National Community Nursing Specification

Overarching principles, characteristics, and functions of Community Nursing in Wales

October 2022

Strategic Programme for Primary Care

October 2022

Executive Summary

The National Community Nursing specification outlines at a strategic level the overarching principles, characteristics, and functions of Community Nursing in Wales for individuals aged 16 and over. The experience of individuals and families using or accessing community nursing services are at its centre, via the use of core principles focused on providing person centred, preventative, safe and effective services. Its aims are:

Standardise care where possible to reduce variation and raise quality	Sets out key principles	Section 4
	Sets out working hours for District Nursing services & response times	Section 5
	Identifies key skills and knowledge for Community Nurses	Section 7
Simplify systems and processes to make people's experience better and nurses working lives easier	Access for other health & care services	Section 5 & Section 6
	Reduces Variation	Section 9
	Improves Quality	Section 6 & Section 9
	Values Nurses	Section 11
Collaboration with other nurses and professionals around the person	Improving Communication	Section 10
	Role of Community Nurses as clinical leaders	Section 8
	Opportunities for new ways of working & nursing models	Section 12

➔ **Improved experience for person and their health & well-being**

Section 13

The specification is not able to comprehensively cover all areas of practice and specialism that Nurses working in the Community provide. Therefore, this specification focuses on General Practice Nurses, Specialist Nurses and District Nurses and their teams.

Collectively these groups are referred to as Community Nursing Services and Community Nurses or Nurses, within this specification.

Community Nursing Services do not work alone and are an essential part of the wider nursing team, multi professional team and health and social care system.

Standardising key elements of Community Nursing Services will promote greater collaborative working between nurses and understanding of community nurse's role and value within the wider multi professional team. This will be important as traditional role boundaries change and nurses increasingly work in new models of care to meet the challenges of our health and social care system.

The specification promotes Community Nurses to come together to review the way they work across pathways for people aged 16 and over. It encourages nurses to think about different models of working, how to share and learn from one another and advocates for a move towards a preventative population-based approach to support the people they care for.

Recognising the value Community Nurses offer, the specification outlines how nurses should be enabled to lead and support research and service improvements, have clear development and career pathways and be supported via access to regular clinical supervision.

Community Nurses offer strong clinical leadership and governance to their services and the wider health and care team. This, alongside a consistent approach to the way they work, will enable nurses to further lead, develop, and/or support current and new services, to meet the ambitions of the Primary Care Model for Wales.

Contents

1. Introduction

1.1 The National Community Nursing Specification outlines at a strategic level the overarching principles, characteristics and functions of Community Nursing in Wales for individuals aged 16 and over.

1.2 The National specification aims to**;**

- **Standardise** care where possible to reduce variation and raise quality
- **Simplify** systems and processes to make people's experience better and nurses working lives easier
- **Promote collaboration** with other nurses and professionals around the person

1.3 The specification recognises that the needs of local populations will require nurses with different skills in order to meet those needs. However, **the totality of the service** offered by Community Nursing, should embed the key characteristics, principles and functions outlined here.

1.4 This will ensure there is a consistent approach to the provision of Community Nursing Services which;

- has the experience of individuals and carers using or accessing community nursing services at its centre. This will be via the use of key principles focused on providing person centred, preventative, safe and effective services
- recognises the value and contribution Community Nursing offers to individuals, local communities and health and care professionals across primary, community and secondary care.
- promotes closer working and a clearer understanding of each other's roles, creating more resilient and effective relationships between, generalist, specialist, advanced and consultant Nursing practitioners, who provide episodes of care within the community setting
- reduces variations in the service provided to individuals and carers and to those services or professionals that interface with them

1.5 Community Nursing Services will need to be able to demonstrate how they are achieving the National Community Nursing Specification and its outcomes. A self-assessment tool and measures to demonstrate how the outcomes of this specification will be achieved are included in section 13. Together these will support Community Nursing Services to understand how their services currently meet the principles, characteristics and functions set out in this specification and the actions required to achieve these.

2. Definition of Community Nursing

2.1 Community Nursing can be defined as any nurse working in the community, providing care, treatment and support to individuals. Community nursing covers a breadth of generalist and specialist nurses who work within local communities; see figure 1. For the purposes of the specification, these are grouped in the following way, recognising there can and will be, multiple interfaces between nurses based on an individual's nursing needs;

Generalist Nurses	General Practice Nurses District Nurses and their teams
Specialist Nurses	Disease Specific Specialist Nurses who work with a group of individuals with a specific condition e.g., Diabetes Specialist Nurses, Heart Failure Nurses, Chronic Obstructive Pulmonary Disease (COPD) Nurses
	Practice Specific Specialist Nurses who work within a specific area of practice, but see individuals with a range of need e.g., Prison Health Nurses, Homeless & Inclusion Nurses, Intermediate Care Nurses, Palliative Care Nurses
Specialist Nursing Branches and/or Specialist Community Public Health Nurses	Community Children's Nurses, Community Mental Health Nurses, Learning Disability Nurses, Health Visitors, School Nurses, Community Midwives, Occupational Health Nurses
Significant other groups of Nurses	Care Home Nurses, Dental Nurses

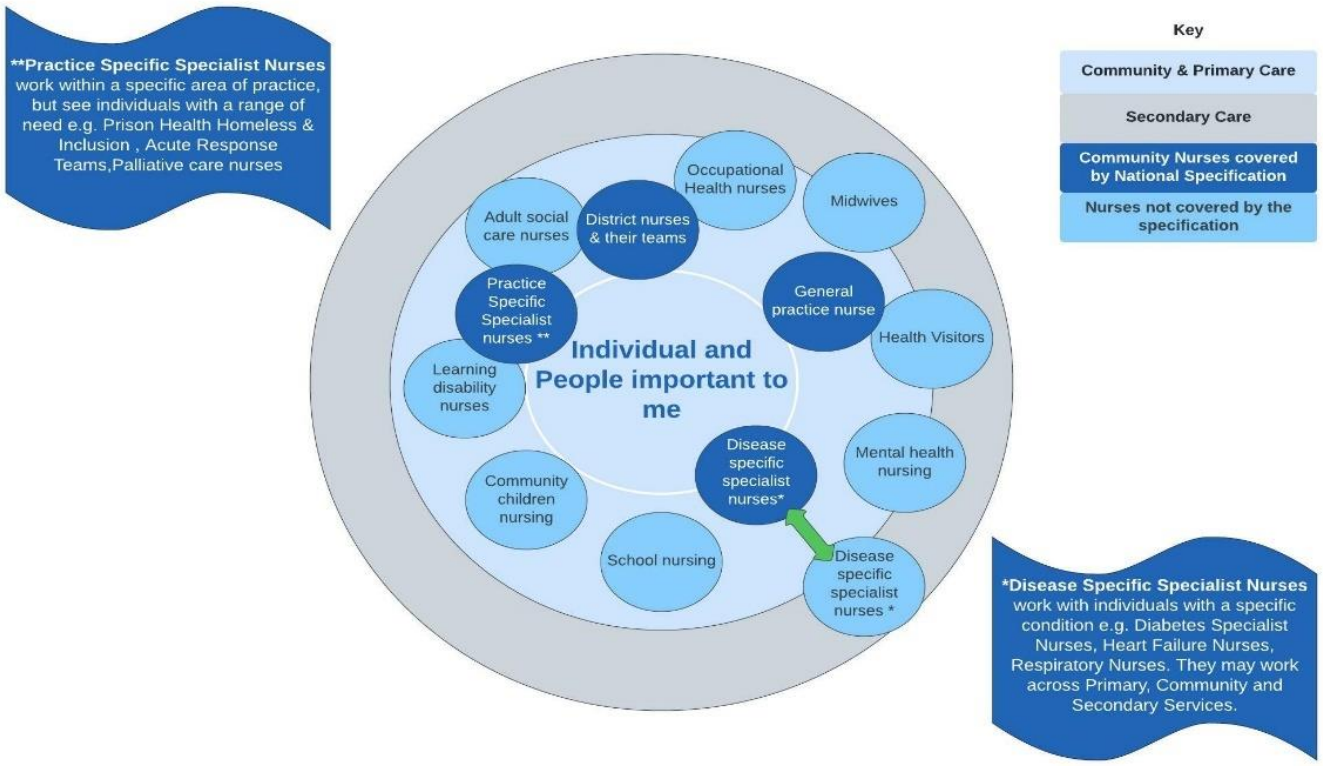

Figure 1 – Community nursing

2.2 In addition, the Community Nursing family consists of a variety of roles and levels of expertise.

- Health Care Support Workers including Assistant Practitioners
- Registered Nurses
- Advanced Nurse Practitioners
- Consultant Nurses
- Nurse Leaders/Managers

2.3 Nurses are integral to supporting people and are key to effective partnership working with other members of the health and care workforce. They have a wealth of varied skills, knowledge and expertise covering individual nursing needs from pre conception to birth, through childhood to adulthood and at the end of life. All nurses throughout an individual's life journey, play a valuable part in empowering and supporting individuals and their families at home, in education and at work.

