Nottinghamshire County Council

Nottingham City Council

Joint City / County Health Scrutiny Committee

Tuesday, 09 December 2014 at 10:15

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

(3) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
7 October 2014 at 10.15am

Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chair)
A Councillor P Allan
Councillor Chris Barnfather
Councillor R Butler
Councillor J Clarke
Councillor C Harwood
Councillor P Owen
Councillor J Williams

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
A Councillor M Aslam
A Councillor A Choudhry
Councillor E Campbell
Councillor C Jones
Councillor T Molife
A Councillor E Morley
Councillor B Parbutt

Also In Attendance

Councillor T Roberts - Member for Newark West
Councillor D Staples - Newark and Sherwood District Council
Pete Barker - Nottinghamshire County Council
Teresa Cope - Programme Director, Urgent Care – Nottingham City CCG
Alan Davis - HVSU Nurse, NUH
Demas Esberger - Clinical Director of Acute Medicine, NUH
Jane Garrard - Nottingham City Council
Martin Gately - Nottinghamshire County Council
Claire Grainger - Healthwatch Nottinghamshire
Dr Hazel Johnson - Notts Healthcare Trust
Dr Ola Junaid - Notts Healthcare Trust
Amanda Kemp - Notts Healthcare Trust
Nikki Pownall - Deputy Director of Operations, NUH
Sally Seeley - Director of Quality and Delivery, Nottingham City CCG

Other Attendees

Ian Hewitt - Keep Our NHS Public (KONP

MINUTES

The minutes of the last meeting held on 9th September 2014, having been circulated to all Members, were taken as read and were confirmed, subject to the following amendment, and were signed by the Chair:-

The date of the previous meeting should read 15th July 2014.

Disappointment was expressed that no member of the NCC communications team was present as previously requested.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor P Allan (other County Council business), and Councillors P Aslam, A Choudhry and E Morley (other City Council business)

DECLARATIONS OF INTERESTS

None

NOTTINGHAMSHIRE HEALTHCARE NHS TRUST AND NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP OUTCOMES OF CONSULTATIONS AND ENGAGEMENT:

PROPOSED CHANGES TO PROVISION OF ADULT MENTAL HEALTH SERVICES IN NOTTINGHAM AND NOTTINGHAMSHIRE

In July 2014 Nottingham City Clinical Commissioning Group and Nottinghamshire Healthcare NHS Trust advised the Committee of proposed changes to the provision of adult mental health services. Amanda Kemp, Deputy Director, Local Services, NHCT and Sally Seeley, Deputy Director of Quality and Delivery, Nottingham City CCG gave a presentation on the proposed changes which form part of a wider transformation programme focused on reducing inpatient beds and improving community based provision.

Following the presentation additional information was provided in response to questions: -

- The 206 inpatient beds were distributed between Highbury Hospital, Millbrook Mental Health Unit at Kings Mill Hospital and Bassetlaw Hospital.

- The Crisis House was located on MacMillan Close, Porchester Road, Nottingham. It was due to open in December 2014 and would have 6 beds. It would be staffed with Third Sector employees and by visiting NHS staff. It would support those who do not require hospital admission and other models suggested that the average stay would be for no more than 5 days. It was situated in the City/south of the County as the impact of the closing of the QMC wards would affect this area. Not aware of problems elsewhere in the County but there was the possibility of opening another Crisis House further north.

- Internal procedures had been tightened to ensure only those who need crisis support receive it with more people supported to move into mainstream services. This had created capacity within the Crisis Team. Additional ward rounds had been implemented and the discharge process had been revised. The demand for beds had declined and on Monday there were only 6 patients on Ward A at the QMC.

- Hospitalisation for some patients who had requested a bed was not necessarily the right course of action. Often a better overall care package was available which involved the patient remaining at home.

- Substantial reinvestment had been made in the crisis teams and a wider skill set was now found within the teams to enable them to support families and an increase in full time equivalent staff. Skills included family therapy, other intervention skills and clinical support. There would always be beds for those that needed them and there would be the Crisis House for those who needed support but not a hospital admission. In response to feedback about issues arising at evenings and weekends, the Crisis Team would be available 24 hours a day 365 days a year, which had not previously been the case.

- Approximately 30% of patients were admitted informally rather than sectioned.

- An annual benchmarking exercise was undertaken by the NHS and the trend over the last few years was that the demand for acute mental health beds continued to decline. It was expected that this trend would continue. The best way to ensure that future need was met was to provide sufficient support to enable people to stay in their own homes.

- In the last year 2 patients had been admitted out of area (plus any Trust staff who are also treated elsewhere for confidentiality reasons).

- There were now no patients at Enright Close although it had not formally been closed yet, and Dovecote Lane and MacMillan Close had both closed. In Newark there was a Community Rehabilitation Team for those requiring intense support for longer term needs. The review of long term bed use had found that demand had decreased substantially. Clinicians had been surprised and pleased at the subsequent positive outcomes for patients at Dovecote Lane and MacMillan Close. This had been achieved through giving patients more choice eg on budgets and treating them in a more appropriate setting.

- Street Triage had also been operating successfully for 6 months. A Community Psychiatric Nurse accompanied police officers until 2am. The numbers being referred to hospital or taken to a police station had declined substantially as a result. The Police appear to be satisfied at how well the scheme is working and it was not anticipated that they would withdraw.

- Though treatment at home may well be the best option there was a risk that patients could become isolated. The Community Rehabilitation Team did provide intensive support including support to patients' own networks. The Peer Support Workers comprise people who had been seriously ill previously or who had used the community services and they were able to give a valuable insight

into what kept people well through means other than clinical. The Prism Team was also able to signpost patients to available voluntary services and physical and mental health care options.

- Concern was expressed that despite the holding of 14 events not everyone had been aware of the consultation period regarding the proposed changes. The Trust was really confident that it had carried out a thorough piece of consultation and been open and transparent in reporting on the feedback. There was a long list of consultees including voluntary and third sector groups and some smaller groups that were sometimes neglected in consultation exercises e.g. the travelling community. A special effort had been made to contact those who could not attend an event. Attendance was highest in those areas where the changes had been identified and engagement was better than for previous similar consultation exercises carried out by the Trust.

- Users' views would continue to be sought and their challenges and feedback would influence the development of the plans. There was an awareness that the help users required needed to be available when they need it and not at some point in the future. Models would be refined as a result of any concerns subsequently raised and Committee would be kept informed as to what was working well and what was not.

- Healthwatch and Keep Our NHS Public (KONP) shared others' concerns about the comprehensiveness of the consultation process. A meeting between the Trust and Healthwatch was scheduled for the following day where those concerns would be discussed.

- Patient safety was taken very seriously and risk assessments were carried out and updated monthly.

The Committee considered that it had been properly consulted and that the proposed changes were in the interests of the local health service. There were some concerns about the public consultation carried out and although there was no intention to delay the implementation of the proposals it was felt that lessons learned needed to be incorporated into any future consultations. The Committee requested that a written paper on the learning identified from the consultation process, including outcomes from discussions about this with Healthwatch, be provided to the Committee.

Councillor Clarke abstained.

NOTTINGHAMSHIRE HEALTHCARE NHS TRUST AND NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP OUTCOMES OF CONSULTATIONS AND ENGAGEMENT:

PROPOSED CHANGES TO PROVISION OF MENTAL HEALTH SERVICES FOR OLDER PEOPLE IN NOTTINGHAM AND NOTTINGHAMSHIRE

In July 2014 Nottingham City Clinical Commissioning Group and Nottinghamshire Healthcare NHS Trust advised the Committee of proposed changes to the provision of mental health services for older people. Amanda Kemp, Deputy Director, Local

Services, NHCT gave a presentation on the proposed changes which formed part of a wider transformation programme focused on reducing inpatient beds and improving community based provision.

Following the presentation the additional information was provided in response to questions: -

- A reduction in mental health care budgets together with an ageing population meant that change was unavoidable. The CQC had rated the directorate as 'outstanding' in care and there was a commitment to maintain that standard.

- The Trust's Quality and Risk Committee was looking at all paperwork and assessment tools supporting the delivery of mental health services for older people and considering how they could be improved.

- Liaison between different teams did occur to ensure that not everyone visited a patient at the same time. The IRIS team was an integrated multi-agency service including social care. The aim was integration not duplication. The length of visits would vary over the 6 week period depending on patient need. Councillors expressed their support for this approach.

- Older people presenting in crisis after 10pm was extremely rare.

- Commissioners had a role overseeing the quality of service delivered by all providers and it did monitor and challenge performance. The Trust also considered that it had a duty of care to not ignore bad practice, and report it appropriately.

- As for consultation about changes to adult mental health services, concern was expressed that despite the holding of 14 events not everyone had been aware of the consultation period regarding the proposed changes. The Trust was really confident that it had carried out a thorough piece of consultation and been open and transparent in reporting on the feedback. There was a long list of consultees including voluntary and third sector groups and some smaller groups that were sometimes neglected in consultation exercises e.g. the travelling community. A special effort had been made to contact those who could not attend an event. Attendance was highest in those areas where the changes had been identified and engagement was better than for previous similar consultation exercises carried out by the Trust.

- Healthwatch and Keep Our NHS Public (KONP) shared others' concerns about the comprehensiveness of the consultation process. A meeting between the Trust and Healthwatch was scheduled for the following day where those concerns would be discussed.

The Committee considered that it had been properly consulted and that the proposed changes were in the interests of the local health service. There were some concerns about the public consultation carried out and although there was no intention to delay the implementation of the proposals it was felt that lessons learned needed to be incorporated into any future consultations. The Committee requested that a written paper on the learning identified from the

consultation process, including outcomes from discussions about this with Healthwatch, be provided to the Committee.

Committee requested that a progress report be brought to Committee 6 months after the implementation of the changes in both the provision of adult mental health services and the provision of mental health services for older people to provide an opportunity for the Committee to review implementation of the changes and to consider the initial impact of the changes for service users and carers.

INTOXICATED PATIENTS REVIEW – RESPONSE TO RECOMMENDATIONS

Demas Esberger, Clinical Director of Acute Medicine, NUH and Alan Davis, HVSU Nurse, NUH introduced a report which examined the impact of intoxicated patients on the Emergency Department at NUH.

Following the introduction the additional information was provided in response to questions: -

- The differing levels of service provision available in the City and County areas were a source of frustration.

- Cannot assume that drink was the cause of all problems. Information gathering could be more sophisticated, for example alcohol levels are not measured. The figures were likely to be an under estimation as those recorded only included those whose sole attributable reason for referral was alcohol.

- NUH staff very good at isolating patients likely to soil the general area in A&E. Those able to were encouraged to clear up their own mess.

- It had not been possible to begin the study into the perception of the problems caused by intoxicated patients on others as currently going through a period of transition. Other studies would be looked at and methodologies compared.

- There was an awareness of the work of the street pastors. All were volunteers, a ‘drunk tank’ was provided but patients were sent to A&E if this was required. Their premises, which were located in a pub, were being refurbished at the moment. There was the possibility that the pastors’ roles would expand from their current ‘Samaritans’ type service into one that also provided medical care.

- Mr Davies’ post was unique in the country as it was a full-time post. A&E departments in Derby and Leicester both wanted to introduce a similar post in their establishments.

The committee requested that Mr Esberger and Mr Davis return to Committee once their work had been completed.

RESPONDING TO PRESSURES ON THE URGENT CARE SYSTEM

Teresa Cope, Programme Director, Urgent Care, Nottingham City CCG and Nikki Pownall, Deputy Director of Operations, NUH gave a presentation on the work taking

place to address current pressures on the urgent care system, including the preparation for dealing with winter pressures.

Following the presentation additional information was provided in response to questions: -

- The main difference this year (an election year) was that the level of funding for dealing with winter pressures was notified in June rather than in November as previously. This had allowed a level of planning and consequently a quality of service that had not been possible in the past. Councillors felt that it was important that the significance of this was fed back to national decision makers.

- In the last week an additional 70 beds had opened at NUH, including for respiratory patients and an older persons ward. In two weeks time additional oncology beds would be made available. Changes were being made to the Emergency Department to create an additional 12 cubicles from the end of November and arrangements were in place to be able to fully staff those additional cubicles. From December there would be additional trauma beds and in January additional respiratory and surgical beds would be available. Overall there would be 108 additional beds available to cover the winter period, with 48 beds remaining open beyond April through recurrent funding.

