**National Quality Board**

**Edition 1, December 2017**

Safe, sustainable and productive staffing

# An improvement resource for the district nursing service

This document was developed by NHS Improvement on behalf of the National Quality Board (NQB).

The NQB provides coordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
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# Working group patient perspective

For me, the most significant piece of evidence to emerge from this workstream, particularly the evidence review, is that there is a distinct lack of evidence. The design of the tools and processes for safe caseload staffing in the community is an intensely complex issue and has thus far defied attempts to generate adequate information for evidence-based decisions.

In an evidence-based culture, this raises a tough question: do we do nothing until evidence is gathered or do we take some action to tackle the known district nurse staffing problems? From a patient perspective, the 'do nothing' option does not sit comfortably – I do not believe we can wait for years searching for definitive evidence.

Instead, a balance between pragmatic common sense and puritanical evidence-based, risk-averse inactivity must be struck – and the unearthing of evidence should continue.

The report has been produced with input from stakeholders and experienced practitioners in all relevant disciplines – the right staff, skills, place and time. It highlights the critical directions in which to start advancing.

Rather than discussing it again and again, let's break this 'unsolvable' issue into manageable chunks and work together, including patients in the process, to take action. Now.

Iain Upton

# Summary

Patients cared for by the district nursing service, often have complex care needs. The care environment adds to that complexity. We use the term 'safe caseloads' in this improvement resource reflect this.

It is important to recognise the expert knowledge, skills and capabilities of district nursing teams and the value of strategic workforce planning as well as operational workforce allocation, to ensure that a caseload is managed safely.

A variety of caseload management tools exist and as a result benchmarking across services and systems is challenging.

Evidence-based standardisation of the approach to determining safe caseloads is recommended, along with the metrics used to evaluate the quality of care provided. NHS Improvement recommends the co-ordination of the above areas; however there are actions that providers can take now and they are included in the table of recommendations below.

## What does good care look like?

The nine characteristics of good quality care in district nursing identified in the King's Fund report are illustrated below (Maybin et al 2016):

# Recommendations

The recommendations below originate from an academic literature search, experiential evidence from an expert panel and related evidence from other settings.

Recommendations to support nurse staffing in the district nursing service: for members of the board, with strategic partners.

| | |
|---|---|
| 1. | Organisations should work together locally, to define safety in the context of district nursing and agree a suite of metrics to provide assurance of safety and quality across the system. |
| 2. | Include metrics regarding: patient outcomes, patient safety, patient experience, staff experience with system-wide measures. Standardise collection and monitoring of metrics. |
| 3. | Plan the multiprofessional workforce to provide safe caseload management around the agreed definitions of safety and quality. |
| 4. | Use technology to support remote monitoring and a more agile workforce. |
| 5. | Use an evidence-informed decision support tool, triangulated with professional judgement and comparison with relevant peers. |
| 6. | Undertake an annual strategic staffing review of all healthcare professional groups. |
| 7. | Review a comprehensive staffing report after six months to ensure workforce plans are still appropriate. |
| 8. | Review a local dashboard of quality indicators to support decision-making on a monthly basis. |
| 9. | Review local recruitment and retention priorities regularly and maximise flexible employment options and efficient deployment of staff. |
| 10. | Introduce a process to determine additional uplift requirements based on the needs of patients and local demography. |
| 11. | Introduce an escalation process in case staffing does not deliver the outcomes identified in the appropriate plan. |

| 12. | Respond to changing patient requirements and new ways of working/new care models. |

We recommend further research is undertaken as a priority, to identify the evidence base for determining safe caseloads in the district nursing service.

## Demonstrating safe caseloads

Case studies are included in the improvement resource with contact details.

# 1. Introduction

This is an improvement resource to support nurse staffing in the district nursing service. It is designed for use by staff involved in clinical establishment setting, approval and deployment – from the team leader of the district nursing service to the board of directors. The resource may also be useful to commissioners and users of the district nursing service.

While we acknowledge that district nurses are part of the multiprofessional team, this resource focuses on the district nursing service, as this is the universal element of adult community nursing.

We refer to 'safe caseloads in the district nursing service' rather than 'safe staffing', as this better reflects the complexity of determining the required staffing levels. The resource is based on the National Quality Board's (2016) three expectations:

**Figure 1: National Quality Board expectations (2016)**[1]

| Safe, Effective, Caring, Responsive and Well- Led Care | | |
|---|---|---|
| **Measure and Improve**<br>-patient outcomes, people productivity and financial sustainability-<br>-report investigate and act on incidents (including red flags) -<br>-patient, carer and staff feedback- | | |
| -implement Care Hours per Patient Day (CHPPD)<br>- develop local quality dashboard for safe sustainable staffing | | |
| **Expectation 1** | **Expectation 2** | **Expectation 3** |
| **Right Staff**<br>1.1 evidence based workforce planning<br>1.2 professional judgement<br>1.3 compare staffing with peers | **Right Skills**<br>2.1 mandatory training, development and education<br>2.2 working as a multi-professional team<br>2.3 recruitment and retention | **Right Place and Time**<br>3.1 productive working and eliminating waste<br>3.2 efficient deployment and flexibility<br>3.3 efficient employment and minimising agency |

The resource builds on the evidence review published by the National Institute for Health and Care Excellence (NICE) (Fields and Brett 2015), and draws on an academic literature search, experiential evidence from an expert panel and related evidence from other settings and institutional websites.

This resource is closely aligned with *Leading change, adding value* (NHS England 2016), which makes 10 commitments. Commitment 9 states "We will have the right staff in the right places and at the right time" to achieve the triple aim of better outcomes, better patient and staff experiences, and better use of resources.

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[1] The care hours per patient day (CHPPD) metric was introduced to the adult inpatient setting in 2016. It is calculated by adding the hours worked by registered nurses and healthcare support workers and dividing that total by the number of inpatient admissions in a 24-hour period (at midnight). Its consistent use allows benchmarking against peers. This could be explored for use in other environments of care in due course.

