

2020

Vision

5 years on

*Reassessing the Future
of District Nursing*

2020 Vision - 5 years on

Reassessing the future of district nursing

Contents

Foreword.....	2
Executive Summary.....	3
The Queen’s Nursing Institute.....	3
Brief Historical Overview.....	4
Review of previous studies.....	4
Progress since 2012.....	7
Methodology.....	9
Findings of the new 2020 Vision survey.....	9
Conclusions from the survey.....	41
Actions Required.....	42

Foreword

In 2009 the Queen's Nursing Institute published a landmark document, *2020 Vision*, which described the District Nursing service in the UK and the challenges and opportunities, from the perspective of those working in the service at the time.

Since then there has been a change of government and a total reorganisation of the NHS architecture. The financial situation in the UK continues to be a challenge to the sustainability of a national health service which is under increasing pressure from a growing older population with multiple complex needs and co-morbidities.

There has been a disproportionate focus on hospital based care in the general and professional media in recent years, which is understandable when viewed in the context of the Francis Reports of 2010 and 2013.

However, there is now a need to rebalance the focus on caring for people in their own homes - and the systems and services required to ensure that the people receive the highest quality of care in their own homes and communities when they need it, provided by the right nurse with the right skills.

District Nursing is a ubiquitous, highly trusted service which is present in every community in the UK. The service requires nurses with specialist skills to lead a team to deliver care to people of all ages, often with needs and levels of acuity that have previously been seen only in the hospital environment.

There are opportunities to embrace new ways of working and new technology to support caseload allocation, workforce planning, and self supported care, whilst still maintaining the core purpose of the District Nursing service to support people to maximise their health and wellbeing in their own homes and to avoid hospital admissions wherever it is safe to do so.

This report describes, from the perspective of the professionals within District Nursing, where the service is working well and where there are some significant challenges, particularly in the systems that support the service.

The QNI presents this wide-ranging report to provide an evidence based insight into the current position of the District Nursing service to meet the increasingly complex health needs of our population.

The challenges are also presented alongside potential solutions. Presented in this way, it is anticipated that this report will inform the development of government policy which supports the provision of nursing care in people's homes and communities.

**Dr Crystal Oldman, Chief Executive
The Queen's Nursing Institute**



Executive summary

This report provides a picture of the District Nursing profession at the time the survey was carried out, in late 2013. The study provides an update on the picture that existed in 2009, as depicted in the QNI's report published that year, '2020 Vision'.

We asked a number of key questions of District Nurses, to gather intelligence about key elements of the structure, organisation, and challenges currently facing the District Nursing service.

The ongoing imperative to gather data about today's District Nursing services comes in light of the rapid change in NHS organisation, and the continuing fall in District Nurse numbers.

The report presents some troubling figures, particularly in regard to confusion around job titles, methods of service planning, use of technology, communication with other health and social care organisations, and morale.

There are also some areas for cautious optimism, including the recognition of the value of the District Nursing Specialist Practitioner Qualification, in the growing use of patient outcomes as a service metric, and in partnership working with certain key colleagues such as General Practitioners.

The report draws a number of conclusions from the survey results, and proposes a number of actions to address these conclusions.

The Queen's Nursing Institute

The Queen's Nursing Institute (QNI) is a registered charity, founded in 1887, with the original purpose of organising the training and supply of District Nurses on a national basis. It operates in England, Wales and Northern Ireland, while a separate charity, QNI Scotland, carries out similar purposes there. The charity is incorporated by royal charter and is governed by a board of trustees, who include nurses and other health professionals, and members who have other areas of expertise.

Today the QNI works with all community nurses, not just District Nurses, to improve healthcare for patients in their own homes and communities. To find out more about the work of the QNI please visit our website at www.qni.org.uk.

Brief historical overview

District Nursing as a profession came into existence in 1859, almost ninety years before the NHS was established in 1948. During that long period of time, most District Nurses were employed by local voluntary organisations, which were funded by donations and fundraising, and managed by committees. These local District Nursing societies were usually affiliated to county nursing organisations, which in turn were usually – though not always – affiliated to the Queen’s Nursing Institute (QNI). The smallest local societies employed only one or two nurses. The QNI itself was established in 1887 to organise the training and supply of District Nurses on a national basis.

The QNI set the most widely recognised syllabus for District Nurse education, the Queen’s Nurse examination, and the Queen’s Nurse (QN) qualification was awarded until 1967, when District Nurse education was absorbed into higher education. The QN title was reintroduced, in a different form, in 2007.

The whole voluntary structure of local District Nursing organisations ceased to exist around 1948, when the NHS was created and healthcare effectively nationalised. In recent decades, we have seen a gradual erosion of this position, as healthcare is now delivered by a more diverse range of providers than ever before.

The results of this survey indicate that by far the majority of District Nurses are still employed by NHS organisations, but that it is by no means unusual for them to be employed by social enterprises or private companies, contracted to provide national health services.

In recent decades, the NHS has experienced enormous change, the result of epidemiological, social, economic and political trends that only appear to continue accelerating. It is against this background that the District Nursing profession has had to work constantly to update itself and to adapt in order to continue to meet the needs of patients, families and carers.

Review of previous studies

The Invisible Workforce (2002)

The QNI published this report partly in response to the 1999 ‘first assessment’ report by the audit commission, which we felt did not adequately reflect the reality of District Nursing from a clinical perspective. It is interesting to note some of the key findings and trends included in the invisible workforce. The report began by noting that there were 14,500 District Nurses employed in England (Department of Health 2000). This compares to the whole time equivalent figure of 5816 that was reported for December 2013 (<http://www.hscic.gov.uk/catalogue/PUB13718>).

The report also identified themes that have echoed through almost every report concerning community healthcare since that time. It stated that, ‘increasingly, those who require District Nursing care are more highly dependent and have multiple and complex needs.’ it added, ‘the future imperative will be for more people to be nursed at home as a preferred option to hospital admission’. These are very familiar themes to us today. The question is how much progress as a

“The future imperative will be for more people to be nursed at home...”



whole the healthcare system has made towards realising them.

It also highlighted themes of:

- Integration into community teams
- The development of skill mix within those teams
- Greater management responsibility
- Challenges to caseload and workload management
- Earlier discharge from hospital to community services
- A corresponding 'loss of a clear identity' for District Nurses.

The report was controversial, in part because many District Nurses did not relate to being labelled an 'invisible workforce'.

Vision and Values (2006)

This report, compiled from focus groups, built on the observations of The Invisible Workforce, and reinforced some of its key themes. It reiterated that the need for home and community nursing had increased, thanks to early discharge, delivery of complex care in the community, and the need to prevent readmissions. It noted that more patients were very elderly, and noted the increased trend for people to want to die at home.

The report also raised concerns about pay reductions, an ageing workforce, and continuing challenges to the District Nurse identity caused by new specialisms, confusion of job titles, new team organisations and administrative burdens. It noted, 'in the last five years most had experienced several major changes to the primary care organisations in which they worked...' there was also concern that the specialist District Nursing qualification was being eroded.

The report envisaged 'a digital dawn' with aspirations to work in 'an entirely paperless health service'. The focus groups made a plea 'for computer systems that could speak to one another' and 'highlighted the growing gap between policy rhetoric and the reality of their daily experience'.

It also highlighted the growing gap between public perceptions of District Nursing: 'patients recognise the title, have faith in it and respect it', and perceptions within NHS organisations: 'nobody knows what the DN qualification means any longer.'

The report did call for a new national strategy with clear 'vision and values' for community nursing, as a means of addressing the crisis of professional identity and sense of disengagement that many felt. It took several more years for this recommendation to become a reality (Care in Local Communities, a Vision and Model for District Nursing, Department of Health January 2013).

2020 Vision (2009)

This report was based on a printed survey distributed through the British Journal of Community Nursing. It was published to coincide with the QNI's celebration of the 150th anniversary of District Nursing.

The report reiterated the core values, clinical and management roles of the profession, but noted that 'District Nursing services are currently being diluted by loose use of the title... and lack of recognition of the value of their specialist education.'

2020 Vision summarised the challenges facing District Nurses caused by the seismic shifts in NHS organisation over the previous ten years. It noted, '... employers have developed the skill mix in District Nursing teams, with major growth in general registered nurse (rather than DN-qualified) and health care assistant numbers in primary care. This has been matched by a sustained decline in the number of qualified DNs, and the numbers of nurses seconded for the DN specialist practitioner qualification.'

The report also reflected the disparity noted in vision and values between the public and NHS management's perception of the DN title: understood by patients but not appreciated by managers.

2020 Vision criticised previous reports (including the 1999 Audit Commission document) for judging District Nursing too narrowly and simply on its tasks, rather than holistically for its actual importance to patients living at home with complex health needs.

The 2020 Vision survey found that:

- 13% of respondents' employing organisations no longer used the DN title at all
- 29% of respondents' employers no longer seconded nurses to the DN SPQ
- 52% of respondents' employers did not require DN team leaders to have the DN SPQ (and a further 19% planned to discontinue the requirement).

In terms of measurement of work it found:

- 94% of respondents measured work primarily by number of patient contacts
- 16% used or were planning to use 'delivery of packages of care'
- 17% used or were planning to use 'patient outcomes'.

Looking towards the year 2020, the report covered the familiar themes of more health care being delivered outside hospital, with 'a focus on the patient's journey' within a transformed primary care, characterised by 'increasingly complex but portable medical and monitoring equipment'.

The report's final call to action was: 'there is no need to 'reinvent' the District Nurse. It is however time to reinstate the District Nurse.'

