The Queen's Nursing Institute

International Community Nursing Observatory

District Nursing Today

The View of District Nurse Team Leaders in the UK

The Queen's Nursing Institute

The Queen's Nursing Institute is a charity dedicated to improving nursing care for patients at home and in the community.

We work with nurses, managers and policy makers to make sure that high quality nursing is available for everyone in their homes and communities. Our aim is to ensure that patients receive high quality care when and where they need it, from the right nurse, with the right skills.

Today we improve nursing in the home:

- By funding nurses' own ideas to improve patient care and helping them develop their skills through leadership and training programmes.
- Through our national network of Queen's Nurses who are committed to the highest standards of care and who lead and inspire others.
- By influencing government, policy makers, and health service planners, and campaigning for resources and investment in high quality community nursing services.
- By supporting community nurses working with people who are homeless through our Homeless Health Programme which provides news, guidance and workshops.
- By listening to nurses and developing resources and guidance to support them.
- By offering financial assistance to community nurses in need and providing grants for community nursing courses.
- By encouraging social interaction between current Queen's Nurses and retired Queen's or community nurses through our telephone project, 'Keep in Touch'.

Contents

Authors:
Adrian Swift
Dr Geoffrey Punshon

Foreword

This report by The Queen's Nursing Institute (QNI) is the first general review of the District Nursing workforce since the publication of '2020 Vision Five Years On' in 2014.

This report is the first to be published under the aegis of the QNI's new International Community Nursing Observatory. The International Community Nursing Observatory (ICNO) will be taking data driven approaches to better understand the community nursing workforce and the challenges faced by community nursing. The ICNO will collate and analyse data about community and primary care nursing services at a regional, national and international level.

This first report of the QNI's ICNO is launched against a background of continuing organisational change in the National Health Service, of political uncertainty and of social change including population growth and in particular a growing number of older people living longer and with more complex healthcare needs. In 2019, the Department of Health and Social Care has made clearer than ever the need for a fundamental shift away from hospital care towards care being delivered in the community. In England, this policy is enshrined in the hugely influential Long Term Plan (2019), which sets the direction of travel in England for the next ten years. In the other countries of the UK, national policy is also firmly committed to enhancing healthcare delivered in the community, for the benefit of individuals, families and carers.

The report is based on the responses of 2858 individuals in District Nursing teams working in all countries of the UK. This rich data will provide a source of intelligence for the work of the ICNO beyond the publication of this first report. The nurses responding to the survey collectively represent a large body of experience and knowledge, acquired by years of providing nursing services in diverse healthcare settings and also via educational opportunities, in particular the Specialist Practitioner Qualification. This report focuses on four key themes: profile of the workforce, information technology, continuing professional development, and capacity in nursing teams.

The report is intended to be of use to policy makers, commissioners and service planners, to help inform the continuing development of excellent District Nursing services in their delivery of individual and population health in communities everywhere.

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


The Queen's Nursing Institute
We believe in the best possible nursing care for patients at home and in the community

‘We have become hospital at home! Our skills and knowledge have multiplied immeasurably. We provide a holistic service to all and ensure we are up to date with the whole range of complex conditions.’ District Nurse response to: ‘How have DN services adapted and changed to meet the needs of communities in the last five years?’

Summary of the findings

Profile of the Workforce:

- There is a huge variety of job titles for nurses working in community settings with over 1000 different job titles given in response to this survey;
- The majority of respondents (60%) are over 45 years of age; this is an ageing workforce.
- 46% of the respondents plan to either retire or leave in the next six years (25% planning to retire and 21% planning to leave).

Information Technology:

- 36% of survey respondents said that improved information technology is one of the three most significant things that could make a difference to their work;
- One of the main issues reported was connectivity and IT infrastructure as not fit for purpose.

Continuing Professional Development

- 73% of survey respondents are independent prescribers;
- Education and training are often deferred when community nursing teams are busy or short staffed;
- Of those who stated that they plan to leave in the next 1-2 years, approximately 10% stated that they do not have an annual appraisal and 53% stated that they do not have access to regular clinical supervision (at least once a month).

Capacity in nursing teams:

- There is a wide variation of caseload sizes across teams. Almost 30% of teams have a caseload of over 400 patients/people;
- There is significant variation in the role and responsibilities of team leaders and significant regional variation in the pay band of District Nurse Specialist Practitioner Qualification (DNSPQ) holders;
- 48% of respondents defer visits or delay the delivery of patient care (work left undone) on a daily basis;
- 63% of respondents state that their team never refuses referrals despite staffing or other resource issues; This correlates with the narrative responses from nurses who state they do not defer or leave work undone, due to pressure from employers to complete their caseload allocations;
- 75% of respondents state they have vacancies or ‘frozen posts’ in their team;
- 28% of respondents have no access to administration support staff;
- 1 in 5 (22%) of respondents are working a day or more of unpaid overtime each week. One third of survey respondents work over 4-7 hours per week that is not reflected in their salary;
- Unpaid overtime is undertaken by 90% of all respondents to the survey. There is also significant variation in the amount of unpaid overtime according to pay band.

Introduction

The District Nursing workforce is a critical part of the National Health Service in all countries of the United Kingdom. District Nurses deliver care to patients in their own homes in communities everywhere, working closely with GPs, other community specialists, as well as patients, families and carers themselves. In doing so they allow patients living with long term conditions in their own homes to be cared for safely and reduce unplanned hospital admissions. As the UK population ages, there is an imperative to support people to manage their own health conditions and for many people this can most effectively be achieved by working in partnership with District Nursing teams in the community.

The Queen's Nursing Institute is a registered charity based in London that operates in England, Wales and Northern Ireland. Its sister charity, QNI Scotland, is based in Edinburgh. The charity was originally created to organise the training and supply of District Nurses on a national basis, in 1887 and the system that it created was inherited and built upon by the NHS from 1948. Since that time District Nursing services have changed in almost every respect, while retaining some of their essential characteristics. Today the QNI no longer trains District Nurses, but it offers a wide range of support to all nurses who work in community settings, including research, professional development, educational events, grants and other financial awards.

Today, District Nursing services are provided by a wide range of community and integrated healthcare organisations and this varies from one area to another. One challenge that community healthcare organisations face is that the importance of their work is often not clearly understood by employers, the media or the public. Working largely behind closed doors, there is a lack of appreciation of the difficulty and complexity of the specialist care they deliver. As a charity that works with and supports District Nurses, and campaigns for better healthcare for people in the home, the QNI has identified the need to generate better data about nursing in the community today, including workforce numbers, educational trends, professional development, information technology and the barriers and enablers to healthcare delivery.

The QNI's International Community Nursing Observatory is a new initiative that represents a fresh approach in generating and analysing data about the community nursing workforce. This first report of the ICNO is the beginning of a programme of work that will develop new insights about nursing in the home, for the benefit of commissioners and service providers, for nurses, and ultimately for people in need of specialist community healthcare and their families.

Survey method

The Queen's Nursing Institute (QNI) operates in England, Wales and Northern Ireland. QNI Scotland was involved in the drafting of the questions in this survey, to take account of national variations that might impact on the responses. It was not possible to limit the survey to particular parts of the UK; however, respondents were asked in what region/s of the UK they deliver care. The survey was constructed by QNI and expert external advisors and consisted of 59 questions, the majority of which were multiple choice format, with some free format responses requested, to allow for the collection of more detailed responses and qualitative data.

SurveyMonkey was used to collect responses between 1 June 2019 and 18 July 2019. The survey was promoted principally via nursing media (printed and online) and by the QNI's own networks, including email and social media channels.

2858 responses to the survey were received. As there is no national data collection for this group, it is not possible to determine a response rate. This report presents a detailed analysis of both the qualitative and quantitative data that was supplied by respondents. A random sample of 500 free text answers were subject to thematic analysis by NVivo 11 software. The analysis of the survey results was undertaken by independent analysts, Adrian Swift and Dr Geoff Punshon.

Findings of the survey

Profile of the Workforce

Staff recruitment and retention is acknowledged as one of the biggest challenges facing nursing in the 21st century and 46% of respondents to this survey said they planned to leave or retire in the next six years. Safe staffing levels, clearly established by commissioners and providers, are needed to determine the number and skill level of staff needed to manage patient caseloads. Additional staff are needed to cover absences within teams including sick leave, annual leave, and professional development opportunities. A widely reported lack of administration support is also likely to hamper the effectiveness of community nursing teams.