The principles of setting safe caseloads in the district nursing service outlined in this resource will apply where services are reconfigured, such as in the development of new health and social care models. We recommend that organisations work together to implement the principles.

It is also useful to identify and recognise the role professional organisations and unions can provide in supporting this work. A partnership approach with staff side representatives is important in developing and monitoring workforce policies and practices and in influencing the organisational culture.

## 1.1.  The district nursing service

The District Nursing service is typically commissioned by the CCG as part of a community services contract, to provide nursing services to people in their homes and communities within a local population, defined by a geographical location or a GP registered list. For more information on the care provided by the District Nursing service, see section 1.2 It is an autonomous, accountable nurse led service. The commissioned district nursing service is made up of many teams of staff nurses and healthcare support workers, with a leader for each team. The teams deliver services to individuals in their homes in a defined geographical area within their community, and/or to patients registered with a named general practice. Team leaders normally have the Nursing and Midwifery Council (NMC) recordable Specialist Practitioner Qualification (SPQ) in District Nursing, and are skilled in the following (the Queen's Nursing Institute and the Queen's Nursing Institute Scotland 2015):

- providing a wide range of nursing care in home and community-based settings
- assessing and managing unpredictable situations flexibly and responsively
- advocating for and co-ordinating care, whether anticipated or unscheduled, with individuals and their families, through acute illness, long-term and multiple health challenges and at the end of life
- working collaboratively and creatively with colleagues in general practice, social care, community pharmacy, nursing specialisms, allied health

professions and others to improve the health and care of individuals, families and communities, particularly the most vulnerable

- managing the care of people with multiple pathology and long-term conditions whose mobility is impaired
- leading and managing a team to deliver care in the home and community (this includes mentorship of students and use of data to monitor service provision).

It is important to recognise the expert knowledge, skills and capabilities of the district nurse team leader.

## 1.2. What does good care look like?

Figure 2 shows the nine characteristics of good quality care in district nursing identified in *Understanding quality in district nursing services – learning from patients, carers and staff* (Maybin et al 2016). Patients and carers involved in the development of this resource confirmed Maybin et al's (2016) finding that the three most important characteristics to patients, carers and staff were: caring for the whole person, continuity of care and personal manner of staff.

**Figure 2: Nine characteristics of good quality care in district nursing (Maybin et al 2016)**

This quality framework (Maybin et al 2016) may be helpful in developing an assessment tool for measuring the quality of the district nursing service locally and supporting discussions with frontline teams about how they can self-assess the service they provide. A national agreement to assess the district nursing service using the nine characteristics would facilitate benchmarking across teams and services, sharing of best practice and productivity gains.

## 1.3. The district nursing caseload

The term 'district nursing caseload' refers to the care of patients (at individual and team level) and the related activities that support them, their families and carers, over a specified period in a specified area. It may reflect a geographical area and/or be aligned to general practice registration. The district nursing caseload may vary in size and complexity depending on the specific patient needs at any one time, the demographic profile of the population served and other factors such as where the service base is located in relation to the geographical distribution of patients.

Although there are few studies which look at safe caseloads in district nursing services, relationships have been found between numbers and skill mix in the hospital sector. The relationship between staffing and outcomes in district nursing services needs to be further understood, developing the work by Ball et al (2014).

The approach to determining a safe caseload is not based on nurse-to-patient ratios. This is because many elements which are not fixed need to be considered to meet the needs of all patients within the caseload.

## 1.4. Factors influencing safe caseload management

Within the adult community nursing service, 'safety' is poorly defined in terms of the workforce required (see the evidence review). Increasing demand on district nursing

services and the complexity of the patients being cared for need to be considered in shaping a financially and operationally sustainable service that is safe for patients.

Without the physical restriction of a defined number of beds, this service may attempt to absorb additional workload. Maybin et al (2016) highlight that district nursing teams increasingly care for patients with complex healthcare requirements, helping to reduce unplanned admissions to hospital and reducing length of stay.

Factors to consider in safe caseload management include, but are not limited to, the following (The Queen's Nursing Institute 2016):

- needs of patients, their families and carers
- patient safety
- geography (eg urban or rural, implications for travel and ability to use mobile technology)
- housing and the home as an environment for care
- staff safety (eg lone working or care that needs to be given by more than one member of staff)
- care pathways and interventions (eg collaboration with other services providing care in the home, such as the allied health profession, third sector and social care)
- location of the care environment beyond the patient's home, including residential nursing homes. Some district nurses hold clinics in GP surgeries and community centres
- knowledge, skills and experience of staff.

## 1.5. Determining a safe caseload

Determining a safe caseload requires both a focus at a strategic level as well as at an individual patient level. This process is illustrated in the following graphic which emphasises a feedback loop from patient and staff outcomes. Determining a safe caseload  at a strategic level requires an assessment of the current and projected population needs, the skills within the service and across local organisations that are required to meet those needs, and how the identified skill shortfall will be addressed.

New and sustainable ways of working, such as technology to support remote monitoring and a more agile workforce, need to be considered.

At an operational level, determining a safe caseload  requires an assessment of the healthcare needs of patients, their families and carers at a service and a team level, and how appropriate members of the team can be deployed at the right time and place to meet these needs.

Critically, the outcome for patients, their families and carers must be captured in any measurement of the impact of the district nursing service.

Figure 3 summarises the available methods and tools to support safe caseload management at a strategic and operational level.

