Survey of district and community nurses in 2013

Report to the Royal College of Nursing

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Foreword (from the RCN)

The RCN has long been an enthusiastic and committed advocate for district and community nurses - promoting the value of their work caring for people in their own homes, as well as calling for the necessary action to secure the sustainability of these critical services.

The value of district nursing is indisputable and we know that nurses working in the community consider their role to be both professionally fulfilling, as well as a great privilege. Providing the care and support people need to manage periods of illness, both short and long term, and helping people live out the end of their lives as they would wish in the comfort and familiarity of their own homes, calls for dedicated and skilled nursing professionals which district and community nurses quite clearly are. However, as the health service as a whole strains under the continued pressure of having to do more for less, district and community nursing is fast becoming the service that is unable to say 'no'.

The RCN commissioned this research to examine the state of the district nursing workforce. It has been clear for several years that district nurses are under ever increasing pressures, coping with greater workloads and caring for patients with increasingly complex conditions. Yet their numbers are in persistent decline. The RCN has been calling for more to be done to reverse the decline in district nursing numbers. District nurses are highly skilled and autonomous, responsible for delivering sophisticated and complex care.

This research provides us with a clearer picture of the workload of both teams and individual nurses, as well as the composition of those teams and the type of work they do. It also sheds light on the daily challenges and rewards of district and community nursing and of how they are working as part of the wider health and social care system.

Central to the concept of integrated care is that patient experience will be improved if care is better co-ordinated. District and community nurses are often the interface between a variety of services and agencies which may be involved in the care of an individual patient. Their experience and skills are therefore essential to future models of integrated care.

This report helps articulate the role which district and community nurses must play in the future if the vision for integrated care is to be realised and we hope that all those with an interest in, and responsibility for designing health services will find it useful and illuminating.

Dr. Peter Carter

Chief Executive and General Secretary of the RCN

Executive summary

In recent years there has been a policy to shift care delivery away from hospitals to community settings. However, the proportion of the nursing workforce working in the community has changed little in the last 15 years, and the number of district nurses, historically the key to the delivery of community based care, has fallen by about 40%. There is a lack of data or research evidence on the composition and structures of community district nursing teams, and the nature of working conditions for nursing staff providing district nursing services. To meet this gap in workforce knowledge the RCN commissioned a study to undertake a census survey of its members who are working as district nurses, community matrons and community staff nurses in England.

The survey

The survey was undertaken in November and December 2013 and included all 8,023 nurses in England recorded as working in the relevant areas. Most (6,240) members were contacted via an email link to an online survey and the remainder were contacted by post. By the end of December 2,438 responses were received (30% response rate).

Profile

Supporting national data, the study found that the average age of community based nurses is 46 with 35% of district/community nurses aged 50 and over (a higher figure than amongst hospital nurses). Respondents were divided into 5 main groups according to the main posts held: district nurse (25%), community staff nurse (49%), community matron (8%), team leader/case manager (11%), specialist nurse (6%).

District nurses are much more likely to hold prescriber qualifications than community staff nurses. Across all roles 51% of those working in community/district nursing are employed on pay band 5, 29% are on band 6 and 20% on band 7/8. Two thirds (65%) of DN qualified nurses are employed on band 6 and 19% on band 7/8 with 16% on band 5. In contrast, 95% of community staff nurses are on band 5. The vast majority (all but two) of community matrons are on band 7/8. Nurses who hold both a SPQ and prescriber qualification are likely to be in more highly paid posts (47% are employed on band 7 or 8).

Areas covered

Travel is an unavoidable aspect of working in district nursing teams. Most respondents were working in urban environments (57%) with an average distance to the furthest point of 10 miles. Four in ten respondents were based in predominantly rural areas with an average 17 miles to the furthest point in the area. Advanced/specialist nurses cover larger areas – a mean of 17 miles to the furthest point as opposed to a mean of 10 miles across the other job categories. Nurses spent an average of 85 minutes per day travelling.

District nursing teams

On average 75% of the staff employed in district/community nursing teams are registered nurses (including DNs, staff nurses/sisters and community matrons) with a further 17% of the team being band 1-4 healthcare support workers. Administrative and clerical staff and others make up the remaining 6% of the staff employed.

The typical district nursing team is made up of approximately 15 members of staff (mean average), representing 11 whole time equivalent (WTE) posts. This team typically consists of approximately two district nurses, 5 registered nurses (without DN qualification), one community matron, 2 HCAs/other support workers, one clerical/administrative staff and half an 'other' staff. But these averages mask considerable variation in the composition of teams; in 16% of cases there were no district nurses employed, 43% of teams had no community matrons and 38% did not have any administrative/clerical support staff.

Across all teams, district nurses comprise an average of 20% of staff employed (WTE).

Working hours

Working significant amounts of excess hours is commonplace among nurses working in district/community nursing teams. 81% reported they worked additional hours on their last shift, on average working an additional 80 minutes. Across all respondents (including those who did not work any extra time) nurses working in the community worked 70 minutes extra on the last shift.

Those working as case managers/team leaders had the longest additional hours (89 minutes), with other district nurses averaging 85 minutes, community matrons 81 minutes, nurse specialists/advanced role nurses 60 minutes, and community staff nurses worked an additional 54 minutes.

Caseloads

The average total number of staff on duty, on the respondents' last normal working day, was 8.6 and typically 14% of the total team were DNs, 49% community nurses (with no DN qualification), 6% community matrons, 2% nurse specialists, 18% HCAs and other support workers and 8% administrative/clerical staff.

On average, respondents reported having seen nine patients on their last shift with 25% of respondents reporting that they had seen 12 or more patients.

The estimated *potential* patient contact time (that is total time spent working, including additional hours, minus the time spent travelling and doing administration) varies from approximately 30 minutes per patient for community staff nurses to 40 minutes for district nurses. This figure would be lower still if nurses did not work significantly beyond their contracted hours. Qualified district nurses spent longer per patient than community staff nurses working in district nursing teams, and thus typically saw two patients fewer on their last shift. This suggests that their caseload and roles may be qualitatively different to nurses who are not qualified as district nurses.

Role and division of time

Direct care accounts for the largest proportion of time spent by nurses in district nursing teams, but nurses do not spend as much time on this activity as they would like. On average 37% of time is spent on 'direct care', 20% on 'assessment, care planning and coordination', 11% on 'leadership and management' and 13% of all time is spent 'travelling'. About a fifth (19%) of each day is spent on 'administration'.

Very few respondents (20%) are satisfied with the distribution of their time between core activities. Across the different roles, nurses working in the community (but particularly so for District Nurses) would like to spend less time on administration and more on direct care and leadership.

Two thirds (69%) felt that there were activities that they (or their staff group generally) currently undertake that would be better done by other staff. More than a half of all respondents indicated that some administrative/clerical activities should be undertaken by other groups and one in five also thought there were care procedures that would be better, or more cost effectively, done by other staff groups.

Quality of care and caseloads

When asked about the care on their last shift, 19% described it as excellent, 61% as good, 18% as fair, and 2% as poor. 95% of those who rated the quality of care provided as 'poor' or 'fair', agreed or strongly agreed with the statement *'there are not enough staff to get the work done'*.

The reported quality of care is significantly correlated with the number of patients seen. Nurses rating the care provided as 'excellent' had seen an average of 8.1 patients on their last shift; those rating care as 'fair' or 'poor' had seen 11.0 patients in their last shift. Despite differences in average caseloads between staff groups, the correlation between numbers seen and assessment of quality holds true for each group – those with higher caseloads are more likely to have described the quality on that shift as 'poor/fair' compared to those who had seen fewer patients.

Where nurses described the overall quality of care provided as 'poor', the average estimated *available* patient care time was 38 minutes, compared to 53 minutes for those providing a 'fair' level of care, 63 minutes for those providing 'good' care and 71 minutes per patient among those providing 'excellent' care.

Delivering good care in difficult circumstances

Nurses working in district nursing teams are generally positive about their work lives. Typically they report enjoying being able to care for people in their own homes, developing a good relationship with clients and their families and reducing the need for hospitalisation, particularly at the end of life. Many nurses also gain satisfaction from the autonomy and independence of the role. Despite the many satisfactions of providing care in the community and the fact that 94% consider that in general 'the team provides good care for patients', the provision of good quality care is achieved at considerable cost to the individuals who routinely work way beyond their contracted hours. The effect is significant pressure:

77% report that their ‘workload is too heavy’, 83% say there are not sufficient nurses to get the work done, and 75% report specifically that there are not sufficient district nurses on their team.

Many of the frustrations for nurses working in district/community nursing are interlinked. The most frequently cited sources of frustration, often described in language expressing considerable distress, are: excessive and unpredictable caseloads and workload; poor staffing levels and inadequate skill-mix (exacerbated by work related sickness absence and recruitment and retention difficulties), lack of administrative support, poor IT resource to support work, and concern about the effect insufficient staffing/time is having on the quality of care and health and wellbeing of nurses themselves and other team members. How others understand the district nursing service and what it can (and cannot) offer contributes to the pressure; challenges include high public expectations, inappropriate referrals, and being treated as a limitless ‘catch all’ by other agencies.

The net effect is that 44% of those working in district/community nursing report they are not satisfied with their current job and 40% would leave their job if they could.

1. Introduction

There is a lack of data and evidence concerning the working lives of nursing staff providing district nursing services in the community. Attention is frequently focused on staffing levels, quality of care and work demands of nurses working in hospitals but little research has been undertaken on the workloads and work lives of nurses providing care in the community. To address this, the RCN funded a study of its members who are recorded working as district nurses, community matrons and community staff nurses. The purpose of the study is to profile the community/district nursing workforce, explore variation in staffing levels and skillmix, and describe the morale and motivations of this group.

1.1 Context

One of the key challenges for 21st century healthcare systems is a growing mismatch between the demand and supply of healthcare services. As the population grows older, the quantity and complexity of care required is steadily increasing. Demographic pressures also apply to the workforce; the net effect of a shrinking pool of formal and informal caregivers and demand increasing is a substantial future care gap. The WHO report that this, combined with the increasing costs of hospitalised care, has prompted governments, commissioners, and policy makers worldwide to explore different approaches to healthcare delivery that may be more sustainable[1]. Moreover, healthcare has seen considerable advances in health information and communication technology that are also influencing the nature of healthcare professional work and specifically what can be done by whom and where[2].

Healthcare policy in the UK and beyond places considerable emphasis on 'shifting' care out of hospitals and closer to the community and people's homes[3]. The launch of the White Paper 'Our health, our care, our say'[4] in England in 2006, and in 2011 the Department of Health's 'Transforming community services'[5] programme, deliver a clear message of intent, to strengthen and improve community care. International experience suggests that increasing community-based care can reduce hospital readmissions and offers increased patient choice and satisfaction, and that investing in health

[1] World Health Organization (2006) The World Health Report: Working together for health. Geneva: World Health Organization. Available at: www.who.int/whr/2006/en/ (accessed March 2014).

[2] Imison C and Bohmer R (2013) NHS and social care workforce: meeting our needs now and in the future? Perspectives. London: The King's Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/perspectives-nhs-social-care-workforce-jul13.pdf (accessed March 2014).

