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Transforming Nursing, Midwifery and Health Professions' (NMaHP) Roles:
pushing the boundaries to meet
health and social care needs in Scotland

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Paper 3
The district nursing role in integrated community nursing teams

In partnership with

SEND
Scotland's Executive Nurse Directors

Healthier Scotland
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Paper 3
The district nursing role in integrated community nursing teams

This series of brief papers on the Transforming Roles programme aims to update stakeholders on the professions' contribution to the wider transformational change agenda in health and social care in Scotland. The third paper outlines how district nursing roles are being developed in NHSScotland.

Background

The Chief Nursing Officer is committed to maximising the contribution of the nursing, midwifery and health professions (NMaHP) workforce and pushing the traditional boundaries of professional roles. The Transforming Roles programme aims to provide strategic oversight, direction and governance to:

- develop and transform NMaHP roles to meet the current and future needs of Scotland's health and care system
- ensure nationally consistent, sustainable and progressive roles, education and career pathways.

Phase 1 of Transforming Roles focused on nursing roles.

Integrated community nursing teams

Shifting the balance of care from hospital to community and primary care settings at or near people's homes aims to improve population health, increase quality and safety, and secure best value from health and social care services.

Delivering on these aims requires a different approach that enables community nursing staff to develop new and innovative ways of working to provide safe, effective, person-centred care and clinical interventions tailored to need. District nurses and their teams will work with practice nurses, mental health nurses, specialist nurses, and nurses in the third and independent sector as an integrated community nursing team to provide a seamless interface and reduce any boundaries between their practice and place of care.

Integrated community nursing teams will play a key role in planning, providing, managing, monitoring and reviewing care, building on current roles and best practice to meet the requirements of people with more complex health and care needs in a range of community settings.

Annex 1 sets out responsibilities and roles in the wider community nursing team, with examples of levels of knowledge and skills from healthcare support worker level to advanced practitioner. The framework is organised around the four central pillars of practice.[1]

1 **The four pillars – clinical practice, facilitation of learning, leadership, and evidence, research and development – are defined in the NHS Education for Scotland Post-registration Career Development Framework for Nurses, Midwives and AHPs (http://www.careerframework.nes.scot.nhs.uk/using-the-framework/pillars-of-practice.aspx).**

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Developing a district nursing role for the future

Work that began in 2015 in light of recommendations from the national out-of-hours services review outlined the future role of a senior practitioner/district nurse (Level 6). The work emphasised district nurses' leadership role in areas such as anticipatory, palliative and end-of-life care. The aim was to develop, agree and drive implementation of a refocused district nursing role for NHSScotland by:

- developing a vision and model to meet future health needs
- defining key components of future roles
- identifying specific core education required
- considering future guidance on caseload and resource-allocation models.

Analysis of the current challenges and complexities in delivering district nursing services included a review of:

- the wider policy landscape and implications
- the need for seven-day/24-hour services
- the move towards locality multidisciplinary teams
- the public health review and policy, including place-based and community approaches to care delivery and outcome-focused care
- the GP contract and refocused GP and general practice nurse roles
- the integration and creation of health and social care partnerships
- care home and independent/third sector links and requirements
- current district nurse roles and services
- workload and workforce challenges
- current education provision.

A rapid review of evidence to identify effective home-based nursing interventions provided by district nurses was carried out by the Chief Scientist Office Nursing, Midwifery & Allied Health Professions Research Unit at Stirling University to support the review. Findings from two national scoping exercises also informed review processes, and NHS Education for Scotland hosted three full-day participatory events that effectively engaged stakeholders from across health, education, social care and the third and independent sectors.

Future vision for district nursing in Scotland

District nurses will play a pivotal role in integrated community teams. They will be at senior practitioner level within the career pathway and will be supported by the wider community team, including healthcare support workers, registered nurses and advanced nurse practitioners, to promote health and wellness, enable self-care and deliver personalised health outcomes in people's own homes or communities. Services will be integrated appropriately with social care and other partners and properly signposted to ensure a full range of locally led, co-ordinated, high-quality, accessible and well-understood services are in place.

District nurses will have defined high-level generalist competences and be able to work flexibly and in partnership with patients, carers, communities and a range of other professionals, including social care and voluntary workers and carers. They will be enabled to work across hospital and community boundaries and beyond traditional professional and employment demarcations, with flexible skills and the ability to adapt and innovate.