**Figure 3: Safe caseload management methods and tools**
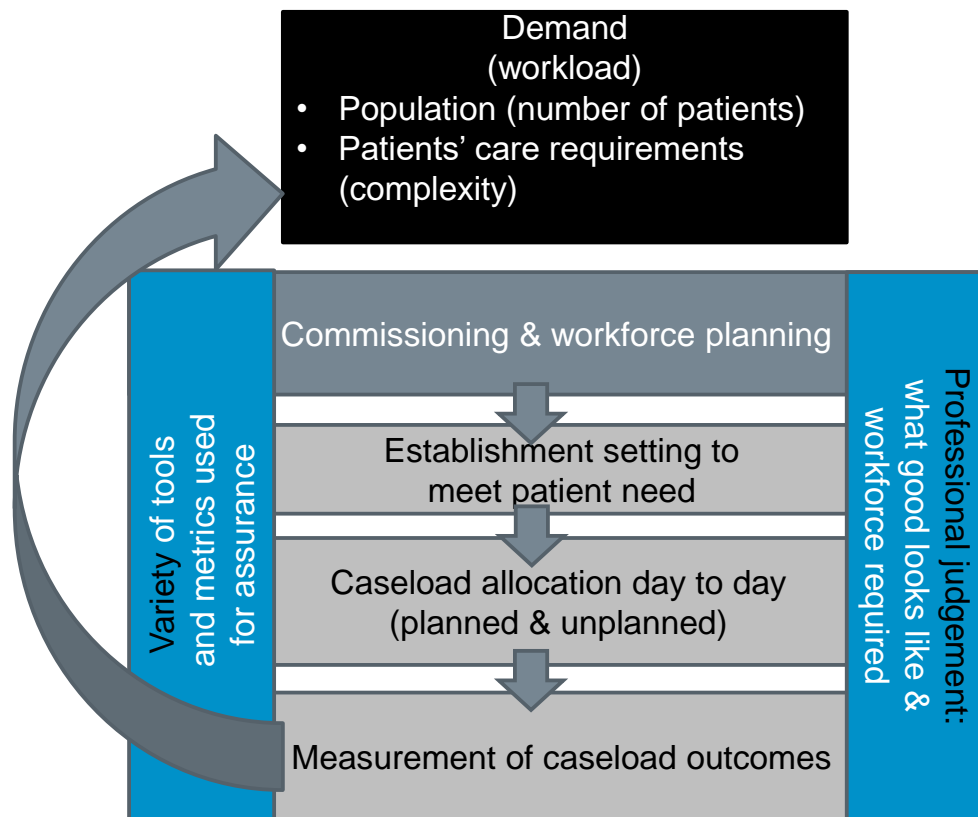


The recommendations (see Summary) build on the principles of safe staffing identified by NHS England (2015) and apply in any district nursing setting. Their implementation at both strategic and operational levels should be considered for the whole system, working with partner organisations identified in sustainability and transformation plans (STPs).

More detail of how this can be applied in practice, can be found in Appendix 2: **Case study 1** – Adult community nursing workload and complexity tools: capacity versus demand (Rotherham, Doncaster and South Humber NHS Foundation Trust).

# 2. Right staff

Staff capacity and capability in the district nursing service must be sufficient to provide safe, cost-effective care to patients at all times, and this provision must be sustainable. Staffing decisions must be consistent with operational and strategic planning processes so that high quality care can be provided now and on a sustainable basis.

The 'nursing establishment' is the total number of registered nurses and healthcare assistants employed to work in a particular service or team.

The establishment and the number of staff available to be rostered on any given day must be identified. The importance of supervision and the ability of the team leader to lead and manage the team must not be overlooked when determining the total establishment required.

Boards should ensure planning of a sustainable workforce and that the workforce is regularly reviewed against the changing needs of patients. Workforce planning should follow evidence-based processes and may use validated tools, professional judgement and benchmarking against other providers and metrics.

All healthcare providers must strategically plan for an interdisciplinary workforce that can meet the often complex needs of people with learning disabilities (see Appendix 1).

## 2.1. Evidence-based workforce planning

### Annual staffing reviews

Boards should review staff establishments annually (National Quality Board 2016) or more frequently when planning services changes. The important features of this planning approach are:

- a systematic, evidence-based approach to determine the required number and skill mix of staff (see section 2.2)

- benchmarking against peers (eg other provider organisations) and sharing the learning
- professional judgement exercised for specific local needs, but with care not to duplicate elements included in other tools
- account taken of national guidelines developed by professional consensus.

The decision-making process to determine safe and sustainable caseloads must be clear and logical, and take account of the wider multiprofessional team.

There should be a transparent governance structure, including team-to-board reporting of staffing requirements, for determining staffing numbers and skill mix and for monitoring effectiveness. Increased use of technology and support services can release time to spend providing direct care and should be considered.

## Strategic workforce planning

Strategic workforce planning needs to consider local partners – commissioners, social care and, where available, voluntary services, eg 'hospice at home' service – to ensure safe care is delivered cost-effectively (see the evidence review).

Sustainability and transformation partnerships and accountable care organisations/systems provide the strategic opportunity to align workforce planning with the needs of the local population.

Providers should agree what 'good' looks like for patients and staff with local partners and patient representatives. Outcome measures must be included in benchmarking and the evaluation of workforce planning and future commissioning of services.

New care models may impact on how community services are designed and delivered, including district nursing services, eg by reducing lengths of hospital stay. A strategic review of the increased capacity and capability required to accommodate such a change should be assessed before any new model is implemented. Agreed

care pathways will help identify and standardise the care/skill mix the district nursing service needs to provide.

Providers of district nursing services need to plan for strategic service and multiprofessional workforce development at local and regional levels and inform national workforce planning (Ball et al 2014).

## Operational workforce allocation

In the absence of a robust dependency classification system allocation of team members to deliver care in patients' homes and communities relies on professional judgement (see the evidence review). Professional judgement may be supported by a caseload management software programme, but the decision is more complex than simply considering how long a particular care activity takes. It should take account of the following factors:

- patient need
- complexity of care required
- use of technology
- local geographical factors, such as housing, travel time and car parking
- capacity of other health and social care services
- staff knowledge, skills and abilities.

It is important to capture and record any unmet need or postponed care, if demand exceeds capacity, and the clinical and other consequences of this, including the impact on the patient, family and carer experience. More detail is provided in section 2.2.

More detail of how this can be applied in practice, can be found in Appendix 2: **Case study 2** – Sheffield Community Caseload Classification System: articulating the hidden work of community nurses (Sheffield Teaching Hospitals NHS Foundation Trust).

