National Quality Board

Safe, sustainable and productive staffing

An improvement resource for the district nursing service

Contents

Working group patient perspective

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

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

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

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

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

Iain Upton

1. Introduction

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

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

We refer to 'safe caseloads in the district nursing service' rather than 'safe staffing', as this better reflects the complexity of determining the required staffing levels.

The resource is based on the National Quality Board's (2016) three expectations[1]:

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

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

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

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

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

1.1. The district nursing service

The district nursing service is typically made up of many teams of staff nurses and healthcare support workers, with a leader for each team. The teams deliver services to individuals in their homes or in a specific locality in their community, and/or to patients registered with a named general practice. Team leaders normally have the Nursing and Midwifery Council (NMC) recordable specialist practice qualification (SPQ) in district nursing, and are skilled in the following (The Queen's Nursing Institute and The Queen's Nursing Institute Scotland, 2015):

- providing a wide range of nursing care in home and community-based settings
- assessing and managing unpredictable situations flexibly and responsively
- advocating for and co-ordinating care, whether anticipated or unscheduled, with individuals and their families, through acute illness, long-term and multiple health challenges and at the end of life
- working collaboratively and creatively with colleagues in general practice, social care, community pharmacy, nursing specialisms, allied health professions and others to improve the health and care of individuals, families and communities, particularly the most vulnerable
- managing the care of people with multiple pathology and long-term conditions whose mobility is impaired
- leading and managing a team to deliver care in the home and community.

1.2. What does good care look like?

Figure 1 shows the nine characteristics of good quality care in district nursing identified in *Understanding quality in district nursing services – learning from patients, carers and staff* (Maybin et al, 2016). Patients and carers involved in the development of this resource confirmed Maybin et al's (2016) finding that the three most important characteristics to patients, carers and staff were: caring for the whole person, continuity

of care and personal manner of staff.

Figure 1: Nine characteristics of good quality care in district nursing (Maybin et al, 2016)

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

1.3. The district nursing caseload

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

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

1.4. Factors influencing safe caseload management

Within the adult community nursing service, 'safety' is poorly defined in terms of the workforce required (see the evidence review). Increasing demand on district nursing services and the complexity of the patients being cared for need to be considered in shaping a financially and operationally sustainable service that is safe for patients.

District nursing services are often said to act like a 'sponge' (The Queen's Nursing Institute, 2016) – without the physical restriction of a defined number of beds, as on a hospital ward, it is easier for this service to absorb additional workload. Maybin at al (2016) highlight that district nursing teams increasingly care for patients with complex healthcare requirements, helping to reduce unplanned admissions to hospital and reducing length of stay.

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

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

1.5. Determining a safe caseload

Determining what the safe caseload is at strategic level requires assessment of the current and projected population needs, the skills within the team and across local organisations required to meet those needs, and how the identified skill shortfall will be addressed. New and sustainable ways of working, such as technology to support remote monitoring and a more agile workforce, need to be considered.

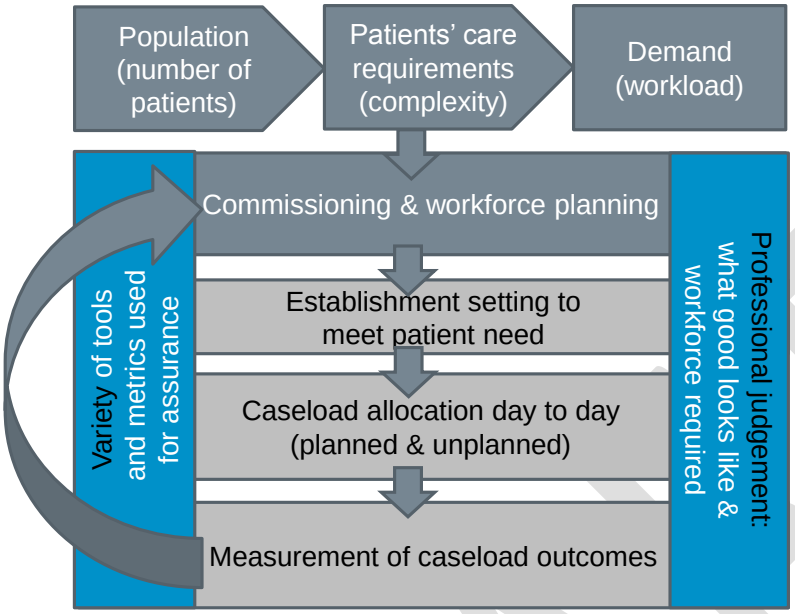
At an operational level, determining what the safe caseload is requires assessment of the district nursing needs of patients, their families and carers at a service and a team level, and how appropriate members of the team can be deployed at the right time and place to meet these needs.

