system options that could be used to support the delivery of community care. It is not within the remit of this paper to comment on the applicability of the systems currently available, though it is recommended that a review of the existing systems available in Wales should be undertaken.

It is important to note that in the short to medium term no single system will meet all the requirements of community staff and consequently an evolutionary approach, using the most appropriate technology platform (both fixed and mobile) will be necessary, these platforms include:

- The Welsh Clinical Portal - this approach would be flexible, though owned by the Trust and in the short term to medium term there would be no General Practice information available within the system.
- Existing GP Systems – these systems are fully functioning for use within the Practice, in some geographical areas information from these systems is available in unscheduled care settings at present, though this information is not universally available to community staff and does not link to Trust Information Management and Technology systems.
- Specific community systems – this bespoke approach meets the requirement for service level information and some care planning activity. The systems that are operating within some Trusts, in time need to be made aligned to the national architecture.

Each of the options presented i.e. the use of the Welsh Clinical Portal, the use of existing GP Systems, the use of Specific Community Systems or a combination of options for example a bespoke community system operating from within the Welsh Clinical Portal or the extension of the GP systems should be appraised for its suitability to deliver improved patient / client care and service delivery.

All these requirements depend on the availability of appropriate IT devices and of the 24/7 technical support to ensure continuity of use. It must be recognised that community nurses have special requirements over and above those which pertain to hospitals. A desktop portable computer in an office base is of limited use to a community nurse who leaves base at the beginning of the day and may not return to it until the end of the day and who may require facilities to print in addition to recording patient information.

Community Nurses undertake wide ranging activities, supporting these activities with technology requires both fixed and mobile platforms. Some examples of current and future technologies required for a reliable mobile platform include mobile telephones, geographic position systems and wireless and satellite technologies as well as laptops, tablets and PDAs.

It is essential that any of the approaches suggested are linked together to ensure that information can be shared reliably and securely and this requires an underlying fixed and mobile infrastructure that can support care delivery across the range of care settings.

There are additional considerations with respect to each of the options presented including; the financial investment required by NHS Wales; development and delivery timescales and the interoperability of systems within and outwith the healthcare environment.

### **The availability of functions within technical applications to support professional decision making**

Supporting professional decision making with technical applications has been proven to be efficient and effective. Functions that are available to improve safety include alerts and warnings for example alerts relating to administration of medications. As more complex care is delivered in community settings, including people's homes this functionality will be extremely important.

### **Appropriate levels of training and education for nurses.**

The training and education of nurses to support the community nurse strategy is the subject of a separate chapter and indicates that there are opportunities to inform the newly emerging career structure for nurses, midwives and public health specialists. Whatever the specific requirements for preparation for community nursing, it is critically important that preparation for practice in an electronic world is embedded in all educational programmes at all levels. Training in basic IT skills where necessary and specific training for use of specific systems are essential, but the biggest challenge is to embed within all educational programmes an understanding of information management, information governance requirements and the underlying principles upon which information systems and the proper use of IT in healthcare depend. Proposals for the inclusion of competencies relating to e-health need to form part of this development.

### **Methodologies for measuring the effect of interventions supported by technology**

Audit packages, scheduling systems and the development of intelligent performance indicators are potential methods for measuring the effectiveness of interventions supported by technology.

The Community Health Across Agencies Project (CHAAP) that is underway in Powys is looking at information flows, data capture, data storage, performance monitoring reports, data sharing, additional information available for community staff and changes to working practice. The outcomes of this work will be important in the context of the emerging community strategy.

It is important to learn from the experience of other countries. Scotland has undertaken a great deal of work on developing systems for community nursing, including a recent "Community Nursing Census"<sup>85</sup> which, in addition to providing a great deal of useful information about community nursing in Scotland, has included the development and testing of various methodological issues such as the development of clinical templates and the use of standardised terminology for community nursing. Preliminary discussion with the nurses responsible for this work has suggested that it would be possible to replicate, and perhaps build on, some of this work in Wales.

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<sup>85</sup> <http://www.isdscotland.org.isd/5373.html>

Work currently being undertaken by the health statistics department of the Welsh Assembly Government, aims to establish the information requirements needed to support community health and chronic condition management and will be important in the context of the community nursing strategy to ensure the development of useful outcome measures.

## Chapter Nine

### Education

#### Background

This chapter outlines the current position regarding the provision of education for nurses working in a community environment in Wales. It considers the direction of travel indicated by key policy documents and identifies a framework for future community nurse education that is based on developing safe and competent practitioners able to deliver care across the continuum of acute and community care. The framework acknowledges role and career progression horizontally and vertically across the 4 levels of the Pyramid of Patient Need (Figure 1). It is based on the Skills for Health Career Framework<sup>86</sup> and the work outlined in Supporting the Development of Advanced Nursing Practice, developed by the Scottish Government<sup>87</sup>. It also takes cognisance of developments in Wales pertaining to specialist and advanced roles.