Information technology

Nurses are concerned that computer hardware and software provided by their employers has many shortcomings. In order to be most productive, nurses need access to up to date equipment which works, reliable and fast internet connectivity, and the ability to access patient records remotely.

Continuing Professional Development

Education and training are often deferred when community nursing teams are busy or short staffed. Access to the District Nurse Specialist Practitioner Qualification requires capacity in many key areas in order to be successfully delivered and students on the course should be supernumerary in order to have protected learning time. Practice supervisors need to have time in order to give clinical supervision to students and placements must be properly supported so that students are provided with a well-resourced, professional learning environment.

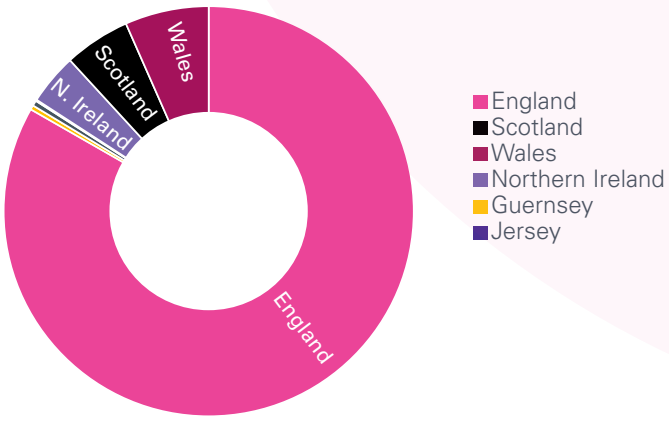
Capacity in Nursing Teams

The survey asked two related questions – whether teams were unable to accept referrals of patients, and whether they deferred patient visits until a future time. There is a significant indication of 'work left undone' within many teams, either on a daily, weekly or monthly basis. This issue has a serious knock on effect to the rest of the primary health care sector, in terms of managing increasingly complex patients in the home and community setting and in preventing deterioration and potential hospital admission.

Location

Respondents were asked in which region/s of the UK they deliver care, which showed a broad geographical spread. In terms of country distribution, the respondents are located as follows:

Figure 1: Responses by Country




sister

‘Training is constantly cancelled, mentor support has been seriously lacking, leave is regularly denied or cancelled, and I have been denied much of the preceptorship support offered to hospital-based colleagues.’ District Nurse response to: ‘Does your team ever have to refuse referrals because of capacity or workload issues?’

Table 1: Responses by Country

Country	Number of responses	Percentage
England	2380	83%
Guernsey	10	0.3%
Isle of Man	12	0.4%
Jersey	3	0.1%
Northern Ireland	115	4.0%
Scotland	149	5.2%
Wales	189	6.6%
Total responses	**2858**	

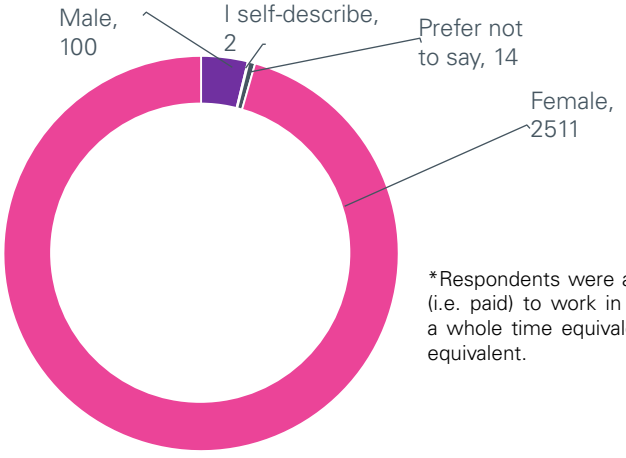
Table 2: Breakdown of responses from regions within England

Region	Number of responses	Percentage
England - London	178	8%
England - Midlands and East	635	27%
England - North	856	36%
England - South East	445	19%
England - South West	266	11%
Total responses	**2380**	

The response varied significantly between different countries of the UK and between different areas of England. The highest response was from the England - North region and the lowest from London, compared to the actual populations of those regions. It is not possible to say whether this reflects a variation in the number of nurses per head of population in those regions, only the response to this particular survey.

Workforce profile

Figure 2: Workforce profile by disclosed gender by WTE*



*Respondents were asked ‘How many hours per week are you contracted (i.e. paid) to work in your role?’ allowing relevant data to be reported on a whole time equivalent (WTE) basis using 37.5 hours as one whole time equivalent.

Figure 3: Whole time equivalent (WTE) count by region

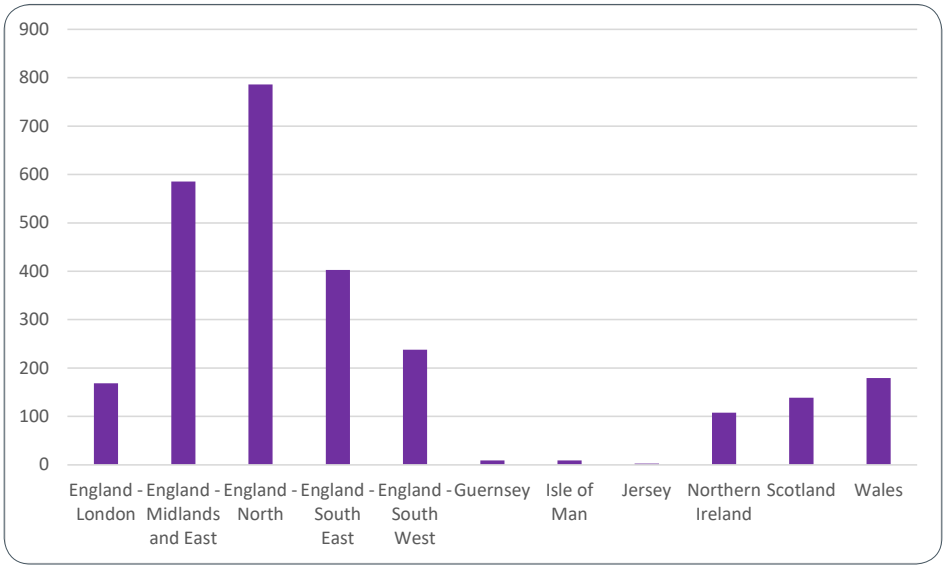


Table 3: WTE by region

WTE by Region (% of Total WTE)	
Region	**WTE by Region**
England - London	168.5 (6.4%)
England - Midlands and East	585.2 (22.3%)
England - North	786.2 (29.9%)
England - South East	402.8 (15.3%)
England - South West	237.9 (9.1%)
Guernsey	9.4 (0.4%)
Isle of Man	9.0 (0.3%)
Jersey	2.8 (0.1%)
Northern Ireland	107.9 (4.1%)
Scotland	138.6 (5.3%)
Wales	179.6 (6.8%)

The highest number of respondents stated that they deliver care in England – North, with approximately 30% of the total WTE count. Although the option was offered, there were no responses stating that the delivery of care was for more than a single region. As above it is not possible to infer conclusions about the size of the nursing workforce in the different regions, only the response to this survey.

Job Title

The respondents were asked to confirm their job title with a free format submission. There were over 1000 different job titles submitted, represented in the word cloud on page 13.

The word cloud suggests a very strong association with the term District Nurse. The word cloud also reflects that the survey respondents were drawn from those who identify as senior team members and leaders.

Figure 4: Submitted job title

The diversity of roles stated by respondents reflects previous research in this area (Leary et al. 2017) that showed great variation in job titles in the nursing workforce and no standardisation across regions or localities. There is a risk that patients and families have a limited understanding of the educational or professional level of nurses and other health care workers who visit them in the home and other community settings.

This may lead to unrealistic expectations about the level of care delivered, and inequitable comparisons with experiences elsewhere. Lack of consistency of job titles causes confusion to the public, employing organisations, colleagues and commissioners of services.

Respondents' job responsibilities

Table 4: Responses stating team leader involvement

Region	Responsibility for allocation of work to the team (% of total responses for the region)	Performing the duties of a team leader or caseload holder/manager (% of total responses for the region)
England - London	108 (60.7%)	109 (61.2%)
England - Midlands and East	410 (64.6%)	430 (67.7%)
England - North	608 (71.0%)	608 (71.0%)
England - South East	273 (61.3%)	314 (70.6%)
England - South West	177 (66.5%	183 (68.8%)
Channel Islands and IoM	11 (41.7%)	17 (68.3%)
Northern Ireland	82 (71.3%)	77 (67.0%)
Scotland	114 (76.5%)	109 (73.2%)
Wales	142 (75.1%)	147 (77.8%)
Total	**1925**	**1994**

'As a Band 7 I no longer have the time to visit patients or have days with staff members. I spend all my time on governance issues. I am now firefighting instead of looking for new ways of working and reducing admissions into hospital.' District Nurse response to 'Does your team ever have to refuse referrals because of capacity or workload issues?'