[3] Goodwin N, Smith J, Davies A, Perry C, Rosen R, Dixon A, Dixon J and Ham C (2012) Integrated care for patients and populations: improving outcomes by working together. A report to the Department of Health and the NHS Future Forum. London: The King's Fund. Available at www.kingsfund.org.uk/publications (accessed March 2014).

[4] Department of Health (2006) Our health, our care, our say: a new direction for community services. Norwich: Stationery Office (Cm 6737). Available at: www.official-documents.gov.uk/document/cm67/6737/6737.pdf (accessed on March 2014)

[5] Department of Health (2011) Transforming community services: demonstrating and measuring achievement: community indicators for quality improvement. Leeds: DH.

promotion, early intervention, and prevention strategies through integrated care pathways can deliver prompt and effective care across settings[6].

Fundamental to delivering this vision is the healthcare workforce, including nurses working in the community[7]. The Queen's Nursing Institute 'Right Nurse, Right Skills' campaign and the 'Nursing People at Home' report[8] identified a need for staff with specialist knowledge and skills, ability to manage risk, assess complex needs, apply a variety of complex clinical interventions and work across organisations. NHS England set out a plan to develop community nursing (and mechanisms for planning the community nursing workforce) as part of its 'Compassion in Practice' action plan[9] and, more recently, the Department of Health has identified district nurses as key professionals in realising the ambitions of the National Health Service reforms and published[10] a model for district nursing that sets out clear ambitions to modernise the service and reduce variation between different parts of the country.

Despite the well-established policy agenda to increase community-based care, the proportion of nursing staff employed within the community in the NHS has changed little over the last ten years[11]. Nursing care in the community covers a wide range of services provided in a variety of settings[12]. In the past, district nurses have been central to the provision of these services, yet the number of district nurses has fallen by more than 40% in the past 15 years, with the knock on effect that whilst in 2005 district nurses made up 20% of all NHS staff recorded in the community, in 2012 only 12% of community nursing staff were qualified as district nurses[13]. This is likely to impact on the nature of teams at local level, but to date there is little information or evidence regarding how community nursing teams are staffed.

This report examines the nature of the workforce providing district nursing services in England, and aims to capture the reality of community nursing teams. In particular, it sets out to: identify the structure and organisation of services provided by district nursing teams; examine the roles, staffing levels and skillmix of these teams; and produce a demographic profile of the nurses working in district nursing that can inform future workforce needs.

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[6] Royal College of Nursing (2013a) Moving care to the community: an international perspective. London: RCN. Available at: http://www.rcn.org.uk/support/policy/policy_briefings/2013_briefings (accessed March 2014).

[7] Royal College of Nursing (2013b) District nursing. Harnessing the potential: the RCN's UK position on district nursing. http://tinyurl.com/p4wn5cr (accessed March 2014)

[8] The Queen's Nursing Institute (2011) Nursing People at Home: the issues, the stories, the actions. http://tinyurl.com/cbp9flj (accessed March 2014)

[9] Department of Health (2012) Compassion in practice: Nursing, Midwifery and Care staff. Our vision and strategy. Leeds: DH

[10] Department of Health (2013) Care in local communities: a new vision and model for district nursing. http://tinyurl.com/or4zkw3 (accessed March 2014)

[11] National nursing Research Unit. Policy+ Issue 40. District nursing – who will care in the future? London: KCL.

[12] Royal College of Nursing (2010) Pillars of the community: the RCN's policy position on the development of community nursing.

[13] Health and Social Care Information Centre 2013

1.2 Method

A cross-sectional survey of all Royal College of Nursing members working in district and community services in England was undertaken in November and December 2013.

The survey population included all members recorded with the job title of district nurse, community staff nurse or community matron (N= 8,023). The entire eligible population was used as the sample (i.e. a census).

The majority (6,240 members) were contacted via an email and asked to take part through an online survey (13th November 2013). Four reminders were sent to non-respondents over the following five weeks, and the survey closed on 17th December 2013.

All those without an email address were contacted by post and sent a paper copy of the survey (1,783 members). The postal survey 'pack' contained a covering letter, a screening page (to identify whether or not potential participants were currently working in a district nursing service) and an eight-page A4 questionnaire (with free-post envelope). The paper survey was mailed on 27th November and closed on 17th December 2013 (with no reminders).

1.3 Response rate

In total 8,023 questionnaires were distributed by email and post. However, 172 questionnaires did not reach the recipients due to having an invalid email or postal address and 605 of the responses received indicated they were not district or community nurses, or were not currently working in England. In total 2,438 responses were received (30% response rate).

The eligible population that could be reached and met the study criteria was therefore 7,246. A total of 1661 eligible nurses (working in district nursing teams / the community) completed the survey (23% of the possible 7,246). A further 174 eligible participants responded but indicated they did not want to take part.

To test for response bias, the profile of respondents (age and gender) was compared to that of the population. The respondents represent the population in terms of gender mix but there was a statistically significant difference by age with younger nurses under-represented amongst respondents (see Table 1.1).

Table 1.1: Population sampled and respondents profile by age band

Age band	Valid population %	Respondents %
Under 30	7.3	3.9
30-39	23.7	18.8
40-44	15.5	14.2
45-49	18.4	21.1
50-54	18.6	21.6
55-59	11.2	14.0
60 plus	5.3	6.3
Base N= (100%)	*7435*[14]	*1661*

Source: RCN/KCL District Nurse Survey, 2014

To redress this imbalance, a simple weighting procedure has been applied to the data to ensure that the respondents were representative of the population by age. This ensures a higher degree of confidence that the findings presented in the report are representative of the district/community nurse population surveyed.

In the remainder of the report we use 'district/community nurses' as a short hand to refer to all survey respondents.

1.4 Structure of the report

The remainder of the report presents the findings.

- Chapter 2 looks at the overall profile of district and community nurses including the demographic make up of respondents as well as their employment profiles.
- Chapter 3 describes district/community nurses' working patterns.
- Chapter 4 presents data on the populations served, services provided and workforce employed.
- Chapter 5 examines issues around staffing levels, workload and quality of care.
- Chapter 6 presents findings on the roles and activities undertaken.
- Chapter 7 considers the views of nurses working in the community and district nursing teams and reviews what they find satisfying and frustrating in their roles.
- Chapter 8 concludes with a discussion of the report's findings.

[14] Excluding sample who replied saying they were not district nurses or working in the community.

2. Profile of nurses working in district/community nursing

The purpose of this chapter is to provide the context for the rest of the report. In order to make sense of staffing and case-load data, and views of respondents about their work lives, we need to establish more precisely who nurses providing district/community nursing services are, in terms of their demographics, how they are qualified, the job titles of the posts they fill, and their pay.

To address this, we present findings from the survey that can be used to create a profile of nurses working in district/community nursing. We start by looking at the job titles and roles in which these nurses are employed and the qualifications they hold, before examining the demographic profile.

This is a key variable that is used to explore all the other findings. Community and district nursing is staffed by distinct subsets of nurses; district nurses, community staff nurses, community matrons, other specialist nurses and generically titled 'team leaders/case managers'.

The age profile of community nurses has been noted previously (e.g. in reviews of the UK nursing labour market[15], and previous cross-sectional surveys of nurses[16]) and has implications for workforce planning. National data indicate that community nurses have an older age profile than hospital based nurses, with larger proportions nearing retirement age. The survey gives us an opportunity to go beyond this general understanding of community nurse demographics, to examine how age varies between the sub-groups that make up the community/district nursing workforce. It provides information on which groups are nearer to retirement age and what qualifications/skills will be lost once they retire. Finally, we describe the pay bands on which district/community nurses are employed.

2.1 Job title and employer

Respondents were asked to indicate which job title most closely matched their own. The findings indicate that district/community nursing services are provided by a much wider range of staff than just district nurses (see Figure 2.1).

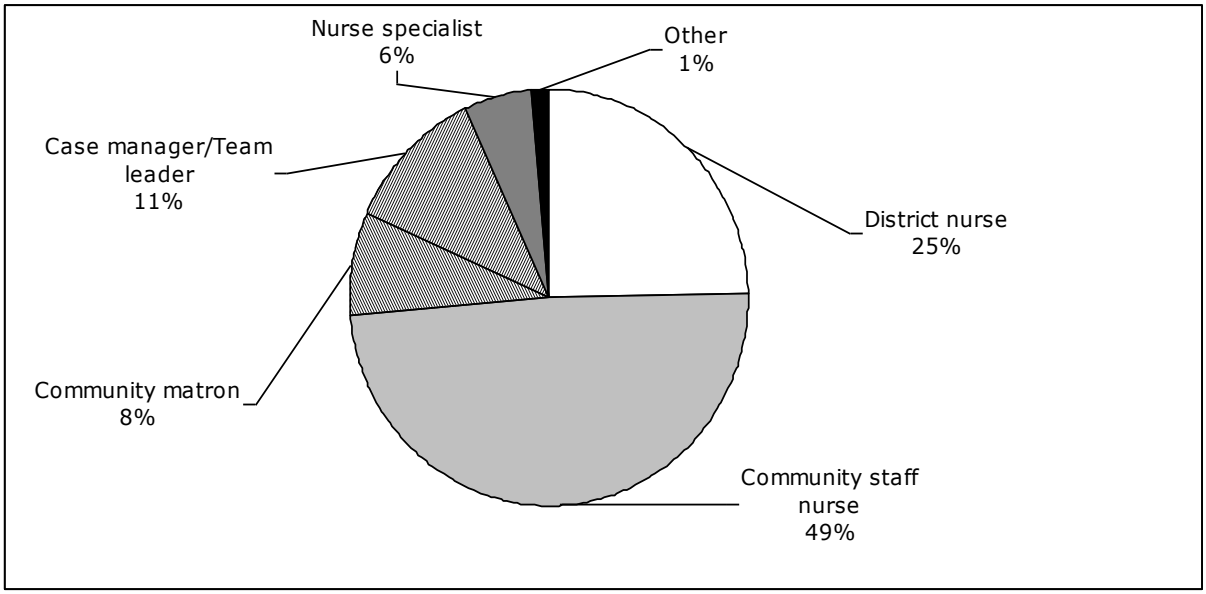
One in four (25%) reported that their job title was 'district nurse' whilst a half (49%) indicated that they are in 'community staff nurse' posts. A smaller proportion (8%) described their role as a 'community matron'. The remainder gave their titles as case managers/team leaders (or other 'lead') (11%), community nurse specialists/advanced nurses or other specialists (6%), or other roles (1%). Note that respondents selected the title they felt most closely matched their own; definitions were not provided for terms such as 'community nurse specialist', so each category is likely to cover a range of similar but different posts.

The 'job title' is used as the basis of classifying respondents throughout the report.

[15] Buchan and Seccombe (2013) Labour Market Review, RCN, London.

[16] Ball and Pike (2009) Past Imperfect, Future Tense: Nurses Employment and Morale in 2009, RCN, London.