“ It is time to reinstate the District Nurse.

”



Nursing People at Home (2012)

This document was published shortly after the QNI launched its flagship campaign, 'right nurse, right skills', which argues for a properly resourced and trained home nursing workforce. The report drew on the personal experiences of patients and their carers, as well as the experience of nurses. It was inspired by a growing concern that home nursing services were reaching tipping point in terms of loss of skills and experience, as District Nurse posts were increasingly being replaced with health care assistants (HCA). One striking figure from the research was that 43% of patients visited at home did not know whether they were being visited by a registered nurse or an HCA.

The report highlighted a huge variation in the quality of care being delivered. A high proportion of patients rated it 'excellent' or 'very good' but others reported instances of care that were clearly unacceptable. These instances of poor practice appeared to derive from staff who did not have the knowledge, skills, or time, to deliver the care that was needed.

The report also identified three key qualities that the public looked for in a nurse: competence, confidence, and a caring approach. These 'three Cs' presaged the 6Cs that have since been codified into national nursing policy.

The report also contained a series of recommendations for future action, many of which have since been met or are being implemented.

Progress since 2012

Care in Local Communities: a vision and model for District Nursing (2013)

This document was published by the Department of Health and NHS Commissioning Board (now NHS England), with significant input from The Queen's Nursing Institute.

It is a landmark document because it helps to address the lack of 'vision' and 'identity' that were highlighted by District Nurses in the surveys reviewed above. It is a detailed document that contains a number of key commitments from stakeholder organisations. In order for it to be most effective, the document should be regularly reviewed for its action points, by both commissioners and service providers.

The document can be accessed online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213363/vision-District-nursing-04012013.pdf

District Nursing Education Report (2012-13)

In 2013 the QNI also carried out a piece of research into the number of students undertaking the District Nursing specialist practice qualification, to help quantify fears that these numbers were falling steeply. The QNI compiled the report from information obtained directly from universities. The report revealed widespread and significant concerns in the number of new District Nurses being educated, particularly in England. In the academic year studied, the numbers being trained were nowhere near the 'replacement level' required to maintain the District Nursing workforce.

Key figures include:

- 21% of District Nursing courses in England did not run a cohort in 2012-13
- At least 67% of District Nursing courses running in England in 2012/13 had 10 students or fewer on the programme and 13% had only 5 students or less.

These numbers called into question the viability of some of the courses being offered.

The 2013 report can be accessed on the QNI's website at:
http://www.qni.org.uk/docs/DN_Education_Report_2012-13.pdf

Since this report was published, it is anticipated that numbers have improved slightly. However the QNI is currently undertaking a new study (May 2014) to quantify this exactly.

District Nursing workforce and caseload planning project (2013-14)

The QNI was commissioned by NHS England, as part of the Chief Nursing Officer's Community Nursing Strategy Programme, to undertake a key study into what tools are necessary to make caseload planning and workforce allocation by District Nursing teams as efficient as possible.

The study to date has comprised a review of the relevant literature, and a full report with recommendations for further action.

The report can be accessed on the QNI's website at:
http://www.qni.org.uk/docs/District_Nursing_Workforce_Planning_Report.pdf

Other new sources of support

During 2013 the QNI also created two other key resources that are designed to increase the capability and capacity of community nursing teams. These are:

- Transition to Community Nursing Practice
- Supporting Carers learning resource

Both can be accessed from the QNI's website.



The New Survey: Methodology

An online survey hosted by SurveyMonkey.com was carried out with the aim of gathering 1000 responses from District Nurses. The survey was publicised using the QNI website, social media, e-newsletter and through publicity in the nursing press. The survey was open for a period of ten weeks during autumn 2013.

We invited responses from all community nurses who visit patients in their own home, not just those with a specialist District Nursing qualification.

Respondents were given the option to skip questions, hence the variation in the total number of responses to each question contained in this report.

Where responses required a single answer, the corresponding percentage figures equal 100% (allowing for variation caused by rounding figures up to the nearest 0.1%). Where it was possible to give a number of answers to the same question, the corresponding percentages reflect the multiple responses given and do not total 100%.

This report presents a general overview of both the quantitative and qualitative data that was supplied by the survey respondents.

Findings of the new survey

The new survey was answered by 1035 nurses, a much larger sample than the original 2009 Vision survey in 2009. The 2009 survey was paper based, rather than online, and it also contained fewer questions. We have compared figures between the two surveys where the questions were the same. The difference in sample size and method of data collection should be borne in mind when making comparisons. However, responses to the two surveys show a remarkable degree of consistency. The QNI operates in England, Wales and Northern Ireland, but survey responses were received from all parts of the United Kingdom, including Scotland.

1. Use of the DN title

Is the job title 'District Nurse' still used in your organisation?		
	Response percent	Response count
Yes	85.4%	856
No	14.6%	146

Compared to 2009, the above figures represent no substantive change in the number of organisations where the term 'District Nurse' is used (less than 1% differential since 2009). This - and the comments from nurses - indicates strongly that the title of District Nurse is overwhelmingly the usual choice for home visiting nursing services.

If you answered 'yes' to the above question, is it only used for nurses with a specialist practitioner qualification (SPQ) in District Nursing?		
	Response percent	Response count
Yes	58.7%	515
No	41.3%	362

The responses to the same question in 2009 were: yes: 68%; no: 32%. This suggests that there has been a substantial change in the way that the District Nurse title is now used, compared to five years ago. There has been a 9% fall in the number of organisations where the title is *only* used for those nurses who hold a specialist practice qualification (SPQ).

In 2009, only one survey respondent commented that health care assistants were referred to as 'District Nurse' within their organisation, though it is not clear whether this was by staff within the organisation or externally. In the 2013 responses, this mislabelling has become far more widely established. Many respondents indicate that the title 'District Nurse' is used indiscriminately and colloquially for almost any healthcare employee visiting a patient at home, particularly by people outside the employing organisation itself.

Responses to the question, 'who in your organisation is known as a District Nurse?' included:

'Anyone who the patient thinks is a District Nurse - the podiatrists, healthcare assistants, homecare...'

'A person who is has been appointed at band 6, who are responsible for the management of a defined caseload of community nursing patients and management of a team of community staff nurses and health care assistants.'

'All community nurses. DN team leaders no longer have a specialist qualification - they may or may not have relevant degree modules in community nursing.'

'All community staff nurses - District Nurses is used in context so that patients are aware of who we are - however we are aware that only sisters who have done their District Nurse degree have the title DN.'

'All trained nurses are known as District Nurses because patients understand the title.'

'Band 6 team leaders and lower grades tend to use it when describing themselves. Nearly always choice of description by general public and other professionals.'

'Community staff nurses are known to patients as District Nurses, and probably wouldn't know who we were if we said our actual title and would ask for the District Nurse!'

'Everyone within the District Nursing team, no matter what grade. Staff usually will say to a patient or relative, "I am your District Nurse"'

'I work in a mental health foundation trust. When liaising with District Nurses I do not know what qualifications they have.'

'Patients refer to community nurses as "District Nurses" as it's the term they are familiar with, same for GP practices.'

'There are several nurses with the DN qualification who would like to be known as DNs but our trust has decided to no longer use this title. However, our patients seem to prefer the DN title.'

'...Officially they (DNs) are more than likely referred to as community staff nurses, but this doesn't mean anything to anybody, and so they are referred to as District Nurses by GPs, allied healthcare professionals and nurses as well as patients and their relatives.'

What the survey indicates is that there is now a very significant gap between how patients (public) refer to healthcare workers, and how healthcare workers refer to themselves. Overwhelmingly, patients speak of 'District Nurses' because this is a familiar, concise and easily understood term. Patients are unlikely to be familiar with the precise job titles of most healthcare workers, in an era when these titles have become longer, more diverse and complex.

Respondents were invited to give their further views on the District Nurse title. This proved to be a very controversial subject, generating 600 responses. Some representative examples are given below.

'All nurses working in patients' homes (including health care support workers) call themselves "District Nurse," which is not appropriate. This title should be applicable only to staff holding an SPQ.'

'Although it is a specialist title, historically, patients have always known community nurses as "District Nurses". This is the job title that they understand. Given that there are so many different specialist roles in community nursing it can be confusing for patients and their carers to know who does what.'

'Believe it should be protected like "health visitor", and retain meaning that the nurse has a higher qualification.'

'District Nurse title should be used by specially qualified nurses. Community services would be strengthened by reintroducing District Nurses who are appropriately qualified to deliver the long term conditions agenda. District Nurse is widely understood by both health professionals and the public to mean a skilled and educated community nurse.'

'I feel very strongly the title should be restricted to those with the SPQ. This is not to discredit other community nurses, but the title health visitor or midwife is not used in the same way for those not qualified.'

'It is a title that must not be lost. The patients know about the District Nurse and they get very

unsure of what to expect if the title has been removed. It was removed in the trust in which I work to one of 'case manager'. The local patients' forum insisted that it was returned, as they stated that they didn't know what that title meant or what care would be delivered. The trust reinstated the title and many patients commented on how reassured they felt and they now knew who was looking after them and what to expect.'

'My title just confuses everyone; I usually refer to myself as a District Nurse.'

What emerges from the responses is that confusion about job titles, qualifications and roles is now the norm rather than the exception, among healthcare professionals almost as much as the general public. For some this was a cause of resignation or despair, but most respondents wanted the title 'District Nurse' to be more carefully controlled, and restricted to those who hold the SPQ.

