

Understanding safe caseloads in the District Nursing service

A QNI Report

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Introduction

The District Nursing Service provides nursing care and support for patients, families and carers in homes and communities in every part of the UK. District Nursing teams comprise the District Nurse team leader, registered nurses and health care support workers, and may include allied health professionals and social care workers.

District Nursing services often act like a 'sponge', absorbing additional workload in an environment without the physical limits of a defined number of beds. Modelling demand is important not only for operating current services, but crucially to plan services for the future, taking elements into account such as population health, demographics and the opportunity for remote monitoring and supported self-care.

This report aims to demonstrate the complexity of creating, maintaining and predicting caseloads within the District Nursing service that are safe for both patients and staff. By describing the elements that should be taken into consideration when planning safe caseloads, the Queen's Nursing Institute (QNI) intends to contribute to the current wider dialogue around workforce planning and deployment of nursing teams in the community setting.

The QNI wishes to open up the conversation for researchers of workforce and workforce modelling to identify where more evidence is required. The experts brought together by the QNI (see below) reflected on the paucity of evidence available and felt that further work was needed in a number of areas:

1. Development of a framework of principles for future workforce planning and deployment. NHS Improvement is currently undertaking work on safe sustainable staffing in a variety of settings, and the QNI hopes this report will be useful in supporting the work relating to community nursing services. Any workforce planning guidance for the District Nursing service should provide a framework of principles, which can be flexibly applied depending on professional judgement and local circumstances. Both patients and staff from the District Nursing service should be involved in the development and interpretation of any guidance.
2. Modelling of future demand, including the impact of rising multi-morbidity in the ageing population.
3. Promotion of the use of clinical outcomes and identification of good practice to articulate what a good District Nursing service looks like in terms of outcomes and how staff are best deployed. Innovation and good practice in workforce planning should be widely shared in order for commissioners, providers and staff to learn from each other, both within the UK and overseas.

It is anticipated that the report will provide a means of stimulating debate amongst all stakeholders in the District Nursing service and in doing so, the QNI welcomes comment and feedback on the report, providing affirmation of the content where appropriate and any additional elements and factors to be considered in creating safe caseloads.

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Background

A caseload refers to the patients served and all the activities involved in supporting people requiring care from the District Nursing service over a specified period in a specified locality. The QNI advocates using the term 'safe caseloads' rather than 'safe staffing' to reflect a more comprehensive and inclusive approach to nurse workforce planning and deployment in the community setting, which aims to provide assurance that the right nurse, with the right skills, will be in the right place, at the right time delivering high quality care. For these reasons, the safe caseloads approach is not based on using nurse to patient ratios.

The QNI developed this report on safe caseloads in the District Nursing service based on intelligence gathered from experts in the field of community workforce planning and previous work carried out by the QNI (NHS England/QNI, 2014; QNI, 2014). In particular, discussions held at a meeting organised by the QNI in September 2015 have contributed to this report (see Appendix for list of participants). Whilst this group initially considered wider service delivery in the community, including community children's, mental health and learning disability services, it was considered that the focus should be on the District Nursing service, albeit that some of the principles may apply to other nursing services delivered in the community setting.

Who is the report for?

The QNI considers that this report will be useful to those involved at every level in the provision of community nursing services to inform staff deployment. This includes chief executives of provider organisations, executive nurses, professional leads, commissioners and District Nurse team leaders. In addition, this report will give policy makers a greater understanding of the complexity of the District Nursing service and the factors to be considered when creating policies that support the delivery of more care in the community.

Rationale

This report is particularly timely in the context of the UK-wide policy focus on moving more care from hospitals into the community (NHS England, 2014; NHS Scotland, 2013; Department of Health, Social Services and Public Safety (Northern Ireland), 2011; Welsh Assembly Government, 2010). It is vital to understand what constitutes a safe caseload for District Nursing team members in order to ensure that community nursing services are safe, effective and provide a high quality of patient experience.

The health, wellbeing and safety of staff must also be considered, given that pressure from the growth in patient demand and scarcity of resources can lead to increased staff stress, low morale and difficulties in recruiting and retaining staff (QNI Community Safe Staffing meeting, 2015). Further indicators of growing pressure on the workforce include increased staff turnover, vacancy rates and sickness absence.