However, for the purposes of this specification, Nurses who fall under the Specialist Nursing Branches, Specialist Community Public Health Nurses and Significant other groups are not included here.

This is due to either the specialist area of practice they provide, which the specification would not be able to fully cover, or that their area of practice falls outside the age remit of the specification, which is 16 years and over. While some nurses will have significant interfaces between children and adult services, this is covered within 'Transition' in section 6.

2.4 Community Nursing Services will also work within the wider context of Multi Professional Teams. This may be as a standalone service which collaborates with other professionals, as a key part of a multi professional team or within an integrated service. The inclusion or exclusion of any Nurses within this specification, is not intended to prevent Nurses from collaborating together, either with each other or within the wider health and social care system, to meet individuals and local populations nursing needs.

2.5 The National Specification for Community Nursing focuses specifically on the three following groups;

- **District Nursing Services** are a nurse led service run by a District Nurse team leader who holds an NMC recordable specialist practitioner qualification (QNI 2022), providing leadership and expertise that focuses on care in the home. District Nurses and their teams are an integral part of the multi-professional primary care team. These teams take a public health approach, caring for a designated population, aligned within a cluster, promoting independence, safety, quality and experience with the ethos of home being the best and first place of care.

- **General Practice Nurses** (GPN's) work within a General Practice setting where they autonomously assess individuals and provide evidence-based care and treatment to individuals of all ages, presenting with a wide range of health conditions. These include individuals experiencing a short-term illness, management of chronic conditions, as well as supporting those who are palliative. GPN's play an important part in enabling people of all ages to stay well by providing screening and health promotion, as well as delivering care and treatment for acute and chronic illness. They also provide vaccinations and immunisations, contraceptive and sexual health services, wound care and support General Practitioners with minor surgery.

- **Specialist Nurses** play an important role in commencing and optimising treatments, educating the person on their condition and helping the person to stay well. They are an integral part of the enhanced multi-professional primary care team, specialising in a particular area of practice or health condition. Specialist nurses may work autonomously either alone or as part of a multi professional team.

There are significant interfaces between District Nursing Services, Specialist Nurses and General Practice Nurses in the Community and the people they provide care, support and treatment to. The National Specification ***does not require these groups to operate in the same way***, but rather as a totality, to ensure they work in partnership regardless of the organisation they are employed by, to support the **underlying principles** (section 4) of Community Nursing and the provision of high quality, seamless and coordinated care.

3. Strategic Context of Nursing in Wales

3.1 Community Nursing Services are central to achieving the ambitions of 'A Healthier Wales's (2019) and the Social Services and Well-being (Wales) Act (2014) which collectively focus on people at the centre, enabling health and well-being through prevention of illness, delivered through partnership and co-operation. They form a significant part of the multi professional team and cluster working, essential components in achieving the Primary Care Model for Wales (2019) and ambitions of the Six Goals for Urgent and Emergency Care, supporting care closer to home.

3.2 Community Nurses play an important part in improving health and social care outcomes and delivering equitable, person centred quality services that recognise the needs of its population, addresses inequalities and adopt an anti-racist approach (Anti-racist Wales Action Plan 2022).These are three of the five CNO's priorities for Nursing (2022) and are also reflected in the learning from the Evaluation of the Neighbourhood District Nursing Pilots and recommendations (2020).

3.3 Community Nurses provide strong compassionate clinical leadership within the health and social care system and are ideally placed to develop and lead services using a Value Based Health Care approach to achieve the principles of Prudent Health Care (2016).

3.4 The development of the Community Nursing Workforce therefore, which is underpinned by the Health and Social Care Workforce Strategy (HEIW 2020), and the Digital Strategy for Wales (2022) will be essential in realising the ambitions of these national strategies and the significant transformation required to do so.

4. Community Nursing Principles

The following principles, based upon National Strategies including 'A Healthier Wales's (2018) and developed in discussion with Nurses must underpin how community nursing services work:

4.1 Person centred	4.2 Preventative and Population health focused
• Community Nursing services support individuals to understand their physical, mental, sensory health and emotional wellbeing needs. • Community Nursing services enable individuals to make decisions based on 'what matters to me', using a co productive personalised care planning approach. • Community Nursing Services recognise the cultural rights and practices of the people they support. This includes ensuing individuals have access to information about their condition and treatment in the language of their choice. • Community Nursing Services are able to make an active offer of Welsh and English to all individuals seen. • All individuals have access to information about their condition and treatment in the language of their choice. • Individuals are enabled to take responsibility for their health and well-being through self-management of their conditions and are empowered to make decisions to achieve their outcomes. • Community Nursing Services recognise the rights of individuals to make decisions which to others may appear risky, whilst enabling them to live safely within families and communities. • All individuals should receive equitable levels of access, treatment or support regardless of where they live, their ethnicity or whether their need is due to a physical or mental health condition. • Community Nursing Services should be designed to provide a holistic approach recognising the individual and their networks, promoting choice and independence. • Consistent treatment, support and continuity of care, is delivered where ever possible by small groups of nurses who know the individual well.	• Nurses working in community nursing services at each contact, offer opportunities for individuals to better understand, maintain and improve their health and wellbeing. • Nurses take a biopsychosocial approach to interventions, that recognises the individual as a whole and how other factors may impact upon both the individual's health and wellbeing and the choices they make. • Nurses understand their local population's needs and there is active collaboration, engagement and clear referral pathways with other community services and organisations, at neighbourhood and/or cluster level. • Community Nursing services are supported to access risk stratification software alongside local population data, to understand the nursing needs of local residents • Nurses work collaboratively with members of the wider Nursing community and multi professional team, to identify opportunities for preventative services and early interventions. • Community Nursing Services are empowered to shift from a focus on ill health to one of prevention, maintenance and improving health and wellbeing. • Community Nursing services consider how they support and recognise opportunities to maintain and improve the health and wellbeing of carers they have contact with. This may include signposting carers and/or supporting them to access support through collaborative working with others.

4.3 Skilled workforce	4.4 Whole system pathway
• Nurses working within community nursing services are developed to provide holistic care, which has advocacy and compassion at its core. • Nurses are enabled to obtain, understand and use local population data to identify the skills required to support the health and wellbeing needs of their population. • Nurses use behavioural and motivational techniques to enable individuals to stay well and take responsibility for their health and wellbeing, including the management of any long-term conditions. • Access to training should where ever possible, be part of a multi professional offer. This allows community nurses to learn alongside colleagues from different professionals, recognising that community nurses work and support individuals as part of a wider multi professional team. • Community Nursing Services have a clear career and development pathway which enable nurses to work effectively to the full remit and opportunities offered by the nurse's job description and which is responsive to the changing needs of its population. • Nurses have access to restorative supervision which offers opportunities for nurses to reflect on their practice, identify development needs and facilitate wellbeing and person-centred care via advocacy. • The development needs of Nurses should be considered and delivered across the traditional boundaries between practice, district and specialist nurses, enabling nursing care that is seamless and coordinated across organisational and nursing interfaces. This ensures consistent practices particularly in regard to management of long-term conditions and increased understanding of roles. • The specialist nature of the breadth of Nurses who practice up to advanced and consultant level within Community Nursing should be recognised via the offer of specialist advanced practice programmes, including the specialist practice qualification (SPQ). This enables Nurses to make high-level decisions (Hill 2020) and supports prevention of unnecessary hospital admission (Kraszewski and Norris 2014: Barrett et al 2007). • All Nurses should have opportunities to develop compassionate leadership, with Nurses responsible for teams being offered additional training in case management, coordination of care, coaching, mentoring, clinical supervision, change management and negotiation. • To enable this, all Community Nurses, require access to dedicated continuous professional development time and access to funding.	• Community Nursing Services work collaboratively as part of a whole system multi professional pathway, which has a co productive and preventative approach, based on population needs and underpinned by shared visions and goals. • Community Nursing services have access to shared electronic systems which allow for greater integration and coordination of care across and between other health/care professionals and services within their cluster or neighbourhood. This is essential for safe joint working, coordination, timely sharing of information and preventing nurses from duplicating record keeping. • Community Nursing services are responsive to individuals urgent nursing needs, maximising opportunities for working across traditional boundaries such as employer, profession or location. • Community Nursing Services response to nursing need, is based on ensuring care provided to the individual is at the right time, by the right person with the right skills. • Community Nursing services and their representatives are a core part of any development of services, advocating for a whole system partnership approach within their Neighbourhoods or Clusters. • This recognises the skills Nurses have in identifying, planning, leading, influencing, coordinating and delivering person centred services, at neighbourhood, cluster and regional level, based on local population needs. • Specialist Nurses are an integral part of community nursing services and wider multi professional team. Specialist Nurses should be supported and permitted to develop their services within the context of seamless integration. • Alongside their traditional roles, Specialist Nurses should be enabled to work with local populations, primary and community services, 111 and out of hours services, on identifying preventative and public health approaches to meet the local population's needs.