## 2.2.  Tools to support safe caseloads

Several commercial caseload management tools are available, but there is little published evidence of their reliability and validity (see the evidence review). NHS England's (2015) framework for commissioning community nursing identified a number of tools and compared their usefulness to the district nursing service. There are now many more commercial tools and tools developed locally by providers. Use of data from these tools for peer caseload review and benchmarking is described in section 2.5. Users should check a tool's specification against the principles for safer caseload management in this document.

A tool's broad and complex, requirements are summarised in the infographic on the next page, which has been developed with the National District Nurse Network (NDNN) membership and members of the QNI Community Nurse Executive Network (CNEN). The infographic is useful when developing a specification for a caseload management and e-rostering tool and/or to assess the elements of a tool currently in use, as it separates factors influencing strategic caseload management from operational issues. The breadth of influencing factors makes this graphic very complex. However it demonstrates the inter relationships between the factors and their impact

We recommend that a common classification system for patient acuity/dependency/frailty/complexity is agreed and the further development of tools takes this into account.

# Requirements Of A Software Tool Supporting Safe Caseloads

## System Overview

Should use up to date technology design

Should engage with end user during design

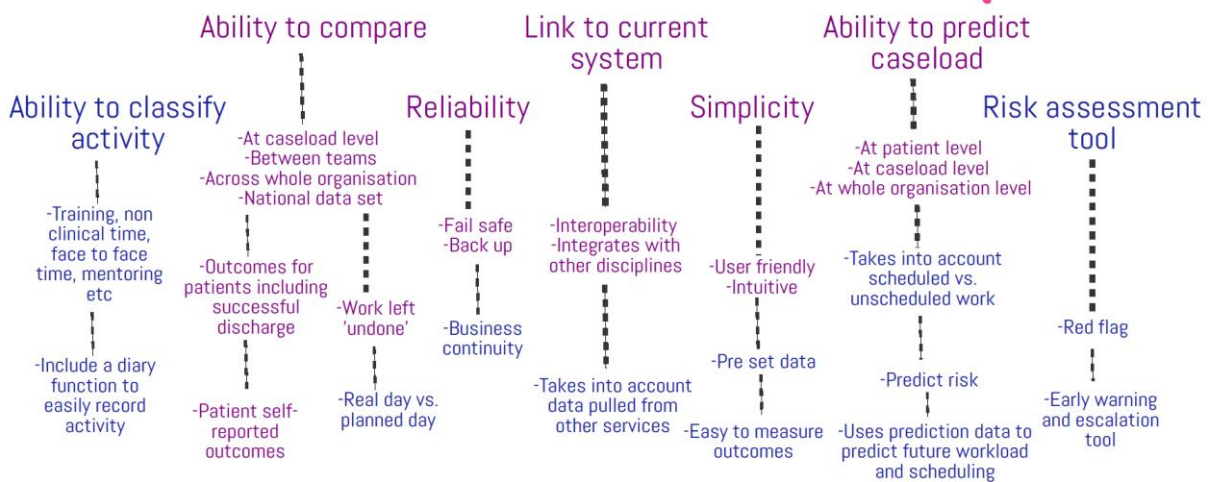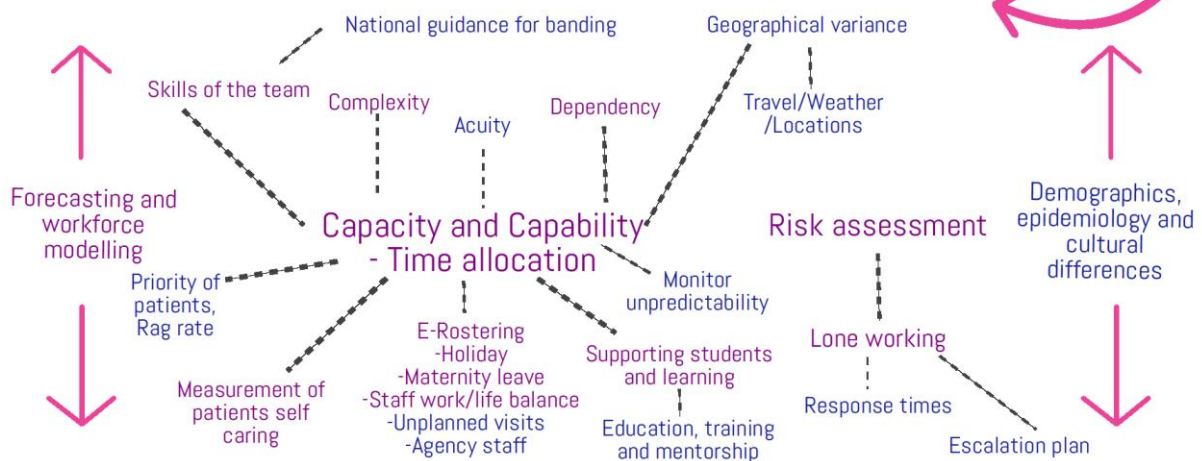Allows for different methods of data collection e.g. data pens, remote monitoring, telehealth

Caseload 'limiter' function

Uses read codes/SNOWMED-CT Codes

Professional judgement 'Override' function

Works to the practice guidelines the user follows

Tool should include resource library containing national guidance, relevant statistics, research and best practice guidelines

Secure

Compatible on mobile & desktop

Financial aspects considered

Tech support provided in real time

Staff training hubs and workshops

Must have realtime data dashboard

At whole organisation and team level

Reporting and Alerting Triggers

KPI Indicator

Admin support

24hr support

Live e-rosters for demand and capacity

Reports back to related departments e.g. HR

Audits

## The System Must Have

**Ability to classify activity**

-Training, non clinical time, face to face time, mentoring etc

-Include a diary function to easily record activity

**Ability to compare**

-At caseload level
-Between teams
-Across whole organisation
-National data set

-Outcomes for patients including successful discharge

-Patient self-reported outcomes

**Reliability**

-Fail safe
-Back up

-Work left 'undone'