For some respondents, the term 'District Nurse' clearly carries historic overtones, some calling it 'old-fashioned'. It is something of a mystery that 'District Nurse' is singled out in this way, when other terms such as 'General Practitioner' and 'Health Visitor' also have a long history going back decades before the creation of the NHS, and the word 'midwife' much longer than any of them.

In thinking about job titles, it should be recognised that most patients are unlikely to engage fully with NHS terminology in this area. Patients are likely to use terms that are familiar, reassuring and useful in an everyday context. NHS managers and staff may therefore have to accept the reality that terms such as 'District Nurse' have a great deal of general currency, whereas job titles such as 'complex case manager' are unlikely to achieve this. Equally, for the same reason, it may be unrealistic to expect the public to limit their use of the District Nurse title to staff with an SPQ.

However, it is clear that the title 'District Nurse' should be appreciated as an entirely modern term, which is precise, useful, and easily understood by patients, families and carers. If there was greater consistency about the use of the title across employers, there would almost certainly be improved understanding by the general public of precisely what the term means.

In the case of the respondents whose organisations did not use the title 'District Nurse' at all, by far the most common alternative given was 'community nurse' or variants thereof.

“ There is now a very significant gap between how patients refer to healthcare workers and how healthcare workers refer to themselves. ”



2. Employer, location and profile of workforce

Who are you employed by?		
	Response percent	Response count
Trust or Foundation Trust	78.6%	808
Integrated Trust	4.4%	45
Community Interest Company	4.2%	43
Social Enterprise	5.4%	55
Charity	1.3%	13
Private Company	2.0%	20
Other (please specify)	4.3%	44

Answers to 'other' included university, hospice, self-employed, health board, General Practitioner, Clinical Commissioning Group and care services. In 2009, almost all respondents to the survey were employed by Primary Care Trusts. This may reflect the much wider way in which the 2013 survey was distributed and responses collated. However the diversity of employing organisations listed in 2013 gives some indication of the changes to the healthcare employers that have taken place in the past five years. Most District Nurses will have experienced a reorganisation during this period. The qualitative data gathered as part of this survey gives some indication of the effect that these reorganisations have had on nurses.

Where are you located?		
	Response percent	Response count
GP Practice	32.4%	325
Clinic (no GP)	16.6%	167
Hospital	9.4%	94
Office	26.1%	262
Other (please specify)	15.5%	156

Regarding their location, of the 220 who gave answers to 'other', these included: university, mobile working, health centre, home based, healthy living centre, hospice, school, council building, agile working, prison office, and some who were in transit between premises because of reorganisation.

How long have you worked in the community?		
	Response percent	Response count
Less than 2 Years	4.2%	43
Less than 5 Years	8.9%	92
Between 5 and 10 Years	23.5%	242
More than 10 Years	32.8%	338
More than 20 Years	23.8%	245
More than 30 Years	6.9 %	71

Are you planning to retire in the next ?		
	Response percent	Response count
3 Years	12.2%	125
5 Years	12.5%	129
10 Years	24.7%	254
None of the above	50.8%	520

The questions, ‘how long have you worked in the community?’ and ‘when are you planning to retire?’ were not asked in the 2009 survey.

The purpose of these questions was to get a sense of the age spread of the District Nursing workforce, and also to assist in determining how many new District Nurses will need to be recruited in order to sustain or grow the workforce. The QNI’s District Nursing Education Report (2013) showed conclusively that at the present time, not enough District Nurses are being trained to replace those who are retiring.

The above data may be of interest to workforce planners. It is difficult to make comparisons with similar data about other nursing professionals, in part because nurses often choose to become District Nurses later rather than earlier in their careers.

3. Education and Specialist Practitioner Qualification

Of 1029 who answered the question, 577 held the SPQ in District Nursing and 452 did not. This represents 56% of the respondents who have undertaken the SPQ. In 2009, 88% of respondents indicated that they held the SPQ – a difference of 32%. Because of the difference in sample sizes and survey method, the percentage difference cannot itself be taken of proof that there are fewer community nurses holding an SPQ now than there were in 2009. Given the far larger number of people who responded to the new survey, and its greater accessibility online, it suggests that a far more diverse group responded in 2013 than did in 2009.

“ The role ... is seen as ‘generalist’ but few in the health service have the width of expertise that is integral to the role.

”



Does your organisation second community nurses to the SPQ course for District Nursing at a higher education institution?

	Response percent	Response count
Yes	78.1%	739
No	21.9%	207

This represents a positive change compared to 2009, when only 71% of those who answered the question indicated that their employer seconded nurses to the SPQ course. The difference, of around 7%, is fairly small, but suggests an incremental increase.

Respondents were also asked to give additional evidence of what other educational opportunities were offered by their employer if secondment to the SPQ was not an option. Of the 249 responses, only one stated that the educational offer was 'excellent'. All others described a situation beset with problems, some of them severe. A representative sample is given below:

'Although I did answer yes [to SPQ being offered], it is sporadic, none in our area for a few years, two last year and none again this year. In another locality they had virtually eliminated the qualified DN and certainly had none giving hands on care; following some disastrous episodes that ended up in a coroner's court that locality are now seconding nurses onto the course.'

'Training budgets this year have been slashed by 50%. Only modules funded on the post qualification framework are available, and the options which are available are greatly reduced - to mentorship, leadership and palliative care, non-medical prescribing and clinical examination. But if you have all of those qualifications, how do we progress further?'

'There has been no DN course for several years. Now the university has had a new course validated but short-sightedly the commissioners have not deemed it necessary to provide any backfill to release the band 6's who do not have the SPQ to be freed up to attend the course. Nor have they contracted the practice educators who are qualified to fulfil the PE (practice educator) role and mentor these students...'

'The trust will pay for it but it has to be applied for as you would a job and you resign from your current position. Not available to part time staff which is very frustrating.'

'The District Nurse SPQ course ran highly successfully for many years at the institution where I work. A few years ago the trust withdrew their support and the course closed. During this time, the trust

became aware of the problems in practice that arose without appropriately qualified practitioners i.e. District Nurses, and the course has now been running again for the last two years.'

'No nurses have been seconded since 2005 to do the SPQ course. However, this has just been re validated at our local universities and money has been ring fenced to second five nurses this year. Unfortunately, there are no other monies available for backfill for the nurses, so releasing them from practice to undertake the course is proving difficult.

The overall picture is one of sporadic educational offering, lack of choice, lack of continuity, lack of a clear and holistic educational vision, and significant obstacles placed in the way of nurses who want to further their education.

Respondents also make a clear and direct connection between nurse education and the quality of patient care: where education has been cut back, patient care has suffered.

There are some positive indications in the number of respondents who report that the SPQ is being reintroduced, following recognition by commissioners that the available alternatives were not sufficiently robust.

In your organisation, are all leaders of District Nursing teams required to have the SPQ?		
	Response percent	Response count
Yes	54%	507
No	46%	432

This figure is also at variance with the figure in 2009, where only 48% reported that their employing organisations required District Nurse team leaders to hold the SPQ. It is difficult to draw a strong conclusion from the figures in this case - a 6% increase on the 2009 figure is fairly marginal, particularly in light of the different sample sizes, but it suggests that the SPQ still has a central place in District Nursing education and career advancement.

Respondents were also asked what other qualifications were necessary to be a team leader, in the absence of the SPQ. The responses to this question were very varied but essentially reflected one overriding theme: team leaders are being drawn from whoever is available. There were 329 responses to this question. Some specified that a degree in nursing was all that was required. Others stated, 'advanced practitioner', 'RGN', 'sign off mentor', or pointed to length of experience, rather than education, as the qualification.

Given the lack of availability of the SPQ in many geographical areas in recent years, it is noteworthy that there no generally accepted alternative to it, reinforcing the overall picture of lack of educational opportunity and workforce planning.

“ Sporadic offering, lack of choice, lack of continuity, and significant obstacles placed in the way of nurses who want to further their education.

”



Benefits of the District Nursing SPQ

Respondents were asked what they saw as the three key benefits of the SPQ. Almost all respondents were extremely positive about the importance and value of the SPQ. The responses given provide concrete evidence and examples of the benefits nurses gained from undertaking the qualification; benefits that directly impact on the quality of patient care.

Examples include:

*'Developing more knowledge to question current practice and improve systems
Gain confidence in challenging poor practice
Improve physical assessment skills and obtain prescribing qualification.'*

'Prolonged period of taught and supervised practice - being guided by a practice teacher, most of whom are the best in the business. Learning while doing free from the day to day pressures of your own practice / team.'

A one stop course providing everything you need for the job - full prescribing status, history taking, physical exam skills and managing long term conditions.'

Recognition that leaders are made (shaped) not born - the course does provide insight into leading and managing a team. Most DN teams are very stable, tight units who know each other very well. When problems occur they are particularly hard to deal with. So equipping people with the skills to manage conflict...'

'A formal District Nursing course offers structure of work within a different locality to the one the nurse is used to working in order that she/he may draw comparisons and utilise new skills and knowledge from working with a District Nurse.'

'Offers experience in assessing and managing complex patients and complex situations with the ongoing support of a District Nurse mentor and working more closely with the multidisciplinary team.'

Enables the person to explore locality profile and implications on practice, populations, which enables a greater understanding of health and how it will impact on District Nursing caseloads. This in turn builds on the individual's ability to understand the importance of caseload management, being proactive rather than reactive to health.'

'A standard skill set which can be replicated.'

'A unique understanding of the community needs and not 'learning on the job' when coming from a lower grade or from acute trusts.'

'The development of an ethos of care and a level of socialisation that is not easily replicated.'