Figure 2.1 Job title: percentages (weighted data)



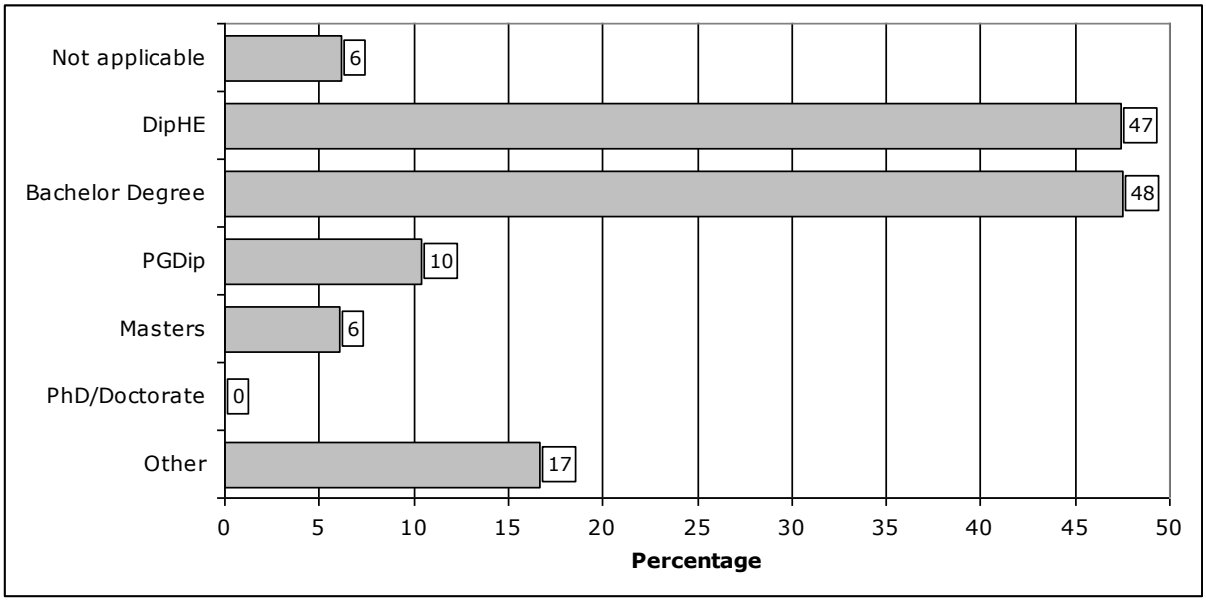
Source: RCN/KCL District Nurse Survey, 2014

Whilst 88% indicated that they are employed by the NHS, 12% worked for other healthcare providers. More specifically, 42% are employed in combined NHS Acute and Community Trusts, 23% in NHS Community Trusts and 22% in NHS Care Trusts. Just one in ten respondents (10%) work for social enterprises and two per cent work for independent providers. There is little difference in the distribution of different job titles by type of employer.

2.2 Qualifications

Nurses were asked two questions relating to qualifications – specifically which academic qualifications in nursing they held, and a more general question asking about all their nursing qualifications. Just under a half of respondents hold a nursing degree (48%) and 47% hold a diploma in nursing. Six per cent hold a Master's in nursing and one in ten hold a postgraduate diploma. Nobody responding to the survey indicated that they had a doctorate in nursing (Figure 2.2).

Figure 2.2 Level of academic nursing qualification held: percentages[17] (weighted data)



Source: RCN/KCL District Nurse Survey, 2014

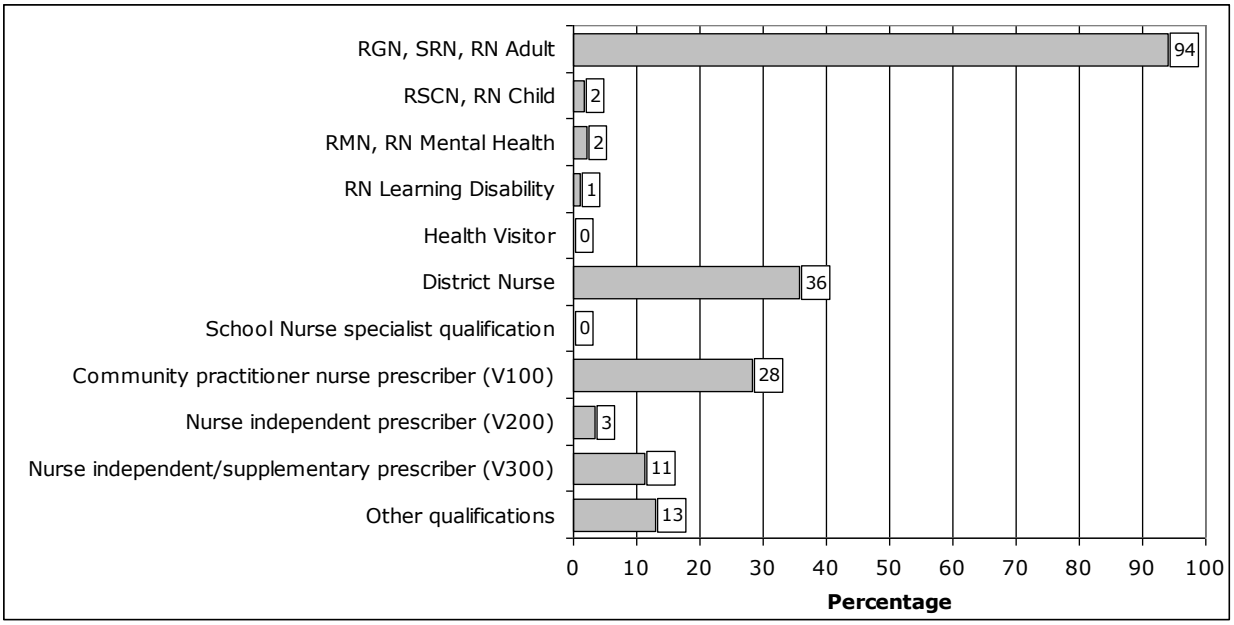
Six per cent reported that they did not hold an academic qualification (responding 'not applicable'). Nurses aged over 50 are more likely to indicate that they do not have an academic nursing qualification (11% compared to 7% of those in their 40s and none of those aged under 40) and to report that they hold 'other' qualifications (26% compared to 16% of respondents in their 40s and 6% of those aged under 40). Conversely, younger respondents are more likely to have DipHE (59% of those aged under 40) and to hold bachelor degrees (55%).

Figure 2.3 shows the nursing qualifications held by respondents. A third (36%) hold a district nurse qualification and 28% indicated they have the community practitioner nurse prescriber qualification (V100). A new variable was created to group together those nurses who have specialist community/ public health nursing qualifications (SPQ - district nursing, health visiting, school nursing), and those with registered nurse qualifications alone (RGN, RSCN, RMN, RN learning disability). A third (36%) of all respondents have a specialist practitioner qualification while two thirds (64%) have registered nurse qualifications only. Four fifths (81%) of specialist practitioner qualified nurses hold a prescribing qualification (compared to 13% of nurses who do not have a SPQ).

The age profile varies according to whether respondents hold a SPQ. The average age of those with an SPQ qualification was 47 compared with 43 among nurses without and 46% are aged 50 plus compared to 28% of those without.

[17] Note that percentages sum to more than 100 as respondents were allowed to select more than one response.

Figure 2.3 Nursing qualifications held: percentages (weighted data)



Source: RCN/KCL District Nurse Survey, 2014

Table 2.1 Job title by type of nursing qualification and whether hold prescribing qualifications: percentages (weighted data)

	District nurse	Community staff nurse	Community matron	Case manager/Team leader	Nurse specialist	Other	All respondents
RN only	26	94	40	32	69	70	**64**
SPQ[18]	74	6	60	68	31	30	**36**
N= (100%)	*409*	*806*	*136*	*188*	*93*	*20*	***1652***
Prescribing qualifications							
No	34	91	11	37	65	62	**62**
Yes	66	9	89	63	35	38	**38**
N= (100%)	*409*	*806*	*136*	*188*	*93*	*21*	***1653***

Source: RCN/KCL District Nurse Survey 2014

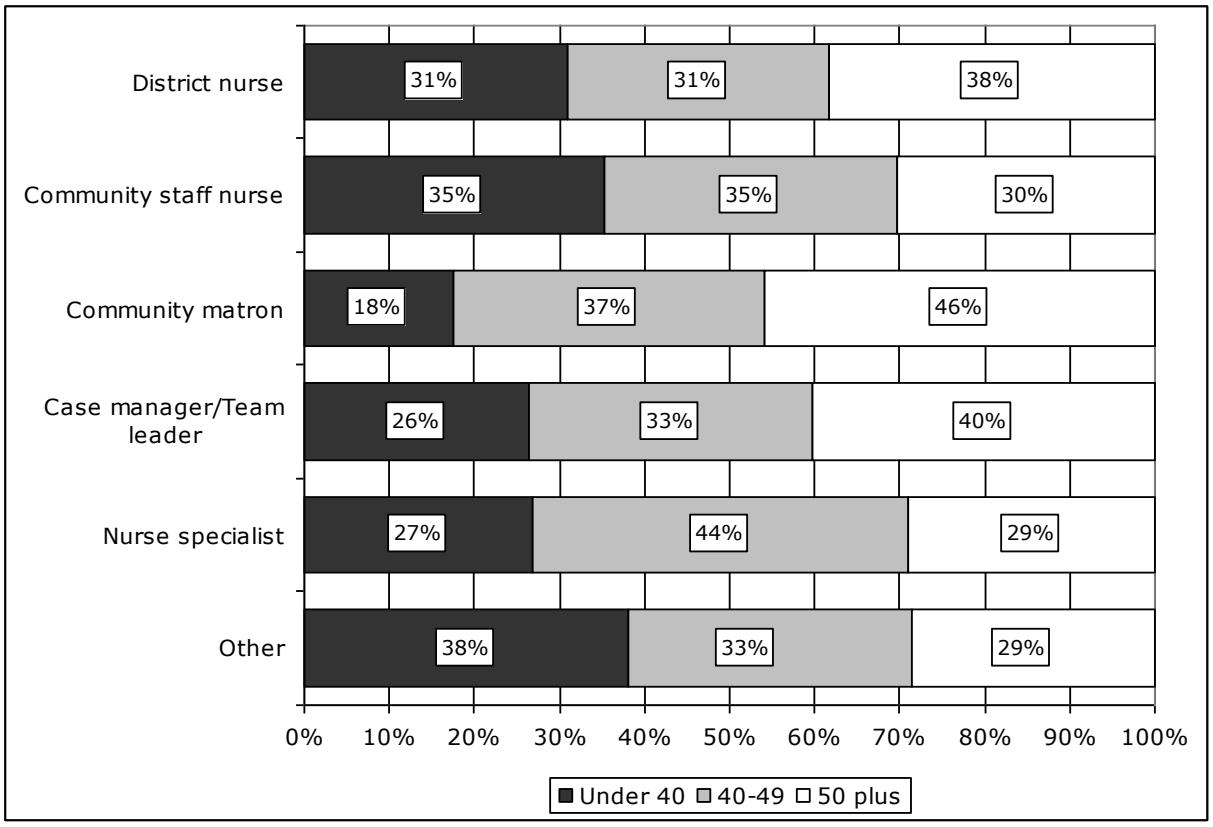
District nurses (74%), community matrons (60%) and case managers/team leaders (68%) are all more likely to hold 'qualifications in specialty' than community staff nurses (6%) and nurse specialists/nurses in other advanced roles (30%). There is a similar difference by job title in whether respondents hold prescribing qualifications too, as shown in Table 2.1.