Critically, the outcome for patients, their families and carers must be captured in any

measurement of the impact of the district nursing service.

Figure 2 summarises the available methods and tools to support safe caseload management.

Figure 2: Safe caseload management methods and tools



The recommendations (see section 6) build on the principles of safe staffing identified by NHS England (2015) and apply in any district nurse setting. Their implementation at both strategic and operational levels should be considered for the whole system, working with partner organisations identified in sustainability and transformation plans (STPs).

See Appendix 2: **Case study 1** – Adult community nursing workload and complexity tools: capacity versus demand (Rotherham, Doncaster and South Humber NHS Trust).

2. The right staff

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

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

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

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

2.1. Evidence-based workforce planning

Annual staffing reviews

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

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

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

- a systematic, evidence-based approach to determine the required number and skill mix of staff
- benchmarking against peers (eg other provider organisations) and sharing the learning
- professional judgement exercised for specific local needs, but with care not to duplicate elements included in other tools
- account taken of national guidelines developed by professional consensus.

Strategic workforce planning

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

STPs provide the strategic opportunity to align workforce planning with the needs of the local population.

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

New care models may impact all community services, including district nursing services, eg by reducing lengths of hospital stay. A strategic review of the increased capacity and capability required to accommodate such a change should be assessed before any new model is implemented. Agreed care pathways will help identify and standardise the care/skill mix the district nursing service needs to provide.

The district nursing service needs to tell Health Education England (HEE) of its plans for strategic service and multiprofessional workforce development at local, regional and national levels (Ball et al, 2014).

Operational workforce allocation

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

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

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

See Appendix 2: **Case study 2** – Sheffield Community Caseload Classification System: articulating the hidden work of community nurses (Sheffield Teaching Hospitals NHS Foundation Trust).

2.2. Tools to support safe caseloads

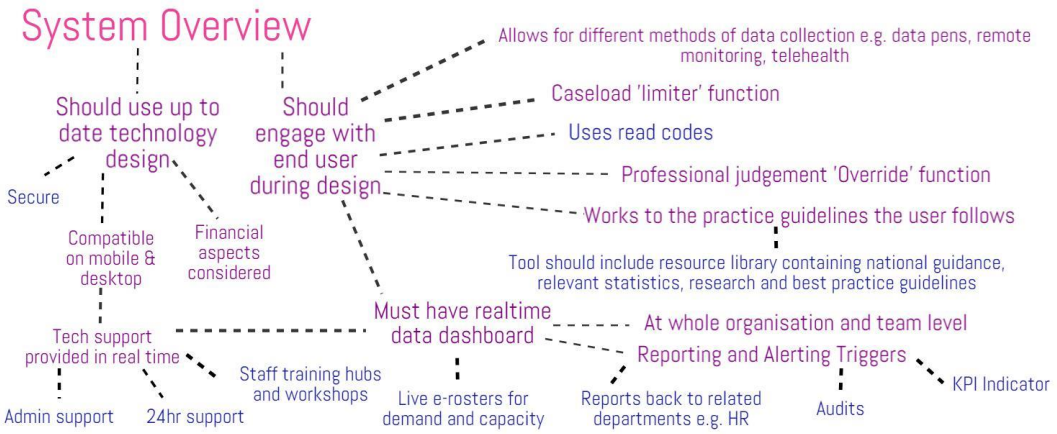
Several commercial caseload management tools are available, but there is little published evidence of their reliability and validity (see the evidence review). NHS England's (2015) framework for commissioning community nursing identified a number of tools and compared their usefulness to the district nursing service. There are now many more commercial tools and tools developed locally by providers.