-Business continuity

-Real day vs. planned day

**Link to current system**

-Interoperability
-Integrates with other disciplines

-Takes into account data pulled from other services

**Simplicity**

-User friendly
-Intuitive

-Pre set data

-Easy to measure outcomes

**Ability to predict caseload**

-At patient level
-At caseload level
-At whole organisation level

-Takes into account scheduled vs. unscheduled work

-Predict risk

-Uses prediction data to predict future workload and scheduling

**Risk assessment tool**

-Red flag

-Early warning and escalation tool

## When Predicting Caseloads The System Must Take Into Account

Forecasting and workforce modelling

National guidance for banding

Skills of the team

Complexity

Acuity

Dependency

Geographical variance

Travel/Weather/Locations

Demographics, epidemiology and cultural differences

Capacity and Capability - Time allocation

Priority of patients, Rag rate

Measurement of patients self caring

E-Rostering
-Holiday
-Maternity leave
-Staff work/life balance
-Unplanned visits
-Agency staff

Monitor unpredictability

Supporting students and learning

Education, training and mentorship

Risk assessment

Lone working

Response times

Escalation plan

Metrics to evaluate workload and thus safe caseload management need to be standardised, to permit national district nursing service benchmarking and identification of improvement opportunities at local, regional and national levels. Many individual organisations have developed their own caseload management tools using local evidence.

When considering the use of a tool to support safe caseloads, the following points should be noted:

- staff must be trained to use the tool and adhere to associated guidance
- independent and systematic validation should be undertaken so that the tool is applied consistently across the organisation and as directed by the evidence base on which the tool is built
- transparency, including data sharing, in the use of the tool within and across teams, to permit benchmarking and maximise the capacity of the staff
- staff have the capacity to respond effectively to changes in patient need and other demands for nursing time that occur often but may not be predictable: for example, transfer of care from hospital at short notice and end-of-life care. Capacity to deal with unplanned events should be built into the nursing establishment, based on identified patterns of historical data
- professional judgement is essential in deciding safe caseloads (see section 2.4)
- an agreed allowance for planned and unplanned leave (accommodating uplift as outlined below).

## 2.3. Setting establishments to include planned and unplanned leave

While leave needs to be managed efficiently and responsibly, district nursing establishments should include an 'uplift' to allow for planned and unplanned leave and effective management of absences. This will support nurse staffing in the district nursing service.

The uplift is for:

- annual leave in line with Agenda for Change (AfC) or local terms and conditions
- study leave
- appraisals and personal /professional development
- maternity/parenting leave
- sickness/absence/carers/compassionate leave.

The uplift needs to be realistic and reviewed at least annually as part of the budget setting process. Factors to consider when setting uplift include:

- operating a central pool to cover maternity/parenting leave (eg calculated at team level and then managed centrally)
- leave entitlements increase with length of service (where AfC applies)
- planning should take account of sickness/absence and measures to address it
- estimates for study leave should include mandatory training and elements of core/job-specific training
- learning activities such as fulfilling link-nurse roles and participation in a quality improvement collaborative
- the allowance for study leave uplift needs to be appropriate for the proportion of part-time staff
- as teams become more multiprofessional, applying the study leave allowance across the whole team should be considered
- uplift should allow for supervisory time for the leader of the district nursing team. The amount of supervisory time should be determined locally, with an appropriate impact assessment and analysis.

The recommendation in the _Report of the Mid-Staffordshire NHS Foundation Trust public inquiry_ about the supervisory capacity of the clinical nurse manager of a ward is applicable to registered nurses who lead and manage district nursing teams. The clinical manager "… should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision… They should know about the care plans relating to every patient... They should make themselves visible to patients and staff alike, and be available to

discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal."

The size, geographical spread and complexity of a District Nursing caseload requires appropriate additional support in the supervision of team members to enable a district nurse team leader to know every patient's current care plan. This may include the use of up-to-date technology to enable record sharing, supervision and communication at any point throughout the 24-hour period.(see section 4.2)

Table 1 is an example of how an uplift may be set when determining the nursing establishment.

**Table 1: How an uplift (sometimes referred to as headroom) may be set**

| Element | % | Rationale |
|---|---|---|
| Annual leave | 14.7 | Average annual leave across the nursing workforce, in line with AfC, and taking account of local patterns of length of service |
| Sickness/absence | 3 | Target/aspiration level for the organisation and should be aligned to plans to implement improvement |
| Study leave | 3 | Includes mandatory and core/job-specific training and learning activities such as link nurse roles |
| Parenting leave | 1 | In some organisations this is managed centrally. It includes maternity, paternity and adoption leave. This is driven by local workforce demography |
| Other leave | 0.5 | Includes carers and compassionate leave |
| **Total** | **22.2** | |

## 2.4. Professional judgement

Staffing decisions based solely on professional judgement are subjective and may not be transparent. Professional judgement and scrutiny however are critical to any decisions about safe caseloads.

The principles of professional judgement are:
- team leader judgement made in collaboration with the team
- takes account of the actual workload during a specific period of time
- includes all activity, eg planned and unplanned workload and irregular activity
- informs decisions on required team numbers and profile
- validated by peers/manager.

Professional judgement should be used to interpret the results from evidence-based tools, taking account of the local context and patient, family and carer needs and desired outcomes. This triangulated approach combines outcomes from evidence-based tools, including clinical quality indicators and comparisons with peers.

Professional judgement and knowledge should inform real-time decisions on staff skill mix taken in response to changes in the caseload, acuity/dependency/frailty/complexity and activity.

## 2.5. Comparing staffing levels with peers (benchmarking)

Peer comparisons can act as a platform for further enquiry and time should be allocated for this important benchmarking activity. While some caution is needed, comparison of staffing with peers can act as a 'sense check', particularly for assumptions and professional judgements, and help sharing of good practice. It can additionally be helpful to compare data relating to demand and capacity from district nursing teams within the provider service to understand any variability and to determine the underlying reasons for this and whether this may be warranted or unwarranted.

# 3. Right skills

If the workforce is to be used efficiently and effectively the skills needed to deliver the care required must be identified and the right staff deployed to deliver it. Continuity of the person providing care over a period of time must also be considered (Maybin et al 2016).