[18] Specialist Practitioner Qualification – used here to denote qualifications in district nursing, health visiting, school nursing

2.3 Demographic profile

The vast majority (96%) of nurses working in district/community nursing are female, with just 63 male respondents to the survey. The average age is 46[19]; 35% of district/community nurses are aged 50 or older. Figure 2.4 shows the age profile by job title.

Figure 2.4 Age profile by job title - percentages (weighted data)



Source: RCN/KCL District Nurse Survey, 2014

Nurses responding to the survey have been qualified for an average of 19 years although 13% have been qualified for five years or less. The average length of time working in district/community nursing is 11 years, suggesting that most have been working in this sector for approximately 60% of their careers.

The profile of nurses working in each broad job title area varies significantly. Table 2.2 summarises these data for each broad category of job.

[19] As noted in chapter 1, the respondent age profile differed slightly from that of the population. The data has been weighted so that the respondent profile matches that of the population. The analysis in the reminder of the report is based on weighted data.

Table 2.2 Job title by experience in district nursing - percentages (weighted data)

	District Nurse	Community staff nurse	Community matron	Case manager/Team leader	Nurse specialist	Other	All respondents
Years worked in district/community nursing							
< 5 years	9	37	8	9	12	18	**23**
5-9 years	22	28	24	17	37	45	**25**
10-14 years	25	19	20	28	19	9	**22**
15+ years	44	16	48	46	32	27	**30**
Mean years	14.6	8.4	15.1	14.9	11.9	11.1	**11.5**
Mean age	46	44	48	46	45	44	**45**
N= (100%)	*326*	*607*	*96*	*145*	*57*	*11*	***1242***

Source: RCN/KCL District Nurse Survey 2014

There is a slightly higher concentration of older and more experienced nurses working for independent providers but nurses working in different sectors are no more or less likely to hold specialist community or prescribing qualifications, as later sections describe.

District nurses, community matrons and case managers/team leaders are all more likely to have been working in this field for longer. Just under a half of each group have been working in the field for 15 years or more. Conversely, nearly four in ten (37%) staff nurses (community) have been working in this field for less than five years.

2.4 Pay bands

Across community/district nursing respondents, 51% are employed on pay band 5, 29% are on band 6, 18% on band 7 and two per cent on band 8[20]. The pay bands of the different groups covered by the survey varies considerably, as shown in Table 2.3. Two thirds (65%) of district nurses are employed on band 6 and 19% on band 7/8 with 15% on band 5. In contrast, 95% of community staff nurses are on band 5. The vast majority (all but two) of community matrons are on band 7/8. There are no differences in pay bands by type of employer or gender.

[20] For the remainder of the report, band 7 and band 8 are merged as the number of cases in band 8 are insufficient for detailed analysis.

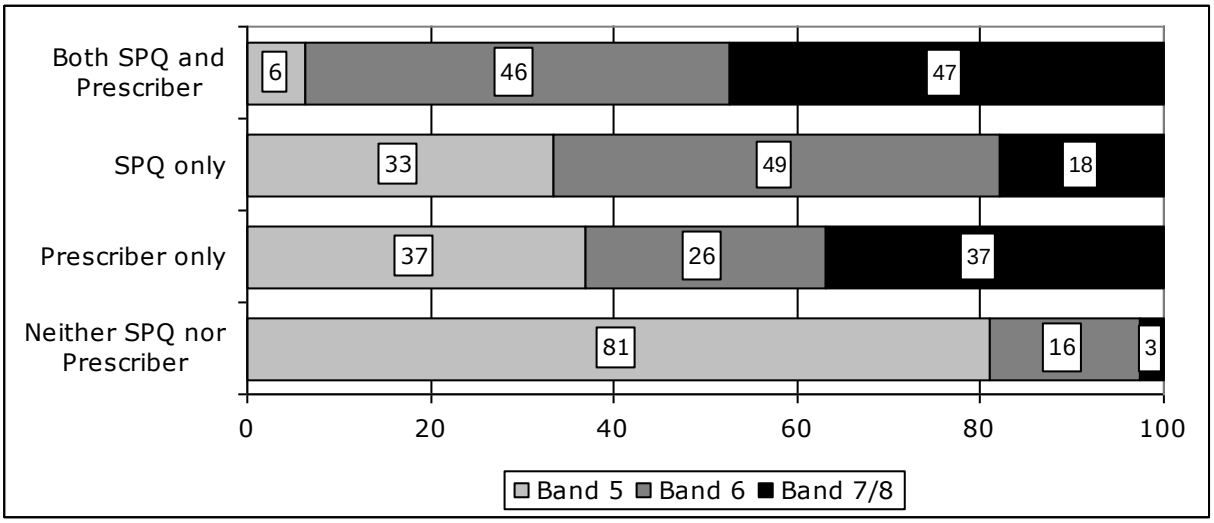
Table 2.3 Pay band by job title: percentages (weighted data)

	District Nurse	Community staff nurse	Community matron	Case manager/ Team leader	Nurse specialist	Other	All
Band 5	16	95	1	0	16	58	**51**
Band 6	65	7	1	49	55	25	**29**
Band 7/8	19	0	98	51	29	17	**20**
N= (100%)	*324*	*607*	*96*	*144*	*58*	*12*	***1241***

Source: RCN/KCL District Nurse Survey 2014

District nurses are much more likely to hold prescriber qualifications than community staff nurses. Figure 2.5 presents pay dband by whether respondents hold a specialist practitioner qualification and whether they hold a prescribing qualification. Those with both SPQ and prescriber qualifications are most likely to be in more highly paid posts – 47% on band 7 or 8.

Figure 2.5: Pay band by type of qualifications: percentages (weighted data)



Source: RCN/KCL District Nurse Survey, 2014

2.5 Key points

National data indicate that community nurses have an older age profile than hospital based nurses, with larger proportions nearing retirement age. The survey found that the average age of nurses responding is 46 with 35% of district/community nurses aged 50 and over. One in four nurses working in district nursing teams are qualified DNs while a half are in 'community staff nurse' posts.

District nurses are more likely to have been working in this field for longer than community staff nurses with just under a half working in the field for 15 years while nearly four in ten (37%) community staff nurses have been working in this field for less than five years.

The average length of time nurses responding to the survey have been working in district/community nursing is 11 years, suggesting that most have been working in this sector for approximately 60% of their careers.

Across all community/district nursing respondents, 51% are employed on pay band 5, 29% are on band 6 and 20% on band 7/8. Two thirds (65%) of district nurses are employed on band 6 and 19% on band 7/8 with 15% on band 5. In contrast, 95% of community staff nurses are on band 5. The vast majority (all but two) of community matrons are on band 7/8.

District nurses are much more likely to hold prescriber qualifications than community staff nurses. And nurses with both SPQ and prescriber qualifications are most likely to be in more highly paid posts – 47% are employed on band 7 or 8.

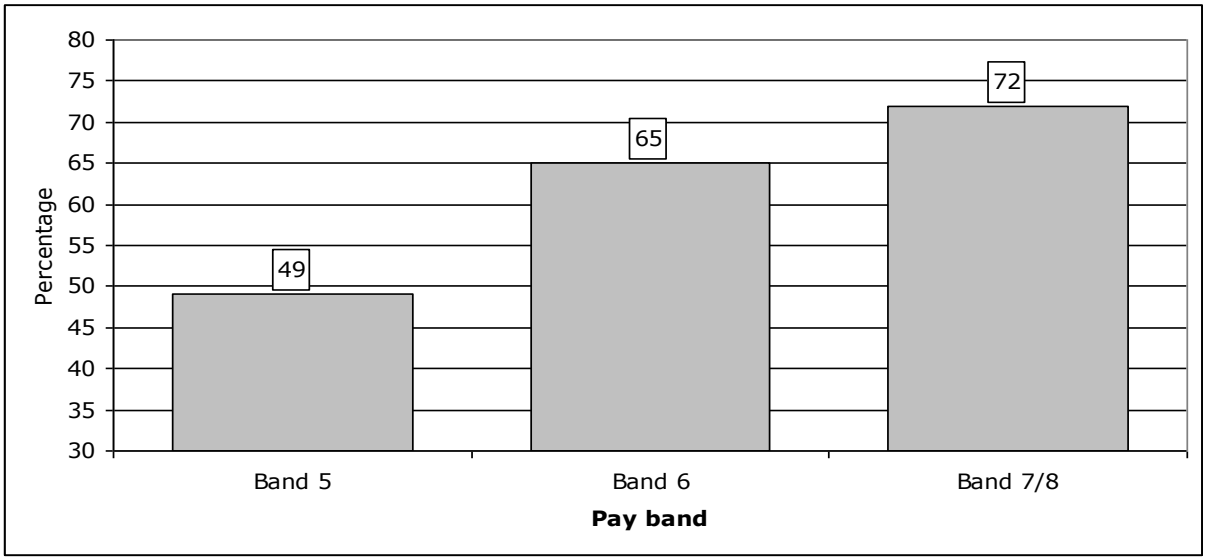
3. Working patterns and hours

This section examines the working patterns of district/community nursing participants. In particular, the data examine full-time or part-time work patterns; provide information on the number of hours a week and the typical length of shifts; as well as the amount of time participants worked beyond their contracted hours.

3.1 Full or part-time working

Six in ten (59%) nurses working in district/community nursing work full-time and the rest (41%) work part-time. Working hours is related to pay band with nurses on higher grades more likely to be full-time (see Figure 3.1). Respondents who have joined this field of nursing more recently are also more likely to be working full-time. Three quarters (71%) of nurses who have been working in district/community nursing for less than 5 years work full-time, compared to 65% of those who have been in the field for between 5-9 years and 50% of those 10 years plus into their district nursing careers.

Figure 3.1 Full-time working by pay band: percentages (weighted data)



Source: RCN/KCL District Nurse Survey, 2014

More than half (56%) of all respondents work 37.5 hour weeks. One in five (20%) of respondents work less than 23 hours per week, one in five (21%) work between 23 and 32 hours per week and three in five (59%) work more than 33 hours per week. Again, stage of career is strongly correlated with those in the later stages of their careers most likely to work the shortest working weeks e.g. a third (33%) of those respondents more than 30 years into their careers work fewer than 23 hours, 25% work 23-32 hours and 42% work more than 33 hours per week. Table 2.4 summarises working pattern by job title.

Table 3.1 Working hours by job title: percentages and mean hours (weighted data)

	DN	Community staff nurse	Community matron	Case manager/ Team leader	Nurse specialist	All respondents
Full-time (%)	59	49	73	70	57	**57**
Part-time (%)	41	51	27	30	43	**43**
Mean hours (FT)	37.3	37.1	37.5	37.5	37.5	**37.2**
Mean hours (PT)	24.0	23.5	27.3	26.5	24.8	**24.1**
N= (100%)	*333*	*597*	*101*	*148*	*61*	***1250***

Source: RCN/KCL District Nurse Survey 2014

3.2 Shift lengths

The vast majority (85%) of respondents work 7-9 hour shift lengths, nine per cent work less than seven hour shifts and six per cent work longer than nine hours. However, working large amounts of additional hours is commonplace.