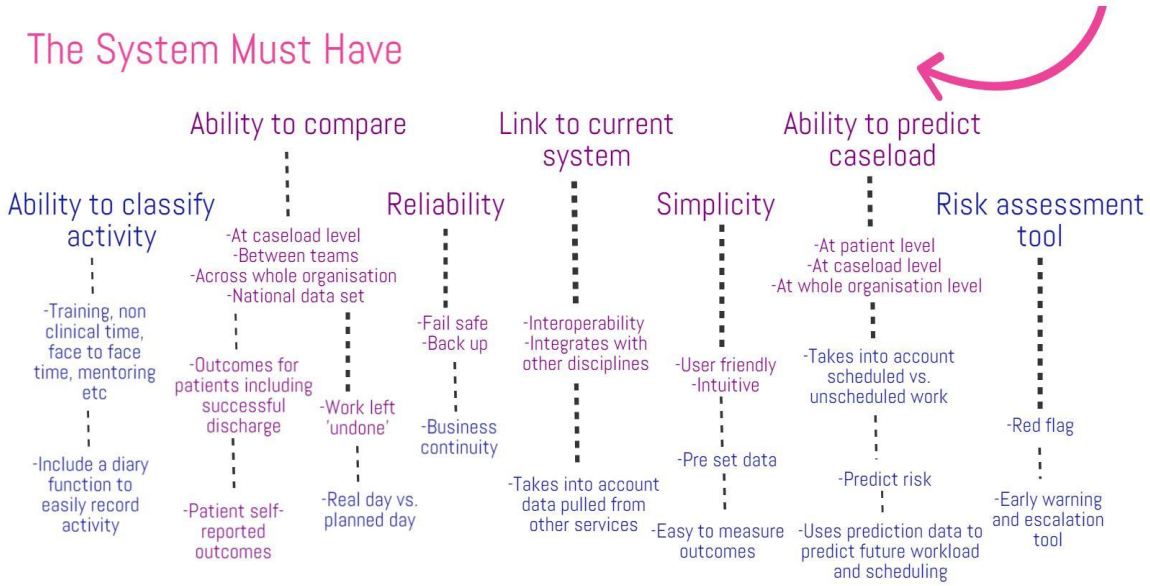
Users should check a tool's specification against the principles for safer caseload management in this document.

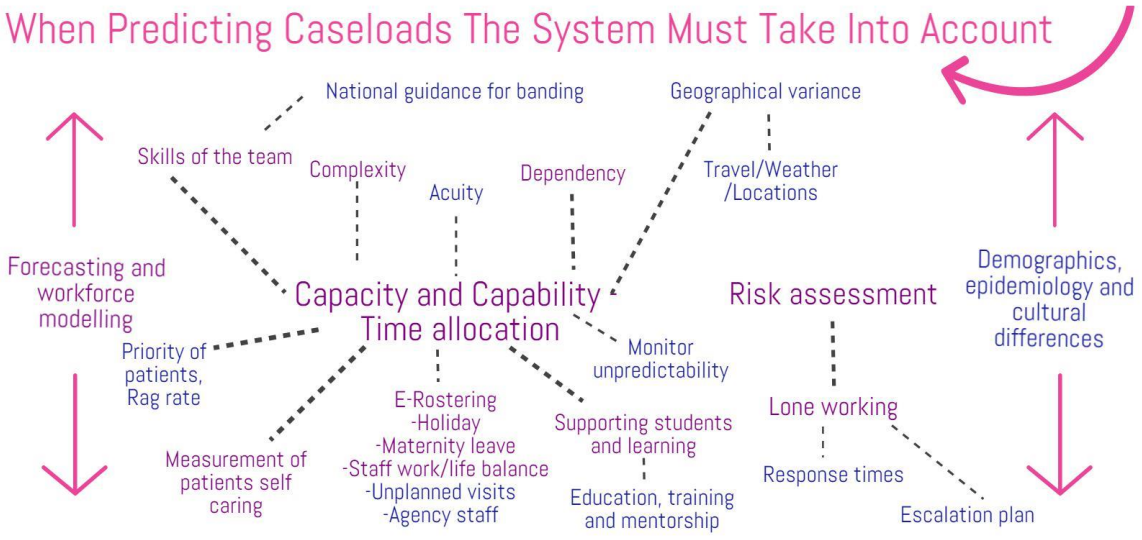
A tool's requirements are summarised in the infographic on the next page, which has been developed with the National District Nurse Network (NDNN) membership and members of the QNI Community Nurse Executive Network (CNEN). The infographic is useful when developing a specification for a caseload management and e-rostering tool and/or to assess the elements of a tool currently in use.

We recommend tools are developed to include an agreed method for classifying patient acuity/dependency/complexity.

Requirements Of A Software Tool Supporting Safe Caseloads







Qni The Queen's Nursing Institute

CNEN

NHS National District Nurses Network

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

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

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

2.3. Setting establishments to include planned and unplanned leave

While leave needs to be managed efficiently and responsibly, district nursing establishments should include an ‘uplift’ to allow for planned and unplanned leave and effective management of absences.

The uplift is for:

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

Local factors to consider when calculating the percentage allowances for inclusion in uplift. The uplift needs to be realistic and reviewed at least annually. Factors to consider when setting uplift include:

- operating a central pool for parenting leave (calculated at team level and then managed centrally)
- leave entitlements increase with length of service (where AfC applies)

- planning should be based on the organisation's ceiling target level of sickness/absence, eg 3% to 4%
- estimates for study leave should include mandatory training and elements of core/job-specific training
- learning activities such as fulfilling link-nurse roles and participation in a quality improvement collaborative
- the allowance for study leave uplift needs to be appropriate for the proportion of part-time staff
- as teams become more multiprofessional, applying the study leave allowance across the whole team should be considered
- uplift should allow for supervisory time for the leader of the district nursing team. The amount of supervisory time should be determined locally, with an appropriate impact assessment and analysis.

