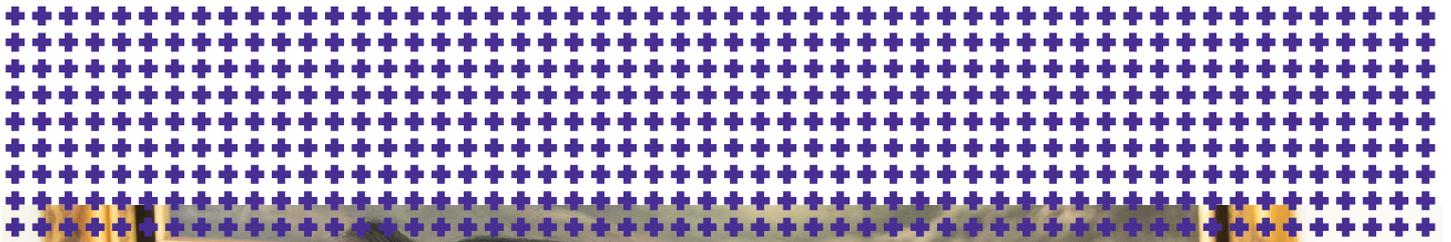


# Workforce Standards for the District Nursing Service



## **The Queen's Nursing Institute's International Community Nursing Observatory**

The QNI launched the International Community Nursing Observatory (ICNO) in November 2019.

The ICNO analyses data and trends in the community nursing workforce data in greater depth, to aid understanding of the challenges faced by services. It will collate and analyse data about community and primary care nursing services at a regional, national and international level.

Professor Alison Leary MBE, Chair of Healthcare and Workforce Modelling at London South Bank University (LSBU) and a Fellow of the QNI is Director of the ICNO.

The idea behind the foundation of the ICNO originated from an independent strategic review conducted in 2018 by executives at Barclays Bank plc, through the 'Unlocking Insights' programme, led and managed by the charity Pilotlight. The 'Pilotlighters' at Barclays highlighted that data relating to the community nursing services workforce is often incomplete and this leads to barriers which prevent the progression of policy development, service enhancement and improvements to the care of individuals, families, carers and communities.

The ICNO seeks commissions designed to support data gathering and analysis that will provide evidence to enhance service planning and delivery in health and social care settings.

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‘The QNI understands from District Nurses, other nurses working in the District Nursing service, commissioners, and employers that workloads are far exceeding the capacity of services. This document sets safety standards for the District Nursing workforce in the UK.’



### **Introduction from the QNI Chief Executive**

The QNI’s International Community Nursing Observatory (ICNO) developed Workforce Standards for the District Nursing workforce over the last eighteen months, under the leadership of Professor Alison Leary MBE, Director of the ICNO. We were delighted that 26 providers of District Nursing services participated in gathering data to inform the Standards. We were also delighted that the Royal College of Nursing (RCN) published Nursing Workforce Standards during this time which the QNI fully supports and should be read in conjunction with the District Nursing Workforce Standards.

The QNI is aware that these standards are long anticipated by and will be useful to community service provider organisations, commissioners of services and the District Nursing teams in planning the workforce needed to meet both current and future demand.

The standards cover the factors to be taken into consideration when planning the workforce to meet demand, and the overriding requirement to apply the professional judgement of the expert nurse at all times.

We would be pleased to hear how these standards are used in practice at all levels, and their utility in supporting the evidence for workforce planning at organisational and system levels.

### **Workforce Standards for the District Nursing Service - Introduction**

The QNI understands from District Nurses, other nurses working in the District Nursing service, commissioners, and employers that workloads are far exceeding the capacity of services. This document sets safety standards for the District Nursing workforce in the UK.

It should be read alongside the [Royal College of Nursing Workforce Standards](#) which provide overarching standards for nurse staffing and the NHS Staff Council document [Welfare facilities for healthcare staff](#).

These standards were determined from modelling, using data from several sources:

- The ONS (Office for National Statistics) for population-based data
- Activity analysis (Cassandra) Activity/incident data (local 2015-2021)
- Pulse surveys
- Cross sectional whole population survey (DN Today 2019) n~3000
- Stratified cross sectional surveys (3 months 2021 n=922)
- NHS benchmarking data
- Qualitative data on perceptions of workloads
- Other bespoke research <https://ngs.org.uk/wp-content/uploads/2021/01/LSE-Report-January-2021.pdf>
- Literature (grey and peer reviewed).

The findings were contextualised using data from an analysis of Prevention of Future Deaths reports in England and Wales (2016-2019 inclusive) which focused on recurrent concerns from coroners, the most common of which was missed, delayed or uncoordinated care, lack of care planning and elements of the nursing process.