A series of questions asked nurses about their most recent shift – its length, number of hours scheduled to work and actual number of hours worked. Almost all (95%) had worked a day shift on their last shift with just 73 respondents working a night shift. On average nurses working full-time were scheduled to work 7 hours 40 minutes on their most recent shift while nurses working part-time worked 7 hours 10 minutes.

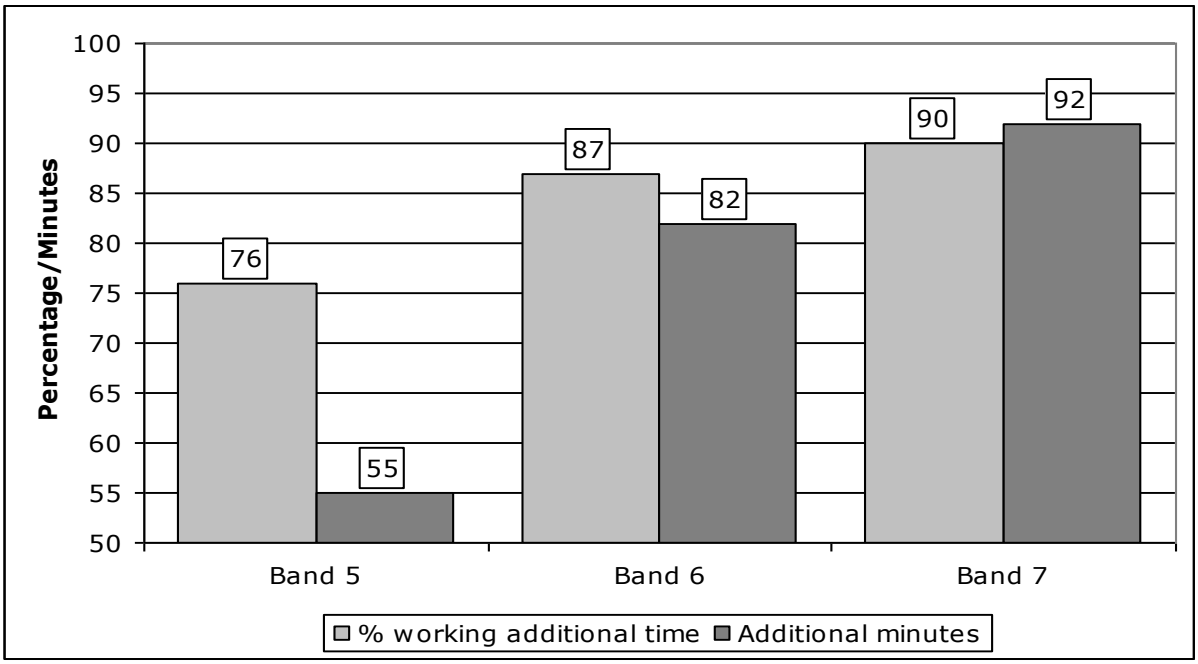
3.3 Actual hours worked – excess hours

On their last shift eight out of ten (81%) nurses worked additional hours to the hours they were contracted to work, typically for an additional 80 minutes.

There is variation both in the likelihood of respondents working additional hours and in the amount of additional time worked over their last shift by job title, type of qualification (i.e. whether or not nurses are qualified SPQ and/or prescribers) and pay band. Pay band accounts for most variation with 90% of nurses on band 7/8 working additional hours and on average across band 7/8 respondents (including the 10% who did not work any additional time on their last shift) working an average of 92 additional minutes over their scheduled shift length. This compares to 82 minutes among those on band 6 (87% of whom worked additional time) and 54 minutes for those on band 5 (76% of whom worked additional time) (Figure 4.1).

Looking at job title, district nurses worked 85 minutes, community matrons 81 minutes longer than their contracted shift length, case managers/team leaders 89 minutes and community nurse specialists and other specialists/advanced role nurses 60 minutes longer. Other staff nurses/sisters worked 54 minutes longer.

Figure 3.2 Working beyond contracted hours (percentages and mean number of minutes worked, across all respondents)



Source: RCN/KCL District Nurse Survey, 2014

Nine in ten nurses who are SPQ qualified worked beyond their contracted hours on their last shift, compared to 77% of nurses who are not SPQ qualified. Also, nurses working full-time are more likely to have worked additional hours (85%) than those working part-time (77%).

Across all nurses (including those who did not work any additional hours on their last shift), the average was 70 minutes worked over and above their shift length.

3.4 Key points

Six in ten (59%) nurses working in district/community nursing work full-time and the rest (41%) work part-time. Three quarters (71%) of nurses who have been working in district/community nursing for less than 5 years work full-time, compared to 50% of those 10 years plus into their district nursing careers.

Working significant amounts of excess hours is commonplace among nurses working in district/community nursing teams. On their last shift eight out of ten (81%) nurses worked additional hours to the hours they were contracted to work, typically for an additional 80 minutes.

District nurses worked an additional 85 minutes beyond their scheduled shift length, community matrons 81 minutes longer, case managers/team leaders 89 minutes and community nurse specialists and other specialists/advanced role nurses 60 minutes longer. Other community nurses worked 54 minutes over their scheduled shift length.

Nine in ten nurses who are SPQ qualified worked beyond their contracted hours on their last shift, compared to 77% of nurses who are not SPQ qualified. Across all nurses working in the community (including those who did not work any additional hours on their last shift), an average of 70 minutes additional time is worked beyond the scheduled shift.

4. Populations served, services and workforce

A key driver for the current study was the lack of detailed information on how community services are staffed. National workforce data (the principle source being the NHS information centre) provide global data on the numbers of staff employed by the NHS based in community settings. But this gives only a partial view of the workforce. For example, district/community nursing services are not identified separately from other community based staff and while staff, such as district nurses, are identified by qualification other roles in the community are less visible. Moreover, the nature of the teams and context in which staff are employed is not captured, nor the extent to which composition of community nursing workforces vary across the country.

This survey addresses these issues by examining the size and skill-mix of community/district nursing teams in order to identify how much variation exists in team compositions and according to where services are based. This section of the report looks at the communities where services are provided and the nature of those services[21]. It is hypothesised that the nature of the environments, whether urban or rural, and the size and distribution of the populations served may affect the workforce required, as will the type of service offered (for example whether available seven days or at nights). Having established these service parameters and the extent to which they vary across England, we describe the composition of district/community nursing teams, in terms of the number and mix of staff employed.

Finally, we bring the population and workforce data together and (whilst acknowledging the potential limitations) present an analysis of the density of district/community nursing workforce per 1,000 heads of population.

4.1 Area and population served

More than half (57%) of respondents work in mainly urban areas (primarily towns/cities), with a third (32%) describing the area in which they work as 'rural with some towns' and 11% serving mainly rural (primarily countryside) communities. The two 'rural' classifications are merged for future analysis, creating a broad rural/urban split.

In terms of the geographical size of the areas covered, the average distance to the furthest point was 13 miles away. Not surprisingly teams based in rural settings covered larger geographical areas with an average of 17 mile radius compared to 10 miles among those in urban environments. Advanced and specialist nurses cover larger areas – a mean of 17 miles to the furthest point as opposed to a mean of 10 miles across the other job categories.

Respondents were asked to give details of the size of the population covered by the team. Only 504 participants provided a response to this question. A large number of participants 1117 (67%) indicated that they did not know and the variation in responses was such that we could not be certain how the

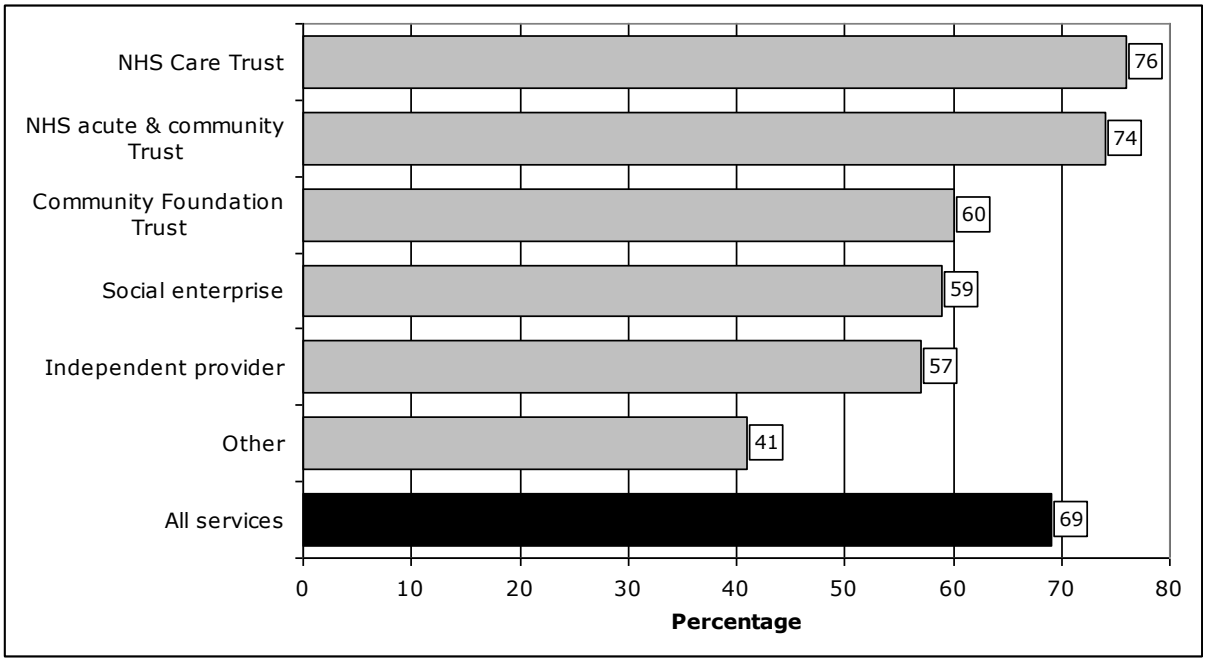
[21] The data presented in this section of the report does not use weighted data as the individuals responding are reporting on their nursing teams and not on themselves as individuals.

question had been interpreted. As a result the population covered data have not been used in the analysis and we have relied more on individual caseload data to provide indicators of demand.

4.2 Service provided

Nearly all community/district nurses responding indicated that the service in which they work is available seven days a week, and 69% said it was available 24 hours a day. Services in urban environments are more likely to be available 24 hours a day (72% reporting 24 hour services available compared to 62% of respondents working in primarily rural settings). Figure 4.1 shows the relationship with type of employer; respondents working for NHS Care Trusts are more likely say a 24 hour service is available (and more so than those in social enterprises and independent providers).