'Gives one a wider knowledge of skills and understanding of the NHS. One can understand that time management is essential. Looking at the public health again opens your eyes. It certainly makes you a more accomplished nurse. You will look at patients more holistically. It has given me

the skills necessary to work in a management role. Also one becomes more innovative, because now we know the reasons why cuts may be made and we need to be more cost effective.'

'For prime example - wet leaky legs due to heart failure - you can visit daily forever to mop up leaky legs, it needs someone with advanced knowledge and experience to assess the patient, check medication is appropriate, have the confidence to discuss such medication with the GP'

'The District Nurse course focuses upon autonomous specialist practice and the legal and ethical requirements to fulfil the role. The role prepares the staff nurse to manage the team of staff and to appropriately delegate visits and her responsibilities to patients who are delegated to other staff members. The course has specific modules on chronic long term disease management, prescribing, health needs analysis, communication and management at masters level and provides the level of education and support through clinical practice to carry out this role. I do not believe this role can be achieved without further study and clinical support.'

'...it is not just about managing a caseload of patients, it is about developing an effective service for a changing population, developing new services within a community setting and much more. In order to do this you need the foundation of the SPQ course...'

In particular the benefits described focus on:

- Overall personal and professional educational value
- Greater understanding of the wider context and influences of care in the community – policy, economy, population, public health
- Acquisition of management skills in context, including team management, conflict resolution, time and caseload management
- Development of skills in delivering complex, innovative and holistic care
- Development of skills in chronic disease management
- District Nursing Service development skills
- Working with the multidisciplinary team and developing a broader understanding of roles in care management in the community
- Standardisation of quality measures specific to the community environment.
- Confidence building to enable the District Nurse team leadership role

Respondents were overwhelmingly positive about the value of this investment in nursing education, from both a personal and organisational point of view.



4. Mentoring and teaching

Are you a qualified mentor? (i.e. have you undertaken a specific training course?)		
	Response percent	Response count
Yes	76%	730
No	24%	230

Are you a qualified practice teacher?		
	Response percent	Response count
Yes	18.5%	176
No	81.5%	775

The fact that so many respondents were qualified mentors gives an indication that the community setting can readily support prequalifying nursing students on placement. There is an urgent need to expose student nurses to the community environment, so that this is understood as being a good career choice when qualified, while recognising that there can be challenges in the number of students being supported, where nurses are guests in patients' homes and there may be limited spaces in an office base. Some District Nurses may not have an office base to go to each day, which is an additional challenge.

Practice teachers are vital in order to support the District Nursing SPQ, and training and development generally, within the workforce.

“ It is not just about managing a caseload of patients, it is about developing an effective service for a changing population... ”

5. Roles and responsibilities

The roles and responsibilities listed in the survey responses are extremely broad and give a powerful, specific demonstration of the range of work that today's District Nurses undertake.

What are the main roles and responsibilities of qualified District Nurses in your organisation? Tick any that apply to qualified District Nurses, even if they are not team leaders.		
	Response percent	Response count
Overall management of staff	82.8%	701
Overall management of patient caseload	92.4%	783
Allocation of staff	76.0%	644
Managing budget	25.4%	215
Prescribing	79.7%	675
Patient physical assessment	81.7%	692
Regular direct patient care	87.4%	740
Attending daily handover with staff	84.7%	717
Interviewing, selection and recruitment	74.7%	633
Managing staff rota/off duty	84.1%	712
Managing staff sickness cover	74.9%	634
Providing clinical supervision of peers	78.6%	666
Managing staff disciplinary	59.1%	501
Providing training and education	60.2%	510
Weekend working	87.7%	743
Categorising complex patients	84.9%	719
Managing complex patients	88.8%	752
Handling complaints	66.7%	565
Referral to and liaison with GPs	88.7%	751
Referral to and liaison with MDT	88.7%	751
Other (please list)		218

The only one of these potential responsibilities not currently carried out by a majority of qualified District Nurses is budget management. The figure of 25% is realistic given that only a relatively small percentage of staff are likely to be in a position of managing budgets in any organisation.

Additional responsibilities that respondents listed included: palliative care meetings, audits, bereavement visits, counselling, health promotion, mentoring, risk assessment, root cause analysis, IT troubleshooting and training in residential homes.

Respondents were also asked what other duties they feel they should be able to undertake, which are not currently part of the role. Responses included:



- Verification that a patient has died
- Budgeting
- Intravenous therapy and other specialist care
- Engagement with senior management and influencing healthcare planning for the local population
- More time to spend with patients.

6. Skills

Respondents were asked what skills they thought were unique to District Nurses. The range of responses was huge, but a representative selection of this diversity includes:

'Assessment, empowerment and reassessment.'

'Using knowledge of local community to benefit patients and families (needs of the population and local resources available).

Adaptable, flexible, resourceful and responsive to ensure best patient care delivered with resources available

Holistic assessment and management of complex needs of people in own home, including social, environmental and family/carer issues (short and long term).'

'Communication being able to show compassion, empathy and care to patients, families, relatives when they need time to understand situations in a relaxed atmosphere of the patients own home.'
'Advanced skills learning such wide variety of skills in supporting people to remain in their home, infection free and closely monitored.'

'Being advocate and representing the people of the community, liaising with various different agencies in order to ensuring the continuity of their care pathway.'

'Excellent communication skills, face to face counselling, production of reports, team working. Wide range of clinical skills with theoretical knowledge framework underpinning the role.'

'Multifaceted role demands everything from pastoral support for staff and patients, to managing staffing issues, managing complaints from patients and relatives. The role is seen as 'generalist' but few in the health service have the width of expertise that is integral to the role.'

'Managing uncertainty - this requires experience, confidence and an exceptional level of risk analysis and risk taking. This is important because you're on your own and a huge element of clinical reasoning and judgement is needed to decide if someone is safe.'

'Invention and flexibility - being able to find creative solutions to problems. Whether adapting aseptic technique to catheterisation with a patient in a double bed to being able to make things work for someone who wants to remain at home for their final hours / days.'

'Expertise in managing a range of problems - from tissue viability, COPD, degenerative neurological diseases to palliative care DNs have a wider range of expertise than most ward-based nurses. A true generalist.'

'Provision of truly holistic care in the home which has far more elements than secondary care.'
'Adaptation of evidence based, socially and medically complex care to the individual needs and lifestyles of patients at home.'

'Ability to work autonomously with minimal real time support yet remain part of larger teams.'

'Understanding of local community and other professionals who work in the area so they can refer quickly.'

'Close working relationships with patients, families, hospices, general practitioners and other AHPs to enable a quality service to our patients.'

'Advanced skills to enable patients with complex needs to be nursed in their own homes. E.g. Intravenous drugs, antibiotics, chemotherapy, vacuum assisted closure therapy, and care of the dying.'

'Wider organisational and strategic thinking to support staff with decisions made by senior management.'

'Highly skilled in patient assessment, holistic care, complex issues and decision making.'

'Generic nursing skills, we do not specialise in just one area, we can do most everything a patient requires outside a hospital environment.'

The responses can be summarised into the general themes below, though simply stated in this way they do not reflect the full range of District Nursing work that is given by the nurses' own words above.

- Holistic management of a wide range of medical conditions
- Communication skills
- Relationship building with patients, families and carers
- Palliative care
- Autonomous working
- Understanding of population base and factors impacting on health
- Assessment and problem solving
- Caseload management
- Crisis and risk management
- Leadership and management of staff
- Preceptorship, education and mentoring
- Liaison with many different practitioners, service co-ordination
- Acting as a patient advocate

“ Motivation to do a good job is paramount.

”



Skill mix and HCAs

Respondents were asked what proportion of each District Nursing team (not the wider healthcare team) were registered nurses. There were 743 responses to this question. In many cases the responses are difficult to categorise, because the nature of many nursing teams has changed so much in the past five years. In addition, many respondents did not use the suggested format for answers that was suggested in the question.

However, as a general guide, most teams indicate a fairly large majority of qualified nurses within the overall team. When reported as a percentage, most responses fall within the range 70-80%, with a wider range of between 60% and 95%.

The survey then asked how this compared to the situation five years ago. There were 798 responses. As with the question above, because of the variety of ways in which the question was answered, some of the answers cannot be counted within the figures. Many report that they are part of much larger teams than they were before, making direct comparisons very difficult. Others report that their workload has grown considerably, outstripping additional staff allocations, which also complicates comparisons. However the following data are clear:

- 304 reported no significant change within the team
- 201 reported fewer trained or higher grade nurses; more HCAs or untrained or part time staff
- 56 reported more trained nurses (without indicating that overall team size had increased significantly)
- 20 reported that team size and structure had changed, making comparisons difficult
- The remainder were either unable to comment, for example because they worked in a different field, or made comments that could not be allocated to the other categories

Taking only those respondents who were able to make a direct comparison with the situation five years ago, this gives 561 results. Expressing the above numbers as percentages, 54% stated that the situation was broadly similar to five years ago, 36% stated that the proportion of qualified nurses in their team had fallen, and 10% reported that the proportion of qualified nurses had increased.

The respondents were then asked whether in their opinion, the team had enough appropriate qualified and trained staff to meet the 'growing' needs of patients. There were 834 responses to this question, which can be summarised as follows:

- No: 496
- Yes: 232
- Indicated that some problems with staffing existed: 86
- Were unclear or unable to comment: 20

Expressed as percentages, almost 60% unequivocally believe that they do not have enough appropriately skilled or qualified staff to deliver the patient care that they think is needed. A further 10% expressed clear reservations about staffing levels or skill mix.