- There was the possibility of staff at risk losing their jobs in the Mental Health Trust due to the proposed changes to adult mental health services. There were however, other job opportunities available within the NUH.

- Recruitment difficulties presented the biggest obstacle to proceeding with the plans to open more beds and all other aspects of the plans were on track. There was a shortage of Band 5 nurses of approx 20-22 to meet requirements for planned bed increases. All other staffing requirements had been recruited to. There was a national shortage of GPs with the East Midlands suffering disproportionately. The inner city was a challenging area in which to work, also the nature of the work may discourage some ie the requirement to be on call.

- It was unclear whether the local authorities could address the recruitment problem and it might be an issue that the Health and Wellbeing Board might wish to consider.

The Committee expressed its reassurance regarding the plans that are in place to manage 2014/15 winter pressures.

WORK PROGRAMME

The contents of the Work Programme were noted.

The meeting closed at 1.10pm.

Chairman

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 December 2014

Agenda Item: 4

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

OUT OF HOURS DENTAL SERVICES

Purpose of the Report

1. To introduce a briefing on Out of Hours Dental services.

Information and Advice

2. Members may recall that the Joint City and County Health Scrutiny Committee requested briefing on Out of Hours Dental Services at its last meeting.

3. Ms Julie Theaker, Primary Care Contract Manager of NHS England's Derbyshire & Nottinghamshire Area Team will attend the meeting to provide a briefing and answer questions as necessary.

4. A written briefing from Ms Theaker is attached as an appendix to this report.

5. Members are requested to receive the briefing, ask questions and schedule further briefing as necessary.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Receive the briefing on Out of Hours Dental Services

2) Ask questions

3) Schedule further consideration

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Out-of-Hours Dental Services in Nottinghamshire

Background

With the introduction of the new General Dental Services (GDS) contract and Personal Dental Services (PDS) Agreement in 2006, Primary Care Trusts were responsible for ensuring that appropriate out-of-hours urgent dental service arrangements were in place for residents and visitors to their area. From 1 April 2013, NHS England Area Teams (ATs) are responsible for ensuring that an appropriate out-of-hours service (OoH) is provided in its area.

The General Dental Service (GDS) Regulations (2005) requires the AT to provide an out-of-hours service and/or treatment 'within a reasonable time'. It has been generally accepted that this will require any necessary treatment to be undertaken within 24 – 48 hours and that a verbal response be made within 6 hours.

The term "out-of-hours" does not refer to a fixed universally agreed period, but refers to services provided outside the scheduled opening hours of a particular surgery.

Key principles

Dental emergency classification

Patients who require emergency care are those requiring immediate attention in order to minimise the risk of serious medical complications or prevent long-term dental complications. Their condition means they are most likely to present in emergency departments with:

- Uncontrollable dental haemorrhage following extractions
- Rapidly increasing swelling around the throat or eye
- Trauma confined to the dental arches

Dental urgent classification

Patients requiring attention for:

- Severe dental and facial pain not controlled by over-the-counter preparations
- Dental and soft tissue acute infection

Dental non-urgent conditions

A number of individuals currently access care from OoH services, who are not in pain and present for treatment regarding non-urgent problems. This may include:

- Patients not in pain
- Aesthetic problems (dislodged crowns and bridges)
- Patients with broken dentures
- Patients with hospital referral letters
- Patients requiring permanent restorations
- Non traumatic problems with orthodontic appliances
- Patients who have no significant pathology
- Patients requiring a second opinion
- Patients using EDs as their regular dentist
- Requiring surgical extractions (wisdom teeth) and are not in pain

Accessing OoH dental services

Patients access the OoHs services across the AT in a number of ways:

Contact NHS 111 directly – any area
Contact NHS 111 signposted by their regular dental practice (South Nottinghamshire and Nottingham City)
Contact Single Point of Access (SPA) signposted to by their regular dental practice (North Nottinghamshire) or 111

Current service provision

The Derbyshire & Nottinghamshire AT commissions a number of providers to deliver OoH urgent dental care. This is based on the historical commissioning arrangements that were in place with legacy Primary Care Trusts (PCTs).

Nottingham Emergency Dental Service (NEDS)

NEDS was commissioned in 2006 to provide OoH urgent dental care for patients resident in South Nottinghamshire and Nottingham City, however the service does accept patients out of area.

NEDS offers a dental clinician led service with access to advice and treatments and is located at Fanum House, Derby Road, Nottingham, close to the city centre and QMC.

This service operates:

- Monday to Friday between 7pm and 9.15pm to provide OoH triage and treatment. The majority of patients will be given over the phone self-care advice and advised to contact a general dental practice within 24-48 hours.
- Saturday from 2pm to 8.15pm – treatment only no triage
- Sunday 9am to 9pm – treatment only no triage
- Bank Holidays - 12.00 to 8.15pm – treatment only no triage

Integrated Dental Unit (IDU)– co located with the Walk in Centre at Seaton House

The IDU offers a nurse led service with fast and convenient access to advice, information and some treatments in and OoH. It is a 'sit and wait' service; patients are seen in order of attendance unless the need is assessed as urgent.

The service currently operates:

- Monday to Friday 7am to 9pm with treatment slots available 9am to 6pm
- Saturday 9am to 1pm
- Sunday and Bank Holidays – closed

Single Point of Access (SPA) – North Nottinghamshire only

SPA is a single point of contact advice line providing access to a number of health services. SPA manages the In-hours and OoH urgent dental slots offered by general dental practitioners (GDPs) across Newark & Sherwood and Mansfield & Ashfield.

SPA is a non-clinical led call handling service providing access to advice and information. Telephone triage is provided 7 days per week (including Bank Holidays) from 7am to 9pm daily and urgent care

patients are booked directly into appointments at dental practices via a roster system. Capacity varies across the area depending on the day of week

Current issues

Over time there has been a steady increase in demand for In and OoH urgent dental care. There are a number of possible explanations for this.

- Since the introduction of the new General Dental Services contract in 2006 the number of patients regularly attending an NHS dentist in Derbyshire & Nottinghamshire has steadily fallen from 62% of the population to approximately 56.4% with an increasing number choosing to access a dentist only when they feel they have an urgent need.
- The cost of dental care is increasing year on year and some patients are choosing to access cheaper or free alternatives e.g. GPs, emergency departments, urgent care.
- The dental nurse triage service provided by NHSD was not commissioned nationally from 111, therefore patients who have not been triaged are often directed to urgent care services when they don't meet the criteria.
- Less general dental access has been commissioned from primary care providers in the past two years compared with previously and often, in areas where access is limited, patients will then rely on accessing urgent care.
- Since 1st April 2006 patient registration ceased to exist and therefore dental practices are not responsible for providing urgent care to all of the patients who attend or have previously attended the practice.

Plans to address capacity concerns

- A working group including AT, CCG, 111 and clinical OoH provider representatives has already been established. This group has developed a short term and long term action plan to develop urgent care dental services going forward.
- A number of changes have been made to the data held by 111 to improve the pathways for patients accessing OoH urgent care.
- The AT has already negotiated with a number of primary care providers, based across the Nottingham City and County area, to increase their In and OoH urgent capacity. Practices are based in Bulwell, Bilborough, Highbury, Arnold, Mansfield, Stapleford and Meadows area.
- Funding has been approved to increase OoH urgent capacity at the IDU, NEDS and SPA. This will help to ease winter pressures on other healthcare providers.
- Funding has been approved to increase access to general dental services in areas of high need and where access is limited. We will use our monthly access survey of all dental practices, Public Health data and data available from 111 to inform this decision.

Future recommendations

Long term it is the intention of the AT to review In and OoH urgent care service provision across the Derbyshire & Nottinghamshire area, and commission a service that delivers the best value for money and the highest quality clinical care for its population. This review will take into account the proposals for the new national dental contract which may impact on the ATs responsibility for commissioning OoH dentistry.

Julie Theaker
Contract Manager Dental and Optometry
Derbyshire & Nottinghamshire Area Team

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 December 2014

Agenda Item: 5

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

DAYBROOK DENTAL PRACTICE – APPARENT BREACH OF INFECTION CONTROL

Purpose of the Report

1. To introduce a briefing on the recall of Nottinghamshire dental patients following the apparent breach of infection control procedures at Daybrook Dental Practice.

Information and Advice

2. NHS England in Nottinghamshire has been working with Public Health England to investigate alleged breaches of infection control procedures by a single dentist, who was contracted to provide NHS dental services at the former Daybrook Dental Practice, 88 Mansfield Road in Gedling, Nottingham.

3. In June 2014, NHS England was contacted by a whistleblower at the practice who had concerns about the standards of clinical care being provided to patients. The whistleblower provided NHS England with supporting evidence, including covertly filmed footage of dentist, Mr Desmond D'Mello.

4. Having reviewed the evidence, NHS England immediately ordered an interim suspension of Mr D'Mello and commenced an investigation into clinical practices at the dental surgery. The investigation is ongoing and no findings have been made at this time in relation to Mr D'Mello.

5. The investigation team also consulted with clinical experts in Public Health England, who undertook a clinical analysis of the potential risk to patients This has identified that patients seen by Mr D'Mello may have been placed at a low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV), due to apparent multiple failures in cross-infection control standards whilst undergoing dental treatment. Based on this clinical advice, Public Health England has recommended screening for all patients who may have been treated by Mr D'Mello, and NHS England has been working with partners to make the necessary arrangements for this.

6. NHS England has been leading a detailed investigation into this matter, with support from clinicians at Public Health England. As part of this, Mr D'Mello has been reported to the General Dental Council, and been suspended by the GDC pending further investigation.

7. NHS England, with support from Public Health England, issued a media briefing on Wednesday 12 November 2014 advising members of the public who were patients of Mr D'Mello of the apparent lapses in infection control standards and the fact they may have been placed at a low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV), whilst undergoing dental treatment. It is understood the number of patients who have been seen and treated by Mr D'Mello during his tenure as a dentist is about 22,000, as he had worked at the practice for over 32 years.

8. Due to the large number of patients who may be affected by this risk and the age of some of the patient records, it is not possible for NHS England to verify historic patient contact details and write to every individual patient within an acceptable time frame. Therefore a mass media exposure approach, coupled with awareness raising by key health partners in Nottinghamshire was used to make the public aware of the need to take action.

9. Despite the low risk of infection, some patients will undoubtedly be worried on hearing this news. NHS England has therefore also established a confidential advice line on 03330 142479 to provide further help and support. This advice line will be open 8am to 8pm, seven days a week.

10. Patients were advised to visit the dedicated Community Clinic - temporarily set up at Arnold Health Centre, located at Highcroft Medical Centre, High Street, Arnold, Nottingham NG5 7BQ - to seek advice about next steps which may be required based on their own individual circumstances. This clinic will initially be open 8am to 8pm, seven days a week.

11. NHS England also wrote separately to the 166 patients who were covertly filmed to explain what has happened, and offer assurances about the security of the footage obtained.

12. Dr Doug Black, Medical Director NHS England, Derbyshire and Nottinghamshire Area Team will attend to brief the Joint Health Committee and answer questions. A written briefing from Dr Black is attached as an appendix to this report.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:
1) Receive the briefing
2) Ask questions
3) Schedule further consideration, as necessary

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers
Nil

Electoral Division(s) and Member(s) Affected
All

Public Health England

NHS England

Derbyshire and Nottinghamshire

21 November 2014

Briefing for Joint Nottingham City and Nottinghamshire County Health Scrutiny Committee

NHS England in Nottinghamshire has been working with Public Health England to investigate alleged breaches of infection control procedures by a single dentist, who was contracted to provide NHS dental services at the former Daybrook Dental Practice, 88 Mansfield Road in Gedling, Nottinghamshire.

In June 2014 NHS England was contacted by a whistleblower who had concerns about the standards of clinical care being provided to patients. The whistleblower provided NHS England with supporting evidence, including covertly-filmed footage of dentist Mr Desmond D'Mello.

Having reviewed the evidence, NHS England immediately ordered an interim suspension of Mr D'Mello and commenced an investigation into clinical practices at the dental surgery. This investigation is ongoing and no findings have been made at this time in relation to Mr D'Mello. NHS England also reported Mr D'Mello to the General Dental Council, and he has been suspended by the GDC pending further investigation.