Figure 4.1 District nursing teams: percentage available 24 hours a day by type of employer



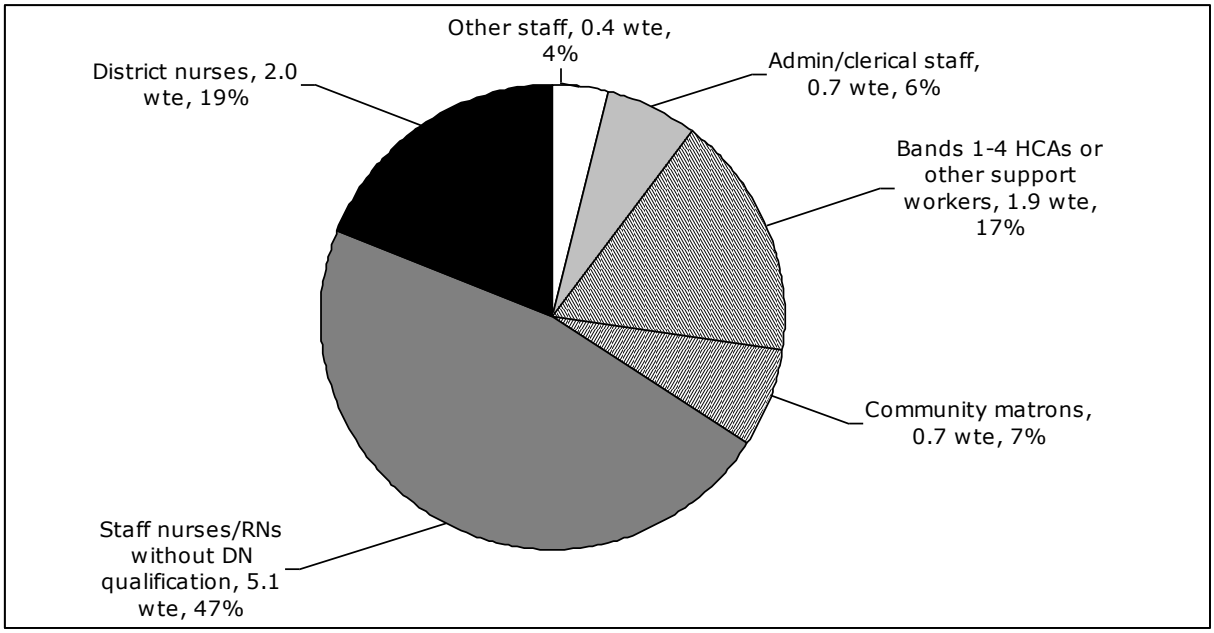
Source: RCN/KCL District Nurse Survey, 2014

4.3 Team composition (size and mix)

Respondents were asked for the number of posts and number of people in each of five main roles (and were given an 'other' category for any other staff groups not covered). This allows the total size of the team (as number of people/headcount and whole time equivalent posts) to be calculated as well as the mix within the team.

The 'typical' district nursing team is made up of approximately 15 members of staff (mean average), representing 11 whole time equivalent (WTE) posts. Figure 4.2 shows the mean numbers of whole time equivalent (WTE) staff in different roles within the team.

Figure 4.2 District nursing teams: average (mean) whole time equivalent (WTE) staff and percentage of team by job title



Source: RCN/KCL District Nurse Survey, 2014

The typical team composition is: approximately two district nurses, five community staff nurses (with no DN qualification), one community matron, two HCAs/other support workers, one clerical/administrative staff and half an 'other' staff. Across all district/community nursing teams this equates to around one in five (19%) of all staff in the team being district nurses, while staff nurses make up approximately a half (47%) of staff on the team.

However, these averages mask significant variation in the overall size of teams. One in eight (12%) teams have four or fewer total staff (WTE) while in 10% of teams there are 20 or more staff, with one team containing 115 staff (WTE). In terms of the variation between teams there is little difference between urban and rural settings or between employer type.

A series of 'skill-mix' variables were created from the above data to make explicit the relative contribution of district nurses, registered nurses and healthcare support workers (HCSW) (Table 4.1).

There is significant variation in team composition, and in particular with the amount of district nursing input. Across all teams, district nurses comprise an average of 20% of staff employed (WTE). However in 16% of cases the teams had no district nurses employed at all, and in a further 10% of cases district nurses made up 10% or less of the staff employed (WTE). On average 75% of the staff employed in district/community nursing teams are registered nurses of some sort (including DNs, staff nurses/sisters and community matrons) with a further 17% of the team being band 1-4 healthcare support workers. Administrative and clerical staff and others make up the remaining 6% of the staff employed.

In 42% of teams there are no community matrons employed and in 38% of teams covered by respondents there are no administrative staff employed on the team.

Table 4.1 Summary statistics for size and composition of teams (WTE)

	Cases				Percentiles[22]				
	N=	Missing	Mean	Median	10%	25%	50%	75%	90%
Total team	991	24	10.9	8.8	4.0	5.7	8.8	13.6	20.0
Registered nursing staff in team (DN+RN+CM)	991	24	7.8	6.3	3.0	4.0	6.3	10.0	14.5
Proportion District Nurses in team (DN/Tot team)	991	24	20%	17%	0.0	9.7	17.2	25.0	42.5
Proportion qualified nurses in whole team	991	24	75%	78%	54.3	66.7	77.8	85.0	92.3
Proportion HCSWs in whole team	991	24	17%	15%	0.0	9.1	14.7	21.9	31.9
Proportion admin in team	991	24	6%	4%	0.0	0.0	4.1	9.1	14.3
Population covered per team (total)	391	624	5192	2632	1135	1818	2631	4000	8000

Source: RCN/KCL District Nurse Survey, 2014

4.4 Key points

Most respondents were working in urban environments (57%) with an average distance to the furthest point of 10 miles. Four in ten respondents were based in predominantly rural areas with an average 17 miles to the furthest point in the area. Advanced and specialist nurses cover larger areas – a mean of 17 miles to the furthest point as opposed to a mean of 10 miles across the other job categories.

Almost all services are available seven days a week, and 69% said their service was available 24 hours a day. Services in urban environments are more likely to be available 24 hours a day (72% reporting 24 hour services available, compared to 62% of respondents working in primarily rural settings). NHS settings are more likely than other types of employers to be offering 24 hour service (75% compared to around 60% of respondents working for other types of employers).

The typical district nursing team is made up of approximately 15 members of staff (mean average), representing 11 whole time equivalent (WTE) posts. This team typically consists of approximately two district nurses, five staff nurses/sisters (with no DN qualification), one community matron, two HCAs/other support workers, one clerical/administrative staff and half an 'other' staff.

Across all teams, district nurses comprise an average of 20% of staff employed (WTE) but in 16% of cases there were no district nurses employed and in 43% of teams there were no community matrons and 38% of teams contained no administrative/clerical support staff.

On average 75% of the staff employed in district/community nursing teams are registered nurses (including DNs, staff nurses/sisters and community matrons) with a further 17% of the team being band 1-4 healthcare support workers. Administrative and clerical staff and others make up the remaining 6% of the staff employed.

[22] The percentiles relate to the proportion of cases up to that point. So looking at row 2 'the proportion of DNs in the whole team', in 10% of cases DNs account for no staff, in 75% of cases DNs account for 25% of staff on the team.

5. Staffing and workload

A key aim of this research was to not only describe the workforce in terms of the staff employed and composition of the teams (covered in Chapter 4), but to examine staffing levels and workloads 'on the ground'; to capture the reality of staffing and caseloads on a typical shift as reported by individual staff, as opposed to simply looking at establishments and posts.

To do this we asked respondents to answer a series of questions about the staff on duty and patients seen on the last shift/day they worked. These responses are used to describe staffing levels on duty (as opposed to planned or in post) and look at the caseloads based on the individual, and for the whole team. Anticipating that workloads vary from day to day, a follow up question asked staff if they felt the last shift they worked was typical, and to provide the 'typical' number of patients they would normally see during a shift.

5.1 Staff on duty and patients seen by the team

All respondents were asked about the last shift they worked; how many patients they themselves saw and the staffing and number of patients seen by the team. Table 5.1 summarises the staff numbers on duty for respondents' last normal working day, showing also the range of responses. The total number of staff on duty, on the respondents' last normal working day, was 8.6. The typical team on duty (using mean results from all nurses) consisted of 1.2 DNs (14% of the total team), 4.2 registered nurses (without DN qualification) (49% of team), 0.5 community matrons (6% of team), 0.2 nurse specialists (2% of team), 1.5 HCAs and other support workers (18%) and 0.7 administrative/clerical (8%). The 'other' roles consisted of a variety of nursing and other professions linked to healthcare.

Table 5.1: Patient and staff numbers on last shift (day only)

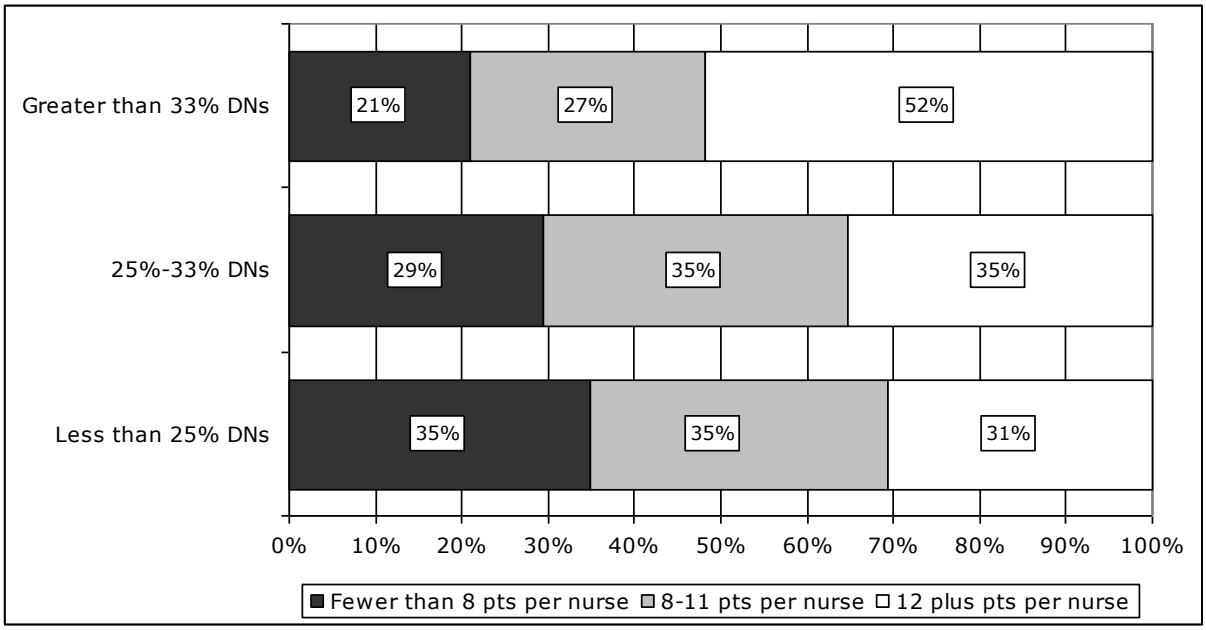
	Cases				
	N=	**Missing**	**min-max**	**Mean**	**as %**
District nurses	1266	131	0-15	1.2	14%
RNs (without DN qualification)	1266	131	0-80	4.2	49%
Community matrons	1266	131	0-10	0.5	6%
Community nurse specialist	1266	131	0-12	0.2	2%
Bands 1-4 HCAs or other support workers	1266	131	0-21	1.5	18%
Administrative/clerical	1266	131	0-24	0.7	8%
Other	1266	131	0-10	0.2	3%
Total number of staff on duty during last normal working day	**1266**	**131**	**1-108**	**8.6**	**100%**
No. patients seen by WHOLE team	1166	231	0-600	61.3	
Average patients seen per member of the nursing team	**1133**	**264**	**0-150**	**11.5**	

Source: RCN/KCL District Nurse Survey, 2014

In 29% of cases there was no district nurse on duty during the respondent's last normal work day, in 63% of cases there was no community matron and in a half (53%) of cases there was no administrative/clerical staff available.