4.5 Technology enabled	4.6 Safe, Effective and Value based
• The use of technology can support and empower some individuals to understand their condition, to recognise when their condition may be changing and to seek advice and support in a timely way. This can enable individuals to have choice in how and where their care is provided, to stay well and to prevent unnecessary contact and attendances with health and care professionals. • Community Nursing Services use technology to work across organisational and professional boundaries to support timely, safe and effective clinical assessment/ diagnosis and individualised care, treatment and wellbeing, during face-to-face visits or via remote consultations. • Community Nurses have access to information in the persons preferred language of choice and support for individuals to use technology. • The use of technology to support individuals, is always balanced with the rights of individuals to refuse this and the acknowledgement that some individuals may not have the financial means, ability, access to devices, or desire to use digital technology. • Community Nurses have access to electronic clinical records and/or integrated records where available and the use of scheduling systems where they have demonstrated benefit. • Community Nursing services are enabled by handheld digital infrastructure and the ability to remotely connect with and access systems across primary and secondary care. This will allow Community Nurses to flexibly carry out their role regardless of setting. • Community Nursing services should consider how Technology Enhanced Care Services (TECS) including telecare, telehealth, telemedicine and mhealth can be used to support individuals to monitor or manage their care within the areas of their practice. • The use of apps, remote health monitoring systems or environmental/personal sensors, which can alert to changes in health or risk of harm are used, supporting community nurses to take preventative actions.	• Community Nursing services provide safe, timely, dignified, individualised, consistent and effective, evidence-based nursing care, which provides value for money, based on prudent healthcare principles and a value-based approach. • Community Nurses are enabled to work together to ensure their generalist and specialist skills and ways of working, are able to consistently evolve to meet the changing needs of their population. This will ensure Nurses unique contribution to the care they offer to individuals and benefits to the wider multi professional team, are recognised and valued. • Community Nursing services have a service improvement and research strategy which supports nurses at all levels to identify, participate or lead quality and/or research initiatives. This is essential to developing, improving and increasing the quality of care and outcomes for individuals. • Community Nurses across primary, community and specialist nursing are supported to learn from one another, explore what works well and use innovation to improve and transform practice. • Community Nurses are able to demonstrate through the use of individual outcomes and population health data, how they are contributing towards people's health and wellbeing both within their own remit of practice and as part of a multi professional team. • Community Nursing Services have access to tools and data which supports their understanding of the capacity, demand, acuity and complexity of individuals seen, to ensure nurses can meet people's needs in a safe and timely manner. • Community nursing services share information including across organisational boundaries, where it will benefit wider understanding of the needs and demands of a population within a neighbourhood or cluster.

5. Key Characteristics of a Community Nursing Workforce

5.1 Operational Standards

Working Hours

5.1.1 District Nursing Services as the core nursing service for the community, must operate a **7 day service that is available 24 hours a day**. District Nursing Teams should as a **minimum** be of a **sufficient and consistent** level across the 7 day period to meet the nursing needs of the local population. This includes how District Nursing services support out of hours services, including urgent discharges from hospital e.g., for individuals who wish to die at home and admission avoidance.

The difference in capacity between 'in hours' i.e., Monday to Friday 8 – 5 pm and the weekend ***should be no less than 80% of District Nursing Capacity Monday to Friday***. Ensuring there is a robust District Nursing workforce over the weekend is essential, as these teams form the underpinning core of nursing availability throughout the 24-hour period.

This will promote a consistent approach, reducing unwarranted variation between District Nursing Services in Wales and key services including secondary care, Welsh Ambulance Service Trust (WAST) and GP out of hours.

The ability to access support during the evening, at weekends or overnight can often make the difference between a person being able to stay at home when unwell, or being admitted to a hospital. District Nursing Services as a 24/7 service, should be supported to review how they work together with other community nurses such as those in intermediate care teams or acute response teams, where available, as well as third sector provision e.g., hospices, local authorities and domiciliary care.

A collaborative approach which brings services together out of hours including overnight, has multiple benefits. For the individual it can help them to stay at home when e.g., unwell preventing deterioration, or in crisis e.g., due to carer breakdown, or at the end of life. For services, nurses and professionals, it can reduce calls to other out of hour's services, provide clinical support and governance and support lone working.

The recognition of District Nursing Services as one of the three central components of community nursing in clusters, is essential to support the ambition of a District Nursing service with its focus on prevention, what matters to me, self-care where possible and enabling care and treatment at home.

5.1.2 General Practice Nursing (GPN) services operate mainly Monday to Friday, although this varies between GP practices. Treatment or care provided by practice nurses, which needs to be continued at weekends, will require nurses across primary and community care to work together to provide wrap around care for the individual. This may mean reviewing current pathways, skills and ways of working to ensure individuals do not experience a reduction in service or quality, due to different services operating hours. Developing communication opportunities for community nurses to come together in person or virtually to review ways of working is essential.

5.1.3 Specialist Nurses – Services may operate a variety of working hours dependent on the way they have been previously developed and commissioned. Wherever possible and if appropriate to the needs of the population they are working with, access to specialist advice for community nurses should be available across the 7-day period during core working hours i.e., 9.00 – 5.00 pm.

This may mean utilising opportunities such as technology to support access to specialist nurses, specialist nurses working across clusters, promoting the use of personalised care plans and/or specialist advice being available from the wider multi professional team. This recognises the increasing complexity of people supported in community settings and the emphasis on enabling people to remain in their own homes and increasing other community nurses' confidence, knowledge and skills.

Specialist Nurses risk being isolated at weekends and consideration of how specialist nurses work in partnership and stay in touch with other specialist nurses and professionals over the weekend should be

reviewed. This could include co-locating District Nursing and Specialist Nursing Services together out of hours and would help reduce the risks associated with lone working and improve efficiency.

5.1.4 Access to **Community Nursing Services** should be easy, both to access and to understand how to do so for individuals and professionals. Single Access Points can be a way of achieving this particularly for District Nursing Services and/or Specialist Nurses. For example, single access points for Palliative Care Nurses and District Nurses and their teams can prevent duplication of effort, ensuring individuals receive a timely response from the right nurse with the right skills, particularly for those individuals at the end of life.

Access to services both in and out of hours for urgent referrals should be direct to the service, rather than via another professional. Referrals to Community Nursing Services out of hours from Urgent Care services including OOH GP, 111 services and the Welsh Ambulance Service Trust (WAST) Clinical Support Desk clinicians and Paramedics where direct referral pathways exist, must be direct to ensure a timely response.

Self-referrals by **individuals known** to community nursing services, particularly specialist nursing services should be in place and the arrangements of how individuals can self-refer, clearly communicated upon admission to the service.

5.2 Response times

The section below refers to all Community Nursing Services unless specified otherwise.

The way community nursing services organise themselves to achieve the two hour urgent response may vary, according to local population need and organisation of services. The definitions for response times below are intended as guidance only, as determination of these should be based on the ***professional's clinical judgement*.**

Urgent - *an urgent nursing need which is likely to result in a hospital attendance or admission if the person is not seen within 2 hours*

5.2.1 District Nursing Services and Specialist Nurses:

To enable people to receive timely care at home, preventing unnecessary attendances or admission to hospital, specialist and district nursing services must be able to respond to urgent calls within a two-hour period. This response may consist of a face to face, telephone/video triage or consultation, resulting in a management plan which meets the individual's needs.