The investigation team consulted with clinical experts in Public Health England, who undertook a clinical analysis of the potential risk to patients. This identified that patients seen by Mr D'Mello may have been placed at a low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV), due to apparent multiple failures in cross-infection control standards whilst undergoing dental treatment. Based on this clinical advice, Public Health England recommended screening for all patients who may have been treated by Mr D'Mello, and NHS England worked with partners to make the necessary arrangements for this.

Patient notification

It is understood the number of patients who had been seen and treated by Mr D'Mello during his tenure as a dentist is about 22,000, as he had worked at the practice for over 32 years.

Due to the large number of patients who may have been affected by this risk and the age of some of the patient records, it was not possible for NHS England to verify historic patient contact details and write to every individual patient within an acceptable time frame. Therefore a mass media exposure approach, coupled with

awareness raising by key health partners in Nottinghamshire, was used to make the public aware of the need to take action.

NHS England, with support from Public Health England, issued a media briefing on Wednesday 12 November 2014 advising members of the public who were patients of Mr D'Mello of the apparent lapses in infection control standards and the fact they may have been placed at a low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV), whilst undergoing dental treatment.

A confidential advice line on 03330 142479 was set up to provide further help and support, which has been open 8am to 8pm, seven days a week, since 12 November. Patients were advised by the helpline and through the media to visit the dedicated Community Clinic - temporarily set up within Highcroft Medical Centre, High Street, Arnold, Nottingham NG5 7BQ - to seek advice about the next steps which may be required based on their own individual circumstances. This clinic has also been open 8am to 8pm, seven days a week, since 12 November.

Patients contacting the advice line, attending the Community Clinic or visiting White House Dental Practice (formerly Daybrook) have been given a patient information pack which explains what action they should consider taking and provides further information about the three blood borne viruses – please see attached.

Other means of notifying the public have included:

- The contents of the information pack, and a You Tube video of Dr Black's media statement, have been made available on the NHS England website since the time of the media briefing on 12 November. Social media has also been used to promote this patient notification exercise.
- An alert was sent to GPs and dentists in the area with guidance on how to advise patients who might contact them and a poster to display, which advises patients of the advice line number and the NHS England website address.
- The poster is on display at the former Daybrook Dental Practice and the community clinic where testing is taking place, along with the patient information. The poster was also sent to local libraries and other community outlets to display.
- NHS 111 and the NHS Customer Contact Centre were briefed, as was NHS Choices which has placed information on its website. Other NHS organisations, including CCGs and provider organisations, were also notified in order to direct patients to the correct place should they present with concerns.
- GPs and dentists were alerted nationally with details on how to advise patients who might contact them with concerns.
- A briefing was sent in advance of the announcement to a wide range of NHS and non-NHS stakeholder organisations. As well as HOSC, these included Health Watch, MPs, Health and Wellbeing Board, local authorities, local safeguarding boards, and the local medical and dental committees. Some of these organisations have put the information on their own websites.

Further promotion around the Nottinghamshire area is planned via leafleting and media promotion.

NHS England wrote separately to the 166 patients who were covertly filmed to explain what had happened, and offered assurances about the security of the footage obtained.

Advice line and community clinic attendance

Week 1	**Calls to advice line**	**Blood samples taken***
Weds 12 Nov	1,333	341
Thurs 13 Nov	759	680
Fri 14 Nov	233	613
Sat 15 Nov	57	305
Sun 16 Nov	21	319
Mon 17 Nov	100	365
Tues 18 Nov	64	275
Totals for Week 1	**2,567**	**2,898**
Weds 19 Nov	36	205
Thur 20 Nov	36	139
Fri 21 Nov	15	136

* does not include those who attended, took an information pack and will return at a future date for testing.

Initial feedback gathered between Wednesday 12 November and Sunday 16 November from the patient experience survey at the Community Clinic, shows good satisfaction levels (a more detailed analysis has not yet been undertaken):

'Overall how would you rate your experience as a patient in this dental recall process'

Excellent	**Good**	**Satisfactory**	**Poor**	**Very Poor**
359	149	41	8	3

Patient queries

Queries have received via the NHS England website, NHS Choices, the NHS England Customer Contact Centre, the NHS England Twitter account, and through media websites. These have all been responded to individually. Eight complaints have been received and are being addressed through the NHS England complaints process.

Evaluation Exercise

A lessons learned evaluation exercise is planned for January 2014 and will include staff involved in the patient notification exercise. Public Health England have identified a facilitator for this exercise.

MP Liaison

A meeting between local Nottinghamshire MPs, the Secretary of State and members of the area team took place on Monday 17 November 2014. It was agreed that MPs would be involved in the lessons learned evaluation exercise planned for January.

Dr Doug Black
Medical Director
NHS England Derbyshire & Nottinghamshire

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 December 2014

Agenda Item: 6

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

ROYAL COLLEGE OF NURSING

Purpose of the Report

1. To introduce a briefing from the Royal College of Nursing on the issues that nurses face.

Information and Advice

2. Members may recall that the Royal College of Nursing (RCN) representatives previously attended the Joint Health Scrutiny Committee in November 2012. At that time, Members heard that the RCN was running a campaign called 'This is Nursing' in response to concerns in the media regarding poor care.

3. RCN representatives indicated that they were keen to work with the committee and provide insights into what was happening on the frontline, give professional expert knowledge, advice and guidance as well as an independent perspective on what is happening across the UK.

4. Ms Marie Hannah, Regional Officer, Nottinghamshire will again provide a briefing and answer questions as necessary.

5. A written briefing from Ms Hannah is attached as an appendix to this report.

6. Members may wish to share and explore with Ms Hannah the sorts of issues that the Joint Health Committee has recently scrutinised, such as intoxicated patients in Nottingham University Hospitals Emergency Department, pharmacy prescribing delays, and the transition to community services.

7. Members are requested to receive the briefing, ask questions and schedule further briefing as necessary.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Receive the briefing on the issues currently faced by nurses

2) Ask questions

3) Schedule further consideration

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Royal College of Nursing

Frontline First
More than just a number
March 2014 special report

Contents

1. Introduction

Since the launch of the *Frontline First* campaign in July 2010, the Royal College of Nursing (RCN) has monitored the damaging impact of £20 billion of NHS efficiency savings in England and subsequent cuts to frontline jobs and services.

At the time, the Government claimed that it would be possible to make these efficiency savings without cutting frontline staff. However, the RCN found that NHS trusts across the country were losing thousands of nursing posts, with proposals to cut many tens of thousands more.

The *Frontline First* campaign has repeatedly raised concerns that nursing workforce cuts, combined with the failure to undertake long-term workforce planning, have left many wards and services dangerously understaffed. At the lowest point, in August 2012, the nursing workforce saw 6,240 fewer full time equivalent (FTE) posts compared to April 2010.

Over the last year, following Robert Francis's Mid Staffordshire Public Inquiry report, and subsequent reports from Sir Bruce Keogh and Professor Don Berwick, there has been a welcome spotlight shone on safe staffing levels, particularly in hospitals.

As the impact of understaffing on patient safety has become clear, many trusts have started to reverse earlier cuts and alter their plans. This has resulted in welcome investment in the nursing workforce in some, but by no means all, areas.

Our recent *Frontline First* report - *Running the red light* - highlighted significant challenges ahead, with an impending crisis in the supply of registered nurses, and employers struggling to recruit to as many as 20,000 FTE nursing vacancies. There is also worrying evidence that the recent renewed recruitment, or 'Francis effect', has been limited to the acute, elderly and general sector, with community services, mental health and learning disabilities nursing lagging far behind; having suffered heavy workforce cuts in past years.

Although any investment in the nursing workforce is a positive development, the RCN is calling for this to be sustained in the long term, across all nursing settings. There is still some way to go in reversing past cuts, as expansion in the midwifery and health visiting workforces has masked the true decrease in registered nurses. According to the most recent data, at November 2013, the NHS was still 1,199 FTE registered nurses short of the position it was in back in April 2010 (HSCIC, 2014a).

Furthermore, the RCN is concerned that hidden within wider trends is a significant dilution of skill mix, as more senior nursing staff have been disproportionately targeted for workforce cuts and found their roles increasingly devalued.

Based on freedom of information data obtained from the Health and Social Care Information Centre (HSCIC), this special report, *More than just a number*, confirms that senior nursing roles have borne the brunt of workforce cuts, leading to a dangerous loss of experience and skills that are essential to ensuring patient safety and driving up care standards.

Total workforce numbers only tell one half of the story. Getting staffing right for patients is about more than just a number.

2. Executive summary

The very first RCN *Frontline First* briefing, in 2010, highlighted members' concerns that workforce reconfigurations are disproportionately targeting more senior staff with key specialist and leadership roles. We have seen evidence that many senior staff have been made redundant, have not been replaced on retirement, or have found their roles downbanded, with some expected to continue their previous senior responsibilities at lower pay.

This briefing confirms that in recent years there has been a significant dilution of skill mix across the country and across all settings, with a considerable loss and devaluation of senior skills and experience.

The RCN has obtained data from the HSCIC under the Freedom of Information Act 2000, on the qualified nursing, midwifery and health visiting workforce in NHS hospital and community services, according to the Agenda for Change national pay and terms and conditions system. This shows that between April 2010 and September 2013, more senior nursing staff working at bands 7 and 8 of Agenda for Change have been lost, in both absolute and relative terms, when compared to more junior staff working at bands 5 and 6 (see Figure 1). Over the period:

- **1,633 FTE posts have been lost at band 8 level (a decrease of 11 per cent)**
- **2,360 FTE posts have been lost at band 7 level (a decrease of 4.5 per cent)**
- **in contrast, band 5 level has seen less of a reduction, with only 340 FTE posts lost (a decrease of 0.2 per cent), and most expansion has been at band 6 level, with 1,887 more FTE posts (an increase of two per cent).**

The RCN is clear that while any investment in nursing is welcome in terms of reversing previous cuts, expansion should take place across the workforce. Limiting investment to band 6 nurses at the expense of higher bands represents a significant dilution of skill mix, and indicates the immediate loss and long-term devaluation of specialist skills and leadership developed through years of experience and investment. While reducing the numbers of more senior nurses at higher pay grades may seem an easy, short-term solution for funding total nursing workforce expansion, we believe this will significantly affect the ability for nursing teams to provide high quality, safe and compassionate care in the future.

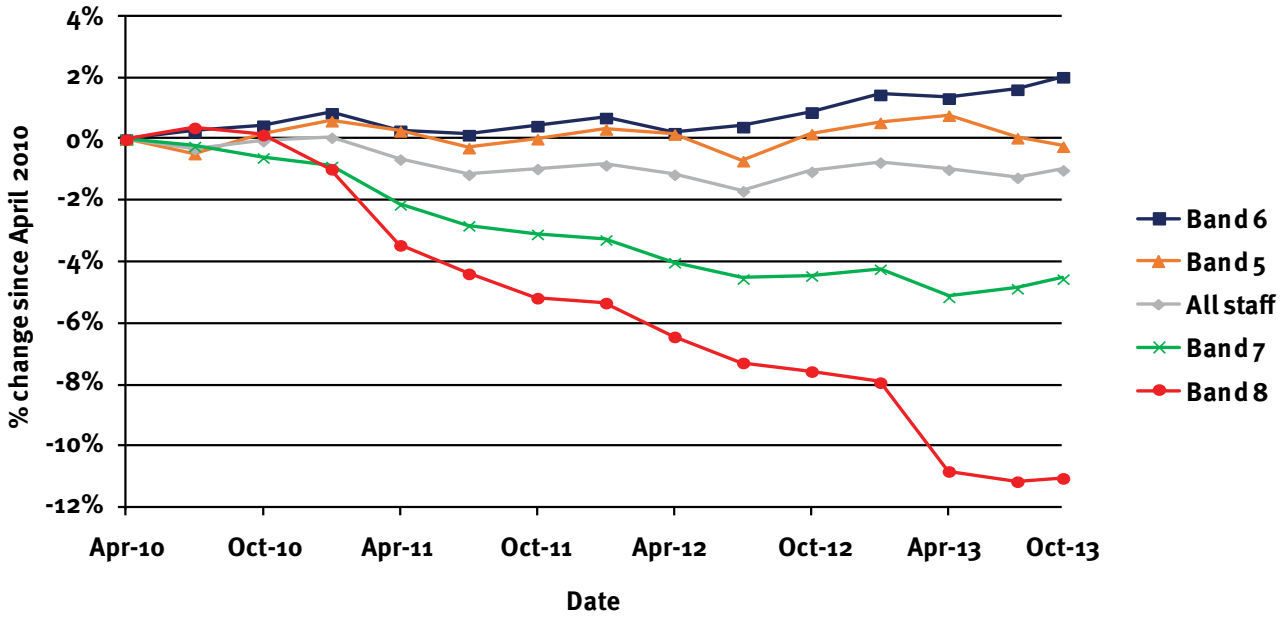
Roles at bands 7 and 8 of the Agenda for Change pay system represent leading roles such as ward sisters, ward managers, modern matrons and community matrons, who serve as the key interface between health care management and clinical care delivery, with many other important responsibilities including improving patient outcomes, driving up clinical standards, and supporting and mentoring staff. The importance of having the right ward leadership in place was highlighted in the recent Mid Staffordshire Public Inquiry, with Robert Francis noting that the role of ward sisters and ward managers was "universally recognised as absolutely critical" (Francis, 2013).