Linear time and motion studies often used for workforce planning do not capture the complexity and unpredictability of working in the community. There is a lack of robust data and evidence about safe staffing for nursing in community settings (Fields and Brett, 2015). In addition to staff activity, data on outcomes are particularly required to understand the economic value of the service and to support value-based commissioning.

The data that are collected by workforce planning and caseload management tools must reflect the complex care that nurses provide, including the aspects of health promotion and prevention. Such tools must also include a way to record or measure care left undone, in order to provide a better assessment of need and understand the cost of missed care. Local datasets could build up to a national level if agreed across provider organisations, providing the opportunity to benchmark and compare services and inform the evidence base for future research activity.

Elements to consider for creating safe caseloads in the District Nursing service

Whilst many of the elements described below are interlinked, they have been separated into sections in order to consider each factor in more depth and relate it to practice.

Needs of patients, their families and carers

- The profile of the population, including demographics, ethnic diversity and disease risk factors, which should be used to assess the level of need.
- The complexity, depth and breadth of the care delivered in the home and community, which is increasing all the time and, as testified by District Nurses who have worked in the community for more than 10 years, bears little resemblance to the care delivered in these environments a decade ago. For example, in many areas, it is now routine for the District Nursing service to provide intravenous therapy and abdominal paracentesis at home.
- The referral criteria and people's expectations of what the District Nursing service offers, both patients and the public, as well as healthcare staff in primary and secondary care. Healthcare professionals, patients, family members and carers may not be aware of the degree to which people can be supported to manage their own care with direct care from the professionals when required.
- Planned patient care delivery, including consideration of the level of patient acuity and dependency, as well as the complexity of delivering all elements of the care that need to be provided, particularly for patients with complex co-morbidities.
- The accommodation of unplanned demand, both new referrals and additional demand from the existing caseload, and whether analysis of data can identify trends that improve the predictability of the caseload.
- The trend for shorter lengths of time in hospital places additional pressure on the District Nursing service to respond to the need for nursing care, with patients who are more acutely unwell being discharged home at an earlier stage in their recovery.
- Lack of planning for the transfers of care from the hospital to the home will impact on the District Nursing service and will add to the need to have capacity for potentially complex unplanned care, as described in case studies 1 and 2 below. The QNI report on Discharge Planning (QNI, 2016) explored this challenging issue and highlighted solutions and areas of best practice.
- The level of unmet need and 'care left undone', which would include, for example, data on the profile of patients whose care is delayed due to capacity issues within the service. This might include a delay in providing, for example, a continence assessment, a Doppler review for a leg ulcer or a dressing change.

Case Study 1

I was called out to see a patient discharged from hospital out-of-hours. There was no discharge letter and the care required included a complex wound and dressing system needing specialist training. This patient also required palliative care with complex symptom control. The family dynamics were challenging and it took two hours to sort out a safe care plan.

Workforce

- The number and skill mix of team members in the District Nursing service, including consideration of their different skills, education, professional development, experience and team conduct. The ratio of District Nurses to registered and unregulated staff should be considered, given that if a team is too large, the ability of the District Nurse to assure the quality of care provided by the service may be compromised. The QNI published a report on the value of the post-registration Specialist Practitioner Qualification (SPQ) in District Nursing (QNI, 2015), which found that this core qualification is critical to building the complex leadership skills required to safely, effectively and efficiently manage the team and caseload.
- Face-to-face availability of staff for clinical activity with patients, compared to non-face-to-face requirements. The latter comprises indirect patient activity, such as travel to and from patients' homes, referrals to other services and multidisciplinary team meetings, as well as non-patient facing activity, including clinical supervision, training, continuing professional development, and mentorship of students on placement. It may be desirable to ring-fence the time for non-patient facing and indirect patient activities, which are critical to ensure the quality and safety of the service, before allocating the time for clinical activity with patients.
- The annual leave allowances of individual staff members, average sickness rates, and maternity leave, in accordance with the agreed percentage 'uplift' of the organisation.
- The rates of staff recruitment and retention, particularly as frequent staff turnover increases the time required for new staff induction programmes and training for those new to delivering care in the community setting.
- Relying on staff to work increasing hours of unpaid overtime in order to complete their work must be avoided.
- The demographics of the workforce, taking into consideration that nurses working in the community may be more mature on average when compared to the overall nursing workforce in the UK. The welcome initiatives to recruit newly qualified nurses also result in a more junior workforce with less experience, requiring more support from their senior colleagues. Consideration may therefore need to be given to targeting experienced members of the District Nursing team with initiatives to improve their retention.