The wider multiprofessional team needs to be carefully considered when deciding who should deliver care to address patient/family/carer needs. Allied healthcare professionals work alongside district nurses to keep people with complex healthcare requirements in their own homes and prevent unnecessary hospital admission.

The appropriate deployment of those in non-clinical, professional support roles should also be considered to support the multiprofessional clinical team to deliver the most effective and productive care.

## 3.1. Skill mix

When considering what the 'right skills' are to meet patient needs, as well as the staff establishment within each team, a wider view needs to be taken of access to the relevant expertise across the service and the local health economy – for example, staff working in primary care, care homes and nursing homes.

In the absence of a universal measure of patient acuity/dependency/frailty/complexity of care, professional judgement (see section 2.4) is relied on to determine the skills required to meet patient need and to deliver a high quality district nursing service, as described by Maybin et al (2016). These skills include the following (adapted from NHS England 2015):

- decision-making, often without support being immediately available
- coaching patients/carers in self-care, to recognise changes in their condition and to respond appropriately
- supporting carers to provide person-centred care, eg end-of-life care at home

- risk assessment in sometimes less-than-optimal conditions for the delivery of clinical care

- preventing unnecessary hospital admission and facilitating timely discharge from hospital

- developing relationships with third-sector organisations

- generating, collecting and responding to honest, considered feedback and using it to improve performance.

## 3.2.  Training, development and education

The evidence review highlights that education and training are the foundation for safe and effective care. This includes education of the patient, family and carer as well as staff. The learning environment must support skill development. This may boost staff retention as well as improve workforce effectiveness. All members of the clinical team must be appropriately trained to be effective in their roles.

### Specialist Practitioner Qualification (SPQ) in District Nursing

The SPQ is a professional recordable qualification regulated by the NMC. The relevance of the NMC standards for the SPQ to modern district nursing was recently reviewed by key stakeholders, culminating in the publication by the Queen's Nursing Institute and the Queen's Nursing Institute Scotland (2015) of new voluntary standards for district nurse education and practice to enhance the existing NMC standards.

The measureable benefits of the skills, knowledge and competence of the SPQ to patients, families, carers and the district nursing team have been explored by the Queen's Nursing Institute (2016).

The RCN endorses the qualification (Bliss and Dickson 2016).

Commissioners and providers must work with Health Education England (HEE) and higher education institutions to ensure suitable and well-resourced district nurse programmes are available to sufficient numbers of registered nurses. Strategic

workforce planning is needed at regional and national level, with providers contributing to the process.

The team leader is responsible for assessing the training requirements of individual team members, and prioritising and developing a plan to meet these within available resources. This assessment can identify opportunities to upskill staff to address gaps in patient care. Education and training needs can be met through, for example, local skills training, e-learning, seminars, shadowing, clinical placement exchanges and rotation programmes. Compliance with appraisal and mandatory training should be incorporated into a local quality dashboard.

The roster must include protected time for administrative work, clinical leadership, meeting education and training needs, clinical supervision, nurse revalidation, appraisal and management of staff, and multiprofessional liaison to co-ordinate care. The appropriate amount of allocated time will be agreed locally. Where district nurse teams cover multiple general practices, time needs to be allocated for each practice to discuss patients, families and carers.

## 3.3. Recruitment and retention

Recruitment and retention strategies at organisation and team level are essential to the overall workforce plan and to support nurse staffing in the district nursing service. Staff should be recruited using a competencies and values-based selection process aligned to the NHS Constitution and local policy. Team leaders can identify or anticipate problems with recruitment and retention by monitoring the following:

- vacancy rates/current staffing levels
- sickness absence
- turnover

- profile of existing staff including age profile[2]
- Black, Asian, minority ethnic (BAME) background and equality of opportunity, valuing diversity and inclusion of all staff[3]
- outcomes from retention/exit interviews.

The age profile of a team can influence retention rates. Strategies to improve retention can prove cost-effective because more experienced staff are retained, and agency and recruitment costs are minimised. Flexible retirement may help retain highly experienced staff to support the novice workforce. To boost retention rates across generations team leaders need to determine what motivates people to stay in their jobs. More details can be accessed through _Mind the gap_ (Jones and Davies 2015). Leadership style and adequate resources strongly influence retention.

More detail of how this can be applied in practice, can be found in Appendix 2: **Case study 3** – E-Community: a capacity and demand management system for district nursing (Whittington Health NHS Trust)

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[2] The NHS working longer group's age profiling tool is available at http://www.nhsemployers.org/your-workforce/need-to-know/working-longer-group/working-longer-group-tools-and-resources/age-awareness-toolkit/age-profile

[3] BAME workstreams include inclusive leadership and the work of the Equality and Diversity Council and Ready Now Programme

# 4. Right place, right time

In this improvement resource, 'right care' is defined as the care documented in the patient's care plan (in collaboration with the patient). An appropriately skilled nurse or other healthcare professional delivers this care in the place and at the time agreed with the patient and, where relevant, their family and/or carer. This is dependent on efficient and effective management and rostering, with clear escalation policies if concerns arise about the capacity and capability of the team to meet the patient's needs.

## 4.1. Productive working

Working practice/processes and workplans should be routinely reviewed at the local and team level to reduce unwarranted variation and increase productive direct care time with patients, families and carers.

District nursing teams use a number of methods to increase productivity, often based on 'LEAN' methods that aim to eliminate waste and add value. An example is the [Innovation and Improvement Productive Community series](#) (2009). This toolkit covers planning and delivery of care, as well as the organisation of the working environment and easy access to patient information (NHS Institute of Innovation and Improvement 2010).

## 4.2. Use of technology

Use of technology should be maximised for effective working of district nursing services. This includes using mobile digital technology (such as tablets and laptops in patients' homes), tele-health and tele-care. Technology should be used to support the nursing care of patients and their families and carers and should include systems with functional interoperability that  permit the sharing of information between health and care organisations, with records that are accessible for patients, with appropriate support.