Only 28% believed that their teams were adequate, though a significant number of these went on to qualify their answers in some way. Factors that impacted teams that were mentioned included sickness, maternity cover, staff vacancies, and shortfalls in other teams, all of which could mean the difference between a team’s ability to cover its workload or fail to do so.

The implication is that even for those teams that are coping with their current workload, they have no capacity to accommodate any increase in the demand for the service.

7. Workload allocation and assessment of patients

How are patients allocated within the team?		
	Response percent	Response count
Manually using a diary	34.6%	282
Computer software package (specify)	37.1%	302
A combination of the above	28.3%	231

It is striking that over a third of respondents indicated that their team use a manual paper-based system for patient allocation. This is almost as many as those who rely entirely on a computer based system.

On one hand, this implies that up to a certain point, a manual system is still ‘fit for purpose’, or arguably it simply would not be being used by so many teams. Manual systems are trusted by those who have had bad experiences of complex and unreliable information technology. They are robust, and can be mastered with relatively little training. They may contain errors, but the risk of a total system failure is very small.

However, paper based systems lack the potential for rapid data gathering, manipulation and reporting, which are all necessary for effective service management, including change management. In addition, paper based systems can be more vulnerable to human error than IT based systems, which may lead to mistakes such as missed visits. Given the number of years that the NHS has been adapting to computer based systems, it is perhaps remarkable that there are still so many paper based teams.

Respondents were asked to say what system was used to allocate patients. The responses are extremely diverse and include the following: Microsoft Excel, Access, Outlook, Adatastra, System One, RIO, CHS, PARIS, Dominic, ECR, Emis, Hydra, NCRS, Lorenzo, PCIS, TPP, T-card system. Many respondents mentioned that paper backup is used in their organisation as IT systems are not deemed completely reliable or trustworthy (for example if connectivity is lost). Many respondents expressed their frustration with the technology that they use, citing in particular the time needed to update it, and the fact that input errors can occur.



A national capacity and demand tool is urgently required.





One respondent wrote:

'We have the caseload on an excel spreadsheet which identifies quickly who is due a visit on what date. This is then transcribed into a visit diary by area. The shift coordinator who can be any of the trained staff allocates for the next day and leaves a secure voicemail for the staff giving their patients. Unless someone needs equipment before the visit, they go straight out to visit their patients without coming into the office in the morning, saving time. We are now recording our notes on a shared MDT electronic system (on the NHS spine) as well as in the home notes aiding communication. Eventually we will allocate visits when we have mobile devices using the electronic MDT system - called System One.'

This example is fairly typical in demonstrating the hybrid system that many teams rely on, and reflects the state of transition to an increased reliance on IT based systems.

Complex care assessments

Within your organisation, how are patients classified as having 'complex' needs?		
	Response percent	Response count
Judgement of team leader	71.8%	595
Judgement of other staff (please specify)	50.8%	421
Local assessment tool	26.9%	223
Validated assessment tool	21.1%	175
Referral from other agency	39.2%	325
Other (please specify)	7.8%	65

The most significant figure is that the commonest means of determining whether patients have complex needs is by the judgement of the team leader. It should be acknowledged that this is an example of one of the many management skills that District Nurse team leaders exhibit in their normal working day. In another 50.8% of cases, other team members aside from the team leader are reported as making this key judgement.

However, where this kind of judgement is made purely in a personal capacity, based on experience alone, it can be very difficult to collate information and to draw wider conclusions about the service provided, and note changes to demography and disease profile.

A formal local assessment tool has the advantage of capturing information about patients in a far

more systematic way, enabling more sophisticated reporting and analysis by service planners at every level. These tools also enable the District Nursing service to demonstrate with a far greater degree of accuracy the nature of the complex cases that they deal with, and the corresponding burden on their workload. Although using an assessment tool may initially appear to be time consuming and cumbersome, once the system is full embedded it should enable efficiency savings and benefits for District Nurses and their patients.

Respondents gave more detail about how patients were assessed as having complex needs. These responses suggest that there are usually formal procedures or understandings within organisations about how to classify and manage complex cases within the community, even where the judgement of the team leader is the method most commonly cited to determine complexity.

Examples from among the 286 responses include:

‘Three or more Long Term Conditions that have an effect on patient’s health and social care needs requiring high levels of input-care package that supports patients that are very unstable, require specific skills etc. The patient will come under care of ‘community ward’ which is a virtual ward and pathway involving a recognised Multidisciplinary Team involving community matrons, a GP employed by the organisation, community nursing team, social worker, specialist nurses, geriatrician.’

‘We work closely with members of the multidisciplinary teams and the patients that we class as complex normally require more than one agency to manage their care. We work with a lot of palliative care patients that require a number of symptoms to be assessed and managed in the community. Judgement is made via validated assessment tools, working with patients and liaising with the multidisciplinary teams.’

‘There is no real classification in process. Some patients are talked about as complex, and informally it may be thought about in terms of individual nurse’s caseload, but there is no overall approach to this. However, the organisation wants one and is looking to the QNI work around workforce and capacity to help with this.’

‘The community matrons case manage patients with complex needs / co-morbidities and are often ideally placed to identify this group of patients along with other health / social care professionals - risk stratification tools are also in use. Community matrons and the District Nursing service liaise to ensure that patients are receiving the most appropriate care.’

‘Patients with single or co-morbidities with frequent unplanned admissions; patients with palliative care needs with sudden deterioration of symptoms/needs; patients with sudden onset of medical or social care needs.’

Refusing referrals

Does your team ever have to refuse referrals because of capacity issues?		
	Response percent	Response count
Yes	25.4%	210
No	74.6%	616

The point is made repeatedly in the responses to this survey (and to previous surveys that have informed other reports cited in this document) that most District Nursing teams cannot refuse referrals in the same way that a full hospital ward can. The complaint is frequently made that patients are referred to the District Nursing service as a 'catch all' if no other option is available. This may result in some patients being referred inappropriately.

The fact that a quarter of teams do refuse referrals is also a cause for concern. Even if this only happens occasionally, the implication is that a large number of patients (on a national scale) are not receiving the right care from the right nurse with the right skills in their own homes. Some of them may therefore be admitted to hospitals or nursing homes in the absence of District Nursing capacity, or the burden may simply fall entirely on carers (who will often be family members).

The 506 further comments given by respondents indicate that those who can refuse referrals, can only do so in exceptional circumstances. The responses also indicate that this is a major cause of stress for nursing teams, and a potential cause of patient dissatisfaction and potentially of risk.

'As a service we aren't allowed to decline referrals unless they are inappropriate. We don't have a maximum demand threshold. We are just expected to cope no matter what the demand on the service and the impact this has on patients and staff.'

'Despite having a capacity tool with escalation process, the service does not feel able to "close its doors." DNs feel that managers will not support this, as concerned with keeping GPs, CCGs and hospital based services happy. We have a particular problem in this county with delayed transfers of care from hospital based services with a lot of work going on to address this, so refusing a hospital discharge would be a no-no.'

'Even though teams are often severely under pressure with staff absence and vacancies they do not refuse referrals but prioritise work. It would be an advantage to be able to determine capacity levels within DN caseloads as happens in nurse/bed ratios on wards, but caseload management in community is a very complex task determined by dependency on nursing team and ability to carry out ADLs (activities of daily living).'

'The community nursing team picks up everything that other specialist community teams state does not fit their criteria. On the rare occasion community nurses become assertive, refusing work e.g. Completing spirometry for the housebound, a risk assessment is completed as to what impact doing this work will have on the general workload. This has to be agreed by a whole chain of managers and then presented to the GPs. Why would anyone be motivated to do that?'

'Unable to close caseloads, this did happen once in summer 2009 and our more senior managers were disciplined. We are expected to accept referrals and prioritize our work load. Due to volume of work load and lack of staff we have become less efficient.'

'We are the default service for every other service in the area. If podiatry cannot manage a foot ulcer patient they are passed back to DNs...leg ulcer service defaults to DNs the list is endless. GPs refer problematic patients for trivial things like collecting an MSSU (mid-stream specimen of urine), when the family are capable of taking it to the surgery etc.'

'It is very difficult to refuse referrals and this is dependent on the individual team leader and her strength of character. We can stop dying patients coming out of hospital but have to justify this with our managers and what capacity we have. There is no detailed assessment of what is a realistic

capacity for a District Nursing team. There is most of the time no ceiling to the capacity so referrals keep coming in regardless of staffing levels.'

'We firstly are not allowed to, secondly we use a variety of other services to try to re-direct or seek support in coping for demand; this can lead to patient dissatisfaction (understandably) when our priorities are not the perceived priorities of patients. It also leads to low morale and increased risk of critical incidents.'

'We have great difficulty refusing patients because it is an assumption from hospitals and GPs that we will take everyone, everywhere and at any time. We have recently started saying we have no appointments which works better than saying we do not have capacity. It would appear that most agencies understand the concept of not having any appointments free.'

'Never, although this will often mean starting early, finishing late, no breaks or lunch breaks, and no time given back.'

8. Measurement of work

Do you know how your team's work is measured by your employing organisation to report to commissioners?		
---	--	--

	Response percent	Response count
Yes	76.6%	641
No	23.4%	196

If you answered 'yes' to the above question, how is this work measured?		
---	--	--

	Response percent	Response count
Number of patient contacts	93.1%	595
Whole time equivalent of personnel in team	32.7%	209
Delivery of care packages	13.0%	83
Patient outcomes	29.3%	187
Specific report package	12.1%	77
Other (please specify)	5.9%	38

In the 2009 survey, 94% of respondents said that their teams measured work by the number of patient contacts – almost no different from the figure in 2013. Taken alone, this is a crude measure of service delivery, and does not illustrate the complexity of care being delivered. It should be noted that, for some, this is not the only measure being used, as 29.3% of respondents use patient outcomes as a measure.