#### Policy Perspective

Major policy documents such as Modernising Nursing Careers<sup>88</sup>, the Framework for Post-registration Education<sup>89</sup>, Designed to Realise our Potential<sup>90</sup>, Role Redesign in the NHS in Wales,<sup>91</sup> the Skills for Health Career Framework<sup>92</sup> and relevant national service frameworks and policies /discussion papers relating to mental health services in Wales and the work currently being undertaken by Welsh Assembly Government on generic, specialist and advanced practice, have influenced the development of this chapter.

The Community Services Framework and Designed to Improve Health and Management of Chronic Conditions in Wales<sup>93</sup> clearly identifies the actions needed to reform service delivery, and the educational framework designed takes into consideration new models of care delivery outlined previously in the strategy. It identifies a framework to support nurses in the delivery of this agenda and seeks to address:

- The move of acute services to the community with the nursing workforce following the patient across all settings (DoH 2006);

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<sup>86</sup> Skills for Health (2006) Career Framework. London: Skills for Health

<sup>87</sup> Scottish Government (2008) Supporting the Development of Advanced Nursing Practice; A toolkit approach. Scotland: Scottish Government

<sup>88</sup> Department of Health (2006) Modernising Nursing Careers: setting the direction. London: DoH

<sup>89</sup> Welsh Assembly Government (2008) Post-registration Career Framework for Nurses in Wales. Cardiff: Welsh Assembly Government

<sup>90</sup> WAG (2008a) Designed to Realise our Potential: A “beliefs and actions” statement for nurses, midwives and specialist community public health nurses in Wales for 2008 and beyond. Welsh Assembly Government, Cardiff

<sup>91</sup> NLIAH (2007) Standards and Guidance for Role Redesign in the NHS in Wales. National Innovation and Leadership Agency for Healthcare, Workforce Development Unit, Cardiff.

<sup>92</sup> Skills for Health (2006) Career Framework. London: Skills for Health

<sup>93</sup> WAG (2007) Designed to Improve Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework. Welsh Assembly Government, Cardiff

- A lifespan approach that includes a focus on public health and self care through to the management of acute and chronic conditions across the four levels within the Pyramid of Need<sup>94</sup> A career framework that allows nursing to 'grow its own'<sup>95</sup> and to follow an established model of progression based on Skills for Health;
- A balance of generalists and specialists;
- Standardisation of specialist roles, advanced practice and consultant roles to enable education programmes and employers to plan services effectively;
- Flexible programmes with a balance of blending learning methodologies to meet service needs.

## Current Educational Provision

At a pre-registration level, students undertaking a Bachelor in Nursing (Hons) to prepare them to become a level 1 nurse working in adult, mental health, learning disability or child nursing undertake a component of primary/community care education as part of the programme. The percentage of the course allocated to nursing in a community setting is variable across Wales and expansion of community clinical experience is restricted by the small number of clinical areas available and the slow re-configuration of services.

There have been moves to be creative and use a variety of settings within the community, for example, schools and nurseries have been used for children's nursing students. Whilst this allows for an insight into social and environmental issues, placements outside of clinical care can restrict opportunities for clinical learning outcomes to be achieved. Some GP practices are used to place nursing students and many provide excellent learning opportunities and mentorship, however, these opportunities are limited depending entirely on the goodwill of the employer. Lack of financial incentives offered to practices and the time required for GP employed staff to facilitate student learning, are some of the reasons why these placements are not made available. The theory component related to nursing in a community environment has been substantially increased in all curricula across Wales, approved in 2007, by the Nursing and Midwifery Council.

Midwifery pre-registration programmes prepare midwives to work across acute and community settings and placements to facilitate the application of theory to practice in all environments are available to accommodate current Welsh Assembly Government funded numbers. Should numbers of midwifery students increase then this position would need to be further evaluated.

The qualified nurse is currently provided with opportunities to access a number of different programmes to prepare them to provide care in the community. The predominant course across Wales is the Specialist Practice Programme (SPQ) in community health nursing. These programmes are NMC approved and prepare nurses to work as district nurses, community mental health nurses, community children's nurses, community learning disability nurses and practice nurses. SPQ courses are normally offered at Bachelor's level (or at Master's level in some HEIs), are funded by the Welsh Assembly

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<sup>94</sup> Welsh Assembly Government (2007) Designed to Improve Health and the Management of Chronic Conditions in Wales. An Integrated Model and Framework. Welsh Assembly Government, Cardiff

<sup>95</sup> Department of Health (2006) Modernising Nursing Careers: setting the direction. Department of Health, London

Government and numbers entering the programme determined by workforce planning figures. However, the capacity to increase SPQ and SCPHN numbers is limited by the number of Clinical Practice Teachers (CPTs) and sign-off mentors available and there needs to be investment in these areas to support capacity building in the community.