Table 4 indicates the number of responses to the question regarding team leader involvement. Responses from Scotland and Wales indicate the highest percentage of total affirmative responses, with about 75% of responses for those countries stating that they are either responsible for the allocation of work or are performing the duties of a team leader.

Responses from Northern Ireland and Scotland indicate that responsibility for allocation of work to the team does not always appear to be performed by the team leader role.

The variation suggests that the understanding and role of team leader varies across the UK according to the practices of different employing organisations.

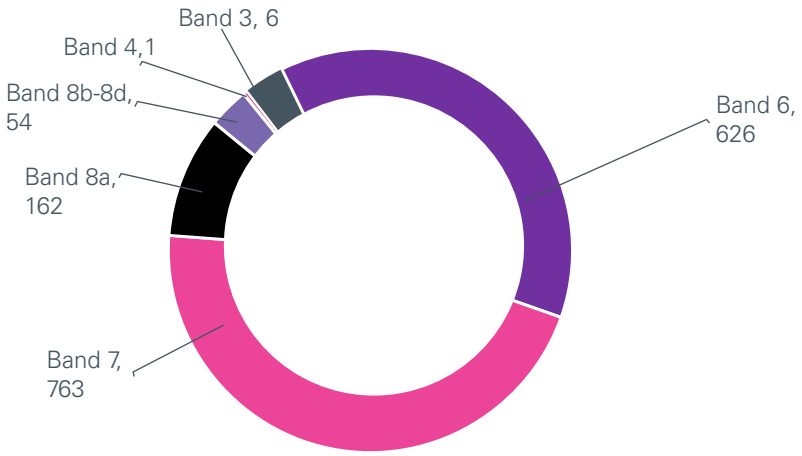
Pay band

Table 5: WTE by pay band

WTE by Age by Pay Band (% of WTE age bracket)								
Age bracket	**Band 3**	**Band 4**	**Band 5**	**Band 6**	**Band 7**	**Band 8a**	**Band 8b-8d**	**Would rather not say**
20-24	1.0 (4.2%)	0.1 (0.3%)	19.0 (78.9%)	4.0 (16.6%)	0	0	0	0
25-29	3.6 (2.2%)	2.7 (1.6%)	62.5 (37.6%)	73.9 (44.5%)	22.5 (13.5%)	1.0 (0.6%)	0	0
30-34	3.5 (1.6%)	2.2 (1.0%)	46.6 (20.6%)	106.5 (47.1%)	63.3 (28.0%)	4.0 (1.8%)	0	0
35-39	4.6 (1.6%)	4.9 (1.7%)	52.8 (18.0%)	135.2 (46.1%)	81.0 (27.6%)	13.0 (4.4%)	2.0 (0.7%)	0
40-44	4.4 (1.3%)	1.0 (0.3%)	44.0 (13.2%)	146.1 (44.0%)	101.5 (30.6%)	22.6 (6.8%)	12.6 (3.8%)	0
45-49	3.4 (0.7%)	6.0 (1.3%)	59.2 (12.6%)	161.0 (34.3%)	170.8 (36.3%)	46.9 (10.0%)	19.3 (4.1%)	3.5 (0.7%)
50-54	10.3 (1.8%)	3.3 (0.6%)	61.3 (11.0%)	144.6 (26.0%)	238.1 (42.8%)	65.9 (11.8%)	30.5 (5.5%)	2.8 (0.5%)
55-59	8.0 (2.0%)	1.2 (0.3%)	40.5 (10.1%)	89.5 (22.4%)	180.3 (45.1%)	45.4 (11.4%)	33.0 (8.3%)	1.8 (0.5%)
60-64	1.9 (1.4%)	0	13.9 (10.0%)	36.7 (26.4%)	68.8 (49.4%)	13.5 (9.7%)	3.9 (2.8%)	0.5 (0.3%)
65-69	0	0	1.0 (5.6%)	6.8 (38.6%)	7.1 (40.2%)	2.4 (13.5%)	0	0.4 (2.1%)
Prefer not to say	0	0	0	1.0 (50.0%)	0	0	0	1.0 (50.0%)
Total	**40.8 (1.6%)**	**21.3 (0.8%)**	**400.7 (15.3%)**	**905.4 (34.5%)**	**933.5 (35.5%)**	**214.7 (8.2%)**	**101.3 (3.9%)**	**10.0 (0.4%)**

Table 5 shows the number of responses (by WTE) comparing age with pay band. There is a strong correlation between age and pay band, in particular on pay band 5, 6 and 7.

Figure 5: District Nurse Specialist Practitioner Qualification (DNSPQ) holders by disclosed pay band



Survey respondents were asked to confirm if they hold the DNSPQ. Those respondents were asked to indicate their current pay band.

The highest number of respondents (763, approximately 27%) disclosed that they were paid at band 7. However, 626 respondents, approximately 22%, disclosed they were paid at band 6, which suggests that some employers pay the team leader at band 6 and that others reward them at band 7. This issue would benefit from further exploration, particularly in light of the recruitment and retention initiatives within the NHS.

Table 6: WTE response by band by selected region where care is delivered

WTE by Band by Region (% of Total WTE per region)*								
Region	**Band 3**	**Band 4**	**Band 5**	**Band 6**	**Band 7**	**Band 8a**	**Band 8b-8d**	**Would rather not say**
England - London	0.8 (0.5%)	2.0 (1.2%)	21.3 (12.6%)	31.3 (18.6%)	75.5 (44.8%)	26.4 (15.7%)	10.2 (6.1%)	1.0 (0.6%)
England - Midlands and East	8.7 (1.5%)	8.9 (1.5%)	96.5 (16.5%)	199.5 (34.1%)	187.6 (32.1%)	60.7 (10.4%)	18.1 (3.1%)	5.3 (0.9%)
England - North	11.1 (1.4%)	4.2 (0.5%)	126.1 (16.0%)	310.1 (39.4%)	262.1 (33.3%)	42.4 (5.4%)	28.1 (3.6%)	2.2 (0.3%)
England - South East	5.0 (1.2%)	4.8 (1.2%)	41.5 (10.3%)	132.5 (32.9%)	157.1 (39.0%)	38.4 (9.5%)	23.5 (5.8%)	0
England - South West	6.7 (2.8%)	0.4 (0.2%)	32.8 (13.8%)	91.2 (38.4%)	81.7 (34.4%)	13.3 (5.6%)	11.0 (4.6%)	0.7 (0.3%)
Northern Ireland	4.8 (4.4%)	0	26.2 (24.3%)	29.0 (26.9%)	33.9 (31.4%)	11.0 (10.2%)	3.0 (2.8%)	0
Scotland	1.4 (1.0%)	1.0 (0.7%)	32.0 (23.1%)	58.0 (41.9%)	42.1 (30.4%)	4.0 (2.9%)	0	0
Wales	2.4 (1.3%)	0	24.3 (13.5%)	52.8 (29.4%)	82.0 (45.7%)	13.5 (7.5%)	4.6 (2.6%)	0

*Data has been removed for regions that present personally identifiable information.

The highest WTE response count is for band 6 respondents delivering care in the England – North region, with approximately 39% of the total WTE for that region.

Responses from England – Midlands and East, North, South West and Scotland all indicated that there is a higher WTE count in band 6 than band 7, with that trend being reversed in England – London, South East and Wales. It is possible that in London, the higher pay band is utilised by employers as a means of attracting and retaining staff in a very competitive labour market. In Wales, this trend may be policy led.

Team profile

Respondents were asked to confirm the number of band 3 and band 4 staff in the immediate team. 2523 responses were received and figures 6 and 7 show the percentage count against the total number of responses received for the number of team members.