These bands also include advanced and specialist roles, such as clinical nurse specialists, advanced nurse practitioners and nurse consultants. These staff have gained specialist knowledge, skills and experience throughout their careers. Practising with autonomy at an advanced level, they often have sole responsibility for patients and their care. These nurses take a leading role in making sure patients get the best care possible, and several studies have shown that advanced and specialist nurses can be a clinically sound and cost-effective substitute for other health care professionals including doctors. The direct and indirect benefits of specialist nursing roles include reduced referral times, shorter hospital stays and fewer post-surgery complications (RCN, 2010).

Therefore, while the RCN recognises that the NHS is experiencing unprecedented financial pressure, we do not believe that financial savings should be made at the expense of these more senior and experienced nursing staff.

With an ever-growing number of patients with increasingly complex care demands, the skills, leadership and added value provided by these more experienced staff are needed more than ever.

Figure 1: Percentage change in FTE qualified nursing, midwifery and health visiting workforce by Agenda for Change band, NHS hospital and community services, April 2010 – September 2013 (Source: HSCIC freedom of information request)



3. The current nursing workforce

Throughout its *Frontline First* campaign, the RCN has highlighted cuts to the registered nursing workforce. Figure 2 illustrates the size of the workforce since April 2010, showing a significant number of roles lost during 2011 and 2012, reaching a low point of 6,240 fewer FTE posts in August 2012.

Having stabilised at these lower levels in 2012-13, there are now signs that earlier cuts are being reversed. Following a year of increased focus on the importance of staffing levels and patient safety, with the publication of the Francis, Keogh and Berwick reports, there is now renewed investment in the nursing workforce, with higher levels of recruitment and reversals in cuts to education commissions. In just three months, between August 2013 and November 2013, an additional 6,875 FTE staff entered the nursing workforce.

While this investment is welcome news, and long overdue, the RCN is calling for this momentum to be maintained across the nursing workforce. Significant growth in the number of midwives and health visitors being included in the workforce data has masked the true fall in the number of nurses, so despite recent improvements, the NHS is still 1,199 FTE registered nurses short of the position it was in back in April 2010. While there is currently a strong spotlight on safe staffing levels, continued financial pressures may mean trusts seek to cut the nursing workforce further down the line. Monitor's 2013-14 review of NHS foundation trusts' three year plans, for example, shows that although trusts plan a two per cent increase in registered nursing staff numbers in 2013-14, this would be reversed by longer-term disinvestment in nursing, reducing numbers by four per cent over the following two years (Monitor, 2013).

Furthermore, as Figure 3 shows, over the last three years, expansion in the nursing workforce has been largely limited to maternity and neonatal; paediatric; and acute, elderly and general sectors. In terms of staff numbers, community services, mental health, and learning disabilities nursing all lag far behind, having suffered heavy cuts in recent years.

Figure 2: FTE qualified nursing, midwifery and health visiting staff, NHS hospital and community services, April 2010-November 2013 (HSCIC, 2014a)

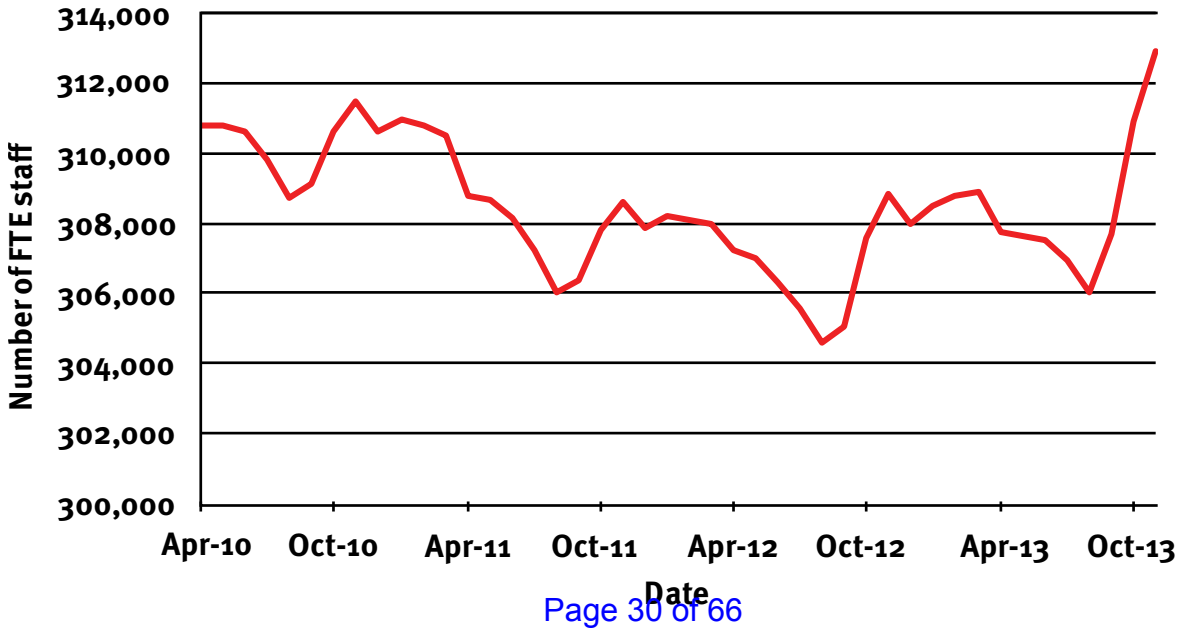
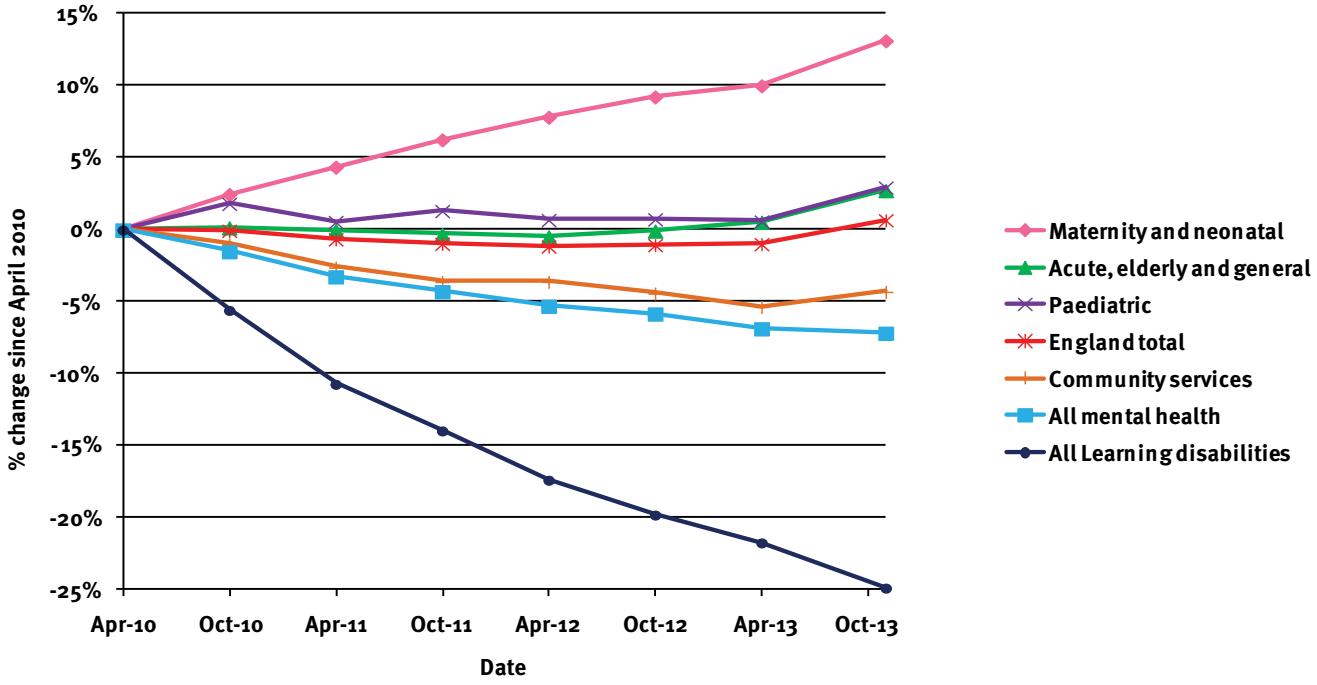


Figure 3: Percentage change in FTE qualified nursing, midwifery and health visiting workforce by service type, NHS hospital and community services, April 2010-November 2013 (HSCIC, 2014b)



Despite some positive signs in terms of overall workforce growth, the data obtained from the HSCIC confirms the RCN's long-held suspicions that years of workforce cuts and efficiency savings have had a disproportionate impact on more senior nursing roles. This has resulted in significant dilution of the nursing skill mix and devaluation of specialist and senior nursing roles.

Even with the recent recruitment drive, RCN freedom of information requests on nursing vacancies for the last *Frontline First* report found that many trusts were continuing to concentrate on more junior posts at bands 5 and 6 of Agenda for Change. Despite considerable efforts, both nationally and internationally, to attract enough nurses to staff services safely, RCN monitoring work suggests there is little indication of any reversal to the dilution of skill mix so far.

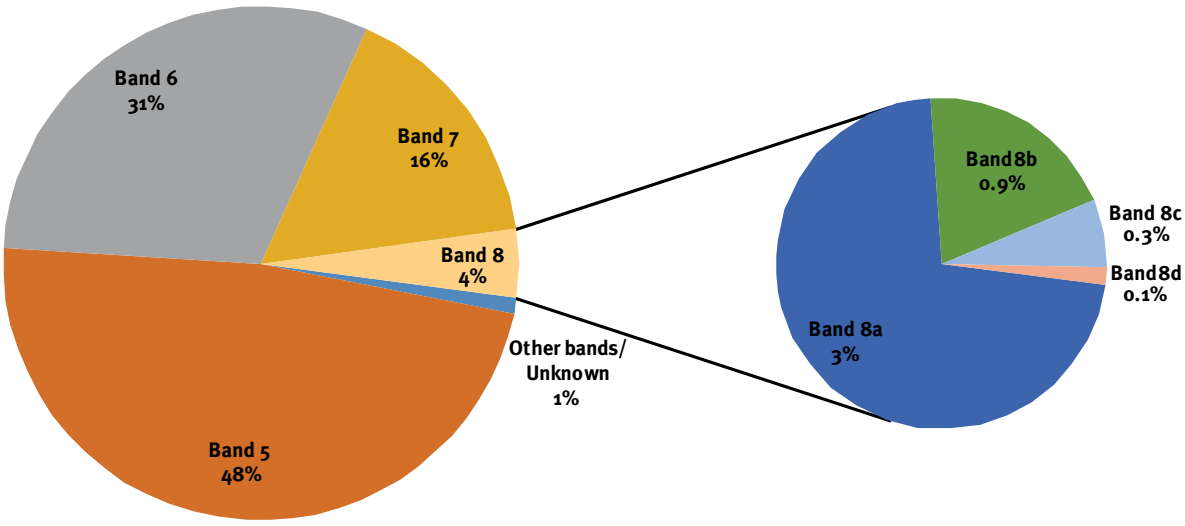
4. Diluting the nursing skill mix

Along with many other non-medical staff, the vast majority of nursing staff working in the NHS are employed under the Agenda for Change national pay and terms and conditions system. Agenda for Change is designed to place staff within nine ascending pay bands based on the knowledge, skills and efforts required for the role.