The course is offered full- and part-time, is based on the NMC outcomes for community specialist practice and the clinical component is supervised and assessed by a CPT or a sign-off mentor. Availability of CPTs/ sign-off mentors is variable across disciplines and this can act as a barrier to increasing the numbers entering the course. It is generally felt the SPQ programme is outdated, inflexible and in need of modernisation to meet the changing health care agenda.

SPQ courses for mental health nurses have been vulnerable to criticism. Courses attract mental health nurses from all fields of practice (including locality-based adult services, functional specialist services, services for young people and services for older people). Coupled with the expectation that courses meet the educational needs of nurses working in these distinct speciality areas, SPQ courses are also expected to contain an element of generic community nursing preparation, with between one third to two thirds of total course content being delivered to community mental health nurses alongside other community nurses. Whilst initiatives to include inter-professional education in SPQ courses have been developed<sup>96</sup> nurses on SPQ programmes typically have no opportunity to spend university-based time learning alongside members of the other professions also working in the mental health field.

Education to prepare SCPHN is also available at either Bachelor or Master's level throughout Wales. Courses were developed in response to the establishment of Part 3 of the NMC register and in some HEIs some learning is shared with the community SPQ programme. It provides education for health visitors, school nurses and occupational health nurses. The majority of health visitor and school nurse places are funded by the Welsh Assembly Government however funding for occupational health nurses remains an issue and one which the government may need to address to actively promote the health of the working age population. Opportunities for school health nurses to access the SCPHN course are also somewhat limited, due to inadequate funding and workforce pressures. The development of a family nurse service in Wales<sup>97</sup> will require resourcing if it is to succeed in meeting the needs of the children in Wales.

Some of the difficulties associated with the SCPHN programme reaching out into areas where it may be most needed relate to the lack of clinical placements available and the difficulty in identifying appropriate CPTs/ mentors. For example, in occupational health, nurses employed by private contractors find great difficulty in acquiring funding and study time to undertake the programme. The same can be said for nurses working in general practice settings and school nurses.

In addition to approved NMC community programmes, there are a variety of courses offered that fall under BSc and MSc post registration frameworks. The majority of HEIs in

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<sup>96</sup> Fowler, P., Hannigan, B. and Northway, R. (2000) Community nurses and social workers learning together: a report of an interprofessional education initiative in South Wales. *Health and Social Care in the Community*. 8 (3) 186-191

<sup>97</sup> Welsh Assembly Government (2008) *The development of a family nurse service for Wales*. Welsh Assembly Government, Cardiff

Wales offer such programmes that prepare nurses for specialist and advanced practice. There is however, disparity regarding academic level and level of practice, with confusion regarding specialist and advanced practice educational provision. Master's programmes usually prepare nurses for advanced practice and cover acute and primary care and mental health issues. Education for consultant nurse roles is perceived to be at doctoral level and the subject of choice is left up to the individual to determine.

In relation to midwives, there is a variety of courses available to advance practice. These are ad hoc and do not normally fall under any SPQ or community framework. Midwives usually access relevant BSc or Master's programmes that prepare them for specific elements of practice. Consultant midwives access professional doctorates or undertake a PhD in a relevant area.

PhD's and Professional Doctorates are provided across Wales for consultant nurses/ midwives. These programmes allow practitioners to research an area relevant to their practice and thus develop leadership and research skills.

The main issues that require addressing in relation to preparing the future nursing workforce are:

- Adequate educational preparation to prepare nurses to work safely and competently across acute and community care settings;
- Modernisation of existing community SPQ programmes;
- Clarification and agreement regarding levels of practice and new roles in the community, from generalist through to specialist, and novice to advanced (expert) practice;
- A framework of education that supports role and career development and service re-design and promotes multi-professional learning.
- Central resources to support learning in practice for all nurses who work within a community setting

## **Key Issues**

The Skills for Health Career Framework has been adopted for the development of the educational framework. This is based on the following 9 levels and the academic level of education required for practice at the different levels, has been added in Table 3.

The National Framework for the Education and Training of HCSWs was launched in 2006.<sup>98</sup> Within the NHS each HCSW employee should have a Knowledge and Skills outline showing the competencies they have achieved and those they should be working towards. The difficulty is that not all HCSW posts have yet been given these outlines and very few HCSWs have had the opportunity to be assessed against them. Furthermore provision for HCSW training across the different health organisations in Wales is mixed. It would be useful for the Welsh Assembly Government to monitor HCSW qualification levels and training provision across the NHS in Wales.