The recommendation in the *Report of the Mid-Staffordshire NHS Foundation Trust public inquiry* about the supervisory capacity of the clinical nurse manager of a ward is applicable to registered nurses who lead and manage district nursing teams. The clinical manager "… should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision… They should know about the care plans relating to every patient... They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal."

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

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

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

2.4. Professional judgement

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

The principles of professional judgement are:

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

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

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

Although the evidence base for some elements of professional judgement is not strong, their consideration is important as they can impact staffing requirements. Some decision support tools contain professional judgement.

2.5. Comparing staffing levels with peers (benchmarking)

Peer comparisons can act as a platform for further enquiry. While some caution is needed, comparison of staffing with peers can act as a ‘sense check’, particularly for assumptions and professional judgements, and help sharing of good practice. See section 5 for further detail.

3. Right skills

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

The wider multiprofessional team needs to be carefully considered when deciding who should deliver care to address patient/family/carer needs. The deployment of those in non-clinical, professional support roles should also be considered to support the multiprofessional clinical team to deliver the most effective and productive care.

3.1. Skill mix

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

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

- decision-making, often without support being immediately available
- coaching patients/carers in self-care, to recognise changes in their condition and to respond appropriately
- supporting carers to provide person-centred care, eg end-of-life care at home
- risk assessment in sometimes less-than-optimal conditions for the delivery of clinical care
- preventing unnecessary hospital admission and facilitating timely discharge from hospital
- developing relationships with third-sector organisations
- generating, collecting and responding to honest, considered feedback and using it to improve performance.

3.2. Training, development and education

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

Specialist Practitioner Qualification in District Nursing (SPQ)

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

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

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

Commissioners and providers must work with HEE and higher education institutions to ensure suitable and well-resourced district nurse programmes are available to sufficient numbers of registered nurses. Strategic workforce planning is needed at regional and national level, with providers contributing to the process.

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

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

3.3. Recruitment and retention

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

- vacancy rates
- sickness absence
- turnover
- profile of existing staff including age and BME background
- outcomes from retention/exit interviews.

Factors important in attracting new staff and retaining existing staff are:

- personal circumstances, aspirations, preferences and career stage
- quality of the induction programme and preceptorship programmes, particularly for those who have not worked in the community previously
- clinical specialty/workload
- team and/or organisational culture
- leadership, recognising the need to support BME staff gain leadership positions
- team dynamics
- flexible working arrangements/shift patterns

- quality of the clinical learning environment and support, eg mentoring
- ongoing education and training opportunities
- geographical location, eg ease of travel access and cost of living
- support for travelling/associated costs as part of the requirements of the role.

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

See Appendix 2: **Case study 3** – E-Community: a capacity and demand management system for district nursing (Whittington Health NHS Trust)

4. Right place and time

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

4.1. Productive working

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

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

4.2. Use of technology

Use of technology should be maximised for effective working of district nursing services. This includes using mobile digital technology (such as tablets and laptops in patients' homes), tele-health and tele-care.

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

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

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

- **Technology to assess patient care requirements** and provide advice during a patient's transition to self-care (as appropriate), eg remote monitoring via tele-health systems, and Skype and Facetime access to healthcare professionals.
- **Technology to record care delivered and share this with other professionals** Technology is essential for caseload management – to schedule care with the most appropriate professional, to record care consistently in a template, to monitor outcomes and to identify any care left undone. Mobile working with the use of tablets/laptops facilitates easy and timely communication within the multiprofessional team and the sharing of assessments and the care provided within and between organisations. Failure to record and share information in this way can mean undelivered care is invisible to those beyond the patient's home.
- **Technology to plan home visits** Patients, families and carers need to know when the district nurse will visit (Maybin, 2016), a point emphasised by carers during the development of this improvement resource. Technology supports e-rostering and the planned allocation of a named professional on a specified day(s) at a specified time(s).
- **Technology to monitor and report patient outcomes** Technology can capture data such as activity, demand, capacity and patient outcomes. It can 'flag' risks, such as overtime worked and postponed nursing care. It can be used to demonstrate outcomes and the impact of the district nursing service on patients, families and carers. This can support business cases for the development of the service to meet patient needs, support people so they can be cared for in their homes, and reduce unplanned admissions and A&E attendances.
- **Technology to inform improvement, workforce planning and commissioning** Recording information about patient outcomes should inform the strategic development of district nursing services and the potential for operational improvement.