Figure 6: Band 3 team members

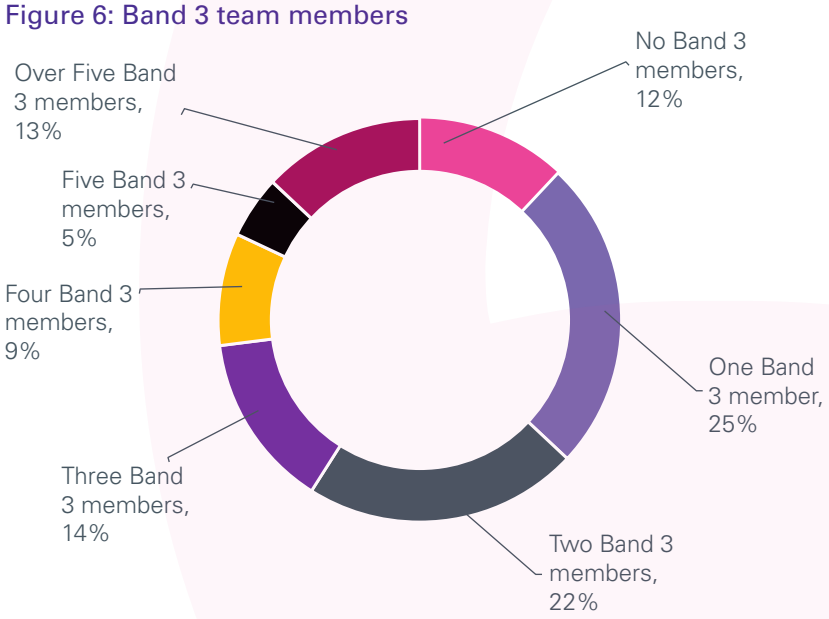
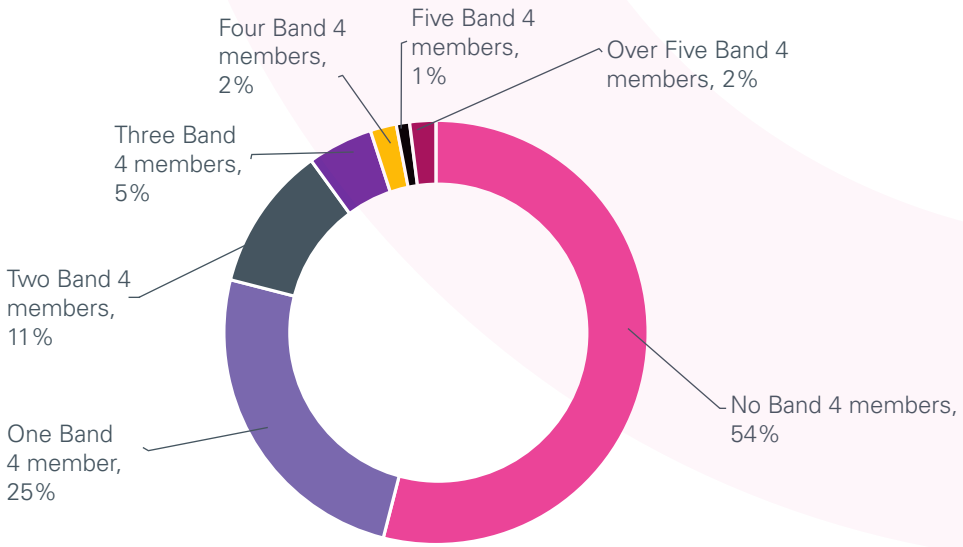


Figure 7: Band 4 team members



'Much more acutely ill and complex patients managed at home, more pressure on families, much more involvement of voluntary sector and informal support.' District Nurse response to: 'How have DN services adapted and changed to meet the needs of communities in the last five years?'

Table 7: Responses to team member by band

Number of team members (No of responses by % of band/title response count)								
No of responses	**None**	**1**	**2**	**3**	**4**	**5**	**5+**	**Not known**
Band 3 team members	308 (12.21%)	629 (24.93%)	534 (21.17%)	340 (13.48%)	226 (8.96%)	113 (4.48%)	314 (12.45%)	59 (2.34%)
Band 4 team members	1,322 (52.40%)	612 (24.26%)	268 (10.62%)	131 (5.19%)	49 (1.94%)	29 (1.15%)	54 (2.14%)	58 (2.30%)

The highest number of responses stated that they had no band 4 team members. In terms of number of team members, the highest number of responses stated one band 3 and one band 4 member, with approximately 24% of the responses for each band/title.

Table 8: Number of Registered Nurses (RNs) in the immediate team

Proportion of RNs in the team (No of responses by % of total responses by Region)						
Region	**None**	**Less than 25%**	**26 to 50%**	**50%+**	**Not known**	**No response**
England - London	3 (1.7%)	15 (8.4%)	28 (15.7%)	105 (59.0%)	6 (3.4%)	21 (11.8%)
England - Midlands and East	2 (0.3%)	27 (4.3%)	91 (14.3%)	419 (66.0%)	14 (2.2%)	82 (12.9%)
England - North	2 (0.2%)	22 (2.6%)	84 (9.8%)	636 (74.3%)	18 (2.1%)	94 (11.0%)
England - South East	7 (1.6%)	24 (5.4%)	87 (19.6%)	265 (59.6%)	10 (2.2%)	52 (11.7%)
England - South West	2 (0.8%)	9 (3.4%)	38 (14.3%)	174 (65.4%)	6 (2.3%)	37 (13.9%)
Guernsey	0 (0.0%)	0 (0.0%)	1 (10.0%)	7 (70.0%)	0 (0.0%)	2 (20.0%)
Isle of Man	1 (8.3%)	0 (0.0%)	0 (0.0%)	10 (83.3%)	0 (0.0%)	1 (8.3%)
Jersey	1 (33.3%)	0 (0.0%)	0 (0.0%)	2 (66.7%)	0 (0.0%)	0 (0.0%)
Northern Ireland	0 (0.0%)	6 (5.2%)	12 (10.4%)	81 (70.4%)	2 (1.7%)	14 (12.2%)
Scotland	0 (0.0%)	1 (0.7%)	5 (3.4%)	125 (83.9%)	3 (2.0%)	15 (10.1%)
Wales	1 (0.5%)	4 (2.1%)	18 (9.5%)	144 (76.2%)	5 (2.6%)	17 (9.0%)

Scotland and Wales have indicated that they have the highest proportion of RNs (over 50%) in their immediate team, with approximately 84% and 76% respectively.

Responses from all other regions indicate that between 60-70% have a proportion of over 50% of RNs in the immediate team.

A small number of respondents indicated that there are no RNs in the immediate team, which seems highly irregular and may reflect an error in completing the question, or that the respondent works alone.

Hours of work

Figure 8: Unpaid overtime

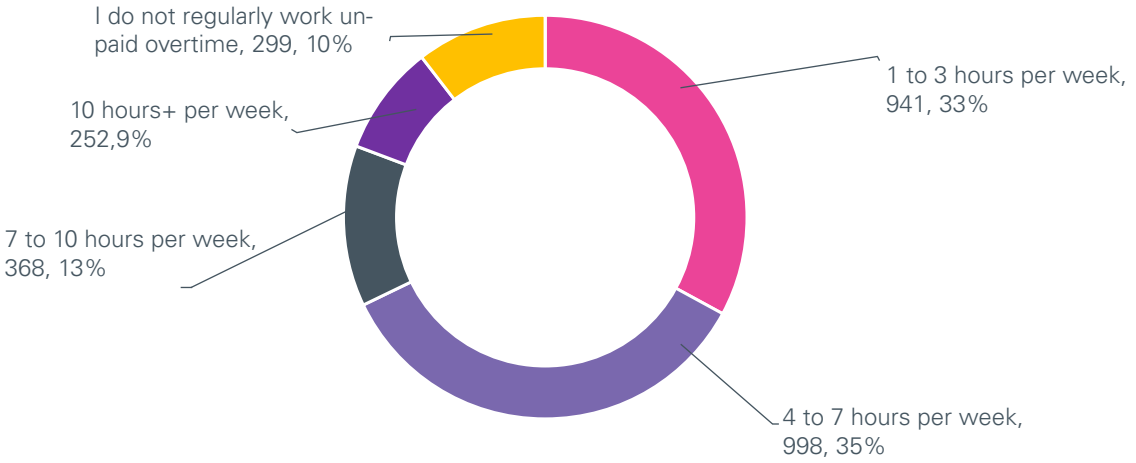


Table 9: Number of hours unpaid overtime by region

Number of hours of unpaid overtime by region (% of total per region)					
Region	**1 to 3 hours per week**	**4 to 7 hours per week**	**7 to 10 hours per week**	**10 hours+ per week**	**I do not regularly work unpaid overtime**
England - London	43 (24.2%)	62 (34.8%)	34 (19.1%)	14 (7.9%)	25 (14.0%)
England - Midlands and East	206 (32.4%)	226 (35.6%)	87 (13.7%)	64 (10.1%)	52 (8.2%)
England - North	293 (34.2%)	293 (34.2%)	103 (12.0%)	85 (9.9%)	82 (9.6%)
England - South East	136 (30.6%)	174 (39.1%)	60 (13.5%)	33 (7.4%)	42 (9.4%)
England - South West	88 (33.1%)	88 (33.1%)	32 (12.0%)	27 (10.2%)	31 (11.7%)
Channel Islands and IoM	12 (48%)	7 (28%)	0	0	6 (24%)
Northern Ireland	41 (35.7%)	37 (32.2%)	15 (13.0%)	8 (7.0%)	14 (12.2%)
Scotland	61 (40.9%)	44 (29.5%)	12 (8.1%)	5 (3.4%)	27 (18.1%)
Wales	61 (32.3%)	67 (35.4%)	25 (13.2%)	16 (8.5%)	20 (10.6%)

Responses indicate that over 90% of respondents regularly work some unpaid overtime every week. In some regions in England, approximately 10% of respondents stated that they regularly work over 10 hours unpaid overtime per week. Unpaid overtime is therefore very common. There is also significant variation in the amount of unpaid overtime according to pay band.

