Appendix 3

DISTRICT NURSING ROLE: CORE COMPONENTS

<table>
<tr><th>COMPONENT</th><th>Outcomes</th></tr>
<tr><td>Public Health / Health Improvement / Reducing inequalities</td><td>Individuals are given information, and advice on opportunities to stay well and manage their own health
Circumstances which may impact directly on individuals health both mental and physical are identified and addressed
Community profiles identify local need
Hospital admissions are avoided.</td></tr>
<tr><td>Anticipatory Care</td><td>Planning is in place for future health needs and well-being.
Hospital admissions are avoided.
Care is person-centred and based on the 5 ‘must-dos’ of the person-centred strategy.
Individuals are given information, and advice on opportunities to stay well and be physically active
Individuals are offered emotional and psychological support from my peers, local community or professionals
Individuals and families develop their own ‘Thinking Ahead’ Anticipatory Care Plan
Key Information Summaries and ECS are shared with emergency teams
Home and housing support wellbeing</td></tr>
<tr><td>Assessment</td><td>District Nurse prioritises the assessment to ensure patients’ person-centred outcomes are delivered on.
Patient and their family are involved in the assessment, evaluation, review and negotiations around the actual outcome. ** Personalised care planning is based on a holistic process that puts the individual at the centre of their own care and focuses on helping them and their carers achieve the outcome they want for themselves (Department of Health 2009). Care planning involves discussion and reflection about goals, values and choices. It covers a continuum from self-management support, care and treatment preferences and carer support to ‘thinking ahead’ anticipatory care planning for potential flare ups or unexpected deterioration. Advanced care planning is a process of discussion and reflection about goals, values and preferences for future treatment when facing anticipated deterioration. </td></tr>
<tr><td>Care / Case Management</td><td>Healthier living :
Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.
Independent living</td></tr>
</table>

	• *People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.* • *Positive experiences and outcomes* • *People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.* • *Carers are supported* • *People who provide unpaid care to others are supported and able to maintain their own health and wellbeing including by having a life outside of caring.* • *People are safe* • *People using health, social care and support services are safe-guarded from harm and have their dignity and human rights respected.* • *Engaged workforce* • *People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.* • *Effective resource use* • *The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.*
Complexity / Frailty	*People will lives that are as long, healthy, active and happy as possible Focusing on four common goals:* 1. *Maintaining Independence* 2. *Recognising and preventing difficulties* 3. *Regaining skills and confidence* 4. *Delivering care that is dignified, respectful and person centred* • *Patients achieve the best possible services and support* • *Patients receive the appropriate level of care based on their individual needs.* • *Independence is maintained as long as possible* • *Appropriate referrals.* • *Patients and their families are included in care arrangements* • *Right care in the right place at the right time from the right individual* • *Care planning and consultations help people to have control over their conditions, care and support and to achieve their personal outcomes* • *Integrated care and support builds on community assets and promotes independence, wellbeing and resilience* • *System pathways are designed to meet the needs of people with multimorbidity and to reduce health inequalities*
Intermediate Care / An	• *Person's Care is provided in the most appropriate environment for their needs.*

acute or unexpected episode	• *Patient’s experience has been a positive one.* • *Supported discharge.* • *Patient has regained his/her maximum potential.* • *Safe and effective clinical practice.*
End of Life Care / Palliative Care	• *The District Nurse [Band 6 Charge Nurse/ Team Lead] is recognised as the key coordinator of care* • *Patients and carers are confident* • *Patients' wishes are respected and achieved* • *Messages are shared and updated and care is coordinated.* • *Personal care is patient centred and responsive* • *Early indication of palliative care phase and early involvement of DN team* • *Quality palliative care within the homely setting.* • *All appropriate services are involved* • *Early identification of end of life phase* • *Comfortable and pain free death* • *Family members feel involved and supported*