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<sup>98</sup> Health Professions Wales, Welsh Assembly Government, Skills for Health and CQFW (2006) Consultation Document: Part 1 National Framework for the Education and Training of Health Care Support Workers in Wales. Health Professions Wales, Cardiff

**Table 3: Skills for Health Framework and required Academic Levels of Education**

Skills for Health Framework Level	Role	Academic level of education required
Level 9	Very senior staff	Professional Doctorate/ PhD
Level 8	Consultant practitioner	Professional Doctorate/ PhD
Level 7	Advanced practitioner	Masters degree
Level 6	Senior practitioner/ Specialist practitioner	Masters or Bachelors degree
Level 5	Practitioner	Bachelor degree
Level 4	Associate practitioner	NVQ
Level 3	Senior healthcare assistant	NVQ
Level 2	Support worker	NVQ
Level 1	Initial entry – for example cadet	Not relevant

The educational framework presented is combined with the Scottish Toolkit for advanced practice.<sup>99</sup> The proposal in this strategy integrates linear and horizontal development to accommodate the changing specialist and advanced roles in community nursing, whilst facilitating career progression in relation to generic as well as specialist practice.

**Figure 11: Relationship between Specialist and Advanced Practice**

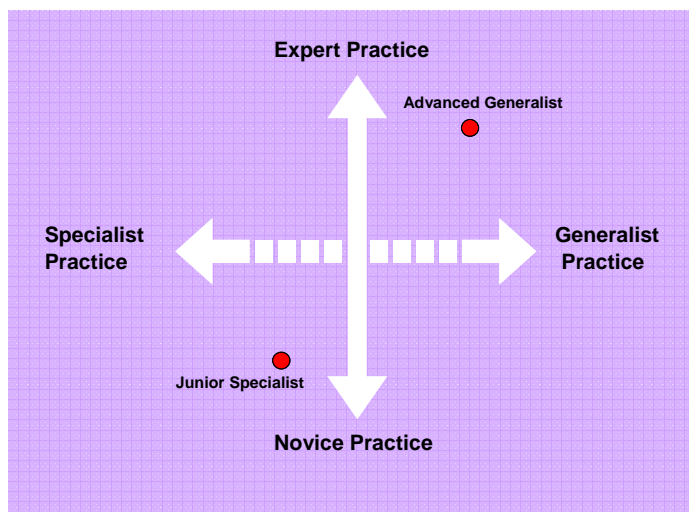


Figure 11 illustrates that a nurse following a generic career in practice may work towards becoming an advanced generalist. The percentage of roles that fall into each category will be dependent upon the areas of practice. There is a clear distinction between specialist and advanced roles outlined in the Scottish Framework. Specialist practice is defined as the focus of an individual’s sphere of practice be it client group, skills set or organisational context. Advanced practice is described as a nationally agreed level of practice denoting

<sup>99</sup> Scottish Government (2008) Supporting the Development of Advanced Nursing Practice; A toolkit approach. Scotland: Scottish Government

expertise and possession of advanced knowledge and skills not exclusively in the clinical domain, but also encompassing individuals working in research, education, managerial/ senior management roles.

Educational programmes will aim to prepare nurses for these roles, with separate and clearly defined parameters relating to specialist practice, advanced practice and consultant roles. Figure 11 illustrates the possible advancement of nurses through generalist and specialist roles into an advanced practice role, whilst working towards expert practice.

### **Education for Skills for Health Level 5/6 (Practitioner/Senior Practitioner)**

Pre-registration nursing and midwifery programmes have been revised to prepare nurses to work in any setting, however further work is required to accommodate changes made to health care delivery as a result of service re-design. This is likely to result in further modifications to pre-registration nursing and midwifery programmes to ensure students at the point of qualifying are equipped with the skills and knowledge to work across acute and community settings with confidence. What is also necessary is further work and re-allocation of resources to ensure the provision of adequate clinical placements to support learning in practice. Midwifery programmes already prepare student midwives to work in any environment.