Individuals who are in the last few weeks/days of life must receive an **urgent response** to calls regarding the management of distressing symptoms and/or significant changes in the person's condition. **This response may consist of an initial triage call and/or a face-to-face visit**, resulting in a management plan which meets the individual's needs.

A proactive approach between professionals and organisations across community/practice settings is key to maximise anticipatory planning and reduce urgent issues which could have been anticipated. The reviewing of such occurrences in team/multi professional meetings should be encouraged to understand the reasons for these issues, if they could have been prevented and if any changes to practice/pathways are required.

Where clinically triaged and agreed with the referrer, a response of longer than 2 hours may be agreed up to a maximum response time of 4 hours for a face-to-face visit. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

Community Nursing Services may develop specific teams to support the achievement of an urgent response. However, this should not prevent the wider community nursing workforce from developing skills or knowledge that enable them to respond to an individual's changing condition at home. Equally, the development of any such teams should not result in duplication, or overlap of provision.

5.2.2 Non-Urgent -Individuals identified as requiring non urgent nursing care must receive a face to face visit within 72 hours, unless after clinical triage and discussion with the referrer a longer response is agreed. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

Non Urgent - *the individual is able to wait for a nursing intervention for up to 72 hours (including weekends & bank holidays)*

5.2.3 Planned - Individuals identified as requiring planned nursing care should receive a face to face visit within 10 working days, unless after clinical triage and discussion with the referrer a longer response is agreed. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

Planned – *the individual is able to wait for a nursing intervention for up to ten working days*

The allocation of visits must be supported via a scheduling system for District Nursing services and should be considered for specialist nursing services. Scheduling systems can support the safe and timely allocation of visits, and support recording of response times, promoting 'the right nurse with the right skills, at the right time' approach. Services will also need to consider how this information is shared with the wider multi professional team, to prevent duplication of visits and the best use of staffing resources. This should also include how services can work together to meet the above response times.

5.4 Clinical Recording Keeping

Community nursing services have electronic clinical systems in place to record their nursing care, either during or immediately after providing care. To achieve this Community Nurses will require a robust mobile digital infrastructure, which allows access to relevant clinical systems. This supports timely nursing practice, clinical safety and prevents duplication of recording information, ensuring high quality and effective care.

Community Nursing Services must have a clear plan to support the development of integrated records and information governance and sharing arrangements, which may be across a range of professionals, organisations and boundaries.

5.5 Use of Technology

Community Nursing Services should utilise technology where possible, to support their interactions with individuals and other professionals. This should include how information is shared back into the individual's main clinical record.

Examples of such technology may include the use of video consultations, e scheduling systems, remote telephone/photo/messaging consultation software, as well as telecare/telehealth technology. The use of technology to support individuals, must always be balanced with the rights of individuals to receive services/resources in their language of choice, the right to refuse and recognition that not every individual may have the financial means, ability or desire to use digital means.

Where scheduling tools are used, nurses with Welsh language skills are identified within the system and are actively matched to individuals who have requested Welsh Speakers. Where the active offer of Welsh cannot be supported, this should be recorded. This allows for the identification of gaps in Welsh language skills and future planning of how the active offer of Welsh can be achieved.

5.6 Place of care

5.6.1 Community Nursing Services may be carried out in a variety of locations including GP practices, clinic settings, care homes, settings in community hospitals or health centres and in the person's own home. Individuals who are able to access settings outside their home for their nursing care, should be encouraged by services and professionals to do so. Regardless of the place a person with nursing needs is seen, the treatment, support and advice provided, must be based on evidence based guidelines and ensure equity in the provision of care.

5.6.2 District Nursing Services specifically focus on people who are unable to access settings outside their home, i.e., those who are termed as housebound. However, some individuals who are not housebound, may

need to receive nursing care in their own home due to illness, significant frailty or another medical condition which would put them at risk e.g., individuals who are immunocompromised.

5.6.3 Community Nursing services and General medical services work together with statutory and non-statuary services to ensure individuals who are unable to leave their home due to a lack of transport, are able to access nursing services in other settings. Social isolation has a significant impact on a person's health and wellbeing (Connected Communities 2020) and a lack of transport should not be a barrier to accessing any service, or the wider community.

5.6.4 Alternative care settings - Individuals may be supported long term within a care setting where there are care workers available. This is the person's own home and individuals are entitled to access the same level of nursing support that is available to any person living in a community setting.

Where an individual lives in a care setting with access to registered nurses, Community Nursing Services may need to provide additional support ***where there is a risk to an individual's health and wellbeing,*** including risk of unnecessary admission to hospital. In these circumstances, Community Nursing services should work together with other members of the multi professional team, to provide wrap around care for that individual and to support the care home workforce.

5.6.5 As Cluster working becomes further developed and embedded, the traditional boundaries between where and how GPN's, DN Services and Specialist Nurses work, may become more blurred. This allows greater opportunity for the nursing workforce to work across place and organisational boundaries focusing on who the right nurse is to meet the person's needs, rather than on traditional organisational boundaries.

To achieve this, Nurses within clusters and across different organisations must be enabled to come together to review current pathways and ways of working. This will ensure Nurses offer the best service to the individual promoting equity and consistency of outcomes, alongside best use of resources. This may be as part of the professional collaboratives and/or the bi monthly community nursing meetings, as outlined in section 10.3.

Where opportunities to develop changes to pathways exist, there needs to be clear structures and processes in place to ensure work is fairly distributed across the totality of the nursing workforce. This must be demonstrated by measures which confirm the benefits, outcomes and experience for both individuals, Nurses, and the wider health and social care system.

6. Specific Clinical Considerations

6.1 Frailty Tools - Community Nursing Services use an evidence-based frailty tool, which may be electronic e.g., Clinical Frailty Scale App. This allows for consistent identification and assessment of frailty. Where required, community nurses should work as part of the wider multi professional team to help complete a Comprehensive Geriatric Assessment (CGA), leading to the development of a personalised care plan. The completion of a CGA, may be led and coordinated by any professional who has had additional training in carrying out a CGA.

6.2 Rehabilitation following illness - Community Nursing Services have the necessary skills and knowledge to support individuals, to regain everyday life and activities following illness. This approach as part of the wider multi professional offer to rehabilitation and recovery, is important in ensuring individuals are able to self-care and manage their needs independently where ever possible.

6.3 Management of urethral and suprapubic catheters –District Nursing Services as the core community nursing service, possess the relevant clinical skills and expertise to manage urgent situations concerning catheters, including blocked catheters, **where they meet the criteria for community change/insertion**.

Community Nursing Services should be available to respond to urgent requests from individuals and/ or other agencies e.g., WAST/111/OOH GP's regardless of whether the individual normally accesses DN services or not. A person with a blocked catheter where urine is not bypassing and **where they meet the criteria for community change/insertion** should be able to make direct contact with a DN service and be seen within 2 hours, unless following clinical triage it is decided they need referral to another service, or do not require

an immediate response. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

6.4 Wound Management – Nurses within Community Nursing Services will have varied levels of knowledge and skills on wound management dependent on their role and area of practice. However, all registered nurses should have the ability to undertake simple wound management including;

- Removal of sutures or clips
- Post-operative wound management e.g., checking of wound and reapplying dressings
- Dressing/redressing of simple non-complex wounds
- Identification of venous/arterial ulcers
- Identification of static or deteriorating wounds
- Identification and management of pressure damage

Complex wounds where nurses require additional training and assessment of competency and/or oversight by Tissue Viability Nurses e.g., negative pressure wound therapy, larvae therapy or compression bandaging, may be delivered in full or part by a range of community nursing services in order to meet the individuals and/or local population needs. This may include referral to local community clinics, rather than the person being seen at home or in a GP practice.

Where an individual's care is shared between different community nursing services, communication systems and processes must be in place, to ensure care is seamless and prevents duplication.

6.5 Transition - Individuals with complex health and wellbeing needs including those with life limiting conditions and their families who require transfer from children services to adult services, can often experience difficulties during this process.

It is essential that Adult Community Nursing Services follow best practice outlined within the All Wales Transition and Handover Guidance (2022). Working collaboratively with education, housing, care providers and other members of the multi professional team and community, is essential to empowering young people to take responsibility for their health. This will need to be supported by the collaborative development of comprehensive personalised care plans and packages of support and the continuation of existing pathways, particularly for individuals at the end of life.

Transition may also include individuals who are moving into a new locality, or to a different support setting. For example, individuals moving from learning disability services, such as supportive living to care homes.

