MODERNISING COMMUNITY NURSING

1 Purpose of the Report

The purpose of this report is to update the Sub-Committee on the end of the pilot of the Community Health Nurse model in North West and South East Local Health Partnership (LHP), and how this has informed the roll-out of Modernising Community Nursing in NHS Lothian.

2 Recommendations

The Sub-Committee is invited to:

2.1 Note the reflections on the lessons learnt and achievements from the Review of Nursing in the Community pilot and how these are informing the progression of the Modernising Community Nursing agenda within Edinburgh CHP.

2.2 Note how Modernising Community Nursing is being progressed both at a Pan Lothian basis and within Edinburgh CHP.

3 Summary of the Issues

3.1 The creation of the new Community Health Nursing discipline was outlined in Visible, Accessible, Integrated Care which was published in November 2006, NHS Lothian was designated a pilot site and two Local Health Partnerships (LHPs) within the city of Edinburgh were designated as the pioneer cohort sites. These were South East LHP and North West LHP.

3.2.1 In December 2008 the Nurse Director supported by the Lothian Partnership Forum following a review of the progress and risks and constraints associated with a single discipline model at a specialist practice level decided not to pursue the model as outlined in Visible, Accessible and Integrated Care. The model tested was based around team working and a shift to ‘cluster working’ building on the skills of the whole team but especially staff nurses.

3.3 Appendix 1 reflects the lessons learnt and the achievements made throughout the pilot. These are helping to inform the work as it is taken forward in Modernising
Community Nursing. Lothian is building on work originally started as part of the Review of Nursing in the Community. Work is concentrating on a team approach in supporting patients, children and families, which has been successfully developed within Edinburgh CHP. This also means the specialist disciplines of District Nursing and Public Health Nursing will remain to focus on their specialist areas of adult community nursing and children and families respectively.

4 Current position – Modernising Community Nursing

4.1 Following discussions, principles to underpin the modernisation of community nursing on a Lothian basis have been agreed. These principles are that the work needs to:

- Be shifted to a pan Lothian approach
- Be sensitive to local requirements
- Take account of the drivers and learning of the original work, namely a projected decrease in numbers of nurses available in future and frustration from users and carers at fragmented care
- Be inclusive to other projects already in progress, such as Family Nurse Partnership
- Consider areas outside the original remit of the project which concentrated on District and Public Health Nursing
- Address individual, family and service needs and needs to be shaped by public involvement
- Be taken forward with the Service to highlight and address issues impacting on community nursing services
- Be taken forward in collaboration with education to ensure staff have the appropriate knowledge and skills to work differently
- Be developed around two service models - Early Years and Adults
- Use Releasing Time to Care: Productive Community tools to identify ways that care can be delivered differently
- Build on the development of the role of a generalist staff nurse which has been piloted and an informal evaluation has been completed.
- Build on the work of senior practitioners who are participating in the Leading Better Care programme beside secondary care colleagues
- Continue to explore the role of non-registered staff which is being developed along with ensuring that the most appropriate people are doing the most appropriate jobs

4.2.1 A Modernising Community Nursing in Lothian Programme Board has been established which acts as a strategic group to oversee developments in community nursing, to ensure strategic oversight and a fit with Board objectives and sharing of good practice. Each CH(C)P is leading its own local modernisation work but in keeping with NHS Lothian’s strategic direction. CHP chief nurses are developing the work through a series of workshops with their senior nursing teams whilst ensuring that practitioners are both involved and kept informed.

4.2.2 Edinburgh CHP held a one day workshop for staff and three workshops for the senior nursing team to take the work forwards. The workshop for staff has helped inform the changes that are being taken forward that the staff feel will help ensure sustainable Community Nursing Services. Staff are currently being kept informed by
newsletters (Appendix 2) and following the workshops local presentations in each LHP are planned. The Director of Nursing will also be holding a meeting for all staff in June to update them on the strategic vision.

5 **Impact on Health Inequalities**

It is intended that the implementation of the cluster model of team development will reduce health inequalities as part of the contribution to achieving the policy underpinning Better Health, Better Care.

6 **Resource Implications**

There are no resource implications from this paper or Modernising Community Nursing

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8th May 2010

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8th May 2010
Appendix 1: achievements and lessons learnt

In order to build on the work to date around the testing and development of the community health nurse and exploit the lessons learnt on the process, the project manager has reflected on some of key learning as well as what has been achieved. The project has been very challenging and at times frustrating for all those involved. Many problems were encountered, some foreseen and others unforeseen. This report covers June 2007 to July 2009.