This vision aims to support people to stay longer at home and in their communities. It balances the role of the district nurse in managing complexity alongside promoting self-care, independence, prevention and community engagement. It reflects a public health approach based on evidence of what works and is underpinned by fundamental principles that define the focus of the role as being about:

- promoting prevention
- adopting strength- and asset-based approaches
- practising relationship-based care
- promoting self-care and independence
- enabling people to manage their own health
- providing continuity of leadership and care delivery
- adopting a lead role in care, including complex care and case management
- promoting ownership, responsibility, accountability and independent decision-making
- working in wider integrated community nursing and multidisciplinary teams that include general practice nurses to achieve effective outcomes realised through interventions by appropriately qualified professionals
- working in localities/neighbourhoods and drawing on local infrastructure and resources
- basing interventions on evidence from research and evaluation and knowledge of individuals and communities
- getting it right for every person every time
- utilising skills in the social care sector and working in partnership.

The district nurse role must be patient-centred, aim to reduce variation, and ensure individuals and their families receive high-quality services that improve health and reduce inequalities. This is achieved by a model that:

- clarifies the unique (specialist generalist) district nurse role of providing care while promoting enhanced integration between health and social care, reflecting the views of professionals and key partners and building on best evidence of what works
- defines relationships with the National Health and Wellbeing Outcomes and related policy work streams, such as the public health outcomes frameworks, and patient safety and quality programmes.

Key features of the district nursing role

The model highlights seven core elements where it is expected district nurses will play a key leadership role:

- public health
- anticipatory care
- assessment
- care/case management
- complexity/frailty
- intermediate care
- palliative and end-of-life care.

Additional key components of the role are shown in Annex 2, and the core components of education for the future role in Annex 3.

Future work

Further work is being undertaken on developing a model of caseload weighting and resource allocation that will complement the national workload and workforce planning tool. This will be based on a validated tool and population data and will incorporate factors such as deprivation, risk prediction, prevalence of long-term conditions, and estimations of complexity, dependency and time.

The aim is to underpin the provision of safe, effective and proactive interventions and care through the ability to direct capacity and additional time to deliver more complex interventions in identified deprived areas. In addition, work will begin to explore the interface and role of general practice nursing, to complement and enhance integrated team-working and development.

Annex 1. Examples of responsibilities and roles in the wider community nursing team[2]

LEVEL	AREAS OF PRACTICE			
HEALTHCARE SUPPORT WORKER (HCSW)	**CLINICAL SKILLS**	**FACILITATION OF LEARNING**	**LEADERSHIP**	**SERVICE IMPROVEMENT**
LEVELS 2 AND 3 Parameters for a HCSW	• Works under direction and instruction from registered professionals • Supervision may be remote or direct • Carries out repetitive, routine and familiar tasks during their working day • Through experience and instruction, develops an awareness of what is normal concerning their patients'/clients' wellbeing and reports that which is outwith normal to registered professionals • Can communicate both routine and sensitive information to patients, clients, relatives and staff • Is able to problem-solve related to the task at hand • As a co-producer, works with patients/clients with varying levels of dependence; at times, they may be considered a 'lone worker' and as such carries out and undertakes familiar tasks with minimum supervision	• Develops organisational and time-management skills	• At all times, acts under the delegation and supervision of a registered practitioner • Makes non-complex decisions and reports these back to assist patient care evaluation • Works on their own initiative within their role remit, which consists of delegated tasks • Plans and prioritises their own work tasks and activities • In some circumstances, spends more time with patients/clients post-assessment than registered staff and is able to report to registered practitioners regarding patient/client progress	• Understands and is able to carry out reflective practice • Recognises risk in relation to care provision

2 **These examples will be further developed to align with Transforming Roles general practice nurse work.**