Discussions between services e.g., between children and adult services or between different providers within adult services on how best to do this, should start as early as possible. This may include sharing policies, guidance and training via children services or specialist adult services, to enable community nurses to develop the skills required to support the individual.

6.6 End of Life Care - Individuals who are at the end of life and whose choice of place of care and death is home and their carers/families, must be able to make prompt and direct contact with Community Nursing services for timely advice and support. In turn, Community Nursing services must be able to directly access 24/7 specialist palliative care advice, and understand how their local services provide this support. This is particularly important during the evening and overnight when the availability of other health professionals will be reduced.

Community Nursing Services must ensure a proactive and personalised care planning approach is taken to support individuals in the last days of life and their families. This should include, for example, daily district nurse review and co-ordination of care and support as needed, as well as rapid access to equipment. There should be 24/7 access to and administration of anticipatory (Just in Case) medications to prevent or reduce delays in managing symptoms and facilitated access to specialist palliative care advice and support in a timely way as required. Where appropriate, and in collaboration with the GP and the family, care should be guided by the All Wales Care Decisions Guidance for the last days of life.

Care to the person and their families extends to after an individual dies. This means Community Nursing Services, alongside other members of the multi professional team, should be able to provide timely

verification of expected death to people seen by their service and be able to signpost carers/family members to practical advice and bereavement support as required.

In order to ensure value-based health and care at the end of life, community nursing services leads need to demonstrate safe and effective care in line with recommendations and metrics endorsed by the National Programme Board for Palliative and End of Life Care and in line with the Quality Statement for Palliative and End of Life Care.

7. Scope of practice

GPN's, DN's and Specialist Nurses provide nursing care, treatment and support across a wide area of nursing practice. While Nurses scope of practice will vary according to the skills, knowledge, ability and registration status of the Nurse, there are some fundamental areas which are common to all. A summary of these areas for all DN's, GPN's, Specialist Nurses and Health Care Support Workers are outlined below. This is **not meant to be an exhaustive list** and the principles of collaborative working providing the right person with the right skills at the right time, remains central to supporting individuals.

Fundamental Areas of Practice & Skills for All Registered Community Nurses and Health Care Support Workers
Person Centred Approach's & What matters to me conversations
Communication skills including respectful communication, empathetic listening, protecting privacy & promoting autonomy
Human rights & Equality & Diversity training
Keeping People Safe (safeguarding & self-neglect) and addressing essential needs e.g., nutrition, personal hygiene, sensory health needs, in a sensitive manner
Understanding of Mental Capacity/Consent & Lasting Powers of Attorney
Making Every Contact Count
Working safely in the Community/Community Settings
Multi Professional Team working including working virtually to develop and maintain collaborative working
Digital skills to enable the use of Technology & mobile working
Undertaking observations i.e., BP, Pulse, Respiratory Rate, Temperature, BP, Pulse, Respiratory Rate, Height, Weight & Completion of NEWS Cymru
Pressure Area Care
Mental Health Awareness
Use of SBAR to communicate concerns
Care of Self & Colleagues
Understanding of clinical audit

Fundamental of Practice for All Registered Community Nurses and Dependent on Role, Health Care Support Workers		
Non-complex wound care	Recognising Frailty	Prevention of illness & Promoting health, self-care & wellbeing
Dementia care training including understanding, recognising and managing dementia-related conditions	Promotion of Continence	Principles and understanding of enabling independence & rehabilitation
Understanding wider determinants of health	Management and resolution of Conflict	

While the following are considered fundamental for **All** registered nurses working within community nursing services, the level of knowledge and skills in these areas may vary according to the area of practice.

Fundamental Areas of Practice for All Registered Community Nurses		
Understanding Population Needs data	Health Promotion Skills including promotion of self-care	Prevention of hospital admission including recognition of the deteriorating person
Immunizations specifically flu, covid-19, pneumococcal	Knowledge of Long term condition management	Knowledge of palliative and end of life care, including verification of Expected Death
Advanced Care Planning/Future Discussions	Wound management - simple wounds	Supporting hospital discharge
Early identification / Screening / Risk reduction / Education and support	Use of technology and mobile applications to help provide advice/assessment of need, monitor health and support self-management	Behaviour change strategies
Integrated collaborative decision making	Holistic assessment Skills & critical thinking skills	Advanced communication skills
Management of risk	Management of safeguarding and self-neglect	Compassionate leadership
Mentorship and/or supervision and or /assessor skills for students and others	Prudent healthcare & Value based healthcare	Knowledge of Quality and service development improvements to demonstrate value of the service
Understanding how to use data to inform practice	Understanding of health inequalities and needs of vulnerable groups	How to use outcome measures to influence and change practice
Knowledge and Understanding of the impact of health on work and work on health	Continuing Health Care Framework and Decision Support Tools in Community & Primary Care	Motivational interviewing
Understanding of Clinical Governance in the context of working in multi professional/integrated services	Understanding of Commissioning process and development of shared budgets on nursing practice	Liberty Protection Safeguards (LPS)

The areas identified below are a small element of the skills and knowledge required to practice at an advanced level. Nurses who work in advanced clinical roles e.g., Advanced Nurse Practitioners, or Consultant Nurses, must have a clear scope of practice and job description which clearly outlines how the 4 advanced pillars of clinical practice below are met;

- Clinical care,
- Leadership and management
- Facilitation of learning and evidence
- Research and development

Fundamentals of Advanced Clinical Practice (Educated to Master's level or equivalent)		
Clinical Assessment and Diagnostic Reasoning	Mental Health and well being	Autonomous practice
Leadership & Critical thinking skills	Practice improvement initiatives and/or Strategic Service Development	Evidence, Research & Development
Facilitating Learning	Detailed understanding of self as a crucial component of the therapeutic relationship and regard i.e., Transactional v Relational care	Non-Medical Prescribing **or** Supplementary Prescribing, dependent on role
Specialist Practice Qualification (SPQ), if relevant to role	Population Risk Stratification	Comprehensive awareness of own values, biases and prejudices

Community nursing services will need processes in place to pro-actively identify and develop skills, reflecting the needs of their local population. Further information on specific competencies and skills for DN and GPN's which may be helpful, can be accessed below;

- District Nursing and General Practice Nursing Service Education and Career Framework (Health Education England 2015)
- An NHS Wales Competence Framework for Nurses working in General Practice
- Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales

8. Leadership & Management Skills

Community Nursing Services will enable nurses to develop and work as compassionate leaders. Compassionate leadership supports Nurses to work within organisational cultures where Nurses are safe to challenge, to be authentic, to lead by example, share their ideas and support quality initiatives working with others to improve care for the individual.

The Health and Social Care system is constantly evolving and Nurses need to be developed to lead and support transformational ways of working.

To achieve this Nurses should be enabled to develop and/or enhance existing skills and knowledge in coaching and mentoring, influencing negotiation, partnership working and decision making. This will empower Nurses to provide clinical leadership, acting as strong advocates, working collaboratively with others to develop care pathways that enable, self-care, enhance an individual's health and wellbeing and which deliver the best outcomes for people.

A variety of resources and clinical leadership programmes can be accessed via the - Gwella HEIW Leadership Portal

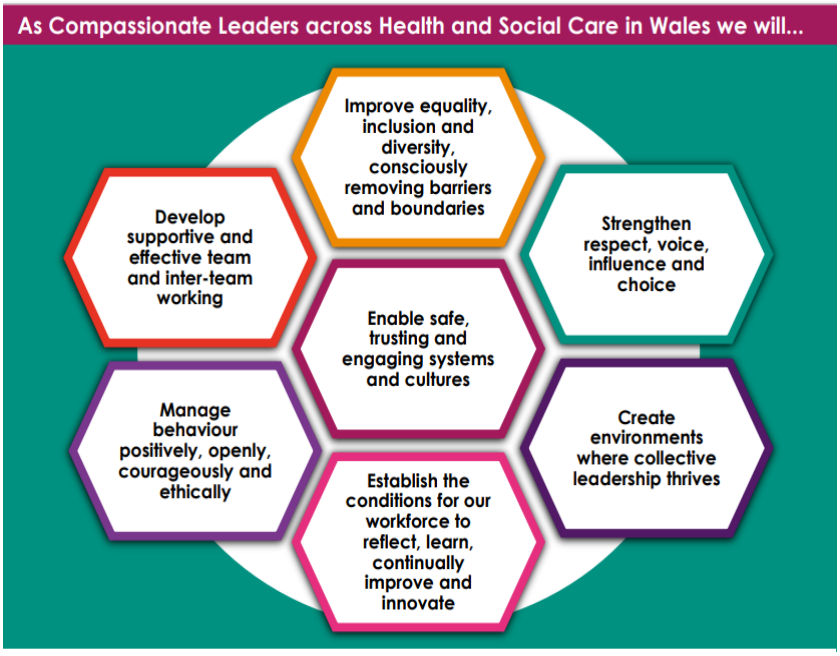

Figure 2 Compassionate Leadership Principles - Gwella HEIW Leadership Portal for Wales

9. Organisation of Care

9.1 Community nursing services are be able to demonstrate how collaborative working underpinned by shared IT systems, shared protocols, guidance, pathways and standard operating procedures is working within and across clusters. This must be in conjunction with the use of shared person reported outcomes and experience measures, which will allow nurses to evaluate the care they provide and identify areas for improvement.