Table 10: Number of hours unpaid overtime by band

Unpaid hours overtime worked (Total responses by % of total responses)					
Pay band	**1 to 3 hours per week**	**4 to 7 hours per week**	**7 to 10 hours per week**	**10 hours+ per week**	**I do not regularly work unpaid overtime**
Band 3	22 (0.8%)	9 (0.3%)	1 (0.0%)	0 (0.0%)	18 (0.6%)
Band 4	13 (0.5%)	6 (0.2%)	2 (0.1%)	1 (0.0%)	2 (0.1%)
Band 5	224 (7.8%)	140 (4.9%)	24 (0.8%)	13 (0.5%)	70 (2.4%)
Band 6	302 (10.6%)	367 (12.8%)	127 (4.4%)	92 (3.2%)	86 (3.0%)
Band 7	313 (11.0%)	361 (12.6%)	152 (5.3%)	88 (3.1%)	80 (2.8%)
Band 8a	50 (1.7%)	88 (3.1%)	37 (1.3%)	28 (1.0%)	23 (0.8%)
Band 8b-8d	13 (0.5%)	25 (0.9%)	24 (0.8%)	29 (1.0%)	16 (0.6%)
Total	**937**	**996**	**367**	**251**	**295**

90% of all respondents do some unpaid overtime on a weekly basis, though the amount varies according to pay band. The highest number of band 3-5 respondents state they work between 1-3 hours unpaid overtime per week. The highest number of band 6 respondents (almost 13%) stated they work between 4-7 hours unpaid overtime per week and the highest number of respondents in bands 7 and 8a also state they work between 4-7 hours unpaid overtime. Approximately 35% (996) of all respondents stated that they work between 4-7 hours unpaid overtime per week and 1 in 5 (22%) of all respondents work a day or more of unpaid overtime each week. This correlates with the narrative responses from nurses who state they do not defer or leave work undone, due to pressure from employers to complete their workload allocations.

Table 11: Number of hours of team administration support provided

Number of hours of admin support by region (No of responses & % of total responses)				
Region	**1 to 7.5 hours**	**7.5 to 15 hours**	**15+ hours**	**None**
England - London	40 (1.4%)	17 (0.6%)	86 (3.0%)	35 (1.2%)
England - Midlands and East	142 (5.0%)	64 (2.2%)	267 (9.3%)	162 (5.7%)
England - North	115 (4.0%)	90 (3.1%)	402 (14.1%)	249 (8.7%)
England - South East	64 (2.2%)	63 (2.2%)	239 (8.4%)	79 (2.8%)
England - South West	44 (1.5%)	26 (0.9%)	130 (4.5%)	66 (2.3%)
Channel Islands and IoM	7 (0.2%)	2 (0.1%)	5 (0.1%)	11 (0.2%)
Northern Ireland	23 (0.8%)	6 (0.2%)	17 (0.6%)	69 (2.4%)
Scotland	29 (1.0%)	18 (0.6%)	38 (1.3%)	64 (2.2%)
Wales	17 (0.6%)	21 (0.7%)	84 (2.9%)	67 (2.3%)
Total	**481**	**307**	**1268**	**802**

The highest number of responses (1268, approximately 44% of the total) indicated that they receive over 15 hours of admin support for their team per week. 802 respondents (approximately 28%) stated that they have no administration support. In these teams, the administrative burden will fall on clinical staff.

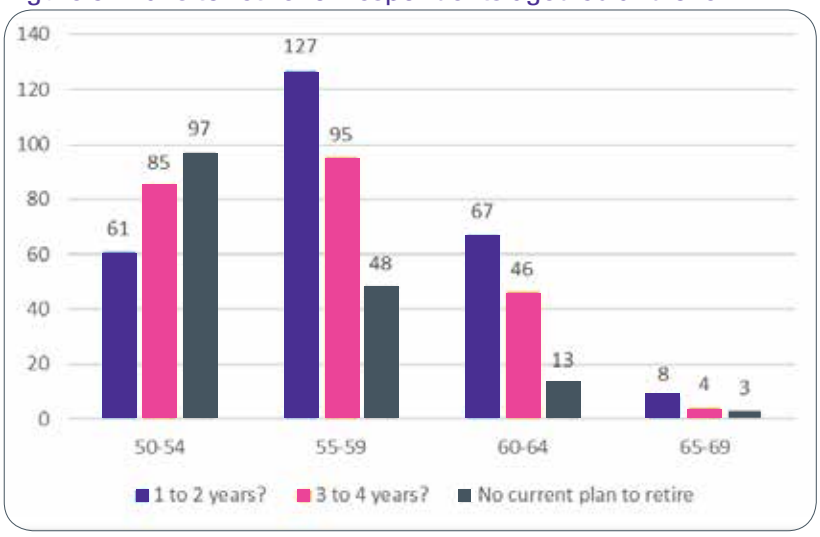
‘Workload puts a strain on the resource, I am proud to say that the teams I manage are not task orientated but treat the patient holistically. I am keen to maintain this level of excellent care.’

District Nurse response to: ‘Does your team ever have to refuse referrals because of capacity or workload issues?’

Future of the workforce

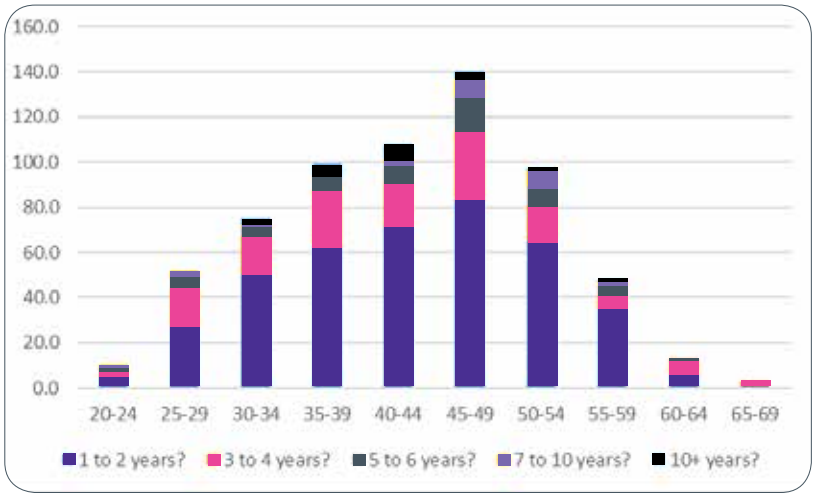
Respondents were asked if they had plans to retire or leave community nursing and in what time frame.

Figure 9: Plans to retire for respondents aged 50 and over



For those aged 50 and older, approximately 17% of respondents stated that they plan to retire in the next 1-4 years. The highest number of respondents who plan to retire in the next 1-4 years are in the 55-59 age bracket. Approximately 6% (176 respondents) of the 50-69 age bracket do not have current plans to retire.