Respondents reported how many patients were seen by the team on their last shift, and the mean average was 11.5. An association is observed between the average number of patients seen and the team composition. Teams with a larger proportion of district nurses on duty tend to see slightly more patients per member of the team. For example, in about a half (52%) of cases, a third or more of the staff on duty were district nurses. These teams saw an average of 9.8 patients per member of the team. In contrast, teams in which DNs accounted for 25% or less of the staff on duty, saw an average of 9.4 patients per member of the team. This relationship is illustrated in Figure 5.1.

Figure 5.1: Patients seen per nurse according to proportion of district nurses on duty



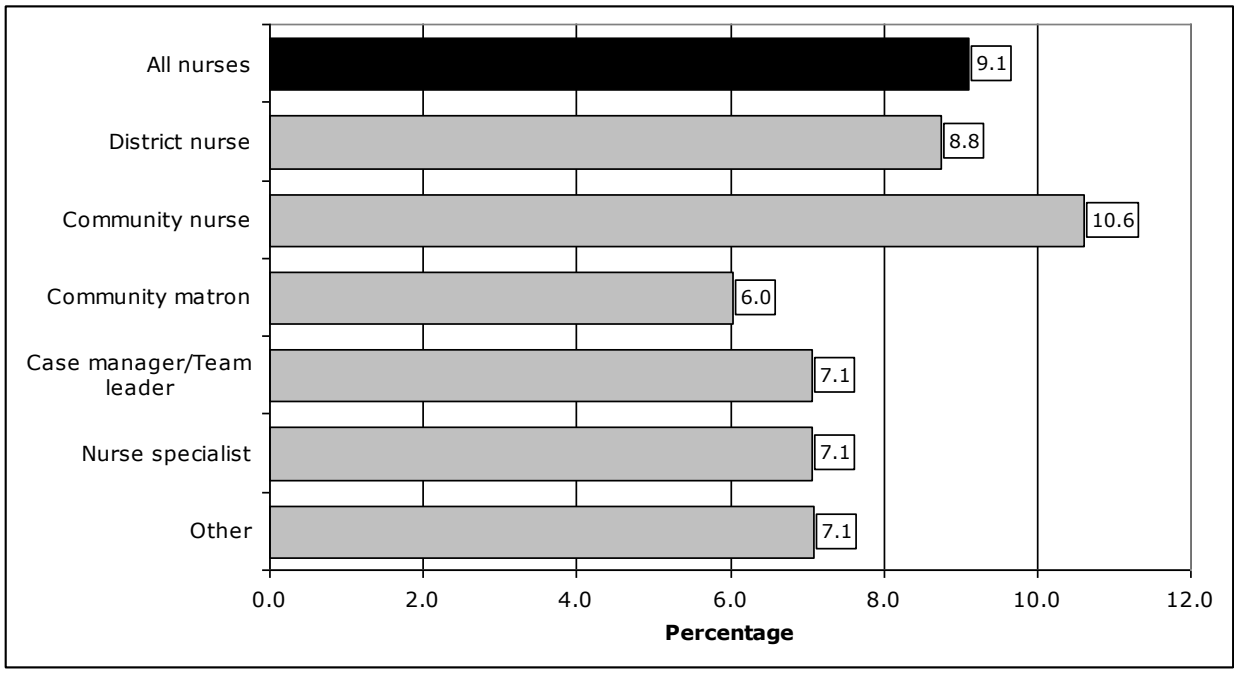
Source: RCN/KCL District Nurse Survey, 2014

5.2 Individual workload on last shift

On average, respondents saw nine patients on their last shift (mean and median both 9) with 25% of respondents reporting that they saw 12 or more patients. Most nurses (80%) reported that the number on their last shift was fairly typical of a normal shift. When asked what the range in the numbers of people typically seen in a single day might be, the average was a minimum of six to a maximum of 14. One in five respondents reported five patients or less on their last shift, nearly a half (47%) saw 6-10 patients and a third (32%) saw more than 10 patients. Interestingly, there is no correlation in the average number of patients seen by nurses on their last shift with the size of the patch in terms of the furthest point that the team covers. There is also no difference in typical caseloads between nurses working in rural or urban environments, those in areas with large or small populations, or between different employer groups. There is however differences in the number of patients seen per day according to job title/role.

Figure 5.2 summarises the difference by job title, showing that qualified district nurses see, on average, two fewer patients than community nurses (with no DN qualification) working in district nursing teams, perhaps suggesting that their case load and roles may be qualitatively different to those of general nurses. Community matrons (6) see three fewer patients on average than district nurses (9) with all other respondents reporting that they saw, on average, seven patients on their last shift.

Figure 5.2: Average number of patients seen on last shift by job title (mean, day time)



Source: RCN/KCL District Nurse Survey, 2014

The data on shift length and hours worked, can be combined with number of patients seen to produce a time *available* per patient figure (Table 5.2). Dividing the total time on duty by the total number of patients gives a figure of 63 minutes per patient. However, this does not take account the substantial amount of time spent in travel and administration (see Chapter 6), or the actual hours worked (beyond the contracted hours).

If administration time and travel time are deducted, and these additional hours included, the estimated *potential* contact time per patient is 39 minutes. Clearly there are other tasks that need to be undertaken in a typical working week that will vary between staff, e.g. management, staff meetings, training, as well as activities that are not direct patient contact, for example planning and assessment.

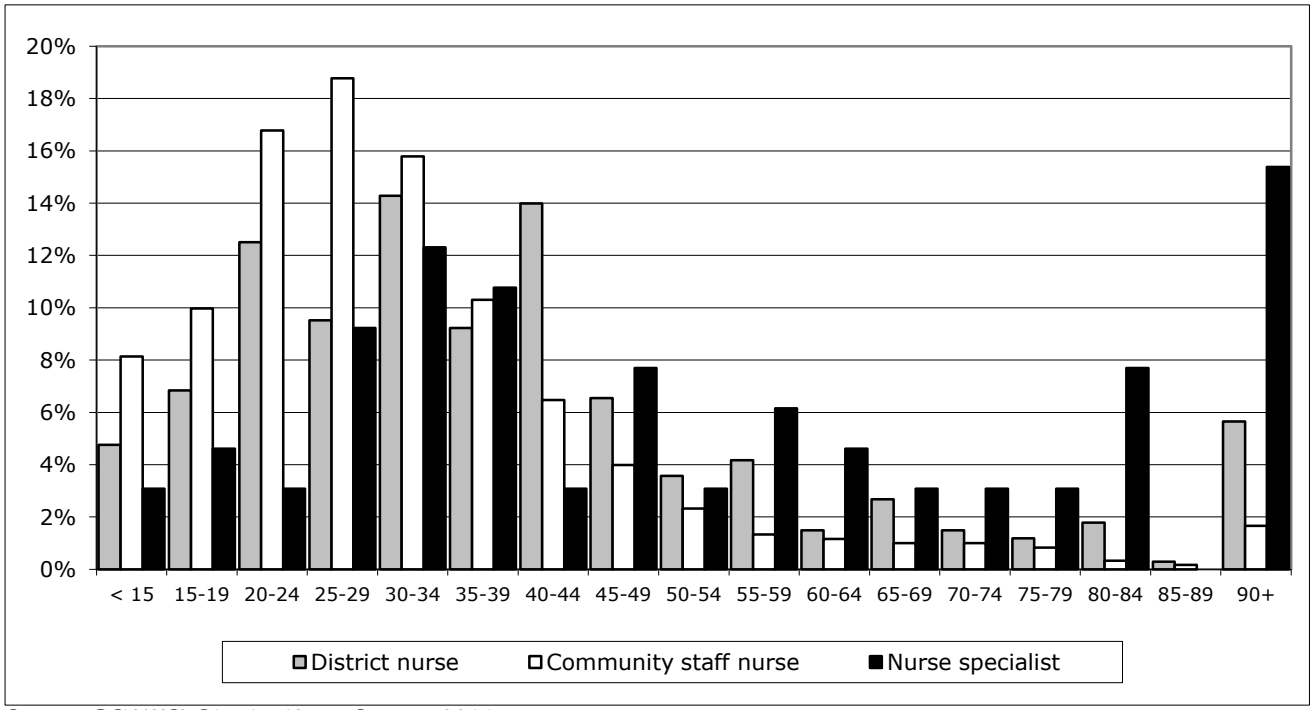
Table 5.2 Patient numbers seen per shift: distributions of key variables

	Cases				By job title[23]				
	N=	Missing	Mean	Median	DN	CN	CM	CM/TL	NS
No. patients seen by WHOLE team	1166	231	61	50	63	59	67	69	45
No. patients personally seen on last shift	1389	8	9	9	9	11	6	7	7
'Typical' no. of patients seen per shift	1375	22	10	9	9	11	6	8	7
Shift length divided by total patients (mins per patient)	1344	53	62.9	50	66	50	90	83	95
Available mins per patient (total time inc. additional time, minus administration and travel)	1259	138	38.7	32	41	32	57	46	55

Source: RCN/KCL District Nurse Survey, 2014

The estimated *potential* patient contact time varies from approximately 30 minutes per patient (excluding travel and administration time) for community staff nurses to 40 minutes for district nurses. This figure would be lower still if nurses did not work any additional time beyond their shift length. These figures are estimates and do not distinguish between the activities associated with care - time spent planning, assessing and doing other tasks in addition to direct patient care. Again there is considerable variation around these means, as Figure 5.3 illustrates. In Chapter 6 we look specifically at the division of nurses' time between activities and nurses' satisfaction with how their time is divided.

Figure 5.3: Variation in available time per patient by district nurses, community staff nurses, and nurse specialists



Source: RCN/KCL District Nurse Survey, 2014

[23] DN: district nurse, CN: community nurse, CM: community matron, CM/TL: case manager/team leader, NS: nurse specialist

5.3 Staffing, workload and quality of care

Nurses were asked two specific questions in relation to the quality of care provided to patients on their last shift.