In 2009, 44% reported that whole time equivalent (WTE) staff in the team was measured, 16% said they were using 'delivery of packages of care' and 17% said that they were using 'patient



outcomes' as a way of measuring work.

Compared to the 2013 figures, 'delivery of packages of care' has fallen slightly to 13%, suggesting that this is not a growing trend in metrics. However 'patient outcomes' has increased to 29.3% - almost double the 2009 figure – which suggests that this is becoming a key metric in the District Nursing service.

The 2013 figures suggest that actual patient outcomes are measured in less than a third of all cases. The total number of patient contacts is collated and reported, but for most of these contacts, there is no reporting to commissioners of the individual patient outcome. This indicates a cause for concern, both for the District Nursing service and for patients.

Nurses were asked to give more detail on the systems used to capture and report the District Nursing team's work. Some focused on the means used to gather the information; others listed the types of information currently being recorded.

Examples of the means of gathering and generating data include:

- Patient surveys
- Computer system reports (RIO, System one, Comcare, etc.)
- Palliative care gold standards framework
- Safety thermometer
- CQUIN quality targets
- Audit tools
- Capacity tools
- Employer's benchmarks

Examples of metrics being used include:

- Hospital admission avoidance
- Earlier discharge
- GP visit avoided
- Death in desired place
- Ulcers healed
- Waiting times for a DN home visit
- Patient complaints
- Meetings with GPs
- Number of contacts
- Number of harms such as pressure ulcers

“ Even for those teams that are coping with their current workload, they have no capacity to accommodate any increase in the demand... ”

The responses suggest a wide range in the types of measures being used, and the data being gathered, according to local systems and priorities. This might be exaggerated by the open ended nature of the question, which invited diverse responses.

Respondents were also asked to give further comments about measurement of District Nursing work. The responses are very interesting, and provide a critical assessment of the current ways of measuring work. To summarise, the respondents' comments highlight a number of issues, in particular:

- Many elements of District Nursing work are not being captured by reporting methods.
- There is too great a focus on quantitative, rather than qualitative measures.
- Some reporting systems are time consuming, onerous or unreliable.
- Some nurses do not have time to use the reporting systems in place.

A representative range of individual comments is given below:

'A national capacity and demand tool is urgently required to ensure the right number of staff are employed to be able to deliver high quality care. Hospitals have set numbers of patients to care for due to bed numbers; District Nursing referrals on the whole have to be absorbed despite the numbers of staff available or current capacity issues.'

'Counting patient contacts is very limited as it doesn't clearly demonstrate the full workload of nurses - the bulk of work is 'unseen'- e.g. completing paperwork, ordering equipment, organising referrals, chasing up messages etc.'

'There has never been a tool to measure qualitative input; various rural localities with increased travel time affects patient contacts as opposed to the town teams.'

'I believe it's very difficult. Quantity and quality are not the same. Some of the best practice cannot be 'captured'. A lot of the surveys are meaningless - there's no point in selecting patients' views from the able patients - it's the very patients who are unable to answer surveys who need the most care.'

'Should be outcome focused. Simply over-visiting patients does not show a quality service. The focus recently has been on harm free care and the paperwork is onerous: 23 sheets of paper to complete.'

'I find many organisations are focused on the number of patients on a caseload and the number of visits seen by a nurse. There is no focus on the quality, how complex the patient's needs are and how much time is actually required to give excellent, safe care. DNs are rushed off their feet. We need a validated risk stratification tool to classify community patients.'

'It is a difficult area to measure as the work is so variable, as is the practice population. We find that the people looking at the measurements have no knowledge of District Nursing work and apply their own interpretations, which can be costly to the teams. For instance we have lost a District



It is time to recognise the significant difference between nursing in clinics... and nursing in patients' homes.





Nursing post because the activity levels for the two teams (in the same office) dictated that there was only the need for one District Nurse. After investigating, the information from the activity levels had been misinterpreted and had missed the input from a full time member of staff.'

'It is difficult to quantify District Nursing work as the electronic system contains national categories that often do not fit the description of what we do. Some elements of nursing can never be captured electronically, such as the personal side, time spent educating, supporting, reassuring patients and relatives. Commissioners are concerned with tasks completed and the time spent doing so. Yet, if we focused on tasks alone we would not be fulfilling the six c's we so much want to deliver in our daily nursing work.'

'Measuring workload by numbers alone does not allow for accurate representation of workload pressure. Ecat reports have allowed greater analysis but also is required to be reported on in context and also in a standard approach, so that like for like is measured. This analysis may then lead to determining what limitations around caseload size should exist. Regionally there is a greater difficulty in determining this, as the makeup of caseload and DN service is so different.'

'There seems to be a focus on how long we are with each individual patient, without consideration of all the other related activities and the effect this has on workload, e.g. Spending 40 minutes with a dying patient in their home, but then many need a similar number of minutes in office to sort referrals / social care / liaising with other professionals. This is essential to quality patient care, but does not seem to be seen as such by commissioners who focus on how much face to face time we are spending with a patient, rather than all the related clinical admin time.'

'Unfortunately due to the level of demand, nurses are spending 100% of their working day carrying out direct patient care. This means that the computer work required to input their day's work is often sacrificed, as they find it hard to prioritise this over visiting patients. This invariably means that every patient contact isn't captured. It's a vicious circle as if patient contacts aren't recorded then managers don't see how busy the teams are.'

'Pressure to attend meetings, training etc. not acknowledged.'

'Audit results are never fed back.'

The responses underline the urgent need for more work into District Nurse workforce planning and reporting at a national level.

“ More open communication from managers and commissioners would be beneficial.

”

9. Mobile technology

Do you use mobile technology to record patient care when you are in the home? (e.g. palmtop or laptop).		
	Response percent	Response count
Yes	25.6%	216
No	74.4%	628

The QNI's report 'Vision and Values' published in 2006 envisaged a 'digital dawn' for community nursing services. In 2012, the QNI published a major report, 'Smart New World' that further expanded on the huge potential for new technologies in home nursing, including remote reporting. The above table illustrates that this 'digital dawn' is still far from a reality, as only a quarter of respondents reported using mobile technology to record patient care.

There are practical new national initiatives in this area, for example the £100m nursing technology fund currently in operation in England, which may go some way towards addressing this issue in 2014 and beyond (www.England.NHS.uk/2013/12/09/nursing-technology-fund/).

While advocates of new technology have often expressed the view that 'some nurses are technophobic', the survey responses provide valid reasons and clear illustrations from practice about why mobile technology is not more widely used.

Positive comments (which represented a small minority of responses) included:

- Saving time by use of new technology
- Ability to allocate team members at any time or place.

The problems highlighted by the survey include:

- There is no reliable wireless internet signal in many places where nurses are treating patients in their own homes - particularly in rural areas - making systems that are dependent on internet access impossible to use.
- Many nurses feel that the need to input data into a laptop computer or other device during a short face-to-face consultation and treatment in a patient's home is a serious barrier to effective communication.
- Concerns about posture when using a laptop in a patient's home or in the car.
- Concerns about safety when carrying laptops or other devices in the community.

Some examples of the individual concerns expressed are given below:

“

A laptop would prevent the interaction with a patient; you get to know them better by active listening, not typing!

”

'A laptop would prevent the interaction with a patient; you get to know them better by active listening not typing!'

'We have mobile technology, but the laptops are very cumbersome, and don't stay charged for a full shift. Very poor connectivity in the area I work.'

'We have laptops but time constraints often prevent us using them in the homes and between each visit. On a good day- i.e. Having about 6-8 patients to see it can be very useful to have the laptop to finish the documentation and makes the service more efficient. However during a time of staff shortage it does not get done.'

'We have just received mobile laptops – however:

- they are very heavy*
- we have been discouraged to use them in patients' home*
- we are unable to access patients' notes*
- currently we are merely "carrying them around"*

'Was tried in my area. The reception was very unreliable and led to enormous increase in time spent with a patient trying to input information. Technology abandoned at request of front line nurses.'

'Very heavy and difficult to carry when carrying all other items needed for patient care. Difficult to use as have to log on with each patient which can take up to 15 minutes which is too time consuming when we are visiting up to 20 patients and have on occasions visited 29.'

'There are many issues with this and it is currently under review, not least safety when carrying laptop into homes, connection has been challenging and has impacted on time and patient interaction, sharing of data has not been viable between organisations i.e. Marie curie - however there are some positive aspects and more work to support system is needed.'

'Not always as this can be impersonal as you lose the face to face contact whilst trying to record information. Helpful on first assessments otherwise a lot of information has to be duplicated in recording electronically when you return to base. However again this can be impersonal on a first visit as you're trying to engage with the patient, it can be seen as a barrier.'

'In an ideal world this would work and I think it would work well, however very rural area, so perhaps signal issues would be a common problem. Spend vast amounts of time doing admin, recording mileage, patient paperwork and recording visits....think that it would be helpful to do this as we go along, rather than trying to remember accurately when we get back to the office.'

'I have found access to my toughbook improves my practice and documentation. However has increased my working hours as often completing documentation at home. I have found my work life balance has suffered because of this.'

Connectivity problems are beyond the control of healthcare service planners, but entirely within the scope and future ambition of internet service providers. The question of patient communication is more complex and deserves more detailed analysis beyond the immediate scope of this report. Developments in technology may make the use of mobile devices more subtle and less intrusive. Equally, greater familiarity with using these devices by health workers generally will make their use more rapid and intuitive, assisted by improved functionality.