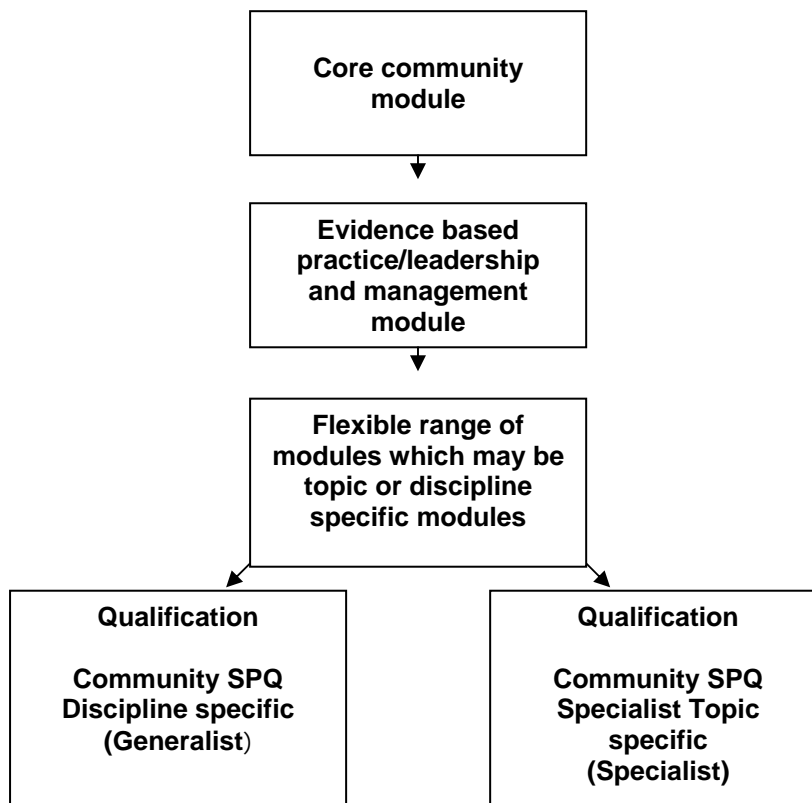
Until such a time that the nursing workforce is prepared at a pre-registration level to deliver re-configured services, a core module has been developed as part of the National Innovation and Leadership Agency for Healthcare's (NLI AH) project to develop community nursing education. This is a 30 credit module at first degree that is suitable for all nurses whose work involves the provision of care in a community environment, but who do not hold an SPQ community qualification. It can also be used to assist with service re-design and prepare nurses working in acute settings to work in the community. It has been designed to be APELed (accreditation of prior experiential learning) into an SPQ qualification in the future, whether this is planned at first degree or Master's academic level. The core module can form a springboard for nurses to build upon to undertake other modules relevant to practice. This can help scaffold learning towards the achievement of a degree/ masters qualification whilst meeting the diverse needs of practice across the Pyramid of Need. For example nurses may choose to undertake modules such as Diabetes, Asthma, Cognitive Behavioural Therapy etc to provide them with the expertise to delivery specialist or generic care in the community.

The SPQ programme for community nurses (excluding SCPHNs) will be re-designed as a second phase of the NLI AH project, and will allow for inclusion of the core module within it. The core module can then be undertaken as a 'stand alone' module or as a module within an agreed SPQ programme. The SPQ programmes developed will be modularised allowing for flexibility and variety in modules accessed. The academic level of such programmes may be developed at Bachelor's or Masters level.

The new framework for programme for nurses whose role involves working in the community is outlined below in Figure 12. This model would allow nurses to become a discipline specific 'generalist' – for example a district nurse, or practice nurse, or community mental health nurse, or community learning disability nurse or community children's nurse. It would also allow nurses to follow topic related modules suitable for

specialist practice in the community, such as Diabetes, Cognitive Behavioural Therapy etc., thus preparing the specialist practitioner. The modules developed will prepare nurses to deliver care according to the 4 levels of patient needs outlined in the aforementioned Pyramid of Need. All modules will be available as 'stand alone' modules which can be accessed outside of the community SPQ framework. To enable this model to be successful, central government funding for all modules must be made available.

**Figure 12: Community SPQ - Educational Framework**



**Education for Skills for Health Level 6/7 (Advanced Practitioner)**

The academic level outlined for nurses working at an advanced level is Master’s. A portfolio of Master’s level modules will be developed that is responsive to service needs and the four areas outlined in the Pyramid of Need, Master’s modules can be undertaken as ‘stand alone’ modules or as part of a whole Master’s. Through a modularised approach qualified nurses may undertake modules that prepare them for either advanced generalist or advanced specialist roles and to work towards the achievement of expert practice.

Programmes of education to prepare the advanced practitioner will be planned around the following pillars:

- Facilitated learning and development

- Research
- Leadership and management (case management)
- Clinical/ professional practice

### **The Consultant Practitioner**

Educational preparation for the consultant practitioner is a PhD or professional doctorate. The area of research chosen must be pertinent to the specialist area of practice in which the consultant practitioner works. Links with local Universities to engage in research and the delivery of education will form an important component of this role.