Capacity – the availability of nurses and their skills within the cluster to meet the needs of the population they see.

Demand – the nursing needs of individuals within a cluster. These may be actual needs or anticipated needs based on local population need and/or local knowledge. This should take account of new housing developments, including new care homes or sheltered housing facilities.

The development of any new community services with nursing must consider any actual and possible impacts on current community nursing services, including duplication of care, impact on seamless care and impact on individuals and families.

Community Nursing Services need to be able to show how capacity and demand are identified and managed, to minimise any impacts on the ability to deliver safe, effective and responsive nursing care or treatments to individuals.

Tools which can help describe the complexity and/or acuity of individual's needs and which can provide additional assurance on how those needs are met, should be considered where available.

9.2 Community Nursing Services are able to demonstrate how they meet the requirements of recognised evidence-based guidance including;

- those related to workforce e.g. Nurse Staffing Levels (Wales) Act 2016 (legislation.gov.uk) or Royal College of Nursing, Nursing Workforce Standards
- National policy and/or guidance from profession specific organisations and/or clinical standards/guidelines.

All Nurses in Community Nursing Services have **sufficient time allocated** to care sensitively for people through;

- 'What matters to me' conversations with individuals
- Holistic assessment of an individual's needs, which incorporates a preventative/educational approach
- Completion of clinical records including care planning, assessment and review of outcomes
- Completion of activities required to support the individual and/or their family e.g., referrals
- Travel time - dependent on role/service

The time allocated, may be reflective of the Nurse's area and level of practice.

9.3 All Community Nursing services have clearly defined escalation measures which outline when demand for nursing care has exceeded capacity and the measures to be taken to ensure nursing care and treatment remains safe, effective and responsive.

Indicators of 'red flags' or areas of concern for any Community Nursing Service, which should be set out within escalation tools include;

- Inability to review individuals within usual working standards for that area of practice
- Deferring home visits which have the potential to negatively impact on an individual's health or wellbeing, every day or most days
- Inability to visit or see any individual with an urgent need, that may result in attendances at Urgent or Same Day Emergency Care services, OOH services, ED attendance and/or admission
- Inability to support people who are at the end of life in their preferred place of care – this may include delayed discharges from hospital or hospices
- High staff turnover and high sickness levels – which may include wider members of the multi professional team, recognising the impact this may have on community nursing services
- Nurses expressing concerns about their own and/or colleagues wellbeing e.g., due to missed breaks, staying over paid hours, being asked to do extra shifts
- Nurses expressing concern that in their **professional judgement**, there is a risk of unsafe care and treatment, which may result in avoidable harm to individuals

9.4 There should be clear systems in place for how changes in demand and capacity are escalated to senior nurses, GP's, cluster leads and other health and care professionals within the cluster. This should include how escalation is responded to, the outcomes of actions taken and how this is fed back to Nurses.

9.5 There may be exceptional circumstances where demand vastly exceeds capacity within Community Nursing Services e.g., during a pandemic. In these circumstances, nurses may be working in situations where staffing levels are below the usual standard for that area, where only individuals with the greatest nursing need are seen and where care delivered to individuals is at risk of being compromised.

It is essential that Community Nursing Services work together in these circumstances to support those individuals with the greatest nursing needs. This may mean working outside a nurse's usual area of practice, in unfamiliar environments or across organisational boundaries.

In addition, to escalation measures used by Community Nursing Services to support increased demand there should be;

- Clear policies on how Nurses are moved between areas and organisations
- Identification of any additional training/support required for Nurses to safely carry out nursing care, if

working in different settings or areas of practice
- Decision support tools to assist Nurses in identifying which individuals are prioritised
- Additional access to emotional well-being support

9.6 District Nursing Services as the core nursing service 24/7, 365 days a year, have caseloads which are manageable and which meet the recommendations outlined in the Queens Nursing Institute's (QNI) 'Workforce Standards for the District Nursing Service' (2022) and the Welsh Audit Office's District Nursing Services in Wales - A checklist for Board Members. This includes considering if mitigating actions are required, based on the Nurses professional judgement where;

- caseloads **per whole time equivalent registered nurse** exceed 150 people
- number of visits exceed 9-10 **per registered nurse, per shift**

The QNI workforce standards highlight how the above factors have an effect of increasing the amount of work left undone, resulting in delays in care being provided to individuals.

To ensure there is sufficient time to carry out the full nursing process the QNI Workforce Standards (2022) recommend a Registered Nurse home visit should be scheduled for a minimum of 30 minutes.

While other professionals may visit people on a DN caseload, the individual should be assessed by a registered nurse at least **every fourth visit, or every 6 months,** whichever is sooner, so the full nursing process can be carried out.

9.7 In situations where the number of visits exceed 9-10 per registered nurse, per shift, additional factors that may need to be considered by the DN Team Leader are;

- The location of visits e.g., a nurse visiting a residential home where they may carry out multiple visits within that setting
- Acuity and complexity of the individuals being seen
- Demand and capacity data from a scheduling system
- Escalation level of the team, service and wider health and social care system.

Following assessment of these additional factors, the DN Team Leader or Deputy, in conjunction with a Senior Nurse may need to increase the number of visits that registered nurses are asked to complete for **that shift.**

9.8. Where visits for Registered Nurses exceed 9-10 per shift in a team on most days (i.e., 4 or more days in a 7 day period), a review of demand and capacity data for that DN team and the wider DN Nursing Service, is undertaken and an action plan with clear timescales developed. The review should include opportunities for safe skill mixing and opportunities to streamline /improve ways of working with the wider multi professional team.

> Increasing visits above 9-10 per registered nurses per day have an effect of increasing the amount of work left undone, resulting in delays in care being provided to individuals (QNI Workforce Standards 2022).

Scheduling systems are designed to help Community Nursing Services schedule visits by allocating individuals to the right nurse with the right skills. While an **indicative length of time** is used for scheduling, this time can be revised by a registered nurse. Scheduling tools are not designed to replace a registered nurse's professional judgement, or prevent sufficient time being allocated to enable nurses to carry out care sensitively.

9.9 DN and Deputy team leaders, along with caseload holders, are supported to undertake additional training such as the Specialist Practice Qualification (SPQ), or a post registration community nursing degree. This is because of the clear evidence base demonstrating the benefits the SPQ provides to people seen by the service.

9.10 To promote the continuity of an individual's care, each DN team within a cluster should have a staffing complement of no greater than 15 staff / 12 WTE. This needs to include a 26.9% uplift for staffing and at least 15 hours administration support per week per DN team.

9.11 DN teams are structured so they are coterminous with the cluster and have a distinct and identifiable geographical neighbourhood, zone or district within the cluster. If the anticipated nursing needs of the local population are increasing and the above recommendations cannot be met, an exploration of the need for additional registered nurses or DN team (where large team size is becoming an issue) must be considered. The use of professional judgement, Interim District Nurse Staffing Principles and local knowledge of factors which may influence DN services, must be included in this assessment.

9.12 Any assessment should include the benefits, disadvantages and risks to the local population, the DN nursing workforce, the wider community nursing workforce and relationships with GP practices and other health professionals. The outcomes of any risk assessment and decision are clearly communicated with all key stakeholders.

10. Communication

Communication with individuals using community nursing services and their carers and/or significant others is essential. This allows for individuals to fully participate in decisions about their care and to take part in the management of their nursing needs where appropriate.

To ensure individuals nursing needs are managed safely, timely communication between nurses within clusters as well as GP's, Allied Health Professionals (AHP's) and other members of the multi professional team is essential.