10. Working with other parts of the health and social care services

Discharge planning

There were 641 responses to the question concerning discharge planning. 95 respondents said that communication with discharge planning was 'good', 'fair' or used a broadly equivalent term. 13 said that it was 'improving' or 'getting better'. The remaining 533 stated that communication was variable at best, through to many who said it was almost non-existent. This equals around 83% of responses where the situation was not satisfactory.

Most of the more detailed responses described very similar scenarios, where hospitals discharge patients often without letting community services know, and without adequate preparation for them to be nursed or cared for in their own home. A typical response was:

'Again the people in the acute side do not always think how the patient is going to manage in their own home. Discharge planners should have or be given community experience in orientation so that they understand the problems that arise with a bad discharge. E.g. no meds, no prescriptions for meds, no easy access to a GP to have meds written up in community home notes at weekends and bank holidays. The same stands for dressings and equipment if the patient is not assessed properly.'

There is a clear indication in these figures that patient care is being affected by poor communication between discharge planners and community services. Discharge is a period of high risk for patients which, if not handled properly, leads to severe stress and increased likelihood of readmission.

Emergency services

Most respondents (595 in total) to this query stated that they found emergency services very helpful. Some stated that they do not have contact with emergency services, implying that they did not come into contact with them during their working day. 147 (around 25%) indicated that there were varying degrees of difficulty in communicating with emergency services – representing about a quarter of the total. Most respondents were not specific about the problems that they encountered, but a number stated that they found the attitude of ambulance staff to be dismissive or patronising, which hindered working relationships.

General Practitioners' surgeries

There were 498 responses to this query. 342 (almost 69%) of them were entirely positive about their working relationships with GP practices. However, 156 of these, around 31%, expressed a degree of criticism. In most cases, the comments were far less severe than the comments made about discharge planning. One respondent commented, 'Good, but only if the nurse makes it good'.

The most frequent causes of concern given were:

- The standard of communication varied between one practice and another (receptionists were cited in a few examples)
- Communication had become more difficult because DN team had moved to separate location from GPs, losing traditional opportunity to engage GPs more regularly

“ Respondents indicated a positive working relationship with allied health professionals... ”

- Communication could only be made by fax
- The role of District Nurses was either misunderstood (resulting in poor referrals) or taken for granted.

It is clear from the comments that DN teams have invested much time and effort in ensuring that relationships with GPs are positive. The overall picture that emerges is that where problems exist, this is due to communication difficulties, related to personalities, inappropriate technology, or remote location.

Social services

There were 533 comments in response to this question. Of these, 245 clearly indicated that there were problems working with social services – around 46% or almost half.

Where specified these problems were most frequently:

- Difficulty in contacting social services (or identifying who was the relevant case officer)
- Slow response times of social services (up to 28 days)
- Inappropriate referrals.

Those who reported a positive working relationship often commented that they worked in the same building, which made communication easier. Where they needed to contact people in another location, this was frequently frustrating. Nurses were very concerned by the slow response times of social services, which several commented put patients at risk.

Allied Health Professionals (AHPs)

Encouragingly, the majority of respondents indicated a positive working relationship with allied health professionals, such as dieticians, occupational therapists, and physiotherapists.

However, almost 27% (just over a quarter) did report problems, which reflected the same issues as working with other staff. The main problems reported were:

- Slow response times and long waiting lists (often linked to AHP services being very overstretched).
- Poor communication (for example one way communication by fax or email, not reciprocated).
- Inappropriate referrals and a sense that services are 'passing the buck'.

Again, those who reported working in the same building or as part of the same team as AHPs reported far better standards of communication.

Specialist nursing services

Almost all respondents indicated a positive or excellent working relationship with specialist nursing services, such as Macmillan nurses, continence, palliative care, respiratory, and cancer specialists. The few problems reported focused on the lengthy forms sometimes required in order to refer to other services.

Multidisciplinary working

Respondents were asked if they had any other comments about working in the multidisciplinary team. Responses were necessarily very varied to this open ended question. The responses to the



Nurses were very concerned by the slow response times of social services



previous questions around working with other professionals have indicated that good communication between health professionals is absolutely vital to effective and seamless patient care. Some respondents expressed a concern that District Nursing can be seen as the 'default' service if others do not have capacity. Most of the problems reported in response to this question can probably be explained by weakness in local management or governance – for example poor provision of information, fragmentation of services, and lack of co-operation between professionals. However the number of these examples in response to this question is few.

11. Job satisfaction and challenges to morale

Pride in District Nursing as a career

Respondents were asked what they were most proud of as a District Nurse. This open-ended question attempted to determine some of the key values, qualities and aspirations that motivate District Nurses. As one might expect, these revolve around giving excellent patient care:

'Being able to care for people in their own homes especially terminal patients. When I first started in the community we did not look after these patients; the family coped or they died in hospital. We now nurse these patients in their homes and we now have a hospice and a hospice at home team and the patients now have a choice and the families have support.'

'Being able to disseminate the knowledge and skills which I have attained over the years to students and staff within my team in order to assist and support in their ongoing development. The privilege I feel of being able to deliver palliative and terminal care to patients within their own home to enable their preference of care to be achieved.'

'Being able to speak up for my patients, giving them a voice.

Healing wounds that haven't healed for years.

Allowing those who are end of life die where they want to in their home, with their family around them in a dignified and comfortable manner.

Being there for patients when they can't get GPs out to see them. Giving them reassurance or seeking further help if needed.

Helping solve problems that patients might have, getting them in contact with the relevant speciality when they thought no one could help.'

'For me, being a District Nurse has meant being in a privileged position to enter into people's homes and into their lives and offer support and care at difficult times of their lives. Having the DN qualification gave me the confidence to work as an equal member of the multi-disciplinary team as well as within the DN team. Being able to adapt and be flexible to meet the very different needs of people in diverse situations and to feel I can make a difference...'

'I am proud to be a nurse in general but a district nurse allows you to be not just a part of a patient's care but a huge part of their lives. You are privy to people's lives in so many ways and are for much of the time more than a nurse to them. Some people would be extremely lonely and forgotten if not for DNs. I feel proud to make a difference and to call myself a District Nurse or deputy at least.'

'I have managed the Evening and Night District Nursing Service for four and a half years. Over this time we have become the forerunners of change in the county District Nursing service. We now have a highly skilled, motivated out-of-hours team with the mantra "we are the team who will do."

'That we are a responsive service that never cites lack of capacity to refuse to provide care. We continue to provide care whatever the resources / weather / outside demands etc. That we enable patients to remain in their own homes as long as possible and to die there if wished. That we are highly skilled and need to learn new skills quickly in order for patients to be discharged home. That we are flexible.'

'When I visit a patient and they tell me how reassured that I am looking after them that I give confidence in the care I deliver.'

'When I had left a patient's home and had to go back as I had forgotten my coat and heard a patient telling her husband how I was very caring and very gentle, and that I always took the time to chat and find out how she was.'

'I am proud to wear my uniform and tell people what my job is and where I work.'

As well as direct patient care, the responses also indicate particular pride in:

- The educational role
- The team leadership role
- The professionalism and status of District Nursing as a career.

Morale

If respondents were clear about the basis for their professional pride, they were also very clear about their current morale and that of their teams. The 675 comments about morale cover the whole range of possible responses, from 'excellent' through to 'very poor'. 105 respondents stated that morale was 'good', 'high' or equivalent term (three said 'excellent'). Around 85 respondents made qualified responses and can generally be classified as 'fair' but cannot be counted as 'good'. Six stated that it was 'improving'. The remainder, 479 responses (over 70%) represent a negative spectrum, from 'quite poor' through to 'extremely poor'.

As the question was open-ended, the responses are personal and subjective and open to a degree of interpretation. However, it is possible to say with confidence that around seventy percent of respondents were generally negative about their team morale. Any public or private organisation that received these responses to a staff survey would find their contents deeply disturbing.

The reasons given for low morale focus on:

- Perpetual organisational change
- Workload, including long hours
- Fear of letting patients down
- Lack of capacity to cover sickness and other absences
- Uncertainty about career
- Zero tolerance culture and climate of fear
- Poor management
- Paperwork
- Lack of support from senior managers/employing organisation
- Cuts to service capacity
- Unpaid hours

A typical response is as follows:

'I feel that morale within District Nursing is at an all-time low. The amount of paperwork has increased by 200% over the past few years. The threat of coroner's court is mentioned constantly and there are just not enough nurses to manage the service as it should be managed. We all work far more hours than we are contracted to with no extra pay and little chance of getting time back, yet this appears to the norm.'

The more positive responses tend to be characterised by an emphasis on the quality of management, and the bonds between team members:

'I remain passionate about the opportunities that nursing people in the home can bring. In the last few weeks, the Trust seem to be responding positively and looking at some of the issues we have been trying to raise for last few years e.g. workload / burden of excessive documentation / lack of respect for clinical decision making / lack of training opportunities (due to short staffing) / demand from care homes . The Trust is carrying out a 'listening' exercise to get the views of front line staff (result of Francis / Keogh). This is increasing morale but we need to see results.'

'Morale is good in our team as we try not to dwell on negative aspects of the role. Motivation to do a good job is paramount and we spend time discussing how we can improve practice to benefit our patients. Things that get us down are not having enough time to complete tasks and we all lose sleep wondering if there was more we could do for individual cases. Our role as healthcare professionals is taken very seriously and the last time we felt 'down' was when other members of the MDT did not respect our role in primary care.'