Case Study 2

A patient with diabetes was discharged from hospital late on Friday night, with no phone call to say he was coming, needing insulin twice a day. The patient had no knowledge of managing diabetes, despite the hospital saying that they had taught him how to self-administer insulin. Both the patient and his wife suffered from alcoholism and were living a chaotic lifestyle. The patient usually went out all day so was not happy to be home by 4.30pm for me to give the afternoon dose. The house was very dirty with not a single work space to put anything down on, as well as a large dog getting in the way.

Having searched the hospital medicine bag, fridge and the rest of the house, I could not find the insulin. It took 15 minutes to get through to speak to the ward staff, who reported that the insulin was still in the fridge on the ward. The hospital agreed to send it by courier and I returned later to administer the insulin, however the morning dose had to be omitted. The time to complete a new assessment and all the documentation, including an incident report about the missed dose, was approximately an hour. Time allocated was 30 mins, but actual time spent in total was 2.5 hours.

Geography

- Whether the area is rural or urban will have an impact on the type of transport used, such as the need to use public transport and bicycles in inner city areas, and the travel time required between patient visits and other appointments and meetings.
- The location in the country and the local geography of the area may also determine the weather conditions experienced, which can impact on travel time and the ability to use mobile technologies in patients' homes.

Housing

- The accessibility of patients' homes, for example accessing top floors of tower blocks and using key safes can take more time.
- Chaotic households can take more time to access and to negotiate safe spaces for the delivery of nursing care.

Staff safety

- The safety of lone working, particularly at night, must be considered. While two members of staff may not be required to provide care, it may be unsafe for a nurse to travel alone through certain areas at particular times of the day and night.
- Two members of the District Nurse service may also be needed to provide the care in some circumstances too, where it may be unsafe for one nurse to be in the home alone, for example, or where the care requires two members of the team to support a patient with their mobility or to change position in a bed.

Duration of cover

- All District Nursing services offer a 7 day a week service, but some may be commissioned to restrict their operating hours to finish at 10pm, or sometimes earlier, with the out-of-hours GP service providing the cover at night.
- There is wide variability with the contract specifications on the evening and night cover of the District Nursing service. The variation will impact on the amount of time required for handover to other services, such as out-of-hours GP services, for patients requiring care when there is no commissioned District Nursing service.

Case Study 3

A patient was referred by the GP for a leg dressing, having attended a GP appointment that afternoon with soaking wet legs. On arrival I found that the patient had recently transferred to the area and only just registered with the GP. The patient had severe chronic obstructive pulmonary disease (COPD) and was on continuous oxygen, waiting for lung transplant. The patient had soaking wet legs and was completely non-compliant. The patient was living on his mum's sofa and I tried to do an assessment while they had an argument over my head.

His mum appeared to have a cognitive impairment as well which I made a note to flag to the GP on Monday. Time allocated 30 mins and total time taken to complete the assessment, dressings, and referrals to our respiratory team for oxygen supply, the tissue viability nurse and social services for housing etc. was about 2 hours.

Pathways of care and interventions

- There are no nationally agreed pathways of care or specifications about the band of staff required to deliver specific care, so care pathways will vary locally.
- There are different models of community nursing delivery and varying degrees of integration and collaboration with other services providing care in the home, such as those of allied health professionals, third sector and social care.
- As well as visiting patients at home, District Nursing services provide care to patients in residential care homes and nursing homes and some hold clinics in GP surgeries.
- Some contracts may not provide cover to ambulatory patients. However, it may be too simplistic to base eligibility decisions solely on whether a person is housebound. Other factors need to be considered, such as whether additional support is needed for that person to travel to a hospital, clinic or GP surgery, or whether they have exceptional challenges to their mobility and caring responsibilities. For example, if the patient is the carer for a spouse with dementia, flexibility and professional judgement need to be applied to make a differential decision on the basis of cost-effectiveness or patient/carer experience.

Case Study 4

A patient with heart failure was referred at 4pm on Friday by an occupational therapist for end of life care. The patient had been deteriorating since a stroke the previous Saturday - not eating or drinking and unable to get out of bed for a week. The patient was seen by the on-call GP last Saturday and her own GP on Tuesday but no referral was made to us. The patient was comfortable so was not distressed about the situation. The patient's daughters, who were looking after their mother with the support of carers, had not been given any explanation or support about dying at home.