Figure 10: Plans to leave (other than by retirement)

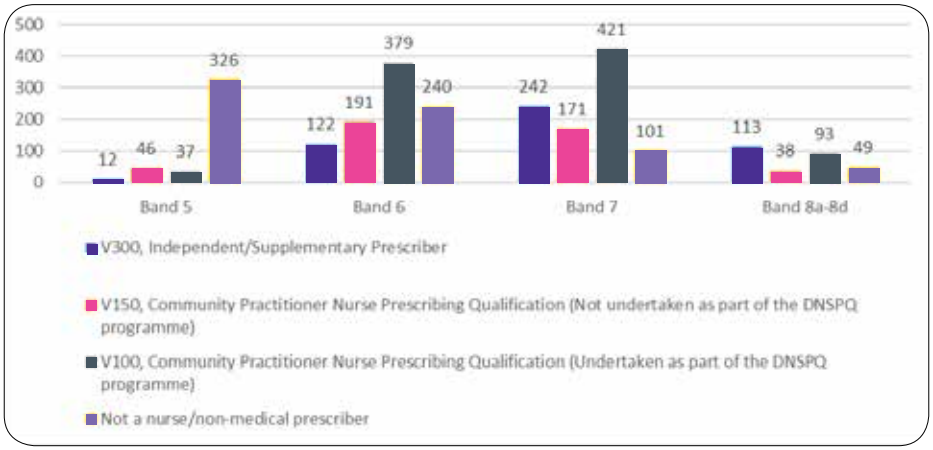


Of those who stated that they plan to leave in the next 1-2 years, approximately 10% stated that they do not have an annual appraisal and approximately 53% stated that they do not have access to regular clinical supervision (at least once a month).

The age profile of community nurses is significant as it suggests that a high proportion of staff members are moving towards retirement age.

Independent prescribing

Figure 11: Nurse/independent prescribing qualification by band

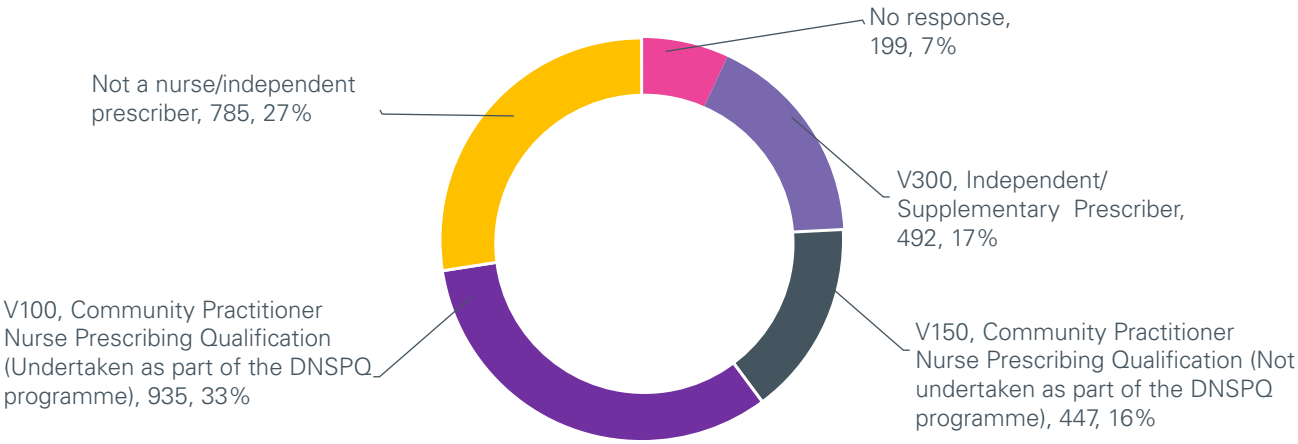


The highest number of respondents stated they are paid at band 7 and hold the V100, Community Practitioner Nurse Prescribing Qualification (Undertaken as part of the DNSPQ programme) with approximately 15% of all survey responses.

There is also a clear correlation between respondents paid at band 6 holding the V100 prescribing qualification and those on band 7 holding the V300 prescribing qualification. Overall, there is a trend towards higher qualifications for those on higher pay bands.

It should be noted that the V300 qualification can now be undertaken as part of the DNSPQ programme in some universities (QNI District Nurse Education Report 2017-18, (QNI 2019)).

Figure 12: Nurse/independent prescribing qualifications held



The highest number of respondents stated that they hold the V100, Community Practitioner Nurse Prescribing Qualification (undertaken as part of the DNSPQ programme) with approximately 33% (935 responses) of all survey responses.

Only 27% (785 respondents) of all respondents stated that they are not a nurse prescriber/ independent prescriber.

Table 12: District Nurse Specialist Practitioner Qualification – employing organisation requirement by region

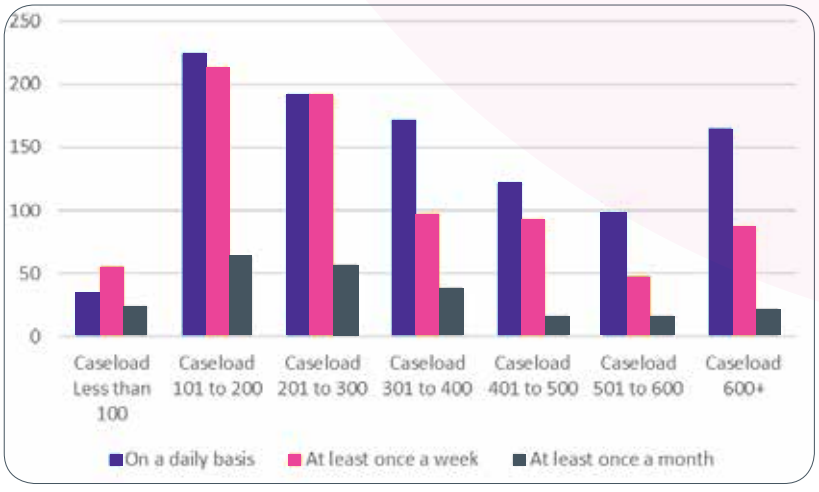
DNSPQ requirement by region		
Region	**Response submitted (No of responses by % of region response)**	
	Yes	**No**
England - London	81 (60.9%)	52 (39.1%)
England - Midlands and East	205 (41.1%)	294 (58.9%)
England - North	469 (65.8%)	244 (34.2%)
England - South East	127 (35.7%)	229 (64.3%)
England - South West	46 (23.2%)	152 (76.8%)
Guernsey	7 (87.5%)	1 (12.5%)
Isle of Man	8 (72.7%)	3 (27.3%)
Jersey	0 (0.0%)	3 (100.0%)
Northern Ireland	74 (77.9%)	21 (22.1%)
Scotland	93 (75.6%)	30 (24.4%)
Wales	146 (86.4%)	23 (13.6%)

Responses to this question indicated huge variation between regions. The highest affirmative response was submitted by Guernsey, Northern Ireland, Scotland and Wales, which may be policy led.

There is significant variation across organisations with regard to holding the recordable qualification of DNSPQ in order to lead and manage a team. It is known from the data published in recent reports (QNI 2019, QNI/RCN 2019) that some organisations appoint registered nurses to the team leader position before they have the DNSPQ; they are appointed at band six in a time limited way before being supported to undertake the District Nurse qualification. There are some areas where policy has led to an increase in DNSPQ numbers, such as in Wales and Northern Ireland, but in other regions there is less value placed on the District Nurse role and the requirement for the Specialist Practice Qualification, including the appointment of 'Case Managers' with no Specialist Practice Qualification (QNI 2019). A consistent approach is required to the training, education and remuneration for the District Nurse team leader role, that takes into account the complexity and responsibility of the position.

Capacity of service

Figure 13: Frequency of referrals unable to be accepted and deferred patients by caseload size




Queen's Nurse

‘Long term condition reviews very often are delayed. Essential bereavement visits are no longer part of the DN’s remit; much more task focused.’ District Nurse response to, ‘Does your team ever have to refuse referrals because of capacity or workload issues?’

Respondents were asked to state the team caseload size and if patients are regularly deferred to a future time and date, or if the team ever refuses referrals. Figure 13 displays the total number of responses to the referrals unable to be accepted and the deferred patient questions, alongside the team caseload size as an indication of a possible correlation. The highest number of responses stated that patients are deferred or referrals are refused on a daily basis.