4.3. Efficient deployment and flexibility

Best practice guidance for effective e-rostering is available from NHS Employers and the Carter team. The principles outlined in these reports apply to all nursing environments, including district nursing.

In a survey of district nurses one-third allocated their workload using paper-based systems (The Queen's Nursing Institute, 2012). This reduces the effectiveness of caseload planning and evaluation, and the ability to benchmark and review a whole service.

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

Flexible working

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

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

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

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

Staff deployment

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

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

Rest breaks

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

Escalation processes

Organisations should have a protocol for frontline staff to escalate concerns about the safety and effectiveness of care.

4.4. Minimising agency staffing

Temporary staff make a valuable contribution to the workforce and can be a useful contingency for filling anticipated staff shortages. They should be recruited from in-house staffing banks. Only if this is not possible should a framework agency be approached. Local training and induction must be part of the engagement process for agency staff. Over reliance on agency staff is unlikely to represent an effective solution to ensuring there are the right staff with the right skills, in the right place at the right time.

5. Measure and improve

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

A local ‘quality dashboard’ should be developed for safe sustainable staffing. Providers should collect team- and organisation-level metrics to monitor the impact of staffing levels on patient outcomes and staff. The aim is to continuously improve patient outcomes and use of resources in a culture of engagement and learning. Evidence-based team-level and service-level metrics may focus on:

- patient outcomes, eg infections, falls, pressure ulcers, leg ulcer healing rates

- patient and staff experience, eg friends and family test and patient complaints
- staffing data, eg appraisal feedback, retention, vacancy and sickness rates
- process measures, eg record-keeping, documentation standards
- training and education, eg mandatory training, clinical training
- productivity and efficiency, eg cost-effectiveness.

5.1. Measure patient outcomes, people productivity and financial sustainability

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

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

5.2. Report, investigate and act on incidents

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

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

Staff in all care settings should be aware they have a professional duty to put the interests of those in their care first, and to protect them if they consider they may be at risk (NMC, 2015). Policies should support staff who raise concerns (whistleblowers).

5.3. Patient, carer, family and staff feedback

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

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

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

Culture

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

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

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

6. Conclusion and recommendations

Determining safe caseloads in district nursing services relies on professional judgement regarding patient need and the availability of the multiprofessional workforce required to deliver high quality, sustainable care. A variety of caseload management tools are used, together with a range of definitions of patient needs and of outcomes to evaluate care. As a result, benchmarking across services and systems is challenging.

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

Safe caseload principles for members of the board, with strategic partners
Organisations should work together **locally, to define safety in the context of district nursing and agree a suite of metrics to provide assurance of safety and quality across the system**.
Include **metrics regarding: patient safety, patient experience, staff experience with system-wide measures. Standardise collection and monitoring of metrics.**
Plan the multiprofessional workforce **to provide safe caseload management around the agreed definitions of safety and quality**.
Use **technology to support remote monitoring and a more agile workforce**.
Use an evidence-informed decision support tool**, triangulated with professional judgement and comparison with relevant peers**.
Undertake an annual strategic staffing review **of all healthcare professional groups**.
Review a comprehensive staffing report after six months to ensure workforce **plans are still appropriate**.
Review a local dashboard **of quality indicators to support decision-making on a monthly basis**.
Review local recruitment and retention priorities **regularly and maximise flexible employment options and efficient deployment of staff**.
Introduce a process to determine additional uplift requirements based on the needs of patients and local demography.
Introduce an escalation process in case staffing does not deliver the outcomes identified in the appropriate plan.
Investigate staffing-related incidents and outcomes on staff, patients, families and carers and ensure action and feedback.
Respond to changing patient requirements and **new ways of working/new care models**.

References

Ball J, Philippou J, Pike G, Sethi G (2014) *Survey of district and community nurses in 2013: report to the Royal College of Nursing*. London: NNRU.

Bliss J, Dickson C (2016) RCN backs the district nurse specialist practice qualification *Br J Community Nursing* 21(8): 383–384.

Fields E, Brett A (2015) *Safe staffing for adult nursing care in community settings evidence review* (National Institute for Health and Care Excellence – unpublished) https://www.nice.org.uk/media/default/news/safe-staffing-community-nursing-evidence-review.pdf

Jones K, Davies A (2015) *Mind the gap*. Health Education England. https://www.hee.nhs.uk/sites/default/files/documents/Mind%20the%20Gap%20Report_0.pdf [accessed 10 March 2017]

Institute of Innovation and Improvement (2010) *The productive community series.* http://webarchive.nationalarchives.gov.uk/20101121133316/http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_community_services.html [accessed on 5 January 2017].