Within the nursing workforce, a newly qualified nurse would be expected to enter the workforce at band 5 level. On gaining experience, some specialist skills and/or leadership responsibilities, nursing staff might progress to band 6, with the most senior nurses employed at bands 7 and 8a-d. Nursing at bands 7 and 8 would include roles such as ward sisters and ward managers, senior specialist nurses, clinical service managers, matrons, advanced nurse practitioners and nurse consultants. These bands represent nurses with considerable technical expertise and advanced specialist skills, and those with considerable leadership, management, supervision and mentorship responsibilities.

As part of its *Frontline First* campaign, the RCN monitors changes in the skill mix of nursing staff as well as the size of the workforce. In order to do this, the RCN submitted a request under the Freedom of Information Act 2000 to the HSCIC in December 2013, asking for data on the qualified nursing, midwifery and health visiting workforce in NHS hospital and community services, by Agenda for Change band. In January 2014, the HSCIC supplied the following data by region and service type, covering the period October 2009 to September 2013.

Figure 4: FTE qualified nursing, midwifery and health visiting workforce, NHS hospital and community services by Agenda for Change band, September 2013 (Source: HSCIC freedom of information request)



Please note that this report uses figures that have been rounded to the nearest whole number and in some case may not equal the exact total.

This data, obtained from the HSCIC, is presented in Figure 4 and shows the current distribution of nursing staff according to the various different Agenda for Change bands. Just under half of the registered nursing workforce is employed at band 5, with around a third at band 6 and around 16 per cent at band 7. Band 8, representing four per cent of the workforce, is divided into four different brackets, representing an increasingly smaller proportion of the workforce as seniority increases. A remaining one per cent includes a small cohort employed at band 9 (around one in 6,000 nurses), as well as a small number employed at bands 2, 3 and 4, and with unknown employment status. The HSCIC notes that this is likely to be due to data quality issues for a limited number of electronic staff records, and cautions that the data should be used as an estimate of staff numbers at each band, rather than an exact accounting standard.

This information also confirms, as the RCN has long suspected, that more senior staff have borne the brunt of workforce cuts. Table 1 shows how skill mix has changed over time between April 2010 and September 2013. Although the workforce overall lost 3,113 FTE posts over the period (a decrease of one per cent), these posts were not lost in equal proportions across the different bands.

Table 1: FTE qualified nursing, midwifery and health visiting workforce by Agenda for Change band, NHS hospital and community services, April 2010-September 2013 (Source: HSCIC freedom of information request)

	Apr-2010 posts	Apr-2010 % of total	Sep-2013 posts	Sep-2013 % of total	+/- posts	% +/- posts
Band 5	147,511	47.46%	147,171	47.83%	-340	-0.23%
Band 6	92,919	29.90%	94,806	30.81%	+1,887	+2.03%
Band 7	51,942	16.71%	49,582	16.11%	-2,360	-4.54%
Band 8a	10,337	3.33%	9,467	3.08%	-871	-8.42%
Band 8b	3,203	1.03%	2,610	0.85%	-593	-18.51%
Band 8c	1,025	0.33%	863	0.28%	-162	-15.77%
Band 8d	243	0.08%	235	0.08%	-8	-3.44%
Band 9	46	0.01%	50	0.02%	+5	+10.56%
Other/unknown	3,580	1.15%	2,908	0.95%	-672	-18.77%
Total staff	**310,805**	**100.00%**	**307,692**	**100.00%**	**-3,113**	**-1.00%**

More senior nursing posts have been disproportionately targeted for cuts, in both absolute and relative terms. At band 7 level, 2,360 posts have been lost (a decrease of 4.5 per cent), and across all band 8 levels, 1,633 posts have been lost (a decrease of 11 per cent).

In contrast, the number of band 5 posts has remained relatively stable, with a small decrease of 0.2 per cent, or 340 posts. The majority of workforce expansion has occured at band 6 level, with 1,887 additional FTE posts, an increase of two per cent.

The net impact of these changes has been a noticeable dilution of skill mix. In April 2010, bands 5 and 6 represented 77.4 per cent of the total workforce; this increased to 78.6 per cent in September 2013. In contrast, bands 7 and 8 fell from 21.5 per cent of the workforce to 20.4 per cent of the workforce over the same period. This represents either a loss or a significant devaluation of advanced clinical and leadership roles.

These losses at bands 7 and 8 are particularly concerning because they represent key leadership roles such as ward sisters, modern matrons and community matrons. **These nurses serve as the critical interface between health care management and clinical care delivery, with many other important responsibilities including mentoring, driving up clinical standards and improving patient outcomes.** Workforce data from the HSCIC over the same period confirms that many of these posts have indeed been lost, with 997 fewer FTE modern matrons (a 20.4 per cent decrease), and 187 fewer FTE community matrons (a 12.2 per cent decrease) (HSCIC, 2014b).

Senior bands also include advanced and specialist roles, such as clinical nurse specialists, advanced nurse practitioners and nurse consultants. **These staff have gained specialist knowledge, skills and experience throughout their careers. Practising with autonomy at an advanced level, they often have sole responsibility for patients and their care. These nurses take a leading role in making sure patients get the best care possible.** Several studies have shown that advanced and specialist nurses can be a clinically sound and cost-effective substitute for other health care professionals including doctors. The direct and indirect benefits of specialist nursing roles include reduced referral times, shorter hospital stays and fewer post-surgery complications (RCN, 2010). The loss of these staff is likely to have significant implications for the quality of patient care and the ability to further develop the skills and knowledge of modern nursing.

5. The experience of different health care services

Although the NHS, as a whole, has lost more senior roles, there is significant variation between workforce provision for different services.

Table 2 shows how senior staff as a proportion of the workforce varies according to service type. Community services, for example, have a higher proportion of more senior staff, with 28 per cent of the workforce employed at bands 7 and 8, compared to a whole NHS average of 20.4 per cent, while acute, elderly and general care has the lowest proportion of more senior staff, at 18.1 per cent. This variation may reflect the specialist nature of community care and requirements for post-graduate education, or it may also reflect different age profiles for the different staff groups. For example, RCN research on the community nursing workforce found that 38 per cent of community nurses were aged 50 and over, compared to 23.6 per cent in the acute, elderly and general nursing setting (RCN, 2012).

Table 2: Bands 5 and 6, and bands 7 and 8 as a percentage of the total workforce, FTE qualified nursing, midwifery and health visiting staff, NHS hospital and community services, 30 September 2013, by service type (Source: HSCIC freedom of information request)

Service type	Bands 5 and 6 % of total workforce	Bands 7 and 8 % of total workforce
Community services	70.98%	28.06%
All learning disabilities	75.76%	23.61%
Maternity and neonatal	77.56%	21.65%
All mental health	79.72%	19.92%
Paediatric	80.46%	18.91%
Acute, elderly and general	80.74%	18.07%
England total	**78.64%**	**20.40%**

Table 3 illustrates how areas of work have lost more senior staff at different rates. Over the period, no services have gained staff at more senior levels, and all services have lost proportionately more senior staff at bands 7 and 8, compared to more junior staff at bands 5 and 6.

Table 3: Percentage changes in FTE qualified nursing, midwifery & health visiting workforce, NHS hospital and community services, by Agenda for Change band by service type, April 2010 – September 2013 (Source: HSCIC freedom of information request)

Service type	% Change total staff	% Change Bands 5 and 6	% Change Bands 7 and 8
All learning disabilities	-24.52%	-23.07%	-28.05%
Community services	-5.06%	-2.89%	-10.60%
All mental health	-7.98%	-5.90%	-12.88%
Acute, elderly and general	+0.82%	+1.52%	-1.15%
Paediatric	+0.44%	+0.91%	-0.64%
Maternity and neonatal	+10.05%	+16.73%	-7.94%
England total	**-1.00%**	**0.64%**	**-5.98%**

Learning disabilities services have lost the highest proportion of nursing staff, from all bands, but they have also seen a particularly high reduction in band 8 staff. Community and mental health services have also lost staff across all bands, but with significantly higher losses for bands 7 and 8.

There has been an expansion in the total number of nursing staff working in acute, elderly and general care, but this has largely taken place at bands 5 and 6, while more senior posts have been lost, with a small contraction in band 7 posts and a relatively large fall in band 8 posts.

Paediatric, maternity and neonatal are the only areas of work to have seen any expansion at more senior levels, with small increases in staff at band 8 level, but this has been more than offset by much larger losses at band 7 level. Combined with higher growth at bands 5 and 6 this still represents significant dilution in skill mix.

6. The experience of different English regions

As with different health care services, the impact of diluted skill mix has also varied between different English regions.

Table 4 illustrates that skill mix is not uniform across the health system in England. There is currently a significantly higher proportion of more senior posts in London (at 24.7 per cent compared to the 20.4 per cent national average), and to a lesser extent the South East. In contrast, there are relatively fewer senior posts in the South West, East Midlands, and Yorkshire and the Humber regions. This variation may be due in part to a higher concentration of specialist services in London and the South East.

Table 4: Bands 5 and 6, and Bands 7 and 8 as a percentage of the total workforce, FTE qualified nursing, midwifery and health visiting workforce, NHS hospital and community services, 30 September 2013, by NHS SHA region (Source: HSCIC freedom of information request)

Region	Bands 5 and 6 % of total workforce	Bands 7 and 8 % of total workforce
London	74.76%	24.72%
South East	77.95%	21.36%
North West	78.98%	20.84%
North East	79.21%	20.66%
Eastern	75.94%	19.81%
West Midlands	80.07%	19.63%
South Central	80.34%	19.30%
Yorkshire and the Humber	80.94%	17.67%
East Midlands	82.05%	17.64%
South West	80.70%	17.33%
England Total	**78.64%**	**20.40%**

Table 5 shows that between 2010 and 2013, every single English region lost proportionally more senior roles at bands 7 and 8 than more junior roles at band 5 and 6. However, reductions in senior posts were not evenly distributed across different regions.

Yorkshire and the Humber has lost both the greatest proportion of staff overall, and the greatest proportion of senior staff, with nearly 12 per cent of staff at bands 7 and 8 lost over the period. There were also heavy losses of senior staff in the North West, with cuts of nearly 10 per cent. The Eastern, South Central, East Midlands and South West regions also lost more senior staff than the England average.

London and the South East saw relatively smaller losses at senior levels. With one single exception, all regions lost posts at both bands 7 and 8. The North East was the only region to see any expansion in senior staff, with an additional 114 FTE posts at band 7. However, when considered against greater growth in the more junior bands, the North East, like other regions, still experienced dilution of skill mix towards lower bands.

Table 5: Percentage changes in FTE qualified nursing, midwifery and health visiting workforce, NHS hospital and community services, by Agenda for Change band and NHS SHA region, April 2010-September 2013 (Source: HSCIC freedom of information request)

Region	% Change total	% Change Bands 5 and 6	% Change Bands 7 and 8
Yorkshire and the Humber	-4.90%	-2.66%	-11.62%
North West	-1.90%	+1.11%	-9.97%
Eastern	-2.75%	-0.79%	-7.91%
South Central	-1.41%	+0.48%	-7.84%
East Midlands	-0.47%	+1.64%	-7.22%
South West	-1.72%	-2.47%	-6.51%
West Midlands	-0.57%	+1.03%	-5.36%
London	+1.26%	+3.25%	-2.64%
South East	+3.11%	+4.60%	-2.23%
North East	+1.23%	+1.82%	+0.68%
England	**-1.00%**	**0.64%**	**-5.98%**

7. Conclusion

The RCN's research indicates that, hidden within wider nursing workforce cuts, there has been a significant loss and devaluation of skills and experience in the NHS over the last three years. Across all regions and all services, posts at bands 7 and 8 have been disproportionately targeted for cuts. Since April 2010, there are 3,994 fewer FTE staff working at these higher levels. While the workforce data does not allow us to track exactly where all these staff have gone, the RCN's experience suggests that this is likely due to a combination of voluntary and compulsory redundancies, failing to replace senior staff on retirement, and downbanding senior staff at lower levels.