	• Is able to recognise patients'/clients' response to care and recognises the basic care needs of patients/clients • Undertakes delegated well-defined routine clinical and non-clinical duties within limits of competency • Supports patients, carers and the wider team		• Shows awareness of patient advocacy and wider patient/client issues (such as home concerns)	
LEVEL 4 Senior HCSWs have all the attributes, skills and knowledge described for HCSWs	• Has a generalised knowledge and understanding of their job role and related tasks and is further developed than a HCSW • Has a broad skill-base related to their practice • Possesses an awareness and relative understanding of what is normal concerning their patients'/clients' wellbeing and reports that which is outwith normal to registered professionals • Following an initial assessment of the patient/client by the registered practitioner, and under guidance and supervision while following set protocols and procedures, carries out routine elements of assessment to enhance the patient/client journey • Communicates routine and sensitive information to patients, clients, relatives and staff • Has an awareness of subtle cues concerning patient/client wellbeing and responds to/takes action concerning common symptoms within agreed protocols and guidelines pertinent to their work area • General workload is likely to increase in complexity where familiar but less routine tasks are delegated to them • Recognises risk in relation to care provision and further develops risk assessment skills • Shows awareness of patient advocacy and wider patient/client issues; recognises and understands role boundaries and limitations • At all times, acts under the delegation and supervision of a registered practitioner	• Supervises and assesses HCSWs of a lower grade and takes a role in supporting students and other health and social care staff • Is expected to participate in running groups and activities, giving help and support to registered colleagues • Supports and acts as a role model to HCSWs	• Is able to problem-solve and take action regarding patient/client care through an awareness of policy and legislation • Works on their own initiative within their role remit, which may involve more advanced clinical skills and tasks than a HCSW, dependent on the area and site of their work • Role remit consists of delegated tasks and duties that they plan and prioritise in consultation with registered practitioners • Has developed organisational and time-management skills • At times, may be considered a 'lone worker' and as such carries out and undertakes familiar tasks with minimum supervision	• Reports back to assist in broader service development and quality-assurance activities • Understands and is able to carry out reflective practice • As a co-producer, works with patients/clients with varying levels of dependence

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LEVEL	AREAS OF PRACTICE			
REGISTERED NURSE	**CLINICAL PRACTICE**	**FACILITATION OF LEARNING**	**LEADERSHIP**	**EVIDENCE, RESEARCH & DEVELOPMENT**
LEVEL 5 Works alone without direct support, undertaking and reporting on autonomous decisions made in practice	• Supports patients/clients with a wide range of conditions to understand and where possible take on self-management of their condition • Possesses clinical assessment skills • Delivers anticipatory and preventive care • Prescribes and works to patient group directives • Undertakes risk assessment • Assesses patients, taking into account their physical, mental and social states alongside the impact of their environment and social support available to them • Negotiates care plans that are person-centred and focused on self-care with clear objectives, using a range of assessment tools pertinent to the patient's needs to inform the assessment and assess risk for patients and staff • Articulates risk and strategy for risk assessment and management	• Supervises experienced or qualified staff and students • Facilitates students and others to develop their experience • Has ability to reflect on practice and utilise clinical supervision and other development opportunities and support • Has emotional intelligence and the ability to support staff at levels 2, 3 and 4 to debrief and reflect on difficult situations to improve learning and enhance self-awareness • Engages with appraisal and the development and activation of a personal development plan	• Co-ordinates the management of a defined caseload, as delegated • Plans, implements and evaluates programmes of care to meet individual health needs • Has ability to prioritise a delegated caseload/workload and effectively manage time and work effectively within the team • Has knowledge of resource management to ensure care is clinically effective and signposted to the patient and family, ensuring principles of confidentiality and disclosure are maintained • Recognises personal accountability and responsibility to monitor and evaluate care to ensure optimal practice	• Contributes to quality-assurance processes and service development • Participates in educational audit • Contributes to review of impact of NMaHP interventions on the wider individual/ patient experience • Has ability to articulate the evidence underpinning patients' care plans and interventions • Has ability to source evidence and appraise it to underpin practice • Recognises any ethical implications of audit, research, clinical trials or service-user involvement strategies