Jackson C, Leadbetter T, Manley K, Martin A, Wright T (2015) Making the complexity of community nursing visible: the Cassandra project. *Br J Community Nurs* 20(93): 127–133.

Maybin J, Charles A, Honeyman M (2016) *Understanding quality in district nursing services – learning from patients, carers and staff.* London: The King's Fund.

National Institute for Health and Care Excellence (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals. http://www.nice.org.uk/guidance/SG1 [accessed on 10 March 2017].

National Institute for Health and Care Excellence (2015) Safe midwifery staffing for maternity settings. https://www.nice.org.uk/guidance/ng4 [accessed on 10 March 2017].

National Quality Board (2016) *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe sustainable and productive staffing.* https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

NHS Benchmarking (2016) *Community services benchmarking* http://www.nhsbenchmarking.nhs.uk/news/view-article.php?id=208 [accessed 5 January 2017].

NHS England (2015) *Framework for commissioning community nursing*. London: NHS England. https://www.england.nhs.uk/wp-content/uploads/2015/10/Framework-for-commissioning-community-nursing.pdf [accessed 10 March 2017]

NHS England (2016) *Leading change, adding value.* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf [accessed 10 March 2017]

NHS Institute of Innovation and Improvement (2010) *Transforming care at the bedside* http://www.ihi.org/engage/initiatives/completed/tcab/pages/default.aspx

Nursing and Midwifery Council (2015) *Raising concerns: Guidance for nurses and midwives*. http://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives [accessed on 10 March 2017].

Reason J (1990) *Human error*. Cambridge: Cambridge University Press.

The Queen's Nursing Institute (2012) *Smart new world. Using technology to help patients in the home*. London: The Queen's Nursing Institute.

The Queen's Nursing Institute (2015) *The value of the district nurse specialist.* London: The Queen's Nursing Institute.

The Queen's Nursing Institute (2016) *Developing our understanding of safe caseloads for the district nursing service.* London: The Queen's Nursing Institute.

The Queen's Nursing Institute and NHS England (2014) *Developing a national district nursing workforce planning framework.* London: NHS England.

The Queen's Nursing Institute and The Queen's Nursing Institute Scotland (2015) *The QNI/QNIS Voluntary standards for district nurse education and practice*. London: The Queen's Nursing Institute.

Appendix 1: People with learning disabilities

All healthcare providers must strategically plan for an interdisciplinary workforce who is able to meet the often-complex needs of people with learning disabilities. It is a legal requirement that reasonable adjustments are made to ensue that people with learning disabilities have equal opportunities for their health needs to be met (Equality Act 2010). People with Learning disabilities are more likely to have undiagnosed or wrongly diagnosed health needs and die prematurely from preventable causes (Healthcare for All 2008, CIPOLD 2013).

Meeting these requirements in terms of safe and sustainable staffing includes:

- ensuring that within the staffing establishment there are sufficient numbers of specialist staff available
- providing regular training to the wider workforce to ensure that they are able to identify people who may present with learning disabilities, autism or other complex communication needs
- flexibility in the way care is delivered allowing enough time and support to enable quality outcomes
- all staff to be aware of their duties under the mental capacity act (2005) and the need to work in partnership with the individual, their families, carers and other multi-agency professionals
- have workforce plans with the capacity to ensure that everyone's right to receive appropriate healthcare is realised
- if reasonable adjustments are not sufficient to ensure equality of healthcare the appropriate liaison with community multi-disciplinary teams is required.

Appendix 2: Case studies

Case study 1: Adult community nursing workload and complexity tools: capacity versus demand

Organisation
Rotherham, Doncaster and South Humber NHS Trust

Contact
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Melanie Gibbons, Head of Nursing, Melanie.gibbons@rdash.nhs.uk

What was the problem?

Staff reported pressures on their service as demand increased:

- they were unable to meet this demand by expanding capacity due to a commissioned historic block contract
- the service needed to show local commissioners evidence of these pressures
- no formal reporting of clinical activity was recorded and monitored
- growing numbers of patients with complex conditions required appropriately skilled staff
- workload had to be allocated fairly
- the trust needed a way of understanding which teams were busy and which less so, to enable staff movement to meet needs.

What was the solution?

Sourcing appropriate workload and complexity tools and engaging staff to agree a way forward. Every day the adult community nursing service's admin support team uses the tools to match predicted capacity and demand. Each patient has a five-minute complexity assessment that places them in one of five complexity categories. A dependency score of 1 unit equates to 15 minutes of care. Patients with multiple straightforward care plans are assigned a maximum of 4 units.