The RCN's work with members and employers has demonstrated many cases of the first two instances, with many senior nurses lost from the workforce entirely, through retirement and redundancy. This represents an immediate loss of specialist skills and leadership that have been built up through years of investment. Failing to replace these staff through effective workforce planning and investment in post-registration education is likely to create significant long-term challenges in securing a workforce with the right skills to meet the increasingly complex health demands of future patients. The RCN is clear that while more senior elements of the workforce might appear to be an easy target for short-term financial savings, there is growing evidence to suggest that more senior specialist nurses provide good value for money in terms of clinical outcomes and delivering excellent patient satisfaction (RCN, 2013c).

Equally concerning is the third phenomenon of downbanding senior staff at lower levels, either through redeployment to more junior roles, or redefining roles so that staff continue to carry out their senior responsibilities at lower pay bands. While this strategy may help retain staff with specialist clinical and leadership skills and provide financial savings in the short term, it is likely to lead to significant challenges around morale and staff retention in the long term. Evidence suggests that many staff are already dissatisfied with their banding; the RCN's last employment survey suggests that as many as 40 per cent of nursing staff do not think their pay band is appropriate (RCN, 2013b). Therefore, while downbanded senior staff may remain in the workforce for the short term, it may not be long before they leave the nursing profession altogether. Permanent devaluation of specialist and senior posts will make it difficult to attract the right people to replace these critical roles.

Used properly, the Agenda for Change job evaluation scheme is a fair and effective way of recognising the value of nursing roles at all levels. It can be an effective system for supporting workforce re-profiling. It can also confirm that the current distribution of tasks and roles is as efficient as possible in delivering a clinically safe service to the expected standards of quality. However, if job evaluation is manipulated to downband roles, this devalues not only the integrity of the process but also the contribution of nursing skills and experience.

The RCN fully recognises the challenges the NHS faces now and for the foreseeable future, with continued financial restraint and ever-rising demand. However, we believe that employers should resist the lure of short-term savings by manipulating a system intended to recognise the value of the skills and experience that nursing staff gain throughout their careers. Whilst recent efforts to invest in the nursing workforce are welcome, it is clear that it is more than a case of numbers. Skill mix is equally important in terms of outcomes, safety and quality. Diluting the skill mix and undermining the important contribution of senior nursing staff may result in a loss of experience and talent that cannot easily, or cheaply, be reversed.

Appendix: NHS Agenda for Change pay scales 2013/2014

NHS Agenda for Change bands (effective 1 April 2013)

Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
£14,294	£14,294	£16,271	£18,838	£21,388	£25,783	£30,764	£39,239	£45,707	£54,998	£65,922	£77,850
£14,653	£14,653	£16,811	£19,268	£22,016	£26,822	£31,768	£40,558	£47,088	£56,504	£67,805	£81,618
£15,013	£15,013	£17,425	£19,947	£22,903	£27,901	£32,898	£42,190	£49,473	£59,016	£70,631	£85,535
	£15,432	£17,794	£20,638	£23,825	£28,755	£34,530	£43,822	£52,235	£61,779	£74,084	£89,640
	£15,851	£18,285	£21,265	£24,799	£29,759	£35,536	£45,707	£54,998	£65,922	£77,850	£93,944
	£16,271	£18,838	£21,388	£25,783	£30,764	£36,666	£47,088	£56,504	£67,805	£81,618	£98,453
	£16,811	£19,268	£22,016	£26,822	£31,768	£37,921					
	£17,425			£27,901	£32,898	£39,239					
					£34,530	£40,558					

High cost area supplements (effective 1 April 2013)

Area	Level
Inner London	20% of basic salary (subject to minimum payment of £4,076 and a maximum payment of £6,279)
Outer London	15% of basic salary (subject to minimum payment of £3,448 and a maximum payment of £4,395)
Fringe	5% of basic salary (subject to minimum payment of £942 and a maximum payment of £1,632)

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District nursing – harnessing the potential

The RCN's UK position on district nursing

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Foreword

Our population is living longer and an increasing number of people are living with long-term conditions. District nursing therefore has a major role to play in the NHS, empowering people to be cared for in their own homes and in the community.

The evidence that district nursing reduces costs in the long-term and provides more appropriate, patient-centred care is overwhelming. However, despite this, the promises of successive UK Governments to shift care from the acute sector into the community are not being realised.

District nursing – harnessing the potential sets out the RCN's position on district nursing, highlighting the current challenges facing the sector. Crucially, it outlines solutions to realise the intentions of all four UK governments to shift care from the acute to the community sector.

We know that investment in district nursing is declining. The percentage of nurses working in the community remained virtually unchanged between 2001 and 2011, and the actual number of district nurses went down by more than a third during the same period. More recently, in October 2012, just five students took the Specialist Practitioner District Nursing course at both under graduate and post graduate levels at London universities.

In a 2012 RCN survey, 59 per cent of community nurses reported spending less time with their patients than they did a year ago. This raises real concerns for the capacity of community services to deal with current demands.

These cut backs only create a 'revolving door' for many patients. Following discharge from hospital, many find the support they need at home is not on hand, and are readmitted to hospital at great expense. In the meantime, the acute sector is being pushed to its limits, with patients being treated for avoidable illnesses.

The very future of the NHS relies on moving care closer to home, yet this is only possible if we invest in district nursing with appropriate workforce planning, education and training, as well as clinical and leadership support. *District nursing – harnessing the potential* will be a useful resource for health care professionals, workforce planners and commissioners in achieving these goals, as we work towards providing community care which meets the demands of a 21st Century NHS.

Peter Carter
General Secretary & Chief Executive
Royal College of Nursing

Executive summary

The Royal College of Nursing (RCN) is the UK's largest professional association for nurses, midwives, health visitors and health care assistants with more than 410,000 members.

This position paper builds on *Pillars of the community* (RCN, 2010), the RCN UK position on the development of the registered nursing workforce in the community, and the findings of the 2011 RCN survey of district nurse views from the frontline. It offers clarity on the position of the RCN in relation to the potential contribution of district nurses in managing demand for health services and enabling effective and efficient care in the community.

In the view of the RCN, the key messages below are the priorities to be considered for the future so that the potential contribution of district nursing is harnessed and sustained.

Key messages

- There is an increasing need for district nursing expertise if health services are to effectively meet emerging demographic, social and disease challenges. These challenges include a growing number of older people and other vulnerable groups needing nursing at home; the rise in the number of people with long-term conditions requiring complex nursing care; and the associated drive to prevent hospital admissions and to ensure end of life care at home. To rise to these challenges the pivotal role of district nurses and their teams must be acknowledged and developed.
- In the quest and drive to ensure faster throughput from hospitals to the community, over the last 10 years we have witnessed a plethora of initiatives designed to augment services in the community. These include the introduction of intermediate care teams, chronic disease management specialist nurses (often called community matrons), virtual wards, in-reach and outreach teams, and specialist teams. The lack of integration of these services with mainstream district nursing services is believed to have resulted in poor outcomes and some unsuccessful initiatives.
- The RCN believes that through a well-planned and concerted programme of development in district nursing together with better integrated care, the four UK countries can achieve their stated intentions to ensure a reduction in acute care and effective community nursing care.
- Significant resources must be found to ensure we maintain an expert district nursing workforce and a quality service that is fit for the future. It must include all community nursing teams, led by nurses with a specialist practice qualification in district nursing. The RCN wishes this position paper on district nursing to inform workforce planners, commissioners, employing organisations and educators about the current state of the district nursing workforce and the problems that have arisen – and will continue to arise – as a result of the dilution of district nursing expertise in the community.
- To ensure improved integrated care and support the avoidance of unnecessary hospital admissions, it is the RCN's view that commissioners and service planners should see district nursing as a 'must do' priority and ensure its full potential is realised for the benefit of patients.

1 Introduction

The purpose of this document is to set out the RCN's view of current day district nursing, the key challenges it faces, and its potential to be a major part of the NHS reforms and the aim to provide more care closer to home. The RCN believes the district nursing service has significant potential to be further developed and harnessed to realise the ambitions of the health service in the UK. The Department of Health (DH) England's document *Care in local communities; A new vision and model for district nursing 2013* also states clearly that district nurses have a key role to provide care and support in the community by:

- population and case management
- supporting and caring for patients who are unwell, recovering at home and at end of life
- facilitating independence.

In a recent report to the DH England and the NHS Future Forum, The King's Fund stated: 'Our view is the care for people with complex and social care needs must be made a real priority for commissioners and providers as this will be the key to assuring people of high quality care and making the health and social care system more sustainable' (The King's Fund, 2012a). The RCN believes adapting to these new environments requires a shift in expectations on how care will be delivered. District nurses must be seen – and indeed, currently are – at the core of these changes, and are the care providers with the greatest potential to offer direct patient care in the community.

This position paper:

- outlines some of the key challenges facing current service provision
- reaffirms the key contribution of district nurses in three main care domains; acute care at home, complex care at home, and end of life care at home
- recommends strategic priority steps to be taken to strengthen workforce, leadership and quality of care in district nursing.

2 Moving from a robust past to maximising future potential

District nursing services have been in existence for more than 150 years. While the foundations of the specialist practitioner district nurse role remains the same, the complexity of care needs in the community have changed. Contemporary district nurses have a significant leadership and management role, and are well placed to lead service and practice development in order to meet the needs of their particular populations. However, there are concerns, as demonstrated by the findings of the RCN 2011 survey on district nursing. These reveal that the current workforce profiles of district nursing services, in terms of their preparation for the role and skill mix in teams, are clearly insufficient to meet political imperatives. The RCN believes that, through a well-planned and concerted programme of development in district nursing and better integrated care, the four UK countries can achieve their stated intentions to ensure a reduction in acute care.

Current challenges

The key challenges facing the service can be captured under four headings:

- workforce; including skill mix and age profiles
- education and training
- performance data
- quality of care and leadership.

2.1 Challenge 1: workforce issues

An RCN report (RCN, 2011a), based on findings from the RCN 2011 employment survey *Views from the frontline* provides a summary of workforce related statistics relating to district nurses comparing results for this group with all nursing staff.

The survey revealed the older age profile of district nurses compared to the rest of the survey sample, with three-quarters (74 per cent) of all district nurse respondents aged 45 or over, compared to two-thirds (63 per cent) of all nursing respondents. When data for the whole NHS nursing staff in England was analysed it confirmed this finding, with 60 per cent of all district nurses aged 45 or over compared to 44 per cent of all qualified nursing, midwifery and health visitor nursing staff, as at September 2010 (see Appendix 1).

These figures raise concerns on the sustainability of the district nurse workforce to meet future demands. In recent years the RCN has been made aware of the increasing pressure that the declining numbers of district nurses have been working under.

While skill mix in itself is not necessarily bad for patient care, if over diluted with insufficient nurse leaders then the quality and outcomes for patients may suffer. Additionally, the deployment of health care assistants to undertake 'extended' roles – including administering insulin to stable diabetics, leg ulcer care and catheter care – is to be welcomed if training, supervision and locally imposed code of conduct systems are in place. However, not all community service providers have the necessary systems in place to ensure such delegated care is delivered safely and effectively.

The RCN 2011 nurse survey also revealed that a higher number of district nurse respondents reported a drop in the numbers of registered nurses in their workplace compared to the whole group of nursing respondents. Over two-thirds (69 per cent) of district nurses reported that staffing levels of registered nurses had dropped. When addressing the need to increase qualified district nurses, it will also be imperative to ensure newly-qualified staff are mentored and developed into the role.

2.2 Challenge 2: education and training

According to the Queen's Nursing Institute (2010) and the Welsh Assembly Government (2009), student numbers on programmes leading to a recordable Nursing and Midwifery Council (NMC) specialist practitioner qualification in district nursing have been decreasing since 1999; indeed, some programmes are unsustainable and no longer recruit students. This is due to the lack of demand from NHS organisations which has been influenced by the NMC standards for specialist education and practice, developed in 1994 and subsequently reprinted in 2001 but not reviewed nor updated since.

Although there has not been specific direction from the NMC, there is a sense the new standards for pre-registration nursing education (NMC, 2010) would strengthen the preparation of new registrants to work within the community setting. Although welcome, this preparation will not equip nurses to practice at the level of the specialist practitioner.

In recent years, higher education institutions (HEIs) have worked with colleagues from the NHS to respond innovatively, within the current standards to meet the needs of nurses working in team leadership roles. These organisations have also been involved in developing community nurses at all levels of the careers framework.