Table 13: Team caseload size by region

Team caseload size by region (No of responses & % of region response)									
Region	**Less than 100**	**101 to 200**	**201 to 300**	**301 to 400**	**401 to 500**	**501 to 600**	**600+**	**No response**	**Unknown**
England - London	10 (5.6%)	23 (12.9%)	26 (14.6%)	18 (10.1%)	14 (7.9%)	5 (2.8%)	6 (3.4%)	72 (40.4%)	4 (2.2%)
England - Midlands and East	22 (3.5%)	104 (16.4%)	63 (9.9%)	63 (9.9%)	35 (5.5%)	22 (3.5%)	71 (11.2%)	230 (36.2%)	25 (3.9%)
England - North	21 (2.5%)	136 (15.9%)	131 (15.3%)	82 (9.6%)	78 (9.1%)	57 (6.7%)	81 (9.5%)	249 (29.1%)	21 (2.5%)
England - South East	27 (6.1%)	67 (15.1%)	69 (15.5%)	37 (8.3%)	20 (4.5%)	21 (4.7%)	25 (5.6%)	174 (39.1%)	5 (1.1%)
England - South West	21 (7.9%)	45 (16.9%)	30 (11.3%)	27 (10.2%)	18 (6.8%)	8 (3.0%)	20 (7.5%)	90 (33.8%)	7 (2.6%)
Channel Islands and IoM	1 (4%)	6 (24%)	4 (16%)	0	0	0	0	14 (56%)	0
Northern Ireland	7 (6.1%)	27 (23.5%)	21 (18.3%)	10 (8.7%)	6 (5.2%)	8 (7.0%)	2 (1.7%)	33 (28.7%)	1 (0.9%)
Scotland	30 (20.1%)	41 (27.5%)	23 (15.4%)	9 (6.0%)	6 (4.0%)	3 (2.0%)	2 (1.3%)	35 (23.5%)	0
Wales	4 (2.1%)	26 (13.8%)	34 (18.0%)	33 (17.5%)	21 (11.1%)	7 (3.7%)	13 (6.9%)	48 (25.4%)	3 (1.6%)
Total	**143**	**475**	**401**	**279**	**198**	**131**	**220**	**945**	**66**

The highest number of affirmative regional responses indicate that the average caseload size is between 101 to 200 with 475 (about 17%) of total responses.

The most common caseload sizes vary by country and by region. Wales has a significant number of teams with large caseloads, having a larger percentage of caseloads of 200-300 and 300 to 400, compared to any other country or region. The East Midlands and North England have a significant number of caseloads over 600.

Table 14: Referrals unable to be accepted, by region

No of responses (%of total responses per region)							
Region							
	No	**On a daily basis**	**At least once a week**	**At least once a month**	**Prefer not to say**	**Not known**	**No response**
England - London	112 (62.9%)	13 (7.3%)	12 (6.7%)	2 (1.1%)	7 (3.9%)	11 (6.2%)	21 (11.8%)
England - Midlands and East	304 (47.9%)	96 (15.1%)	83 (13.1%)	26 (4.1%)	12 (1.9%)	32 (5.0%)	82 (12.9%)
England - North	499 (58.3%)	74 (8.6%)	91 (10.6%)	33 (3.9%)	26 (3.0%)	39 (4.6%)	94 (11.0%)
England - South East	214 (48.1%)	67 (15.1%)	40 (9.0%)	36 (8.1%)	10 (2.2%)	26 (5.8%)	52 (11.7%)
England - South West	132 (49.6%)	28 (10.5%)	33 (12.4%)	20 (7.5%)	5 (1.9%)	11 (4.1%)	37 (13.9%)
Channel Islands and IoM	17 (68%)	0	0	3 (12%)	0	2 (8%)	3 (12%)
Northern Ireland	69 (60.0%)	5 (4.3%)	9 (7.8%)	8 (7.0%)	3 (2.6%)	7 (6.1%)	14 (12.2%)
Scotland	102 (68.5%)	3 (2.0%)	7 (4.7%)	11 (7.4%)	5 (3.4%)	6 (4.0%)	15 (10.1%)
Wales	108 (57.1%)	9 (4.8%)	19 (10.1%)	16 (8.5%)	7 (3.7%)	13 (6.9%)	17 (9.0%)
Total	1557	295	294	155	75	147	335

The highest number of responses was in England – North with about 58% of region responses stating that no referrals are refused.

Table 15: Patients regularly deferred to a future time or date, by region

Patients regularly deferred to a future time and date							
Region	No of responses (% of total responses per region)						
	No	On a daily basis	At least once a week	At least once a month	Prefer not to say	Not known	No response
England - London	34 (19.1%)	43 (24.2%)	53 (29.8%)	15 (8.4%)	4 (2.2%)	8 (4.5%)	21 (11.8%)
England - Midlands and East	51 (8.0%)	304 (47.9%)	161 (25.4%)	25 (3.9%)	2 (0.3%)	10 (1.6%)	82 (12.9%)
England - North	66 (7.7%)	386 (45.1%)	253 (29.6%)	42 (4.9%)	3 (0.4%)	12 (1.4%)	94 (11.0%)
England - South East	34 (7.6%)	213 (47.9%)	103 (23.1%)	25 (5.6%)	7 (1.6%)	11 (2.5%)	52 (11.7%)
England - South West	21 (7.9%)	119 (44.7%)	70 (26.3%)	14 (5.3%)	0	5 (1.9%)	37 (13.9%)
Channel Islands and IoM	5 (20%)	4 (16%)	6 (24%)	4 (16%)	0	3 (12%)	3 (12%)
Northern Ireland	16 (13.9%)	35 (30.4%)	36 (31.3%)	11 (9.6%)	1 (0.9%)	2 (1.7%)	14 (12.2%)
Scotland	27 (18.1%)	32 (21.5%)	51 (34.2%)	16 (10.7%)	3 (2.0%)	5 (3.4%)	15 (10.1%)
Wales	29 (15.3%)	66 (34.9%)	54 (28.6%)	20 (10.6%)	0	3 (1.6%)	17 (9.0%)
Total	283	1202	787	172	20	59	335

Respondents regularly defer work to a future time or date on a daily, weekly and monthly basis. Deferring work is a consequence of having insufficient time to complete allocated work and indicates limited capacity to meet patient need.

Vacancies and frozen posts

Table 16: Vacancies and frozen posts by region

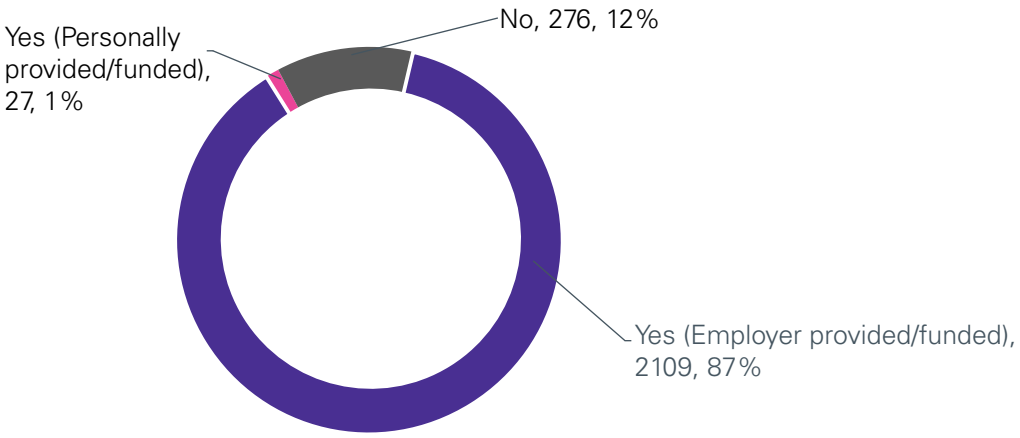
Vacancies/frozen posts per region (No of responses by % of region response)			
Region	Yes	No	No response
England - London	129 (72.5%)	28 (15.7%)	21 (11.8%)
England - Midlands and East	408 (64.3%)	143 (22.5%)	84 (13.2%)
England - North	556 (65.0%)	204 (23.8%)	96 (11.2%)
England - South East	328 (73.7%)	63 (14.2%)	54 (12.1%)
England - South West	169 (63.5%)	60 (22.6%)	37 (13.9%)
Guernsey	4 (40.0%)	4 (40.0%)	2 (20.0%)
Isle of Man	7 (58.3%)	4 (33.3%)	1 (8.3%)
Jersey	3 (100.0%)	0	0
Northern Ireland	78 (67.8%)	23 (20.0%)	14 (12.2%)
Scotland	89 (59.7%)	45 (30.2%)	15 (10.1%)
Wales	106 (56.1%)	66 (34.9%)	17 (9.0%)

‘We are very behind on routine Doppler assessments because of the lack of ‘urgency’ in these visits, and our need to constantly ‘prioritise’ what is truly urgent.’ District Nurse response to, ‘Does your team ever have to refuse referrals because of capacity or workload issues?’