The resulting findings were tested with a range of community services staff supporting the District Nursing Service (approximately 600) working in different roles (team leaders, executive positions, and frontline staff).

These standards enable expert nursing judgement on work and workloads, but they do not replace it. The experience of nurses working in the community regarding demand should always be considered, particularly if they are reporting more work left undone or additional areas of risk for patients and staff.

These standards set out where there are areas of risk and exceeding them should be considered a red flag and escalated. The person to whom the risk should be escalated will be dependent on the organisational structure and context of care, but at the very least should be the responsible line manager in place at the time of the reporting.

### **What is the District Nursing service?**

The District Nursing service typically serves a defined geographical population or neighbourhood. The service is provided in every village, town and city in the UK. It is a nurse-led service, with a team leader who normally holds an NMC recordable specialist practitioner qualification. This qualification provides the training and education that prepares the District Nurse team leader for the clinical leadership of regulated and unregulated staff, and the management of patient safety and risk of all the individuals and their families in receipt of the District Nursing service.

### **What drives workloads in community?**

It is clear from the data and the literature that several elements drive workloads in the community. The data and literature reviewed includes population data, benchmarking data, activity data, work left undone, perceptions of workloads and previous studies of the District Nursing service.

The delivery of interventions and care are not the only drivers of workload. Deprivation, communication issues, social isolation, acuity, complexity, multimorbidity, ageing population, rookie factor (high numbers of inexperienced staff), travel time (rural and urban), frailty, cognitive issues, lack of other services (i.e. dementia or specialist palliative care) and lack of patient support systems (i.e. friends and family) all affect healthcare delivery in the community. These factors need to be considered when looking at demand for District Nursing services. Importantly, these factors should all be considered in detail when setting establishments.

### **Referral criteria**

From the qualitative data we have collected over the last seven years, there appears to have been a shift towards District Nursing teams being a failsafe for many other NHS and social care services rather than a purely District Nursing service.

Patients were being referred to teams simply because other professionals such as dentists, social workers, general practitioners, general practice nurses and services such as Reablement or Discharge to Assess were short staffed or were not offered as a 24/7 service, unlike the local District Nursing service.

Reablement, frailty and rapid discharge services duplicate work and District Nursing teams were a failsafe if these services could not provide care. Commissioners should consider how services will join up with existing services before commissioning anything new. This will avoid duplication of work the generation of higher workloads and division of labour models, where work is divided into tasks and tasks assigned to different individuals and teams. The latter creates more risk, particularly in terms of missed or uncoordinated care. It is important to remember that nursing is a profession of vigilance not simply one of task delivery.

‘From the data we saw that for District Nurses and community staff nurses in the teams, 9-10 visits a day is associated with the tipping point for people deferring work. This applies to Registered Nurses, not for other workers such as support workers and community phlebotomy services.’



District Nursing services should serve the need for nursing care in their defined geographical or neighbourhood community. Each team will understand the needs of their local community but there should be referral criteria that are clear to referrers. These referral criteria should be agreed and documented and exceptions to it should be reported to allow escalation to those organisations, such as commissioning bodies, that are responsible for the provision of the services.

### **Caseloads**

Maximum caseloads are not defined here as there is no one definition of caseload in the community, which makes modelling this challenging. In addition, there is no strong correlation between caseload and workload due to differing levels of complexity of patients. Workload should therefore be the driving factor and factors such as patient acuity and social issues such as isolation should be considered. However, we would urge caution on caseloads per whole time equivalent of over 150 as this seems to be a tipping point into more work left undone and deferral.

### **Capping caseloads**

Although there was no consensus on the size of caseloads, in the modelling a caseload of over 150 was associated with more work left undone and deferring visits. Whilst there was no consensus on number, there was agreement that caseloads should be capped and therefore an agreed caseload size/case-mix should be determined and escalated if exceeded as a risk. Currently there is no limit to District Nursing caseloads and this is problematic.

### **Visits**

From the data we saw that for District Nurses and community staff nurses in the teams, 9-10 visits a day is associated with the tipping point for people deferring work. This applies to Registered Nurses, not for other workers such as support workers and community phlebotomy services. If using scheduling a visit should be at least 30 minutes in duration, not including travel time. The consensus of professional opinion borne out by the data was that a Registered Nurse visit should be a minimum of 30 minutes to allow for the entire nursing process to be enacted (assess, plan, implement and evaluate).