	• Has knowledge of a broad range of conditions, local care pathways and evidence-based management experienced by patients in community and general practice settings (this includes long-term conditions such as diabetes, coronary heart disease, heart failure, hypertension and stroke, chronic obstructive pulmonary disease, arthritis, dementia and other common mental illnesses, frailty and palliative and end-of-life care) • Has an understanding of the presentations of multiple pathology, depression, anxiety states, frailty and delirium, predominantly in older people • Has knowledge of the management of uncomplicated symptoms in patients/clients with palliative or terminal care needs and enhanced communication skills to confidently manage uncertainty • Ensures information is recorded objectively and reported back to the community or general practice nursing team • Can plan ahead for potential scenarios to ensure anticipatory care needs are understood and met • Recognises signs of deterioration in patients and refers appropriately to ensure patient safety and avoid hospital admission • Collaborates effectively with other members of the multidisciplinary team or other agencies involved in the patient's care	• Provides effective mentorship for nursing students and maintains a supportive learning environment with a range of learning opportunities • Shows creativity in developing learning materials for patients and adapting care to support individual needs in patients	• Participates in personal development, appraisal and development of other team members and the links between organisation and team goals • Has ability to recognise poor performance and take appropriate measures • Acts up for the team leader when absent • Assists the team leader in undertaking and reviewing needs assessments and community profiles (in district nursing) or other data in general practice that reflect the demographics and case management within the caseload and broader public health issues within the local community and general practice populations • Demonstrates leadership through appropriate delegation and supervision of non-registered staff	• Uses opportunities to suggest improvements to services, or introduction of other innovations or evidence • Engages actively in data collection for quality assurance and takes responsibility for ongoing evaluation of delegated care

	• Has the ability to recognise the patient's health beliefs and adapts behaviour-change approaches to enable self-management using extended brief interventions • Utilises a range of IT applications and technology where appropriate • Utilises critical thinking to explore and analyse evidence, cases and situations in practice • Draws on a range of sources in making judgements, guided by senior colleagues within defined policies, procedures and protocols			

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LEVEL	AREAS OF PRACTICE			
SENIOR PRACTITIONER (DISTRICT NURSE)	**CLINICAL PRACTICE**	**FACILITATION OF LEARNING**	**LEADERSHIP**	**EVIDENCE, RESEARCH & DEVELOPMENT**

LEVEL 6
Caseload management and care co-ordination involving clinical decision-making and accountability for highly complex patients/clients
	• Uses a range of clinical assessment skills, including:
	  • history-taking, physical examination, cognitive assessment and an approach that fosters a bio-psychosocial model
	  • critical thinking and clinical decision-making
	  • making objective and appropriate referrals
	• Is an independent/supplementary prescriber (V300)
	• Uses care skills, including:
	  • for people with complex needs and multiple long-term conditions
	  • for carers
	  • specific clinical skills such as rehydration therapy, intravenous antibiotic therapy, care of central venous catheters, chemotherapy, parental and enteral feeding
	  • communication
		• Identifies and supports the achievement of learning needs of individuals/teams in response to service need and personal development planning
		• Evaluates the effectiveness of educational interventions
		• Participates in teaching and student selection in higher education institutions and/or other education organisations
		• Uses established models of supervision, mentorship and coaching
			• Leads and manages the district nursing, multidisciplinary and multi-agency team to deliver care in the home and community
			• Works effectively across professional and agency boundaries
			• Provides leadership for quality improvement and service development to enhance people's wellbeing and experiences of health care
			• Actively contributes to a variety of professional networks, such as managed knowledge networks
			• Recognises early signs of poor performance and takes appropriate measures to address concerns
			• Contributes to the development of local guidelines and policy where appropriate at regional and national levels
				• Has knowledge regarding sources of evidence
				• Has ability to generate, manage and utilise data
				• Has ability to critically examine research, including:
				  • its application to clinical practice
				  • facilitating and participating in research
				  • dissemination where appropriate
				• Delivers population surveillance and interventions to improve community and individual health and wellbeing
				• Provides measurement of effectiveness of care

	• Delivers palliative and end-of-life care • Delivers anticipatory care • Delivers person-centred care approaches, including: • supporting self-management, behaviour change, motivational interviewing, compassionate care, personal outcomes, asset-/strength-based approaches and co-production • Role-models the values, behaviours and interactions expected, and ensures patient, family and carer feedback support these in practice • Understands public health • Uses a range of skills related to e-health and technology to enable care and support self-management • Understands mental health and wellbeing	• Contributes to the creation of an effective learning environment, ensuring learning opportunities for students • Participates in educational audit	• Provides leadership around integrated working, risk management, handling of complaints and feedback • Supports staff through change, including building resilience in self and others • Demonstrates advanced communication skills, including motivational interviewing and negotiation	