There is some evidence that use of tablets increases the productivity of the district nursing service. For example, at [the Queen's Nursing Institute conference on district nursing in the digital age](#) in 2015 it was reported that one hour per nurse per day capacity is released with the introduction of tablets.

The Queen's Nursing Institute (2016) has highlighted the cultural challenge and need for change associated with the introduction of digital technology to support a more effective and efficient workforce.

The importance of investing in technology to support safe caseload management as an enabler, cannot be overstated. Technology includes:

- **Technology to assess patient care requirements and provide advice during a patient's transition to self-care** (as appropriate)
  Remote monitoring via tele-health systems, and Skype and Facetime are ways in which technology supports self care with access to healthcare professionals.
- **Technology to record care delivered and to share this with other professionals**
  Technology is essential for caseload management – to schedule care with the most appropriate professional, to record care consistently in a template, to monitor outcomes and to identify any care left undone. Mobile working with the use of tablets/laptops facilitates easy and timely communication within the multiprofessional team and the sharing of assessments and the care provided within and between organisations. Failure to record and share information in this way can mean undelivered care is invisible to those beyond the patient's home.
- **Technology to plan home visits**
  Patients, families and carers need to know when the district nurse will visit (Maybin et al 2016), a point emphasised by carers during the development of this improvement resource. Technology supports e-rostering and the planned allocation of a named professional on a specified day(s) at a specified time(s).
- **Technology to monitor and report patient outcomes**

Technology can capture data such as activity, demand, capacity and patient outcomes. It can 'flag' risks such as overtime worked and postponed nursing care. It can be used to demonstrate outcomes and the impact of the district nursing service on patients, families and carers. This can support business cases for the development of the service to meet patient needs, support people so they can be cared for in their homes, and reduce unplanned admissions and A&E attendances.

- **Technology to inform improvement, workforce planning and commissioning**
  Recording information about patient outcomes should inform the strategic development of district nursing services and the potential for operational improvement.

## 4.3.   Efficient deployment and flexibility

Best practice guidance for effective e-rostering to support nurse staffing in the district nursing service is available from [NHS Employers](#) and the [Carter team](#). The principles outlined in these reports apply to all nursing environments, including district nursing. In a survey of district nurses one-third allocated their workload using paper-based systems (the Queen's Nursing Institute 2012). This reduces the effectiveness of caseload planning and evaluation, and the ability to benchmark and review a whole service.

No single software system has been approved for the accurate recording of patient need/acuity/complexity in the community setting to calculate the staffing profile required to meet the individual and caseload need. However, as illustrated in section 2, the requirements of any software tool to support caseload management have been identified and these can be used, together with cost, as part of the assessment of whether existing and prospective tools are likely to offer value for money.

### Flexible working

Flexible working within and between nursing teams is essential to ensure that patient care needs are met at different times in any 24-hour period and throughout the week.

Flexible working suits many nursing staff and is important to morale and retention. Organisations can offer this in different ways:

- part-time working
- compressed hours
- job share
- self-rostering/range of shift patterns
- flexi-time
- annualised hours
- term-time contracts
- flexible retirement schemes.

NHS Employers' guidance should be followed in developing opportunities for flexible working. Shifts should be planned with best practice principles in mind. While many providers use shifts of varying lengths to accommodate patient need and staff preferences, team leaders planning rosters should aim to organise shift patterns to reduce cumulative fatigue and maximise recovery time. Research findings on 12-hour shift patterns for registered nurses and healthcare support workers are described in *Safe staffing for adult inpatients in acute care*.

### Staff deployment to meet fluctuating demand and unplanned care

District nursing teams need some capacity to respond to peaks in patient need, unplanned care, such as transfers of care from hospital with little or no notice, additional time requirements for palliative and end-of-life care and unanticipated staffing shortages. Capacity can be increased with planned overtime, temporary staffing (see section 4.4) and the movement of staff between teams.

Unplanned overtime should be systematically documented as an indicator of the demand/capacity gap, to understand why gaps occur and to help implement measures to prevent them from occurring.

### Rest breaks

Local policies for managing rest periods must meet working-time regulations. Staff breaks should be taken during the shift rather than at the beginning or end. This reduces risks of staff fatigue, safeguarding staff health and wellbeing, and ensures patient safety is at the centre of decision-making in caseload management. The challenge of identifying appropriate environments for rest breaks and comfort breaks in the community setting should be recognised.

**Escalation processes**

Organisations should have protocols for frontline staff to escalate concerns about the safety and effectiveness of care and the safety and wellbeing of the workforce. Trade unions and professional bodies should be involved in their development.

## 4.4.   Minimising agency staffing

Temporary staff make a valuable contribution to the workforce and can be a useful contingency for filling anticipated staff shortages and supporting nurse staffing in the district nursing service.

They should be recruited from in-house staffing banks. Only if this is not possible should a [framework agency be approached](). Local training and induction must be part of the engagement process for agency staff. Over reliance on agency staff is unlikely to represent an effective solution to ensuring there are the right staff with the right skills, in the right place at the right time.

# 5.  Measure and improve

Boards should ensure a triangulated approach to staffing decisions, using (a) patient outcomes, (b) people productivity metrics and financial sustainability, and (c) patient, carer and staff feedback.

A local quality dashboard should be developed for safe sustainable staffing in line with the local definition of safety (see recommendations in section 6). Providers should collect team and organisation level metrics to monitor the impact of staffing levels on patient outcomes and staff and relate them to the periods of care requirement. The aim is to continuously improve patient outcomes and use of resources in a culture of engagement and learning. Evidence-based team-level and service-level metrics may focus on:

- patient outcomes, eg infections, falls, pressure ulcers, leg ulcer healing rates
- patient experience, eg friends and family test, patient complaints, missed care
- staff experience, eg staff survey
- staffing data, eg appraisal feedback, retention, vacancy and sickness rates
- patient and staff incidents[4]
- process measures, eg record-keeping, documentation standards

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[4] Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and serious incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers' safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (http://www.sciencedirect.com/science/article/pii/S0965206X15000935) and case note review and the FallSafe under-reporting survey (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) for inpatient falls.