1. Achievements to date

1.1 Increased readiness for change. It has taken 18 months for some teams to recognize that the way services are currently delivered is not sustainable in the future. However, the feeling that the Community Health Nurse role was a ‘step too far’ for staff to embrace in terms of safety in clinical practice has not been altered. Some other stakeholders were less able to recognize the need for change.

1.2 Engagement of key stakeholders has been positive – most notably the operational managers – who have been pivotal in supporting staff to date and the processes of change management. Managers have worked hard to overcome the numerous barriers to change.

1.3 Support from Partnership Forum representatives in attending meetings and hearing the views from staff has been strong and helpful.

1.4 At the workshops – good two-way communication between different disciplines, mutual respect and recognition of shared learning was clearly demonstrated.

1.5 Workshops and working groups have begun to demonstrate a willingness to question current daily routine and assumptions; thinking about the future in a different way and identifying specific solutions.

1.6 A decrease in the levels of uncertainty, confusion and misunderstanding about the benefits of a generalist role working across disciplines is emerging.

1.7 The establishment of a project structure with regular monthly meetings which allowed for flow of information between groups as well as acknowledgement of challenges and potential solutions has been essential.

1.8 Communication strategy implemented with a bi-monthly local newsletter widely distributed, alternating with the national newsletter. Intranet pages set up and regularly updated has ensured a wide range of staff can access information. It has also helped to promote transparency in decision making.

1.9 Patients, carers and other service users (parents of children and young mums) have been involved in the discussions and have helped inform the decisions and direction of travel.

1.10 Staff, particularly in the pioneer cohort sites, has welcomed the support from OD and the opportunity to consider different ways of doing things.
1.11 Beginning to address some of the barriers to change – particularly around lack of capacity within teams, leadership/delegation issues and identifying specific problems that are often cited – namely IT and mandatory training.

1.12 Despite all the frustrations and anxiety around the CHN role – many staff are open to change and have been willing to engage in the workshops and the groups that have met to progress work.

Given the scope and magnitude of the changes proposed and the service pressures this is a major achievement. However, this must be balanced with the realisation that service delivery has changed little in the two years of the project.

2. Lessons learnt

All those involved have learned valuable lessons that are relevant and directly applicable to many of the ongoing changes which need to happen in the coming months and years. There is now a need to consolidate what has been achieved and to reach the broader goals that the modernisation of community nursing agenda will set out.

2.1 Vision & strategy

• The two most important drivers for the proposed changes (projected decrease in numbers of nurses available in future and frustration from users and carers of fragmented care) were recognised but not embraced by teams

• It was not possible to develop/create a shared vision for change and identify key individuals to be positive advocates of the changes within the confines of the model

2.2 Culture & Values

• The issues and concerns that are maintaining the status quo and the opportunity to identify factors that will significantly enable change were not sufficiently addressed

• Insufficient consideration was given to explore what values underpin current disciplines and build on shared core values and assumptions.

• Teams and individuals have found it difficult to explore how the distinctions between professional roles could be more fluid or how communication could be enhanced

• Almost constant, reactive responses to staffing crises or potential crises within teams meant that there was little space for creative planning and many meetings were caught up in discussion of management of these problems.

• Lack of appropriate staff to provide backfill to release staff has added to the resistance of some teams to engage in the work. However, some teams were creative and forward thinking in their organisation to enable staff to be released.

• There is little culture within community nursing teams of staff considering how they can develop a culture of continuous improvement (reflecting a sense of constantly being stretched beyond their ability to deliver the service effectively). Many staff saw the proposed changes as a criticism of the way they delivered care.

2.3 Leadership
• There were insufficient champions for change to demonstrate commitment to change through decisions and actions to enable staff to see ownership, commitment and self-motivation, despite strong leadership provided by the Nurse Director and Chief Nurse.
• CNMs and Team leaders were hindered in taking work forward locally because of concerns around the capacities within teams.

2.4 People

• Some staff did not understand or accept the nature and scope of changes being made and some were unwilling to take ownership of pieces of work
• There remained stereotypes between the disciplines with recurrent concerns about HVs ‘doing’ leg ulcers and DNs ‘doing’ child protection, enforcing ‘them and us’ attitudes.
• The work of exploring skill mix was resisted by some and many struggled to envisage how traditional job demarcations could be shifted reflecting the long history within community nursing teams of autonomous caseload holders.
• Professional change management consultants were employed at the beginning of the project to provide team development support and change management support. Their expertise and their perspective as ‘outsiders’ provided helpful insights to the challenges. Participants rated the sessions as useful. The consultants worked closely with Lothian’s own OD team and latterly dedicated support has been provided from within the local team. Both the project manager and teams have appreciated the expertise and support from the OD practitioner(s). The workshops and sessions have been both enjoyed and helpful in moving the work forwards and have been well evaluated. The work would not be where it is today without their support and skills.