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## Appendix 1: Chair and Membership of the Community Nursing Strategy Task and Finish Group

<b>Chair: Richard Jones</b>	<b>Deputy Director</b>	<b>RCN Wales</b>
Jeni Clarke-Moore	Nursing Officer	Welsh Assembly Government
Gillian Devereux	Professional Officer	Unite the Union
Polly Ferguson	Nursing Officer	Welsh Assembly Government
Ian Ferris	Head of Nursing Directorate of Learning Disability Services	Abertawe Bro Morgannwg University NHS Trust
Vicki Franklin	Executive Nurse	Abertawe Bro Morgannwg University NHS Trust
Beverlea Frowen	Director for Social Services and Health Improvement	Welsh Local Government Association
Dave Galligan	Head of Health	UNISON, Wales
Jill Galvani	Executive Nurse	North Wales NHS Trust
Stephen Griffiths	Interim Director of Workforce Development	NLIAH
Lynne Grundy	Welsh Nursing and Midwifery Committee/Head of Professional Nursing and Education	North Wales NHS Trust
Helen Howson	Senior Health Strategy Adviser	Welsh Assembly Government
Kay Jeynes Chair	All Wales District Nursing Forum/Head of District Nursing	Cardiff and Vale NHS Trust
Rosemary Kennedy	Chief Nursing Officer	Welsh Assembly Government
Carol Lamyman-Jones	Director	Board of Community Health Councils in Wales
Dr Richard Lewis	Welsh Secretary	British Medical Association Wales
Jill Paterson	Nurse Director	Carmarthenshire LHB
Sheila Porter	Head of Integrated Services (Older People and Physical Disabilities), Carmarthenshire County Council	Association of Directors for Social Services Cymru
Bev Thomas	Clinical Director (Nursing)	Informing Healthcare
Sue Thomas	Primary Care Advisor	RCN Wales
Lorna Tinsley	National Officer	Royal College of Midwives Welsh Board
Lisa Turnbull	Policy Advisor	RCN Wales
Ruth Walker,	Executive Nurse	Cwm Taff NHS Trust
Dr Dianne Watkins	Cyngor/ Deputy Head of School, Director of External Relations, Learning and Teaching	Cardiff University
Rosalyn Williams	Health Initiatives Co-ordinator	Age Concern Cymru

## Appendix 2 – Chairs and Membership of Sub-Groups of the Community Nursing Strategy Task and Finish Group

<b><u>Level One of Patient Need</u></b>		
<b>Chair: Vicki Franklin</b>	<b>Executive Nurse</b>	<b>Abertawe Bro Morgannwg University NHS Trust</b>
Bobby Bolt	Nurse Director	Blaenau Gwent LHB
Reena Cartmell	Deputy Director of Nursing	North Wales NHS Trust
Wendy Herbert	Head of Health Visiting	Cardiff and Vale NHS Trust
Marnel Owen	Senior Nurse District Nursing	North West Wales NHS Trust
Jill Paterson	Nurse Director	Carmarthen LHB
Samantha Ray	Health Protection Nurse	National Public Health Service
Fiona Reynolds	Head of Nursing Intermediate Care and Reablement	Abertawe Bro Morgannwg University NHS Trust
Angela Roberts	Strategic Commissioning Manager, Children's Health Services	Wrexham LHB
Delia Roberts	Acting Assistant Nursing Director	Gwynedd LHB
Donna Roberts Walters	Interim Head of Health Visiting	Abertawe Bro Morgannwg University NHS Trust
Annette Sage	Senior Nurse Manager in Occupational Health	Abertawe Bro Morgannwg University NHS Trust
Tanya Spriggs	Senior Nurse	Newport LHB
Rosalyn Williams	Health Initiatives Co-ordinator	Age Concern Cymru
Fiona Wood	Deputy Director of Nursing	Merthyr Tydfil LHB
<b><u>Level Two of Patient Need</u></b>		
<b>Chair: Susan Thomas</b>	<b>Primary Care Adviser</b>	<b>RCN Wales</b>
Lorna Burdge	Practice Nurse Advisor	Wrexham LHB
Sue Dunlop	Senior Lecturer	University of Glamorgan
Helen Earland	Nurse Facilitator	RCT LHB/PCSU
Kath Hier	Senior Nurse	Business Services Centre, SE Region
David Hopkins	Borough Manager	Gwent Healthcare NHS Trust/Caerphilly LHB
Rhian Lang	Practice Nurse	Pontyclun, Rhondda Cynon Taf
Mags Moss	Chronic Conditions Nurse	Cardiff LHB
Amanda Poynton	Practice Nurse	Newport
Tanya Spriggs	Senior Nurse	Newport LHB
Jenny Theed	Nurse Director	Cardiff LHB
Yvonne Thomas	District Nurse,	Ceredigion and RCN Wales Board Member
Carolyn Wallace	Senior Lecturer	University of Glamorgan
Vicky Warner	Nurse Director	Torfaen LHB
Caroline Whittaker	Senior Lecturer	University of Glamorgan
Jane Williams	Senior Nurse Primary Care	Merthyr LHB
Sue Willis	Nurse Director	Wrexham LHB