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LEVEL	AREAS OF PRACTICE			
ADVANCED PRACTITIONER	**CLINICAL PRACTICE**	**FACILITATION OF LEARNING**	**LEADERSHIP**	**EVIDENCE, RESEARCH & DEVELOPMENT**
LEVEL 7 Senior level of advanced clinical decision-making and accountability for highly complex patients/clients	• Provides differential diagnoses • Has responsibility for specific areas of service delivery • Undertakes advanced-level assessment, including comprehensive clinical examination to address highly complex health needs and physical and mental health assessment • Takes account of managing clinical risk in dealing with undifferentiated client groups across the age spectrum • Has freedom and authority to request diagnostic investigations and interpret and analyse results • Acts on the results to inform diagnosis and optimise treatment and management outcomes • Formulates an action plan for the treatment of the patient, synthesising clinical information based on the patient's presentation, history, clinical assessment and findings from relevant investigations, using appropriate evidence-based practice • Is an independent prescriber (V300) • Implements non-pharmacological-related interventions/therapies, dependent on situation and technical requirements of care	• Manages/supervises work of others • Provides training support and supervision of staff • Delivers advanced practice through educational development and delivery • Acts as an experienced work-based learning educator/assessor by providing advice to other practitioners • Designs, plans, implements and evaluates learning and development programmes • Engages with education providers to contribute to curriculum development and teaching	• Provides strong and effective leadership across professional and organisational teams/ boundaries • Leads or contributes to community nursing and health policy development and implementation • Practises with autonomy by virtue of advanced knowledge and skills • Offers evidence-informed advice to others on complex community nursing issues • Critically reviews team performance and uses results to enhance self and team-member working • Provides strong and effective leadership across professional and organisational team boundaries • Actively encourages involvement of service users to influence and improve person-centred care	• Ensures the delivery of evidence-informed care and participates/ leads practice development • Leads innovation and quality improvement • Is a role model for the wider team by creating a positive research culture • Utilises skills and knowledge of staff to support or undertake research/quality-improvement activity, such as audit and evaluation • Identifies, promotes, embeds and monitors the measurement of outcomes relevant to area of practice, using findings to enhance practice

	• Has the freedom and authority to admit and discharge from identified clinical areas • Uses new knowledge in innovative ways and takes responsibility for developing and changing practice in complex and sometimes unpredictable environments • Recognises the complexity of operating in multi-agency environments and the need for interdependent decision-making	• Takes a lead role in ensuring the application of standards and guidelines that underpin a quality learning experience • Analyses the range of factors that influence learning • Advises service/ education providers on capability and capacity for student experience on placements	• Ensures organisational objectives are reflected in personal and team objectives • Establishes, leads and supports a variety of professional networks with peers across professional groups	

Annex 2. Fundamental features of the district nurse role

Assessment/review

- Provides a holistic health and social care assessment for all patients, regardless of where they live
- Provides all first assessments, assessments for new referrals, returning patients or deteriorating patients in the home, including assessment of the home environment, circumstances, support networks and impact on health and ability to meet outcomes
- Undertakes assessments with the patient and family that focus on outcomes important to the patient, including the need for specialist assessment and/or referral to additional specialist services where appropriate
- Reviews all assessments following any change to care needs and on a regular (six-monthly) basis
- Reviews patients with two or more inputs from social care and puts an anticipatory care plan in place that includes a self-management plan and guidance for care staff

Care delivery

- Provides relationship-based care
- Provides a single point of contact and co-ordination for patients, carers and families
- Delivers dynamic, flexible care centred on patient need and relationship-building, whether at home, in a clinic or the wider community environment
- Engages with patient safety and continuous quality-improvement initiatives aimed at improving care and reducing variation and harm
- Works with patients and their families to deliver interventions that prevent ill health and enable self-management
- Follows the patient in and out of hospital care to ensure continuity
- Uses early warning tools/indicators with deteriorating patients
- Is supported by full use of new technology, including electronic records, telemonitoring, telecare and telemedicine
- Discharges patients: where people are found to be frail, at risk or meet early warning criteria, they should remain part of the district nurse caseload and community profile
- Facilitates patients' return home, enablement in the community, wrap-around care, teaching and supervision of care workers, anticipatory care planning, respite and carer support, and provides advice on housing/benefits