2.5 Communication

• Rumour is often more relied on as a source of information than cascaded written information or a regularly updated web-site. This was particularly the case for staff out with NW and SE LHP who may have had less interest in investing the time in keeping up to date with written communications.
• Face to face meetings are the most effective.
• There is a need for more efficient information sharing so that lessons learnt through change processes are shared with other teams and good practice is shared.

2.6 Competences

• Risks around broadening of skill base were felt to be too great because of the complexity of care provided in NW and SE LHP. It should be recalled that Lothian deliberately chose areas of high complexity and vulnerability as pilot areas to ensure these issues were taken into account when looking at redesign models.

2.7 Systems, processes and logistics

• The current nursing IT systems do not support a more joint approach to cross discipline working although IT staff were helpful in addressing the problems where they could. It is anticipated that Community TRAK will address some of these practical problems.
• The lack of large facilities has been viewed as a barrier to closer working and learning between different professional groups. However, some practitioners are also ambivalent about joining others in larger, purpose built accommodation.

By building on the achievements, reflecting and learning from the lessons learnt, work across Lothian to modernise community nursing services can be progressed. There is a need to champion change and to continue to provide leadership, guidance and ongoing support to staff throughout the service. Pan-Lothian solutions need to be developed and dialogue needs to be maintained with the various projects and work streams that are being considered.
UPDATE ON PROGRESS

The Senior Nursing Team and Partnership have now had three Away Days, the last of which was on 18th April looking at progressing the Modernising Community Nursing Agenda. As part of keeping you briefed on progress this is the second of the staff updates

Emerging New Service Model

As previously highlighted any new service models need to fit the financial picture. There are many pressures financially on the public sector and this is impacting on Edinburgh Community Health Partnership and Community Nursing. Any new models must fit with the financial picture and in line with business premises strategy.

We have already mentioned that learning from Review of Nursing in the Community we will focus on two service delivery models:

Adult Service.
Children and Families Service.

As we stated in the previous update we will start to work more across LHP boundaries and we will reduce to four Clinical Nurse Managers working two in the North of the City and two in the South of the City. From the 1st June this will be:

South Edinburgh
Aileen Kenny CNM covering the areas of South West and South Central
Dawn Arundel CNM covering the area of South East

North Edinburgh
Frances Fraser CNM covering North West
Ros Boyd CNM covering North East

Each of the CNM’s also have city wide portfolios for specific areas of work. Other operational service changes under this model include:

Evening and Night Nursing Service - which moved from Aileen Kenny to Frances Fraser on the 1st April.
School Nursing Service – moved from management under five CNMs to Ros Boyd on 1st April

Other operational services remain unchanged
Clusters

Work is still underway with regards to Cluster modelling but we are hoping to finalise the Cluster’s by the end of April. However further work will still be required with regards to whether we have the ‘best fit’ regarding staffing within the clusters to meet the requirements of the populations/clients/patients. Your Clinical Nurse Managers and Team Managers will keep you briefed on the plans to date.

Pan Lothian

On a Pan Lothian basis we are moving forwards with the implementation of the ‘Productive Community’, which is the community based model of ‘Productive Ward’, which introduces lean methodologies to team working. Sites in England who have implemented this model have shown a great increase in staff morale in teams that have implemented this. It is a team based model, not a top down model. We are currently just about to advertise secondment opportunities for staff to be trained and developed to become a facilitators to help teams deliver the outputs required to implement ‘Productive Community’. If you are interested keep your eyes peeled for the vacancy adverts on the intranet. Also on a Pan Lothian basis we are beginning the work to develop specific ‘Core Specifications’ for the service areas – Adult Services and Children and Families.

The plans continue to be developed in partnership and the plans are being fed into the NHS Lothian Modernising Community Nursing Programme Board, to ensure that plans developed match a Pan Lothian picture. We also have a Local Implementation Group at a CHP level but in order to ensure staff involvement in the developing plans Local Operational Groups will be developed. As we wish this to be a collaborative process with staff involvement to help inform the process and future service delivery models. To start local engagement a series of Roadshows will be undertaken across service areas by the Clinical Nurse Managers and Partnership during the summer months.

We have plans for further away days through the Summer to keep the work progressing. If you wish to clarify any of the issues raised in this update please do not hesitate to contact me directly or contact your Clinical Nurse Manager

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