'Has been very poor but a line manager who has a DN background has made an enormous difference. She understands the job and is highly supportive. Is a Queen's Nurse!'

These responses and others like them tend to suggest that high morale can survive organisational pressures to some extent, if team management is very good.

Challenges currently being faced

Respondents were asked if they had any other comments to add. 509 made comments, providing a huge wealth of intelligence about the current state of District Nursing. The comments reveal a wide range of concerns, and provide further background for the low morale that many District Nurses report.

Key causes of concern made by many respondents are:

- Lack of understanding of the potential of DN service
- Lack of understanding of DN work by other parts of the health service
- Lack of recognition that home nursing has increased hugely in complexity
- Expansion of workload without commensurate resources
- Cuts to allowances – such as mileage, uniform, parking
- Workload stress causing sickness, resignations, early retirement
- Hospital management failing to invest in community services (integrated service providers)
- Disruptive organisational changes
- Administrative burden that DNs do not have time to manage

The following examples touch on a whole range of issues that are impacting on morale within District Nursing teams.

Workload pressures:

'We are just manageable at present. With the numbers of patients I see every day between 12-17 it can become overwhelming especially if some of those have complex issues That can take between 1-3 hours of my day which sometimes I just don't have. I always miss my lunch hour, usually only taking 10 minutes to grab something in a shop and eat in my car, and go home late every day but I love my job and can't take away care from patients in order to meet my own needs.'

Unrealistic targets:

'All members of the workforce have been under tremendous pressure to achieve the never ending targets set by my management. It is very difficult at times, to motivate staff when we ourselves as managers of small teams are constantly being told we are not achieving our targets i.e. not seeing enough patients. They have recommended that Band 3/4 should be seeing 14-16 patients, Band 5 10-14 and Band 6's 8-10 patients daily. These are not realistic figures and leaves no time for admin or actual patient care! I myself saw 11 patients and travelled 72 miles in one day, this left no time for admin, handovers, safe patient care, lone working compromised etc. I fundamentally believe that we should be given the time to nurse and not perform like robots!'

Reapplying for own jobs:

'Currently going through a consultation which means we need to reapply for our jobs and there are not enough posts to accommodate us all. Work load has massively increased. We are expected to do more, in the same amount of time. Constantly having to start early, finish late and take work home, just to keep up with the demands of the job. Our massive rural mileage doesn't get taken into account and we are constantly being told unless you do your Comcare staff will be taken away, but we are not given time to do our Comcare and end up staying late or doing it at home.'

Low staffing:

'District Nurses are very innovative, dedicated staff, and the one thing all nurses will tell you, is that they want to care for patients. Unfortunately, we are being bombarded with targets, very often not getting feedback with data we collect. The Government keep telling us that patients come first, we agree wholeheartedly with this, but the systems in place are preventing us from doing what we are trained, and want to do. Many nurses are leaving and finding alternative positions outside of nursing. I have been a nurse for 35 years, and have never experienced such a prolonged period of low staffing issues.'

Preventing hospital admissions:

'District Nursing is vital in the prevention of repeat hospital admissions and preferred place of care for our patients at the end of life is more often than not in the home. We are expected to know about everything, and if we don't know something, we have to find out fast. The pressures are immense, yet somehow we continue to provide an excellent service due to the nurses' dedication, however, recruitment and retention is difficult, not just due to financial constraints, but the fact the nurses often feel that District Nursing is the "easy option," but when they realise the truth, they often return to hospital work.'

Nationally low staff numbers:

'Government emphasises the numbers of community nurses as on the increase, but their numbers include Health Visitors and midwives and the actual numbers of nurses caring for adults in the community are dropping, despite the increase in long term conditions and poor health of the nation'

... the cost of services will continue to increase and we cannot keep up with demand so certain services or client groups will suffer. We need to enhance the service to be proactive not reactive.'

'I am very concerned about the declining numbers of qualified District Nurses across the country, and the expectation that District Nurses are to deliver more care on what appears to be a reduction in funding, not a growth. I am also very disappointed that the Government does not recognise the value of District Nursing unlike Health Visiting or School Nursing.'

Lack of understanding of role by the public:

'I feel many of the issues come from a lack of understanding of our role from other services and the public in general. District nurses can spend much of their day sorting out problems for other services because we always accept our duty of care. Clearer referral processes would be a starting point to address this problem. More open communication from management and commissioners would also be beneficial in achieving compliance and understanding from staff.'

'I think it is portrayed inappropriately in the media. Recent TV programmes showed staff just drinking tea/coffee in homes with no representation for any of the difficult things we do such as IV therapy, chemo, end of life care, complex dressings, leg ulcer clinics. Focus always seems to be on acute services such as A and E which is important but District Nursing is more than just visiting the person at home. We often are passed stuff that other 'specialist nurses' do not want such as continence and mundane tasks. Often we are asked to see patients as there are insufficient appointments with practice nurses available or bus service is poor. ...Over the years no one has spoken for District Nursing and it is only now people are getting worried because no one will be there to do the work of looking after patients at home who have the necessary skills.'

Taking up workload for GP practices:

'In the last 6 years or so, I have noticed that the DN caseload has increased tremendously. Also, a great deal of our work depends on practice nurse training and ability to order equipment. e.g. in my team we do PICC line dressings, dopplers, catheter changes, complex wound dressings amongst other things for patients who can go to a GP surgery, as practice nurses are not trained to do them (the GP surgeries don't arrange the training). This clearly increases the DN workload and patients end up with a poorer service as we cannot always guarantee an appointment time for patients who want to go out / go to work.'

Integration with hospital management:

'Management structures are hospital orientated as we have now been taken over by a Hospital Trust. The hospital needs predominate and there is no strong management presence representing the Community division. Hospital managers have unmanageable remits and that is making it impossible for them to devote the time and understanding they would wish to the community aspects of their role.'

Continuous change:

'The continuous changes within the service over the past few years have not fostered good relationships. Care has been delegated to the unqualified members of the team which devalues the training which the qualified staff have undertaken. GPs are under the impression that they are paying the same amount of money to the commissioned services but they do not seem to realise that the community budget is now fragmented into different sections such as extra palliative care services, early discharge teams etc. when they were under the impression that their DNs were the recipients of the funding.'

Conclusions from the Survey

1. The vision, qualities, skills, pride, professionalism and identity of District Nurses are still relevant, coherent, modern, well-articulated and understood.
2. There are currently huge stresses placed on the District Nursing workforce. District Nurses are not alone in facing increasing pressure in the workplace, but their particular challenges and concerns can often be overlooked, where most government and media attention is focused on hospital based care. District Nurses are meeting ever more challenging targets with limited resources.
3. Where working conditions are poor – for example no breaks, unpaid overtime, no backfill when staff are sick or on maternity leave, this places an enormous burden on individuals. This in turn does not support staff retention and cannot support good patient care.
4. Poor communication is a feature of many nurses' working experience. Poor communication is one of the most common complaints by patients, and this is reflected among healthcare organisations' own staff. Physical location of staff has a huge impact on quality of communication. Despite the recent trend towards service integration, the poor communication between hospital discharge staff and community nurses is of particular concern, impacting directly on patient safety.
5. Information Technology – both office-based and mobile – is letting some nurses down.
6. There are stresses related to heavy caseloads, poor/inappropriate referrals, and inability to state when capacity has been reached. Measures of workload and output are not robust in many cases, leading to poor understanding of the DN role and work
7. The conclusions above contribute to poor morale, and serve to undermine the achievements of the District Nursing service.

The conclusions from this survey should also be read with the statistical workforce information available online from the Health and Social Care Information Centre at: <http://www.hscic.gov.uk/catalogue/PUB13718> (accessed 29.5.14). Statistics for England confirm that District Nurse numbers have been falling steadily since September 2009.

Actions Required

1. Employers and commissioners should value and embrace 'District Nurse' as a modern job title. It is recognised and understood by patients and professionals and inspires confidence and respect.
2. A renewed investment in the District Nursing Specialist Practitioner Qualification (SPQ) is required. A national educational standard for District Nurse education and practice, supported by the QNI and QNI Scotland, will be established to support the SPQ.
3. A strategic workforce planning tool for District Nursing is required, to maximise the potential of the existing workforce and enable planned growth.
4. A 'Complexity Tool', which gives an agreed, standardised means of determining which patients are 'complex,' and their consequent care pathways, should be created.
5. A national set of patient outcome measures that all individual District Nursing services report to is also required.
6. There must be greater investment in appropriate Information Technology to support patient care, recognising the specific issues and challenges of the community environment. It is imperative that different systems are compatible with each other, and sufficiently robust to operate in remote locations.
7. Action must be taken to improve partnership working and communication with all other health and social care providers supporting people in their homes and communities. There is a need for a cultural shift if the multidisciplinary team is to provide truly seamless care to patients.

Conclusion

The Queen's Nursing Institute is uniquely placed to ensure that District Nursing fulfils its potential as one of the mainstays of primary health care. As an independent charity with its origins in the creation and development of District Nursing, it has the expertise and long perspective required to contribute to all of the areas of work identified as being necessary in this report.

Taken together, these actions will help to measure and communicate the vital work that District Nurses do, and help fulfil the overriding objective, of delivering more and higher quality patient care in the community in the 21st Century.

Copyright: The Queen's Nursing Institute 2014
WEB VERSION



The Queen's Nursing Institute

1A Henrietta Place
London W1G 0LZ

020 7549 1400
mail@qni.org.uk
www.qni.org.uk

Registered charity number: 213128

Patron HM The Queen

Founded 1887