<b><u>Level Three of Patient Need</u></b>		
<b>Chair: Lynne Grundy</b>	<b>Welsh Nursing and Midwifery Committee/Head of Professional Nursing and Education</b>	<b>North Wales NHS Trust</b>
Jaki Bell	Team Manager, Learning Disability Services	North Wales NHS Trust
Lorna Burdge	Practice Nurse Advisor	Wrexham LHB
Wendy Chaloner	Discharge Co-ordinator	North Wales NHS Trust
Michelle Denwood	Child Protection Nurse	North Wales NHS Trust
Jill Galvani	Director of Nursing and Patient Services	North Wales NHS Trust
Brian Green	Primary Care Lead	Welsh Assembly Government North Wales Regional Office
Isobel Hall	Chair, All Wales Professional Forum for Health Visiting and School Health Nursing	Hywel Dda NHS Trust
Louise Hughes	Professional Development Manager	Abertawe Bro Morgannwg NHS Trust
Liz Pendleton	Senior Nurse Children's Community Nursing Services	Cardiff and Vale NHS Trust
Lynn Prior	Community Services Manager	North Wales NHS Trust
Jenny Theed	Nurse Director	Cardiff LHB
<b><u>Members of the following committees/groups also contributed:</u></b>		
North Wales Nursing and Midwifery Professional Advisory Committee Welsh Nursing and Midwifery Committee North Wales Clinical Network Managers		
<b><u>Level Four of Patient Need</u></b>		
<b>Chair: Kay Jeynes</b>	<b>Chair of the All Wales District Nursing Forum/Head of District Nursing</b>	<b>Cardiff and Vale NHS Trust</b>
Vivienne Cooper	Clinical Nurse Specialist Palliative Care	Velindre NHS Trust
Janet Davies	Discharge Liaison Nurse	North West Wales NHS Trust
Baroness Ilora Finlay	Consultant in Palliative Medicine, Member of the House of Lords	Velindre NHS Trust
Deborah Harris	Discharge Liaison Nurse	Cwm Taf NHS Trust
Judith Hill	Nurse Director	Neath Port Talbot LHB
Heather Piggott	Discharge Liaison Nurse	North Wales NHS Trust
Carol Preece	Continuing Care Manager	Cardiff and Vale NHS Trust
Ruth Walker	Executive Nurse	Cwm Taf NHS Trust
Helen Way	Clinical Teacher and Specialist Palliative Care Nurse	Marie Curie Cancer Care Wales
All Wales District Nursing Forum comprising the professional and operational district nursing leads for all the NHS trusts in Wales, education providers in Wales and professional representation from the RCN and the Community District Nursing Association (CDNA)		

<b><u>Midwifery</u></b>		
<b>Chair: Lorna Tinsley</b>	<b>National Officer</b>	<b>Royal College of Midwives Welsh Board</b>
Helen Rogers	Head of Royal College of Midwives Welsh Board	Royal College of Midwives Welsh Board
Jane Herve	Head of Midwifery	Cardiff and Vale NHS Trust
Julie Richards	Head of Midwifery	Powys LHB
<b><u>Learning Disability Nursing</u></b>		
<b>Chair: Ian Ferris</b>	<b>Head of Nursing Directorate of Learning Disability Services</b>	<b>Abertawe Bro Morgannwg University NHS Trust</b>
Jeni Clarke-Moore	Nursing Officer	Welsh Assembly Government
Madeleine Collins	Senior Community Nurse	Directorate of Learning Disability Services, Abertawe Bro Morgannwg University NHS Trust
Bronwen Davies	Senior Community Nurse	
Angela English	Senior Community Nurse	
Cheryl Evans	Assistant Head of Nursing	
Maria Ham	Senior Community Nurse	
Karen Hopkins	Senior Community Nurse	
Joanne John	Senior Community Nurse	
Martine Marshallsay	Assistant Head of Nursing	
Alun Phillips	Senior Community Nurse	
The following members of the All Wales Senior Nurse Advisory Group for Learning Disability		
Stephen Hughes	(Chair) Service Manager, Head of Nursing Learning Disability	Bryn-y-Neuadd, North West Wales NHS Trust
Neil James	Senior Lecturer	Faculty of Health Sports and Science, University of Glamorgan
Robert Jenkins	Head of Learning Disability	Faculty of Health Sports and Science, University of Glamorgan
Peter Jones	Clinical Governance Co-ordinator, Learning Disability	Bryn-y-Neuadd North West Wales NHS Trust
Ian Mansell	Senior Lecturer	Faculty of Health Sports and Science, University of Glamorgan
Lloyd Nelson	Head of Nursing Learning Disability Services,	Conwy and Denbighshire NHS Trust
Sharon Williams	Senior Nurse Learning Disability Services,	Gwent Healthcare NHS Trust
<b><u>Mental Health Nursing</u></b>		
<b>Chair: Helen Bennett</b>	<b>Head of Mental Health Nursing</b>	<b>Cardiff and Vale NHS Trust</b>
Michael Coffey	Senior Lecturer Mental Health	Swansea University
Ben Hannigan	Senior Lecturer Mental Health	Cardiff University