What were the results?

Statistics show which teams are consistently busy over seven days, and staff move around to help where they are needed. Senior community specialist practitioners case manage patients with high complexity scores. Staff feel empowered now they are capturing and sharing data on their work. Commissioners are aware of service pressures and have invested more funding in the service.

What were the learning points?

- Engage with frontline staff early, when pressures are identified.
- Be open and honest with staff.
- Engage with trust leaders and commissioners.
- Monitor closely by reviewing individual teams' capacity, as well as demand and complexity levels.

Case study 2: Sheffield Community Caseload Classification System: articulating the hidden work of community nurses

Organisation
Sheffield Teaching Hospitals NHS Foundation Trust

Contact
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What was the problem?

Ensuring sufficient staff for community nursing caseloads. Traditional work planning involved the team leader allocating patient visits daily, based on their awareness of the patient's needs and the skills in the team. A move to larger teams, with average caseloads of 500 and up to 150 visits per team per day, made this a challenge. Staff were treating patients with increasingly complex conditions with little evidence of the impact of this. In addition, the organisation needed a better understanding of the resources required to provide more care away from hospitals, as well as improve productivity by increasing efficiency.

What was the solution?

Developing a caseload classification system to group patients' nursing needs and levels of complexity and allow the tracking of activity associated with each group. Nurses classify patients' nursing need by type of care required and level of complexity, defined by social situation and clinical interventions. The electronic patient record captures all the data. The trust can now analyse activity data to identify trends, define resource requirements and inform skill mix. Team leaders can review their caseload by patient need and assess the appropriateness of treatment against evidence-based guidelines.

What were the results?

Piloting of the tool resulted in the assessment of over 3,000 patients' nursing needs. Team leaders systematically reviewed their caseloads: for example, one team reviewed all patients receiving daily insulin injections according to the latest guidelines. They found three patients no longer needed nursing support to administer insulin, releasing 157.5 hours of nursing time over 12 weeks. One team leader commented: 'I can ensure skill mix is correct. I can refer complex patients to matrons. Data pinpoints patients' level of need on my caseload to the wider service. It's a forecast of patient need'.

What were the learning points?

- Operational benefits are crucial to ensuring consistent, accurate recording of information.
- Starting with a local consensus of patients' nursing needs, provides a baseline with which to compare data gathered by tracking activity, and promotes sharing of good practice.

Case study 3: E-Community: a capacity and demand management system for district nursing

Organisation
Whittington Health NHS Trust

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Dale Carrington, Lead District Nurse for Professional Development and Quality, dale.carrington@nhs.net

What was the problem?

District nurses identified that:

- patients were not always visited by staff with the right skills to care for them
- daily demand exceeded capacity, leading to daily acuity prioritisation and potential reallocation of visits
- patients' appointments were moved multiple times
- team leaders spent more time allocating visits than performing clinical duties
- discharge dates were not met
- district nurses walked long distances between visits.

What was the solution?

E-community, a fully hosted and supported system that aligns patients' needs with available resources. The aim was to:

- improve capacity and demand management in district nursing, with all patients seen on time and no visits unallocated
- reduce incidents related to allocation errors
- reduce bank and agency usage
- maintain the district nursing vacancy rate below 10%
- complete a training needs analysis based on identified skills deficits
- reduce staff sickness by managing workload more effectively and reducing stress.

The system would help by:

- allocating visits in advance to reduce delay in clinicians arriving at their first patients
- reducing the time team leaders take to allocate visits by locating all required information in one place – available staffing, competence and training, daily demand and acuity
- improving senior staff's visibility and supervision, improving productivity
- team managers' time freed to care for more complex patients
- continued progress to paperless working
- identifying and managing capacity peaks in advance by moving patients with appropriate needs to days with less demand and ensuring clinicians are used to their full competency
- improving staff satisfaction, leading to better recruitment and retention.

What were the results?

The trust predicts the system will save £310,540 in 2016/17 by releasing 6.45 staff from administration and co-ordination duties for direct patient care.

What were the learning points?

Establishing useful connections between IT platforms can be difficult, so it is worth investing time in creating a bespoke platform for all needs, including data gathering for quality and key performance indicators.

Case study 4: Using quality schemes to reconfigure community services and focus the new provider on quality that matters to cost, patients and clinical quality

Organisation
NHS South Cheshire Clinical Commissioning Group

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Dr Andrew Spooner, GP and Lead for outcomes, NHS South Cheshire CCG and NHS Vale Royal CCG, Andy.spooner@nhs.net

What was the problem?