Table 16 shows the respondents by answer type for the question regarding frozen posts (where employers are not actively seeking to recruit to a vacancy) or unfilled vacancies. England – South East and London both reported a significant number, with over 70% of respondents indicating they have frozen posts or unfilled vacancies.

Access to technology

Figure 14: Access to mobile technology for work purposes



Approximately 87% of respondents confirmed that they have access to employer-provided or funded mobile technology. Over 300 respondents indicated that they either do not have access to or personally fund mobile technology.

Figure 15: Mobile technology use

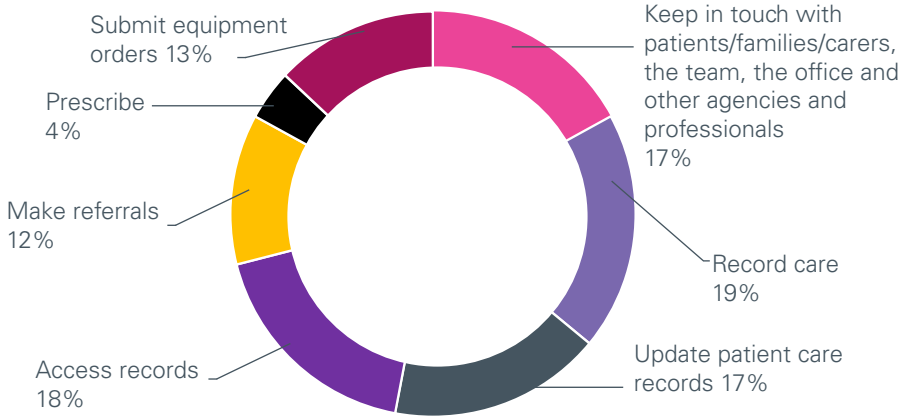
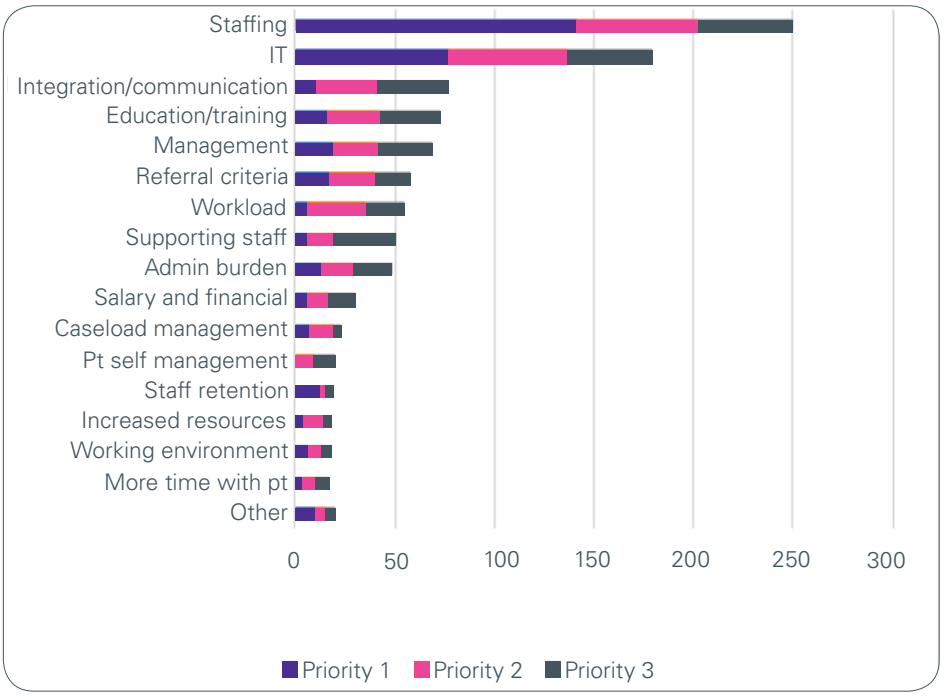


Figure 15 shows the capabilities of mobile technology to support specific categories of work, with about 7300 total individual responses indicating the varied use of the technology. The most often cited category of work was the ability to record care, presenting the highest percentage with 19%. Prescribing was the response with the lowest percentage, at 4%.

Thematic analysis of priorities

Figure 16: Thematic analysis of priorities



Respondents were asked 'What three priority areas would need to change to make a difference to your work?' A random sample of 500 free text answers were subject to thematic analysis by NVivo 11 software. Combining the themes from all three priorities given by respondents (Figure 16) demonstrates that by far the most common concerns were staffing, given by 250 out of 500 respondents (50%), and information technology, with 179 out of 500 responses (36%).

Recommendations

Workforce
The data about why people leave District Nursing before retirement age should be analysed, to establish more clearly the reasons for leaving. Detailed information about the barriers to professional advancement and the extent of the growing workload are needed if policy makers, commissioners and employers are to address the serious ongoing issues impacting on staff retention.

Information Technology
Better information technology has the potential to improve the capability of District Nursing teams to deliver care to their caseloads and more work should be done to establish where IT is being used most successfully, to help raise standards where it is less successful. The views of frontline practitioners must be considered if new IT systems are to be fit for purpose in the community setting and achieve the maximum benefit for patient care.

Continuing Professional Development
Some aspiring District Nurses are in the iniquitous position of being forced to take a reduction in pay if they wish to further their professional development in achieving the District Nurse Specialist Practitioner Qualification. Lack of capacity and staff time is hindering those who wish to develop their clinical and leadership skills. There is a need for policy at national level to address the barriers to staff development in a strategic way.

Capacity in Nursing Teams
District Nursing teams are inextricably linked with other parts of the health and social care system. Rising patient caseloads and patient complexity are presenting growing challenges. Employers, statutory and voluntary organisations all have a role to play in attracting and enabling more nurses to become District Nurses. There is an opportunity for the QNI alongside all national bodies to build on their education and campaigning work, with the public, media and government to ensure that the District Nursing service continues to be at the heart of all communities, providing an essential high quality nursing service which enables people to be cared for in their homes in every village, town and city in the UK.

‘Comprehensive assessments - always rushed. Documentation - sometimes poor standard as again rushed. Leaving patients longer than I would necessarily like to between visits due to capacity constraints.’ District Nurse response to, ‘Does your team ever have to refuse referrals because of capacity or workload issues?’

Conclusion

The direction of travel in delivering more care in people’s homes and communities, in supporting self-care and in delivering personalised care, is well established.

The role of the qualified District Nurse is absolutely central to this vision of the NHS. The education of District Nurses in universities and in practice gives them the confidence, knowledge and skills to support patients, carers and families in self-management. It enables them to promote personalised and person-centred care, and it enables them to be key co-ordinators of care whilst adopting a leadership role in service integration. In England, Health Education England has recently announced new funding to support the District Nurse Specialist Practitioner Qualification in 2019-20, which is to be welcomed in the context of this report.

This report indicates that District Nursing teams are responding on a fundamental level to the changes in healthcare delivery in the UK, but they are severely hampered in their efforts by staff shortages and administrative challenges, and particular limited capability of information technology. Qualitative analysis of the response to the survey indicated staffing shortages and problems with IT as the biggest issues facing their service.

The data in this survey highlights serious concerns about the number of nurses due to retire in coming years, at the same time as the NHS Long Term Plan calls for more care to be delivered in the community. The current generation of experienced District Nurses have a vital role as educators of the new District Nurses that will be needed in the coming years to deliver healthcare to our ageing population, whose health needs are becoming ever more complex.

Information technology, so clearly vital to the effective delivery of healthcare in the home and community setting, in the view of respondents to this survey has many shortcomings. The potential of new technology to ameliorate some of the workforce challenges and to allow District Nurses to remain abreast and ahead of the complex care required in the home setting, presents the greatest opportunity of the 21st Century.

References

- DHSC (2019) *Advancing our Health: Prevention in the 2020s* https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document
- NHS England (2019) *NHS Long Term Plan* https://www.england.nhs.uk/long-term-plan/
- NHS Improvement (2019) *Interim NHS People Plan* https://improvement.nhs.uk/resources/interim-nhs-people-plan/
- Leary, A. et al. (2017) *Variation in Job Titles within the Nursing Workforce* (Journal of Clinical Nursing, 2017) https://onlinelibrary.wiley.com/doi/abs/10.1111/jocn.13985
- QNI (2014) *2020 Vision Five Years On*
- QNI/RCN (2019) *Outstanding Models of District Nursing*
- QNI (2019) *Report on District Nurse Education 2017-18.*

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