I had a full discussion with them about end of life care, preferred place of death, DNR (do not resuscitate), and symptom control. On returning to base I made a referral to the palliative care team and GP for DNR anticipatory medication as nothing was in place. I then arranged daily visits to provide support and care for patient and the family. Time allocated 30 mins, time spent in total 2 hours.

Impact of other services

- The potential impact of integrated and other models of care, including horizontal or vertical integration of services, which should in theory make the nursing services more seamless for the patient when care is transferred between hospital and community settings.
- The 'patchwork' of other services in the local area and the ability to respond flexibly to this.
- The number and size of care homes and nursing homes in the local area and the extent to which they depend on District Nursing services.
- The service provided by General Practice Nurses and General Practitioners, where a limited capacity and capability of a general practice nursing service may increase the demand of the population for community nursing services to be provided in their place.
- The presence of local high quality hospice at home and end of life care facilities, such as those provided by Marie Curie or Macmillan, may reduce the palliative care service requirements of the District Nursing team locally.
- The presence of services provided by voluntary sector organisations, such as Age UK, may impact on the demand for the District Nursing service.

- The access to multidisciplinary health professionals, such as occupational therapists and physiotherapists.
- The quality of social care services and whether District Nursing teams flex their service locally to deliver elements which might otherwise be considered to be 'social care'.

Technology

- The interoperability of the District Nursing IT system with others, including the system used by the general practices, social services departments and hospitals in the area.
- The ability of technology to support the capture of all desired data, including activity, demand, capacity and patient outcomes.
- Access to and performance of mobile working systems, which can be used to record clinical information at the point of care delivery. In addition, mobile working technology can enable nurses to work from home by downloading their schedule of visits for each working day or night onto the mobile device, which saves time and increases productivity. However, the cultural change to mobile working can create a feeling of isolation amongst the nurses in the team and there will be a need to create other ways of maintaining a sense of 'team', particularly for members of the team who are new to the District Nursing service.
- Use of communication technologies, such as Skype video calling, between members of the District Nursing team, as well as with the wider multidisciplinary team and other health and care professionals involved in a person's care.
- Patients' use of teleconsultations (also known as telehealth) and remote/home monitoring systems enabling more self-care can influence how often the District Nursing team need to visit the patient at home.

Economics

- Costs of staff providing the District Nursing service and avoiding unplanned admissions to hospital compared to the alternative of admitting a patient to an inpatient facility for nursing care.
- The need to consider outcomes in terms of clinical outcomes, use of resources, preventing hospital admissions and staff and patient experience.
- The degree to which District Nursing services add value from a preventative, health improvement and health promotion perspective.
- The impact of behaviour change interventions and support for self-care, which may require additional education and training for staff to work in new ways.

"Everyone can cope with one of these days every so often, but it is now the norm and every day is like this. I regularly work at least an extra 2 hours per day, as I see as many patients as the rest of my team plus do all the management, write prescriptions and attend practice meetings as well. Every day is a slog and I return home exhausted. However I love my job and the people I care for. I just wish we were respected more by our colleagues, properly resourced and not treated as a dumping ground for the people that need care but do not fit anyone else's criteria."

- District Nurse Team Leader

Conclusion

The health and care sectors, and the District Nursing service in particular, are facing significant challenges. The ageing population raises concerns around both recruitment and retention of the workforce, as well as growth in the level and complexity of patient need. District Nursing teams are operating in a high pressure environment in which resources are scarce and there is a risk that care may be left undone.

Many of the new models of care are exploring solutions to these challenges, including the transfer of funding and resources into community services, improved use of technology to release time to care, and greater support to enable people to manage their own health. Innovation must be balanced with the need to ensure a safe service for both patients and staff.

In some areas the services may be dependent on staff working unpaid overtime each day in order to complete their work. In these circumstances, it is feasible that actions to increase productivity through the use of technology to support caseload management and mobile working, will result in relieving the burden of unpaid overtime, but may not result in the anticipated increase in the capacity of the existing workforce. The use of an effective digital caseload management system should however contribute to the provision of robust data to demonstrate the profile (including capacity, capability, availability) of the team required to meet the varying needs of patients, families and carers in the locality.