The average travel time from the data examined varies but generally has a mean of 2-3 hours per day. There is an assumption that rural settings increase travel time. Although more miles are covered in rural settings, urban travel times are also high and ebb/rise during the day, for example travel during commuter or school run times. Travel time should be factored into scheduling visits. The minimum visit ratio should be one Registered Nurse visit for initial assessment and then at least every fourth visit to apply the Nursing Process in full and initiate any changes, assess new needs, or evaluate care.

### **Skill mix**

Skill mix of teams should reflect the demand placed upon them by populations/needs. There are currently high rates of deferral and teams felt that too much complex work was delegated. Nursing support workers also occasionally reported the discomfort they felt around the work they were being asked to undertake.



‘Work should be allocated with a focus on risk, unpredictability, complexity and acuity of the situation and not simply task competency. Situational awareness is crucial for safe care.’



Work should be allocated with a focus on risk, unpredictability, complexity and acuity of the situation and not simply task competency. Situational awareness is crucial for safe care. For example, the administration of insulin to a person with diabetes could be uncomplicated or it could be more complex depending on the situation (family support, cognitive issues etc).

The consensus based on the data was that a Registered Nurse (RN) should attend every fourth visit as a minimum to carry out the Nursing Process. Whilst Nursing Support Workers including Nursing Associates can be involved in the Nursing Process and play a vital role in the delivery/ implementation of care, the assessment, nursing diagnosis, planning and evaluation of care is the responsibility of the Registered Nurse.

Based on the data, there was a consensus too on the ratio of skill mix, considering the experience, knowledge and skills of the team members: 60% experienced RNs; 20% newly registered nurses; and 20% Nursing Support Workers. Support workers include many different groups such health care assistants and Nursing Associates.

### **Red flags**

- District Nursing services unable to close a caseload, leading to unremitting and unsustainable demand.
- Deferring work every day or most days should be a red flag and escalated.
- Deferring any high priority work at all (for example end of life care, people with blocked catheters) should be escalated as a safety concern.
- High turnover and high sickness absence should also be considered a red flag for both patient safety and system resilience.

### **Establishments, scheduling, and the use of tools to plan the workforce and the work**

Establishments for services should be based on actual demand from patients. Commissioners of services should work with teams to undertake an estimation of demand and determine establishments.

Establishment setting should align with The RCN workforce standards. When calculating the nursing workforce Whole-Time Equivalent (WTE), an uplift will be applied that allows for the management of planned and unplanned leave and absence. Realistic uplift enables recognition of planned and unplanned leave. Underestimation of either or both planned and unplanned leave will result in an establishment that cannot meet day to day staffing requirements, and an over-reliance on supplementary staffing, such as bank and agency staff, which will impact on overall costs and quality of care. The uplift percentage agreed should not compromise service delivery, safety and quality of care.

Calculating uplift must consider each of the following:

- Annual leave
- Sickness / absence – derived from organisational monitoring of sick leave
- Study leave – this must meet or exceed the statutory requirements for registrants
- Leave for parents/adoption
- Other leave – this includes carer’s leave, compassionate leave etc.

There is no one solution of a model that fits all different places of work and the range of local populations served in any one provider of community services. Day to day professional judgement should be given weight in any decision making. Geographical issues, for example, travel requirements for community-based staff, shift patterns, working day flexible working, acuity, complexity and dependency, professional regulatory requirements and time required to support/mentor learners in the workplace, must all be included in workforce planning/establishment setting.

Scheduling of work must be person centred and individualised. The named Registered Nurse determines the ‘window’ of time to deliver holistic care. This should not be delegated to scheduling platforms or applications as these are currently unproven. Scheduling platforms could be used once workloads are determined by Registered Nurses to organise work and workloads. A ‘timed-task’ approach to plan the work or the workforce should not be used. We found that the timed-task approach was a trigger for workforce discontent and even resignation. The safety of timed-task approaches has also been called into question, therefore the precautionary principle should apply. You should not use applications ‘apps’ or electronic schedulers that do this - for example, an app that allocates 15 minutes for ‘diabetes’. They can be used to inform or plan work and workload, but they should not be used for work itself. Community care is complex and unpredictable and such methods have not been proven safe in this context.

Route planners and other resource allocation applications should not override the priority of clinical care and professional judgement.

## Glossary

**Nursing Process:** The process by which registered nurses assess, plan, implement and evaluate care. Although this can be delivered by many members of the team, the Registered Nurse remains responsible for the nursing process.

**Work left undone:** The work that nurses and support workers do not have time or resources to do, but impact on direct patient care or the organisation of care (for example making referrals).



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