RCN members have reported that while the numbers of staff nurses and health care support workers have increased in some locations, the number of district nurses working with specialist expertise and in leadership positions has significantly decreased.

The RCN 2011 district nurse survey also showed a similar number of district nurses and other nursing staff have completed their first level registration nursing qualifications (around two-thirds) and second level registration. A higher number of district nurse respondents hold a nursing degree (62 per cent compared to 37 per cent of all nursing staff). Around a fifth of district nurse respondents (n=42) reported that they held an 'other' qualification and of these, 76 per cent (n=32) were either district nurse or nurse prescriber qualifications. This demonstrates that the existing workforce is highly qualified, although low in numbers.

For the future, developing newly qualified district nurses and ensuring succession planning is crucial. Support for programmes delivered by HEIs which meet national standards and for district nurse workforce planning is also clearly needed as a matter of urgency. This view is supported by *Care in local communities: A new vision and model for district nursing* (DH, 2013) which states that 'by district nurses, we mean qualified nurses with a graduate level education and specialist practitioner qualification recordable with the Nursing and Midwifery Council.' The DH view is very clear that the specialist qualification should remain.

2.3 Challenge 3: performance data

Historically hospitals have employed approximately 70 per cent of the nursing population and the community 30 per cent. Although the NMC pre-registration programmes aim to prepare newly-qualified nurses to work competently in the community, currently there are insufficient systems in place to ensure supervision and support for these nurses when they enter community settings. Newly-qualified nurses do not manage a busy hospital ward and nor should they be expected to manage the care of patients without senior nurse supervision in the community. Caring for people at home does not have any of the safeguards of a controlled environment (such as a hospital ward or general practice).

The RCN district nurse survey (2011) revealed a high incidence of overtime working across all nursing

staff, with 72 per cent working additional hours at least once a week. This figure is even higher among district nurses (87 per cent). In terms of extra hours worked, almost half the survey's respondents (47 per cent) said they work on average more than four hours a week overtime, compared to a third (36 per cent) of all nursing staff respondents. The impact of staffing level changes is leading to other changes, with half of those surveyed (49 per cent) reporting an increase in patient or client caseload.

These conditions are increasing the work pressures on all nursing staff – and district nurses in particular. The majority of district nurse respondents reported that workload (91 per cent), stress (85.5 per cent) and caseloads (83 per cent) had increased over the last 12 months, while team morale had decreased (80 per cent). District nurse respondents were also more likely to state that the quality of care has decreased compared to other nurse respondents, with 50 per cent stating that quality had stayed the same.

In the acute sector the currency for health care is relatively well developed and supports service line reporting and service line management. This is not the case in the community as block contracts are used to procure community services and there are no standard tariffs for community nursing. One of the fundamental reasons for this lack of refined data collection is that stratification systems for district nursing, for example caseload reviews and profiling, have not been used in a consistent manner across the UK.

There is an urgent need for a dependency classification system that can demonstrate to providers, commissioners, service planners and district nurses the profile of each caseload and the intensity of care being provided by each team. Such a system would assist with a common currency for the service. This would enable more robust service line reporting. In its recent report on service line management, The King's Fund (2012b) advocates the use of such systems to support wider opportunities for quality and productivity improvements.

2.4 Challenge 4: quality of care and leadership

As more complex care is delivered in the community urgent action is required to ensure the capability and capacity of district nursing services. New ways of managing long-term conditions and the advent of telehealth and telemedicine require advanced clinical decision-making skills in managing the care of patients with complex care needs and at the end of their life (see Appendix 2). Many of today's district nurses are also non-medical prescribers, have the ability to perform advanced physical assessment, and increasingly are delivering nurse-led services.

District nurses, along with other nursing colleagues employed by Marie Curie, local hospices and Macmillan, strive to enable those people who wish to die at home to do so. Despite the development of national end of life care strategies, in view of the increased numbers of people destined to die in the next decade (due to the UK's ageing population) there has been insufficient investment to enable district nurses to meet the projected demand for end of life care.

Measuring the quality of care received by patients in the new world of community service delivery will be extremely important. The introduction of Commissioning for Quality and Innovation (CQUINs) and Quality Innovation Productivity and Prevention (QIPP) programmes goes some way to addressing this. However, more robust clinically led performance indicators are required together with caseload data as described in the previous section of this paper.

Effective leadership and management ability are crucial to managing complex care and complex skill-mixed teams. Much can be learnt here from the acute sector ward sister/senior charge nurse developments taking place across the UK. District nurse leaders are the link between management and frontline staff such as registered nurses and health care support workers, and are the interface between management and personal care delivery.

Changes within the workplace over the last 12 months: district nurses compared to all nursing staff

	District nurses %	All nursing staff %
Workload has increased	90.7	81.2
Stress among my team has increased	85.5	76.4
Caseload has increased	82.9	73.3
Team morale has decreased	79.9	69.1
Quality of care has decreased	38.1	30.6

Source: RCN district nurse survey 2011

However, district nurses can only be effective if they have the support, the time, authority and respect necessary to competently and visibly lead their teams on the delivery of high quality care (RCN, 2009).

Efforts must be made to rebuild district nurse leadership in the community. Strong, visible and influential district nurse leadership is needed to plan and manage change and to ensure the safe and effective nursing practice of frontline nurses and health care assistants.

3 Defining district nursing

The RCN believes the fundamental goal of district nursing to be:

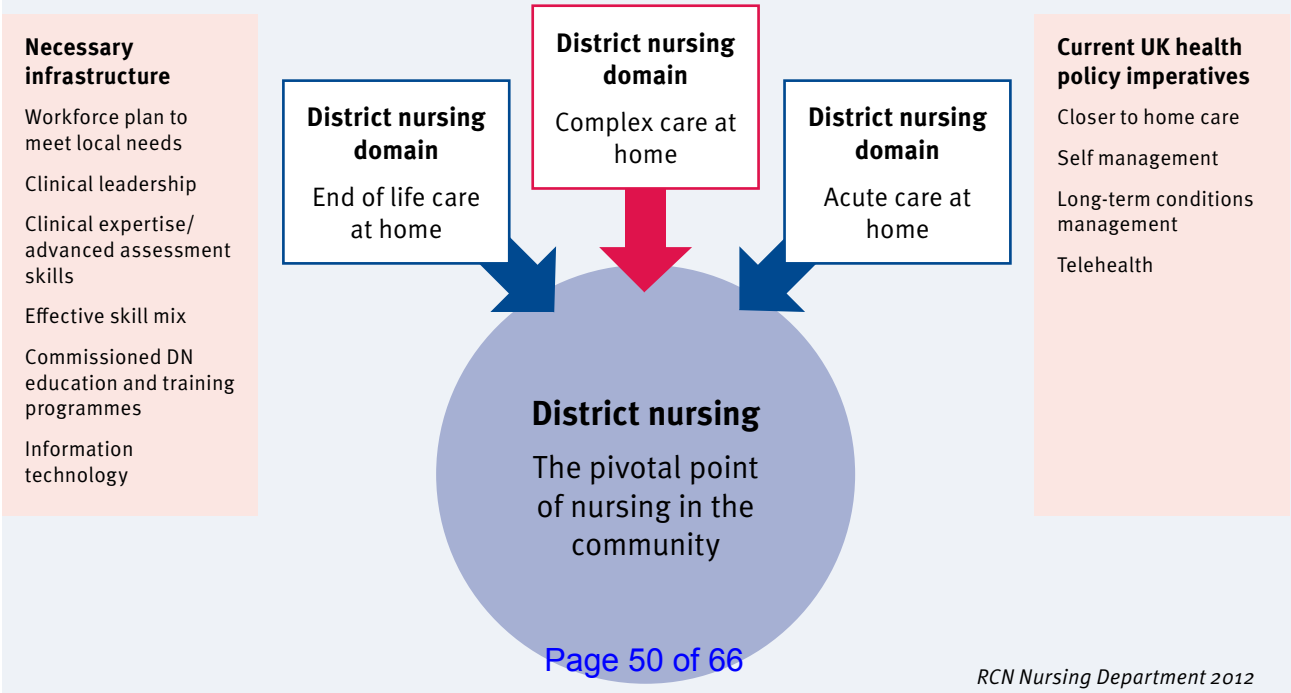
'The planning, provision and evaluation of appropriate programmes of nursing care, particularly for people discharged from hospital and patients with complex needs; long-term conditions, those who have a disability, are frail or at the end of their life.'

In developing this position paper the RCN has identified the three care domains for the effective delivery of district nursing services such as:

- acute care at home
- complex care at home
- end of life care at home.

Integral to all three domains is the key role of the district nurse in delivering public health, as outlined in the RCN publication *Going upstream* (2012b) on the contribution of all nurses to public health.

The three care domains form the basis of the conceptual framework below. The framework depicts the complexity of care provision in the community and the commensurate skills and infrastructure required to deliver care effectively in the community.



RCN Nursing Department 2012

4 Recommended pre-requisites for district nursing services

To improve workforce planning

The pre-requisite: given the demographic trends, there is a need to ensure plans are in place to replace the number of district nurses who are soon to retire. Each of the four national health departments must support the development of district nursing roles so that the current and future health needs of people requiring community services can be met. There needs to be the right skill mix within district nursing teams to enable them to safely nurse patients at home and for district nurses to supervise the nursing care they delegate to health care assistants and community staff nurses.

To enhance the environment of care

The pre-requisite: the RCN argues that the balance between acute and community care must shift if people's health and nursing needs are to be met and the aims of the various health policies and reforms in the UK achieved. The need for robust leadership, support and supervision infrastructures for district nursing continues and needs to be enhanced. The RCN therefore calls for significant investment to be made into building district nurse capacity so that patients have access to expert district nurses and their teams, who are skilled at delivering safe and high quality nursing care. There is also the requirement for the robust support and supervision of nurses new to working in the community setting which includes access to essential mentorship and leadership.

To demonstrate efficiency and productivity

The pre-requisite: the RCN believes there is an urgent need to agree a UK-wide caseload classification system that assists with demonstrating the intensity of cases within each team, and also assists with service line reporting and service line management.

To embed nursing expertise

The pre-requisite: higher education institutions (HEIs) must also be supported and commissioned to provide the programmes essential to ensure the education and development of the appropriate skill mix within district nursing teams. District nurse roles and education programs should evolve locally and nationally, but should be sufficiently consistent across the UK and aligned to the UK's Modernising Nursing Careers programme (DH, 2006). This will enable UK-wide recognition and regulation of nurses who work in the community by the NMC, compliance with EU regulations and a flexible nursing labour market.

To improve the provision of end of life care

The pre-requisite: to provide expert nursing care at home, the district nursing service must receive the essential investment to make this possible. Having well developed 24-hour district nursing services in place ensures that even patients with complex health needs can die well at home and in the way that they choose.

The RCN endorses the national action plan for palliative and end of life care in Scotland (Scottish Government, 2008). This includes the recommendation that NHS boards and their partners should ensure equitable, consistent and sustainable access to 24-hour community nursing and home care services to support patients and carers at the end of life (where the care plan indicates a wish to be cared for at home), and that this is compatible with diverse and changing patient and carer needs.

In addition, all NHS organisations should work towards the early implementation of a 24-hour community nursing service to support existing medical out of hours arrangements. These same principles apply to the end of life strategies specific to all four UK countries.

5 Action plan for practitioners, employers, workforce planners and commissioners

In summary, the RCN believes the key requirements for an effective and efficient district nursing service are:

- a well prepared, capable workforce
- qualified specialist practitioner district nurses in leadership roles
- commissioners and service planners aware of the skills and knowledge necessary to respond to complex long-term conditions care
- a supportive infrastructure and corresponding shift of resources from acute to community care
- a consistent approach to measuring caseloads and workload using caseload stratification systems
- technical and technology investment to support intensive care at home.

The RCN wishes key change agents to be made aware of the data collated by the RCN on the district nursing workforce and to understand its implications for patients requiring nursing at home, and calls for a number of actions.