Articulating what constitutes a safe caseload for the District Nursing service necessarily has implications for workforce planning and training at local, regional and national levels. It is essential to ensure that there are sufficient nurses with the complex skill set required to lead the District Nursing service. In the context of policy objectives to move care into the community, it is concerning that Health Education England (HEE) reduced the number of commissions of the SPQ District Nursing programme by 0.8% in 2016/17 compared to 2015/16 (HEE, 2015). Whilst more community placements for pre-registration student nurses are urgently required to develop the future workforce, this will add to the time pressure on existing staff.

The National Institute for Health and Care Excellence (NICE) evidence review 'Safe staffing for adult nursing care in community settings' made public in July 2015, found a paucity of research that could be used to develop evidence-based guidelines on safe staffing (Fields and Brett, 2015). The studies that were included by NICE were generally observational and the evidence was described as moderate or low quality. No evidence was found that described how factors relating to staff, organisations, the environment, patients or economics should be considered when planning the deployment of the community nursing workforce. The review concluded that it is not possible to be clear about what approaches are effective for assessing and determining nursing staff or skill mix requirements in community settings, nor what outcomes are associated with nurse staffing levels in community adult nursing services.

Guidance for safe nursing, midwifery and care staffing was published in 2013 by the National Quality Board (NOB, 2013), a group comprised of the Care Quality Commission, NHS England, NHS Improvement, NICE, HEE, Public Health England and the Department of Health. An updated version of this guidance was published in July 2016 (NOB, 2013). NHS Improvement is now coordinating work to develop safe staffing improvement resources for a range of care settings.

As well as opening up the debate in relation to safe caseloads, the QNI intends for this report to inform NHS Improvement's work to provide an improvement resource for safe sustainable staffing in the District Nursing service. The QNI is supporting the national work on safe staffing by consulting with directors of nursing, service leads, programme leads, software suppliers, as well as patients and carers.

The QNI will also be collecting feedback on this report to facilitate continued dialogue and further develop our collective understanding of safe caseloads for the District Nursing service.



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Appendix

Participants of the QNI Community Safe Staffing meeting held on 22 September 2015.

NB: roles reflect the positions held by participants at the time of the meeting and in some cases have now changed.

- Dame Elizabeth Fradd, Chair, Fellow of the QNI
- Jane Cummings, CNO England, NHS England
- Ian Bailey, Senior Clinical Informatics Consultant, EMIS Health
- Jane Ball, Principal Research Fellow, NIHR CLAHRC Wessex, University of Southampton
- Sue Boran, Course Director for District Nursing programmes, London South Bank University
- Gill Coverdale, Professional Lead – Education Standards and Professional Development, Royal College of Nursing
- Vari Drennan, Fellow of the QNI, Professor of Health Care and Policy Research, Kingston & St George's University
- Jennifer Edgington, Locality Lead Nurse, Isle of Wight NHS Trust
- Kath Evans, Community Nurse Advisor, NHS England
- Cepta Hamm, Deputy Director of Nursing (Community), Guy's and St Thomas' NHS Foundation Trust
- Carolyn Jackson, Director, England Centre for Practice Development, Canterbury Christ Church University
- Jeannine Johnson, Community Services Manager, Isle of Wight NHS Trust
- Esther Kirby, Chief Nurse/Director of Quality, Bridgewater Community NHS FT
- Alison Leary, Professor of Healthcare & Workforce Modelling, London South Bank University
- Pauline Milne, Head of Clinical Workforce Development and Planning, Health Education East of England
- Crystal Oldman, Chief Executive, QNI
- Louise Patten, Registered District Nurse and Chief Officer, NHS Aylesbury Vale CCG
- Anne Pearson, Director of Programmes, QNI
- David Pugh, Chair of the National District Nurse Network and Senior Team Manager for Community Nursing, Bristol Community Health
- Colin Thompson, Director of Operations and Performance, NHS Aylesbury Vale CCG
- Christina Walters, Director, Hazel Health Consulting Ltd
- Rob Webster, Chief Executive, NHS Confederation
- Christine Widdowson (note taker), PA to the Chief Executive, QNI

Many thanks to the Queen's Nurses who sent the QNI case studies from their daily work as District Nurses and illustrated the complexity of the District Nursing service.



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