Community services had minimal business intelligence and limited understanding of their activity. The CCG needed to have better understanding of which parts of the service were efficient and which were not.

What was the solution?

When the CCG decided to recommission community services, it included person centred quality markers in service specifications. It intends to use the data from them to better understand the services and map how patients move around the health economy. It will then reconfigure community services to improve:

- clinical care
- system cost
- patient satisfaction
- functional change
- clinical staff recruitment.

What were the results?

Staff morale has improved, but as the CCG has only recently recommissioned the service it is too early for concrete results. Moved to clinicians understanding and explaining to patients the reason for a change rather than a protocol based (pathway) solution.

What were the learning points?

- Working methods in community services are efficient but are not valued by the system.
- Understanding and quantifying them across a health economy shows where to make investment.

- When quality markers are refocused on patients, staff confidence grows and morale improves.
- Poorly constructed demand management, and secondary care methods appropriate for a small population implemented as protocols, do not reduce cost or help most patients who do not want to go to hospital.
- True person-centred care provided by skilled staff working with continuity in small teams is efficient, and patients with complex conditions value it.
- Understanding the patients goals and presenting information rather than implementing pathways allowing/supporting patients to make their own decisions
- Understanding the patients goals and presenting information rather than implementing pathways allowing/supporting patients to make their own decisions

Appendix 3: Working group members

Name	Role	Organisation
Dr Crystal Oldman	Chief Executive Chair for safe staffing improvement resource	The Queen's Nursing Institute
Jane Robinson	Clinical Improvement Project Lead Professional lead	NHS Improvement
Ian Bailey	Senior Clinical Informatics Consultant Queen's Nurse Facilitator	EMIS Health The Queen's Nursing Institute National District Nursing Network
Jane Ball	Principle Research Fellow	University of Southampton
Julie Bliss	Chair Senior Lecturer Queen's Nurse	Association of District Nurse Educators King's College, London The Queen's Nursing Institute
Dr Bob Brown	Director of Nursing and Quality Chair Trustee	South Tyneside NHS Foundation Trust Community Nurse Executive Network The Queen's Nursing Institute
Dr David Colin-Thome	Trustee Retired GP	The Queen's Nursing Institute
Anne Cooper	Chief Nurse Fellow	NHS Digital The Queen's Nursing Institute
Professor Vari Drennan MBE	Professor of Nursing Fellow	Kingston University and St George's University of London The Queen's Nursing Institute
Kath Evans	Community Nurse Lead Queen's Nurse	NHS England The Queen's Nursing Institute
Dr Joanne Fillingham	Clinical Director Allied Health Professions Deputy Chief Allied Health Professions Officer	NHS Improvement
Lynne Hall	National Primary and Community Nursing Lead	Health Education England
Carolyn Jackson	Director of the England Centre for Practice Development	England Centre of Practice Development hosted at Canterbury Christ Church University

Pippa Hodgson	Director of Allied Health Professionals	Marie Curie
Esther Kirby	Chief Nurse Queen's Nurse	Bridgewater Community Healthcare NHS Foundation Trust The Queen's Nursing Institute
Professor Alison Leary	Professor of Workforce Modelling Fellow	London Southbank University The Queen's Nursing Institute
Chloe McCallum	Policy Officer	The Queen's Nursing Institute
Dr Pauline Milne	Associate Nurse Director	NHS Improvement
Anne Moger	Primary Care Nurse Lead Queen's Nurse	NHS England The Queen's Nursing Institute
Dr Steve Mowle	GP Assistant Honorary Treasurer	South London Royal College of General Practitioners (London Region)
Andrea Parsons	Integrated Workforce Models Lead – Workforce Redesign Team, New Care Models Programme: Five Year Forward View	NHS England
Anne Pearson	Director of Programmes	The Queen's Nursing Institute
Nick Ponset	CEO	Aleron Group
David Pugh	Community Nursing Team Manager Queen's Nurse Chair	Bristol Community Health The Queen's Nursing Institute National District Nurse Network
Dee Sissons	Director of Nursing	Marie Curie
Iain Upton	Patient perspective	Speaking4Yourself
Christine Widdowson	PA to CEO and Office Manager	The Queen's Nursing Institute
Matthew Winn	Chief Executive CEO Communities Group	Cambridgeshire Community Services NHS Trust NHS Confederation
Kathryn Yates	Professional lead: Primary and Community Care and Integration	Royal College of Nursing

Stakeholders consulted

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

- The Queen's Nursing Institute (QNI)
- Community Nurse Executive Network (CNEN)
- Association of District Nurse Educators (ADNE)
- National District Nurses Network (NDNN)
- NHS Clinical Commissioners, Nurses' Forum (NHSCC)

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