- training and education, eg mandatory training, clinical training
- productivity and efficiency, eg cost-effectiveness.

## 5.1. Measure patient outcomes, people productivity and financial sustainability

No software system measuring patient, carer and family outcomes for the district nursing service interventions has been approved at a national level. More data needs to be collated at a national level to understand the barriers and enablers to accelerating the spread of technology to enable this way of working.

The evidence review highlights the need for an economic analysis of the district nursing service, to understand the cost-effectiveness and impact on the patient experience of being supported to be cared for at home.

## 5.2. Report, investigate and act on incidents

Providers should ensure that best practice guidance is followed at every level, to investigate all patient safety incidents, including root cause analysis for serious incidents. As part of this systematic approach, providers should consider staff capacity and capability, and act on any issues and contributing factors identified.

NHS providers should consider the relevance of 'red flag' issues listed in the NICE guidance (National Institute for Health and Care Excellence 2014, 2015) for inpatient settings and any other incident where a patient was, or could have been, harmed as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (eg for omitted medication), clinical audits or locally agreed monitoring information, such as delays or omissions of planned care.

Staff in all care settings should be aware they have a professional duty to put the interests of those in their care first, and to protect them if they consider they may be at risk (NMC 2015). Policies should support staff who raise concerns (whistleblowers). The National Guardian's office provides leadership and advice for Freedom to Speak Up Guardians regarding best practice to enable staff to 'speak up' safely. More information can be found at http://www.cqc.org.uk/national-guardians-office/content/national-guardians-office

## 5.3.    Patient, carer, family and staff feedback

The views of patients, carers, families and staff can give important insights into staffing capacity, capability and morale, collected using for example national and local surveys, patient or staff stories, complaints and compliments. The findings of incident and serious incident investigations should be considered alongside the suggested list of quality indicators so that the causes of any issues can be quickly identified and acted on.

Unlike for inpatient services and general practice there has been no national survey of patients' views of the district nursing service. Locally it may be helpful to include in the patient survey questions relating to the district nursing quality indicators identified by Maybin et al (2016), as these are strongly influenced by the availability and effective deployment of staff.

Organisations need to be familiar with performance feedback from regulators and agree through their governance processes formal actions in response to this.

### Culture

The impact of organisational culture on individual and team performance should not be underestimated. NHS Improvement with others is developing tools to improve leadership and staff engagement.

*Leading change, adding value* may also be helpful (NHS England 2016).

More detail of how this can be applied in practice, can be found in 3 case studies:

See Appendix 2: **Case study 4** – Using quality schemes to reconfigure community services and focus the new provider on quality that matters to cost, patients and clinical quality (NHS South Cheshire Clinical Commissioning Group).

See Appendix 2: **Case study 5** – Review of community nursing and therapy and intermediate care bed services (Norfolk Community Health & Care).

See Appendix 2: **Case study 6** – Integrated community team workload, acuity and dependency tool (BRAVO) (Derbyshire Community Health Services NHS Foundation Trust).

## Conclusion from working group patient perspective

So here we are, me again, with the final words of this improvement resource and the conclusion of the toughest piece of work I have been involved with since I became a front-line cancer patient in 2011.

Although I am not prepared to say this is a perfect and universal solution to all district nursing problems, I am prepared to say I believe it and I like it. I've worked with some great people whose expert views I respect absolutely, who pulled many strands of work together into this comprehensive, collaborative and coordinated document. And don't overlook the case studies - see the improvements they made while only addressing one aspect of this resource, then consider how their development and integration could start to tackle the deep-rooted issues in community healthcare.

I'm not naïve, I've been on the sharp end of some of the issues, and I recognise that putting these proposals into practice in a resource-constrained, rapidly changing environment, will not be easy.

Nonetheless, everyone engaged in district nursing, from educator to regulator, commissioner to provider, nurse to patient, can help implement these proposals in the way most appropriate to their context. I humbly suggest that you do so. Now.

Iain Upton

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# Working group members

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| Julie Bliss | Chair<br><br>Senior Lecturer<br>Queen's Nurse | Association of District Nurse Educators<br>King's College, London<br>The Queen's Nursing Institute |
| Dr Bob Brown | Director of Nursing and Quality<br><br>Chair<br><br>Trustee | South Tyneside NHS Foundation Trust<br>Community Nurse Executive Network<br>The Queen's Nursing Institute |
| Dr David Colin-Thomé | Trustee<br>Retired GP | The Queen's Nursing Institute |
| Anne Cooper | Chief Nurse<br>Fellow | NHS Digital<br>The Queen's Nursing Institute |
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| Kathryn Yates | Professional lead: Primary and Community Care and Integration | Royal College of Nursing |

## Stakeholders consulted

The following stakeholders were engaged via a facilitated workshop or webinar:

- The Queen's Nursing Institute (QNI)

- Community Nurse Executive Network (CNEN)

- Association of District Nurse Educators (ADNE)

- National District Nurses Network (NDNN)

- NHS Clinical Commissioners, Nurses' Forum (NHSCC)


Our thanks also to the patients, carers, staff and providers who supported the development of this improvement resource.
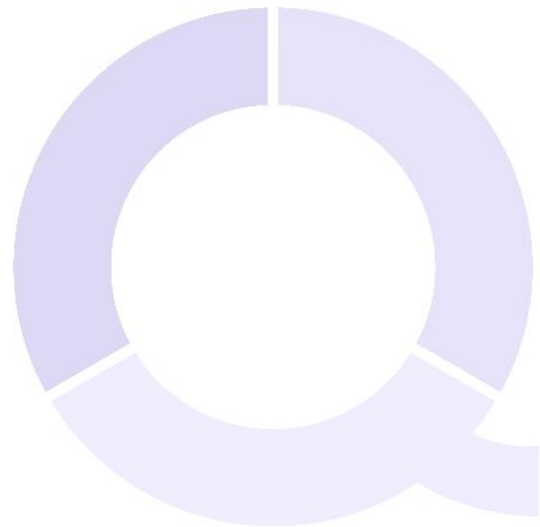
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