Each GP practice should be aware of members of the DN teams and Specialist Nurses, who provide services to individuals registered at their practice. This will help prevent delays in sharing clinical information between nurses and other professionals involved in the person's care.

Technology should be available to support effective communication between nurses, and the wider multi professional team. This needs to be enabled by identified time within the working day, for nurses to attend multi professional meetings and/or have discussion with individuals and their carers where required.

10.1 Person Specific Communication

10.1.1 Community Nursing services are part of regular multi professional meetings in line with best practice, which as a minimum should allow for clinical discussion, review and management of individuals who;

- Have a deteriorating condition, significant frailty or complex health/mental health needs which may result in an unplanned admission or attendance at hospital,
- Have a deteriorating condition, significant frailty or complex health/mental health needs that have resulted in an unplanned admission or attendance at hospital within the past 5 days
- Are considered to be in the last year, months or days of life and have palliative care needs
- Have complex needs that require a multi professional approach
- Are at significant risk of harm due to safeguarding or self-neglect
- Have a condition that is at risk of deteriorating or has deteriorated, resulting in an individual being unable to carry out their work role.

Multi professional meetings can play an important part in developing effective working relationships between members of the multi professional team and where possible, should be used as an opportunity for shared reflection and learning.

10.1.2 For individuals, discussed at multi professional meetings, a named coordinator should be agreed by the team, to support seamless working and prevent duplication. The coordinators details must be shared with the individual, carer and wider members of the multi professional team as appropriate.

10.2 Professional & Team Communication:

10.2.1 There is a Community Nurses meeting at cluster level **every two months,** which allows for GPN's, DN's and Specialist Nurses along with nurses from Specialist Nursing Branches, Specialist Community Public Health Nurses and Significant other groups of Nursing to;

- Have opportunities for networking, including identification of challenges and opportunities
- Support discussion of practice e.g., via case studies, and/or changes in practice based on new research, and/or clinical practice recommendations e.g., NICE
- Identity, carry out and review service improvements and/or research
- Review data from experience and outcome measures
- Provide opportunities for informal/formal education opportunities
- Review current pathways and/or develop new pathways and ways of working in light of local population and outcome data
- Develop collaborative leadership including greater understanding of roles and contribution to local population needs,
- Develop effective working relationships,
- Share learning from compliments/complaints and incidents

10.2.2 At a maximum of six monthly intervals, this meeting should be attended by Cluster leaders, representatives from GP practices, Senior Nurses and members of the wider health and care team, to ensure any learning, development or innovation from the Community Nurses meeting is shared and evaluated.

10.2.3 Nurses from Community Nursing Services should be either part of a Professional Nursing Collaborative, or know how to raise anything they wish to, to their local Professional Nursing Collaborative.

The Professional Nursing Collaborative may be part of the two monthly community nurses meeting or a separate meeting. However, if the professional collaborative is part of the two monthly meeting, it is essential that there is a broad nursing membership representation to meet the objectives of the collaborative's core work.

10.2.4 It is **essential** that Community Nurses are supported by their employers and organisations to network together, as this offers a way for Community Nurses to innovate, build meaningful working relationships and review current ways of working. Ensuring nurses have the time to do this should result in reduced duplication, release time and improve individuals experience and outcomes.

10.2.5 Community Nurses have a system in place where they can come together on a daily basis to;

- Provide support to one another
- Discuss concerns and/or changes in individual's condition
- Review outstanding work and/or new referrals
- Have a meal break

11. Workforce learning and development

11.1 Community nursing services have a workforce plan which includes how nurses are;

- Recruited into the service, including positive recruitment strategies aimed at groups that may be under represented within the local nursing workforce.
- Developed in line with population needs, recognising the skills needed by the nursing workforce, including the development of advanced clinical practice roles, specialist practice qualifications (SPQ) and consultant roles.
- Retained via clear succession planning and development opportunities for nurses at all levels of practice, including access into registered nurse training for health care support workers and into lead clinical or professional nurse roles within the cluster and/or community services.

- Enabled to have a structured career pathway aimed at promoting a lifelong career within community nursing. This should include opportunities for nurses to maintain their clinical skills in senior operational/management roles.
- Supported to have well balanced, reasonable job plans which permit a sense of a job well done and accomplishment.

11.2 Community Nursing Services have an understanding of the reasons why nurses leave, e.g., via the use of exit interviews, which is used to review and inform their work force plan

11.3 Community Nursing Placements are offered across District Nursing Services, General Practice Nursing and Specialist Nursing Services. This supports student nurses to develop a better awareness of the types of nursing available in community settings and supports future recruitment.

11.4 Community Nursing Services ensure there are sufficient clinical assessors and supervisors in line with the NMC 'Standards for student supervision and assessment' as well as Practice Education Facilitators to support;

- student nurse placements
- newly qualified nurses
- nurses returning to practice
- nurses undertaking specialist practice qualifications
- nurses undertaking advanced clinical practice.
- nurses undertaking Non-Medical Prescribing

11.5 Community nursing services have a clinical supervision model in place which provides a structured and protected session at least every 8 weeks. In addition, at least every 6 months there should be a session with a nurse who has received additional training in restorative supervision. This can reduce stress and burnout, improve wellbeing and job satisfaction as well as improving relationships and team dynamics[1]. Clinical Supervision may be offered individually, in groups or a mixture of both. Restorative supervision sessions may also occur at other times in the year for example following a change in role, at times of stress[2] or after a critical incident.

11.6 Each Community Nurse has dedicated time of at a minimum, 4 hours, per 4 week period to undertake quality initiatives. This may consist of clinical audits, development of service improvement initiatives, research or time for writing articles for publication. This dedicated time is essential to support the principle of safe, effective and value-based care.

11.7 Each Community Nurse has a minimum 5% of their working hours during a year, allocated as non-mandatory professional development time. This enables continuous development for nurses which is essential for the provision of safe care.

11.8 Each Community Nurse has an opportunity yearly to discuss with their line manager their professional development, to ensure they are able to meet the requirements of their role and the NMC's revalidation requirements.

[1] Petit, A. Stephen, R (2015) ihv_literature-review_v9.pdf (wordpress.com)
[2] clinical-supervision-for-midwives-in-wales.pdf (gov.wales)

12. Community Nursing Models of Care

12.1 General Practice Nurses, District Nurses and their teams and Specialist Nurses by the nature of their roles and scope of practices will have both generalist and specialist skills. This breadth of skills allows for opportunities to consider different ways of working across neighbourhoods, clusters and primary/secondary care and as part of the wider multi professional team, **while still recognising the value each of these nursing groups bring**.

12.2 Community Nursing Services should be enabled and supported to consider alternative ways of collaborative working which cross traditional organisational boundaries. Examples of this may be;

- Cluster based roles such as consultant nurses who can support both community nurses and other members of the multi professional team
- Shared posts such as DN/GPN team leader roles
- Specialist Nurses who are based in secondary care being aligned with Primary and Community Nursing Services, enabling and developing preventative services where this adds value
- Occupational Health Nurses working alongside and/or aligned with Community Nursing Services at an individual practice or Cluster level
- Community Nursing Hubs
- Community Nurse Led Services, e.g., Nurse Led Family Practices, Nurse Led Ward rounds
- Rotational Nurse posts between Community Nursing Services, secondary care and/or OOH/111/WAST, promoting greater understanding of roles, experience and management of risk
- Specialist Nurses employed in Community Nursing Services, and/or as part of the wider multi professional team rather than secondary care, with a proactive in reach offer to secondary care.
- Collaborative working with Volunteers or voluntary organisations building on current good practice for example, Leg Clubs, Home from hospital schemes and trained volunteers supporting people at end of life.
- Development of new and/or shared pathways between Community Nursing Services which operate over extended service times e.g., evenings/weekends and in alternative settings, to meet the needs of hard to reach groups.
- Development of shared pathways between Community Nursing Services across Health Board boundaries, ensuring care and access to Community Nursing is standardised.

12.3 Where opportunities to develop new models of working exist, this is demonstrated by measures which confirm the benefits, outcomes and experience for both individuals, Nurses and the wider health and social care system.

13. Quality and Outcomes

Community Nursing Services need to be able to demonstrate how they are achieving the National Community Nursing Specification. This includes how Community Nursing meets the needs of individuals, benefits nurses, benefits the system and enables quality, safety, effectiveness and efficiency. The outcomes outlined below provide a value based approach to improving the experience and outcomes of people who have nursing needs and supports the ambitions of the National Clinical Framework, of a learning health and social care system, where collaborative working, local ownership and innovation is key.