The following members of the All Wales Senior Nurse Advisory Group for Mental Health		
Simon O'Donovan	Consultant Nurse for the Older Vulnerable Adult (Mental Health)	Cardiff and Vale NHS Trust
Lynne Roberts	Consultant Nurse for Clients with Serious Mental Illness	Cwm Taf NHS Trust
Mervyn Townley	Consultant Nurse CAMHS	Gwent Healthcare NHS Trust
<b><u>e-Health</u></b>		
<b>Chair: Bev Thomas</b>	<b>Clinical Director (Nursing)</b>	<b>Informing Healthcare</b>
Jayne Anderson	Integrated Care Management Manager	Hywel Dda NHS Trust
Claire Aston	Interim Director of Nursing and Performance	Monmouthshire LHB
Sue Bale	Associate Nurse Director	Gwent Healthcare NHS Trust
Alix Buckley	Lead Nurse	North Wales NHS Trust
Bernard Crane	Nurse Assessor	Torfaen LHB
Dame Professor June Clark	Independent Consultant	
Lynne Cronin	Practice Nurse	Business Services Centre, SE. Region
Aileen Evans	Senior Nurse Professional Development and Training Manager	NHS Direct
Carol Grinszpan	Out Patient Manager	Hywel Dda NHS Trust
Sam Hooi	Head of Nursing Workforce Development	Cardiff and Vale NHS Trust
Dave Hutchison	Directorate Information and Resource Manager	North Wales NHS Trust
Cate Langley	Lead Midwife for North Powys	Powys LHB
Ruth Lawler	Nurse Manager,	Velindre NHS Trust
Christine Lewis	Head of Nursing	Abertawe Bro Morgannwg University NHS Trust
Dave Lloyd	Lecturer in Nursing	Bangor University
Tony Paget	Lecturer in Health Informatics	Swansea University
Dr Roger Richards	Clinical Directorate Manager	Informing Healthcare
Janet Thomas	Directorate Nurse	Hywel Dda NHS Trust
Jane Trowman	Nursing Director	Denbighshire LHB
Wendy Turkie	Assistant Director of Nursing	North Wales NHS Trust
Maureen Whittam	Community Nurse Manager	North Wales NHS Trust
Jane Williams	Senior Nurse Primary Care	Merthyr Tydfil LHB
<b><u>Education</u></b>		
<b>Chair: Dr Dianne Watkins</b>	<b>Deputy Head of School, Director of External Relations, Learning and Teaching</b>	<b>Cardiff University</b>
Marie Bodycombe-James	Lecturer	Centre for Child Health Studies, Swansea University
Judith Carrier	Professional Head, Primary Care and Public Health	Cardiff University

	Nursing	
Ruth Davis	Head of Care Sciences	University of Glamorgan
Sue Dunlop	Senior Lecturer, Health, Sport and Science	University of Glamorgan
Ben Hannigan	Senior Lecturer, Mental Health, Learning Disabilities and Psychosocial Care	Cardiff University
Gaynor Mabbett	Lecturer, Primary Health Care	Swansea University
Jane Montgomery	Lecturer in Adult Nursing	Bangor University
Gina Newbury	Lecturer, Primary Care and Public Health Nursing	Cardiff University
Will Oliver	Senior Education and Contracting Manager	NLIAH
Marie Roberts Davis	Principal Lecturer and Post Registration and Post Graduate Programme Leader	Glyndwr University
Andrea Surridge	Lecturer Practitioner, Primary Health Care	Swansea University
Jo Sutton	Lecturer, Primary Care and Public Health Nursing	Cardiff University
Sue Thomas	Primary Care Advisor,	RCN Wales
Alison Williams	Senior Lecturer and Route Leader for BSc/Post Graduate Diploma in Community Specialist Practice	Glyndwr University
Lynne Williams	Lecturer in Adult Nursing	Bangor University
Sue Willis	Nurse Director	Wrexham LHB