Key change agent	Actions required
Workforce planners	Workforce planning to include the district nursing workforce. The community nursing workforce receives the attention and investment needed for it to provide essential high quality care in communities within a modern health service. This should include investment for staff to undertake specialist training to proceed to qualified district nurse status.
Commissioners and service planners	Commissioners and planners of district nursing services must make it quite clear what standards of care and patient outcomes are expected and that the appropriate workforce is employed to provide that care to the required standard. Develop a consistent caseload classification system with providers to enable more efficient service line reporting.
Provider organisations	Organisations providing home nursing services must work to ensure that the skill mix implemented is right for patients, carers and staff. Ensure supervision and leadership for district nursing services are robust and effective. Develop a consistent caseload classification system with commissioners to enable more efficient service line reporting.
Nurse educators and commissioners of education	Nurse educators to provide the right programs underpinned by national standards to ensure that nurses working in the community are prepared to take on the demanding district nurse leadership, clinical expert role. A commitment to invest in adequate numbers of nurse educators in higher education institutions (HEIs) and practice educators so that there is a comprehensive training and development infrastructure to prepare and skill up the district nursing workforce. Post registration district nursing programs are sufficiently commissioned and/or planned throughout the UK.
District nurses	District nurses to ensure they have the preparation necessary for delivering on the three key domains of district nursing (acute care at home, complex care at home and end of life care) and that they are capable of taking on a leadership role in the communities within which they work.

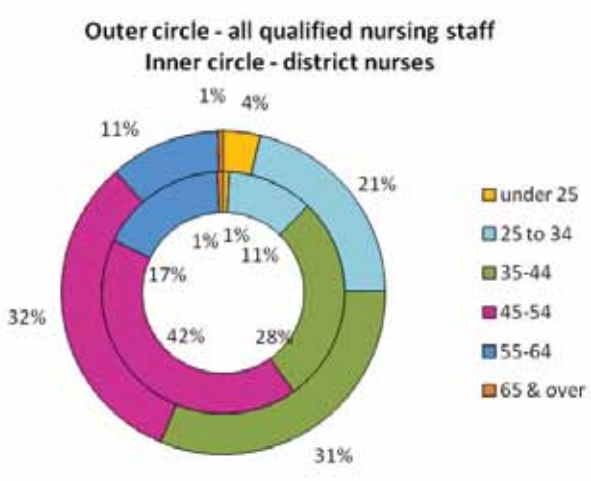
7 Concluding statement

The demands for home nursing will become greater as the health and social care landscape evolves. The RCN wishes to reconfirm that, regardless of the way politics evolve, the need for services to invest in high-quality, home-nursing services is far greater than it has been in the past.

The RCN believes it is time to make the shift from acute to community health services happen, and that district nursing will play a central role in the delivery of health care in the community. This RCN UK position statement on district nursing includes a set of key requirements and pre-requisites that will make it possible to realise the potential of district nursing across the UK.

Appendix 1
NHS England workforce census, September 2010

Chart 1: Age profile of district nurses compared to all nursing staff respondents



Appendix 2
Case studies

Telehealth in Argyll and Bute, Scotland

Over three years ago a plan was established to pilot telehealth in Argyll and Bute, one of three demonstration pilots funded by the joint improvement team. There were a number of challenges to be overcome, including:

- identifying and procuring suitable equipment
- data governance
- geographical issues
- project management
- evaluation
- training and development of the identified team
- specialist support
- IT support and involvement.

The model agreed on for the chronic obstructive pulmonary disease (COPD) pilot was that it would be supported by district nurses.

Bute was selected as a pilot site as it had little access to specialist support. Any access it had required patients to travel off the island to services provided by acute providers and covered by a service level agreement with NHS Highland. Bute also has a high proportion of people with COPD.

Training was delivered by a respiratory nurse to all the community nurses; one community nurse was further developed to deliver pulmonary rehab classes in conjunction with the physiotherapist and became a local champion for the project.

Patients were given a home iPad and asked to do their daily test at around 11am, in the knowledge that the allocated community nurse would review the data and alerts sent through after lunchtime every day. The community nurse triages the alerts and decides on the appropriate action; this could involve a telephone call, a visit or arranging a GP appointment (no action is taken on patients with no alerts, unless for some reason the test has not been completed). Work is allocated on a daily basis and the nurses allocate telehealth in place of one home visit.

Feedback has been excellent from both nurses and patients alike. GPs were unsure of its effectiveness in the early days but have confirmed that it has improved management of patients with COPD.

In 2011, phase one of the roll out commenced across Argyll and Bute; a further 20 units were purchased and split between four localities, using the same community nurse model. Training was delivered and a handbook developed to support teams with the tele-equipment installations, triage and management. A further purchase of another 40 units has been made to enable phase two of the roll out.

Phase one of the roll out focused mainly on extending the COPD monitoring programme to other areas of Argyll. Phase two will continue with COPD and heart failure, but will also include palliative care delivery. There are plans to review how the technology can be used to support people with education, exercise and peer support.

Some continuing challenges have been identified including obtaining full community team support and engagement; role definitions of specialist versus the generalist, particularly with heart failure patients; harvesting the champions and sharing their enthusiasm; sharing good practice across the service and embedding it into the team's work so that it is not seen as an add-on responsibility.

Palliative and end of life care in South West Lincolnshire, England

Lincolnshire Community Health Services NHS Trust

South West Lincolnshire continues to set high standards of end of life care and enables over 90 per cent of people who have expressed a wish to die at home to do so compared to the national average of 35 per cent. This is made possible through close integrated working between the primary health care team, which uses the Gold Standard Framework tool to identify people who may be in the last 6 to 12 months of their lives irrespective of their diagnosis.

Patients' needs are discussed in regular meetings between community nurses, Macmillan nurses and GPs; these discussions make it possible to anticipate future needs of patients, including pre-emptive prescribing. Proactive care also allows the team to anticipate potential problems and plan how to deal with them. The carer's needs are also recognised and every carer receives a supportive care plan alongside the patient's care plan.

The entire team recognise that having involvement at the end of a person's life is a privilege and believe there is only one opportunity to get the care right, and to ensure that the person has a dignified death and their family and carers are well supported before and after the death has occurred.

District nurses are often able to build relationships with their patients over many months, particularly where a patient has a cancer diagnosis, and may have had their treatments supported at home by the community nursing team. With open and honest communication the district nurse can discuss the future wishes of the patient and their family when the time is appropriate, and support people to die in the place of their choice.

John's story is an example of this, as described by the Senior Case Manager of the district nursing team that cared for John.

"John is an 80-year-old gentleman who, until five years ago, led an active independent life as a farmer in rural Lincolnshire. I first met John in 2002 following a hospital admission for retention of urine where it had been necessary for him to be catheterised. The community nurses visited John regularly to undertake catheter care and during the next two years he developed bilateral venous leg ulcers. Despite this, John continued to look after his pigs and farm the land around his home.

In recent months John's health has deteriorated and he is now disabled with arthritis to the extent that he is bedbound and relies totally on a package of care and neighbour support that enables him to remain in his home. Carers visit four times a day – John is transferred from his bed in the morning to his recliner chair, using a hoist, and then put back to bed at teatime. The district nurses also visit daily to change wound dressings, check pressure areas, assess symptom control and to support John with the care he needs to enable him to remain at home. Despite living alone, John is totally motivated to remain at the farm where he has spent most of his life and he continues to manage the workings of the farm from his bedside. He has expressed his wish to die at home and he has the confidence that the community team will support him in the future with end of life care."

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Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

11 November 2014

Agenda Item: 7

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.

3. The draft work programme for 2014-15 is attached as an appendix for information. Also attached is a scoping document detailing the approach to the scrutiny of provider trust Quality Accounts next year.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the draft work programme for 2014-15.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Joint Health Scrutiny Committee 2014/15 Work Programme

10 June 2014	• **Intoxicated Patients Study Group** To consider the report and recommendations of the Intoxicated Patients Study Group • **Terms of Reference and Joint Protocol**
15 July 2014	• **Developments in Adult Mental Health Services** To receive information about developments in adult mental health services (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **NUH Performance Against Four Hour Emergency Department Waiting Time Targets** To receive the latest performance information (NUH) • **New Health Scrutiny Guidance** To receive briefing on the new Department of Health guidance on Health Scrutiny
9 September 2014	• **Greater Nottingham Urgent Care Board** To consider the progress of the Greater Nottingham Urgent Care Board (Nottingham City CCG lead) • **Patient Transport Service** To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead) • **NUH Pharmacy Information** Information received as part of ongoing review (Nottingham University Hospitals/CCG) • **NHS 111 Performance** To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG)

	• **New Health Scrutiny Guidance – Key Messages** Further discussion
7 October 2014	• **Intoxicated Patients Review** To consider the response to the recommendations of this review (NUH) • **Developments in Adult Mental Health Services** To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **Mental Health Services for Older People** To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **Response to Pressures in the Urgent Care System** To consider immediate and medium-longer term planning to address pressures and demands in the urgent care system (TBC)
11 November 2014 CANCELLED	• **Out of Hours Dental Services** An initial briefing following concerns raised at the 9 September committee (Nottingham City CCG, others TBC) • **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN)
9 December 2014	• **Out of Hours Dental Services** An Initial briefing following the concerns raised at the 9 September committee (NHS England) • **Daybrook Dental Practice – Apparent Breach of Infection Control Procedures** (NHS England) • **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN)

13 January 2015	• **NUH Environment & Waste** Initial Briefing (Nottingham University Hospitals) • **Primary Care Access Challenge Fund Pilots** Pilot outcomes and next steps (South Nottinghamshire CCGs and Area Team)
10 February 2015	• **Daybrook Dental Practice – Apparent Breach of Infection Control Procedures** (NHS England)
10 March 2015	• **Patient Transport Service** To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead) • **NUH Pharmacy Information** Information received as part of ongoing review (Nottingham University Hospitals/CCG) • **NHS 111 Performance** To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG)
21 April 2015	• **Urgent Care Winter Pressures – Future Planning** To receive the latest update on lessons learned from winter 2014/15 (Nottingham University Hospitals)

To schedule:

NHS 111 – to consider outcomes of GP pilot and performance following workforce changes

Nottingham University Hospital Maternity and Bereavement Unit
24 Hour Services
Outcomes of primary care access challenge fund pilots
Impact of changes to adult mental health services and mental health services for older people (early summer 2015)
Responses to Pressures in the Urgent Care System (Teresa Cope and Nikki Pownall) - April

Visits:

EMAS
Urgent and Emergency Care Services (various dates)

Study groups:

Quality Accounts
Waiting times for pharmacy at Nottingham University Hospitals NHS Trust (review now taking place as part of the committee meeting rather than via study group sessions)

Quality Accounts Study Group 2014/15 Scoping

One study group for each of the following providers:

- Nottingham University Hospitals
- Nottinghamshire Healthcare
- Nottingham Treatment Centre
- East Midlands Ambulance Service

Not formally considering any other Quality Accounts (unless decided nearer the time)

Study group membership

Each study group to include:

- Minimum of 4 JHSC councillors – Chair/ Vice Chair/ another City councillor/ another County councillor
- Representative(s) of Healthwatch Nottingham/ Healthwatch Nottinghamshire (they usually share the workload between them) – *need to check that they want to be involved again*

Chairing to be shared between JHSC Chair/ Vice Chair/ another City councillor/ another County councillor

Officer support required

Study group remit

To consider the development of the relevant provider's quality account and for JHSC councillors to recommend to the Joint Health Scrutiny Committee whether to submit a comment for inclusion in the quality account and, if so, the content of that comment.

Healthwatch Nottingham and Healthwatch Nottinghamshire to take full part in evidence gathering and discussion but to agree and submit own comment as they feel appropriate.

Study group timescales and meeting plan

Meeting 1 (February)

- Introduction to quality accounts
- Review of performance against current year's priorities
- Development of forthcoming year's priorities, including plans for consultation and stakeholder engagement

Meeting 2 (May/ June)

- Further consideration (as more information becomes available) of performance against current year's priorities
- Outcome of consultation and engagement with stakeholders on draft priorities for forthcoming year
- Draft quality account document

JHSC councillors to agree draft comment to present to JHSC in June for approval prior to submission to provider (quality account to be published by 30 June). If there isn't sufficient time to take draft comment to JHSC, then at a preceding meeting agree delegated authority for the Chair/ Vice-Chair to agree the comment (as happened in 2013/14).

Any additional issues identified during the process can be referred to the JHSC for possible inclusion in the future work programme as appropriate.

Possible issue – City Council elections