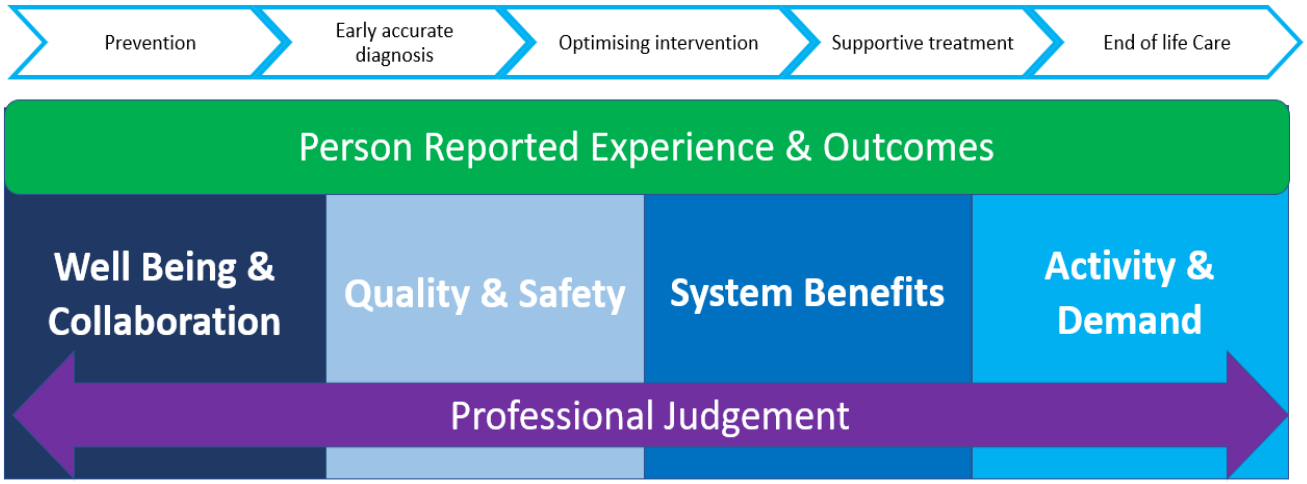

Figure 3 Quality & outcome measures

Demonstration of achievement of the National Community Nursing Specification will be achieved via a two-part process, which should be completed on a 12-month basis, or after any significant transformation of Community Nursing Services and shared with Executive Directors of Nursing.

The two-part process consists of;

1. Completion of the Self-assessment form which covers all key aspects (i.e., sections 4 – 12) of the National Community Nursing Specification – *See Appendix 1*
2. Feedback from Community Nurses, Person reported outcomes and experience measures and data as below;

Person Reported Experience & Outcomes		
What do we want to achieve?	**How will we know?**	**Outcomes**
Individuals are able to share their experience of care within Community Nursing Services Individuals are able to inform how Community Nursing Services provide their care, treatment or support	Use of core service user questions to understand individuals experience of care Examples of how Community Nursing Services have acted on feedback e.g., 'you said, we did'	Individuals accessing Community Nursing Services have a good experience

Wellbeing and collaboration		
What do we want to achieve?	**How will we know?**	**Outcomes**
Access to restorative supervision for Nurses via dedicated time Increased understanding of Nurses own role, value & contribution Ownership of how Nursing is provided in neighbourhood/cluster via use of data which informs and supports practice Development of shared skills, pathways and ways of working which may be outside traditional models Clear career pathway and succession planning for Nurses Sufficient clinical assessors and supervisors to support Nurses Daily handovers/briefings for Nurses	Feedback from Nurses via professional collaboratives and survey Involvement in Professional Collaboratives and/or Community Nursing meetings Self-assessment tool	Nurses have access to restorative supervision via dedicated time Nurses feel included in how changes to services are agreed at their neighbourhood/cluster level Nurses understand the career opportunities that exist within their chosen area of practice Nurses are supported during professional development activities by adequately trained and prepared supervisors/assessors Nurses have a daily meeting with their immediate team/colleagues, where they are able to discuss peoples care & treatment, any concerns and receive support

Quality & Safety		
What do we want to achieve?	**How will we know?**	**Outcomes**
Increased time to provide care – % time spent 'face to face' (actual or virtual) Ability to access clinical systems for Nurses necessary for role Access to SPQ and/or other training required to undertake role Ability to undertake research and quality improvement initiatives via dedicated time Clear escalation routes for all Nurses and areas of practice, underpinned by Nurses professional judgement Use of digital solutions to support practice including e scheduling Use of Multi professional meetings and agreed frailty tools	Feedback from Nurses via professional collaboratives and survey Data from scheduling systems where available Access rates to advanced clinical practice programs including Specialist Practitioner Qualifications Number of services where frailty tools are in place Self-assessment tool	Nurses report they have time to provide holistic care Community Nursing Services can demonstrate how much time Nurses spend with the people they care for Nurses have access to clinical systems and digital means Nurses are able to access the training they require for their role Nurses are able to develop, support or lead research and service improvement initiatives Nurses use a standardised approach to the identification of frailty

System Benefits		
What do we want to achieve?	**How will we know?**	**Outcomes**
Consistency of provision and reduction in variation: access to services in & out of hours, pathways e.g., catheter care	% of people with a urethral or suprapubic catheter who attend an Emergency Department (ED)	People who have a urethral or supra pubic catheter are able to access District Nursing services or an alternative community nursing provision 24/7
Sustainability of core 24/7 District Nursing services –weekend staffing is a minimum of 80% of the usual staffing available Monday – Friday.	Self-assessment tool	People with nursing needs are able to access District Nursing Services 24/7,
Retention of experienced nurses Attraction of community nurses – new to practice, change of practice area, international and returning to practice	Workforce retention, recruitment and vacancy information	Nurses choose to work and stay in community and primary care services

Activity & Demand		
What do we want to achieve?	**How will we know?**	**Outcomes**
Reduced hospital attendances/admissions Reduced hospital length of stay	Use of Healthy Days at Home Measure to indicate areas of high attendances at ED/Hospital	Individuals do not attend ED or hospital unnecessarily
Ability to consistently discharge 7 days a week	Codes in use which relate to delays due to Nursing within Pathways of Care Delays	Individuals with nursing needs do not have their discharge delayed due to a lack of Community Nursing Services. Community Nursing Services are able to accept discharges from hospitals 7 days a week
Ability to meet response times; Urgent 2 hours; Non-Urgent within 72 hours; Planned within 10 days	Data from scheduling systems where available	Individuals with a nursing need are seen in line with agreed response times

14. Glossary of Terms

- **Active collaboration and engagement** - may consist of;
    - Building understanding and relationships on a locality basis.
    - Working with voluntary sector partners to co-produce solutions to identified needs or gaps in care provision.
    - Involving volunteers. e.g., through voluntary or statutory bodies, (WCVA, 2022)

- **Cluster: *"***A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000". (ACD Toolkit)

- **Neighbourhood:** a defined geographical area within a larger community

- **Non-Urgent -** the individual is able to wait for a nursing intervention for up to 72 hours (including weekends & bank holidays)

- **Planned** – the individual is able to wait for a nursing intervention for up to ten working days

- **Professional Nursing Collaboratives** - are networks of professionals with shared expertise working together to use their unique skills to assess the population needs of the local residents where they work.

- **QNI Nursing Process:** The process by which registered nurses assess, plan, implement and evaluate care. Although this can be delivered by many members of the team, the Registered Nurse remains responsible for the nursing process (QNI 2022)

- **Technology Enabled Care (TEC)** - Technology Enabled Care Services (TECS) **-** offers a way to do more with less, care closer to home and delivers benefits to people and workforce. Examples of TEC projects in Wales can be found here; TEC Cymru | Digital Health Wales

- **Urgent -** an urgent nursing need which is likely to result in a hospital attendance or admission if the person is not seen within 2 hours

- Value-Based healthcare **-** focuses on meeting the goals of the people seen and helps manage expectations throughout their care or treatment. It includes, improving how people are involved in decision making, avoiding any unnecessary variation in care and becoming more creative to determine where resources are best spent for improved person outcomes.

- **Work left undone:** The work that nurses and support workers do not have time or resources to do, but impact on direct patient care or the organisation of care (for example making referrals) (QNI 2022)

Appendices

Appendix 1: Self-assessment form which covers all key aspects (i.e. sections 4 – 12) of the National Community Nursing Specification

Appendix 1 Self Assessment Form.xls