Leadership

- Acting as the lead nurse (and in partnership with others, such as community psychiatric nurses and general practice nurses where appropriate), should be responsible for commissioning additional interventions to be carried out by the wider community nursing team, social work, third or independent sector partners
- Oversees all community nursing needs, from enabling self-care and simple interventions (such as simple wound care and single immunisations) to management of patients with complex co-morbidity who are at high risk of hospital admission, mental health problems, addictions and frailty, and those at the end of life
- In partnership, acts to provide leadership, ensuring coordination of care for every adult, meeting predetermined criteria/level of need to lead on case and care management; this should be based on care needs and include any patient who requires clinical input or is at risk of deterioration, including young adults, those with complex care needs and frail older people

- Plays a key leadership role, acting as a conduit and ensuring continuity of care, care planning and appropriate communication within and across all partners and agencies
- Has a lead role with carers that includes setting standards, training, promoting understanding of anticipatory care planning, working together, and ensuring easy access to the district nurse service
- Receives report/feedback from any person involved in looking after a patient during a 24-hour period
- Maintains responsibility and considers care across the 24-hour period, involving all relevant partners

Referral and team-working

- All GP practices have an aligned district nurse or deputy
- Community profiling forms a recognised part of the district nurse role: definitions are redefined, based on GP practice populations; collective decisions by the district nurse, general practice nurse and social workers identify patients at risk or who would benefit from additional support
- Requests for one-off district nurse visits are via referrals that indicate key issues, risks and additional care needs; district nurses then undertake a holistic assessment as indicated and commission care
- The skills of the whole district nurse team, including healthcare support workers, are utilised to enhance service delivery and support the team's capacity to provide a range of delegated interventions, such as ongoing/re-assessment for continence products
- Phlebotomy services are attached to clusters/localities, ensuring timely referral by GPs, district nurses and general practice nurses
- Long-term maintenance/administrations, such as eye drops, are administered by carers and/or healthcare support workers; district nurses undertake assessments over one week then refer/commission wider team members; healthcare support workers in locality teams require education, development and investment to undertake delegated activities as part of the plan of care, such as simple dressings, catheter and bowel care, eye drops and percutaneous endoscopic gastrostomy (PEG) feeds

Annex 3. Core components of education themed around the four pillars of practice

Clinical practice

- Clinical assessment skills, including:
  - history-taking, physical examination, cognitive assessment and an approach that fosters a bio-psychosocial model
  - critical thinking and clinical decision-making
  - making objective and appropriate referrals
- Nurse independent/supplementary prescribing (V300)
- Care skills, including:
  - for people with complex needs and multiple long-term conditions
  - for carers
  - specific clinical skills, such as rehydration therapy, intravenous antibiotic therapy, care of central venous catheters, chemotherapy, parenteral and enteral feeding
  - communication
- Palliative and end-of-life care
- Anticipatory care
- Person-centred care approaches, including:
  - supporting self-management, behaviour change, motivational interviewing, compassionate care, personal outcomes, asset-/strength-based approaches and co-production
- Public health
- A range of skills related to e-health and technology to enable care and support self-management
- Mental health and wellbeing

Facilitation of learning

- Support and supervision
- Reflective practice
- Creating a learning environment
- Teaching, learning and assessment
- Clinical supervision
- Coaching
- Mentorship

Leadership

- Lead and manage the district nursing, multidisciplinary and multi-agency team to deliver care in the home and community
- Change management, including building resilience in self and others
- Caseload management, including delegation and referral
- Risk management
- Performance management
- Supervision of care provided by others
- Handling complaints and feedback
- Locality and strategic planning
- Knowledge of local community needs and resources
- Financial management
- Improvement methodology
- Professionalism
- Integrated working
- Communication skills, including motivational interviewing, negotiation, liaison with other agencies and services, use of technology

Evidence, research and development

- Knowledge regarding sources of evidence
- Ability to generate, manage and utilise data
- Ability to critically examine research, including:
  - its application to clinical practice
  - facilitate and participate in research
  - dissemination where appropriate
- Population surveillance and interventions to improve community and individual health and wellbeing
- Measurement of effectiveness of care

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