1) *Were there any activities that were necessary but were left undone because you lacked the time to complete them?*

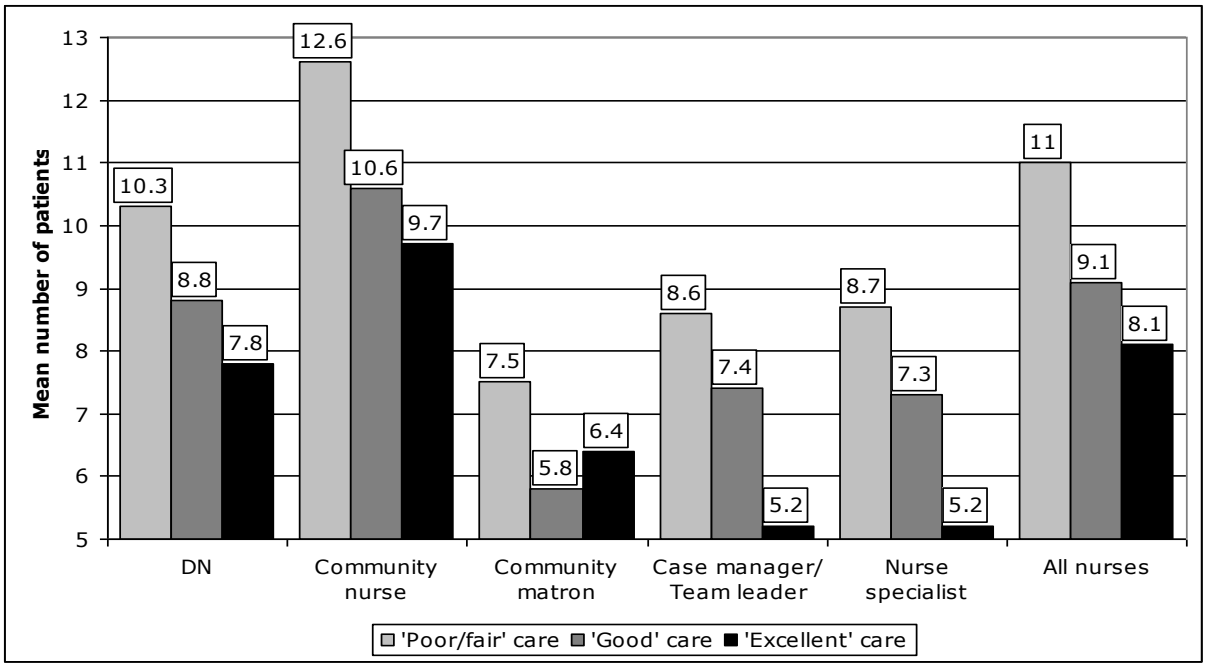
2) *How would you describe the quality of care provided to patients on your last shift?*

Across all respondents three quarters (75%) reported that they had left necessary activities undone. However, despite this, 19% said they had provided 'excellent' care to their patients on their last shift while 61% said they had provided 'good' care, 18% 'fair' care and one per cent 'poor care'. Among those nurses who had left necessary activities undone during their last shift 14% nonetheless reported that overall the care that they had provided was 'excellent' and 63% said it was 'good'.

There is some difference between those who worked a day or night shift, with those who worked at night twice as likely to report that they provided 'excellent' care on their last shift as those who worked a day shift (36% compared to 18%). As the number of nurses indicating that they worked a night shift is small (73 cases) the remaining analysis is based only on those working day shifts.

The reported quality of care is strongly correlated with the number of patients nurses saw on their last shift. Figure 5.4 shows this difference with nurses who indicated that they provided 'excellent' care seeing an average of 8.1 patients on their last shift compared to 11.0 among those who said they provided care assessed as 'fair' or 'poor' care.

Figure 5.4: Number of patients seen on last shift by the quality of care provided (self assessed) and job title (day time only)



Source: RCN/KCL District Nurse Survey, 2014

Although the average case loads are different for each staff group, the correlation between case load and quality of care holds true for each group with higher case loads among those nurses who indicated 'poor/fair' care and lower case loads among those who indicated 'good' and lower still among those who indicated 'excellent' care.

The correlation between the number of patients seen on last shift and the likelihood of respondents indicating that they had left necessary activities undone at the end of their last shift is weaker and on the margins of statistical significance.

There are also relationships, albeit not quite as strong, between the quality of care provided and the total time worked on their last shift (including additional time) and with the average minutes per patient reported by nurses. Where nurses reported providing 'poor' care the total time worked was an average 9 hours 20 minutes compared to 9 hours among those who provided 'fair' care, 8 hours 40 minutes among those who provided 'good' care and 8 hours 30 minutes for those who provided 'excellent' care on their last shift. This is an indication of the extent to which nurses in the community are over-stretched and trying to compensate for a lack of available hours by working beyond their contracted hours.

Where nurses felt they had left necessary tasks undone on their last shift they were also likely to have worked longer hours, 8 hours 48 minutes, than where nurses had not left necessary tasks undone, 8 hours 22 minutes.

These findings suggest that nurses working extra hours beyond their shift length is not contributing better quality care but it is likely to be contributing to their sense of workload pressure (see below).

Where nurses reported providing 'poor' care the average estimated available patient time was 38 minutes, compared to 53 minutes for those providing a 'fair' level of care, 63 minutes for those providing 'good' care and 71 minutes per patient among those providing 'excellent' care. No correlation was identified with the amount of time spent travelling or on administrative tasks and the perceived quality of care provided or with whether or not there were necessary tasks left undone on the last shift, perhaps because they have compensated by working extra hours.

Perceptions of the quality of care provided on their last shift by respondents themselves is also strongly correlated with perceptions of the quality of care provided by their team overall, and their views of staffing on their team. For example, where the quality of care provided by the responding nurse on their last shift was seen as 'poor' or 'fair', 95% agreed 'there are not enough staff to get the work done'. However, even where the quality of care provided by the individual was reported as 'good', 84% do not think there are enough staff to get the work done. And where the individual's care was reported as 'excellent', three in four nurses (73%) do not think there are enough staff. This shows both that there is a correlation between views of staffing levels and likelihood of there being good quality care on the last shift, and that in some cases nurses are providing 'good' care or better despite there not being enough staff to get the work done.

5.4 Key points

The total number of staff on duty on the respondents' last normal working day was 8.6 and typically 14% of the total team are DNs, 49% community nurses (without DN qualification), 6% community matrons, 2% nurse specialists, 18% HCAs and other support workers and 8% administrative/clerical staff.

In 29% of cases there was no qualified district nurse on duty during the respondent's last normal work-day, in 63% of cases there was no community matron and in a half (53%) of cases there was no administrative/clerical staff available.

On average, respondents saw nine patients on their last shift with 25% of respondents reporting that they saw 12 or more patients. Qualified district nurses see, on average, two fewer patients than community staff nurses (with no DN qualification) working in district nursing teams, perhaps suggesting that their caseload and roles may be qualitatively different to those of general nurses.

The estimated *potential* patient contact time varies from approximately 30 minutes per patient (excluding travel and administration time) for community staff nurses to 40 minutes for district nurses. This figure would be lower still if nurses did not work any additional time beyond their shift length. These figures are estimates and do not distinguish between the activities associated with care, for example time spent planning, assessing and doing other tasks in addition to direct patient care.

'Poor' care is linked to long working hours (nurses reported an average 9 hours 20 minutes) compared to 9 hours among those who provided 'fair' care, 8 hours 40 minutes among those who provided 'good' care and 8 hours 30 minutes for those who provided 'excellent' care on their last shift.

Where nurses reported providing 'poor' care the average estimated *available* (ignoring other demands on time and activities such as care planning and assessment) patient time was 38 minutes, compared to 53 minutes for those providing a 'fair' level of care, 63 minutes for those providing 'good' care and 71 minutes per patient among those providing 'excellent' care.

Where the quality of care provided by the responding nurse on their last shift was seen as 'poor' or 'fair' 95% agreed 'there are not enough staff to get the work done'. There is a strong correlation between views of staffing levels and likelihood of there being good quality care on the last shift.

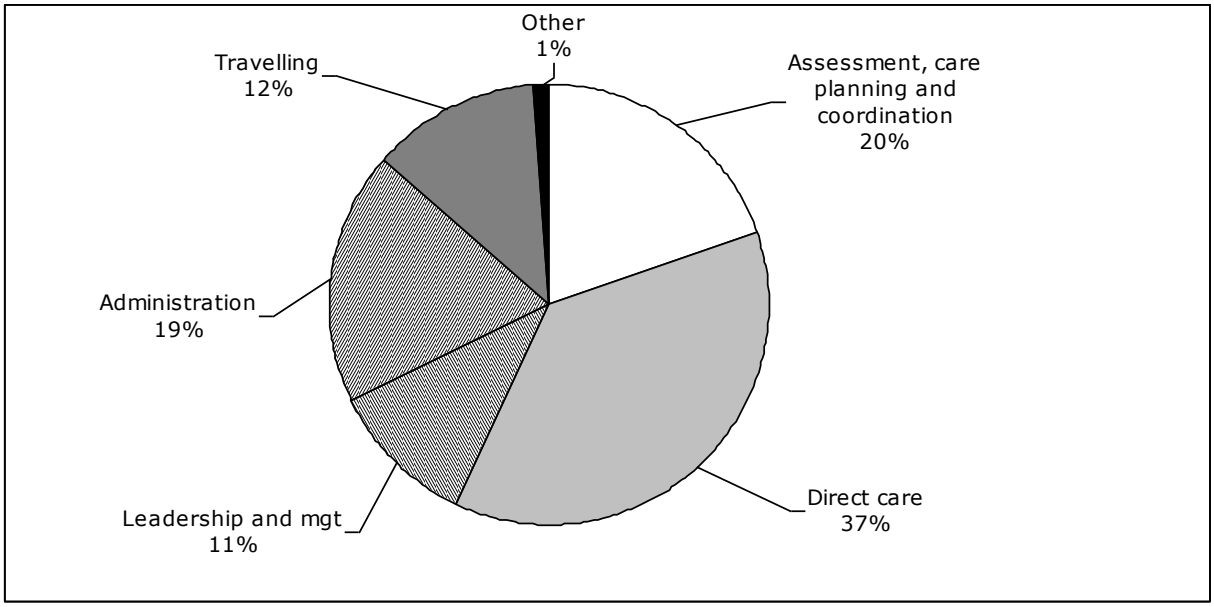
6. Roles and activities

The division of time in community nursing is an important issue as many nurses reported difficulties keeping up with the amount administration and travelling required in their jobs. This section looks at how nurses' time is divided and how their time might be divided differently.

6.1 Division of time

Respondents were asked to report on how their time is typically divided up between different activities. Six categories were presented ('assessment, care planning and coordination', 'direct care', 'leadership and management', 'administration', 'travelling' and 'other') and nurses were asked to estimate the proportion of time they currently spent on each in their jobs. The average distribution between different activities is shown in Figure 6.1 below.

Figure 6.1 Proportion of time spent on key activities: percentage of time



Source: RCN/KCL District Nurse Survey, 2014

Direct care accounts for the largest proportion of time, but not as much as many staff would like. On average 37% of time is spent on direct care activities, 20% on assessment, care planning and coordination (linked to individual patient care), and 13% of all time is spent travelling. About a fifth (19%) of each day is spent on administration and 11% on average is spent on leadership and management.

Most variation is found in the proportion of time spent on direct care (Table 6.1) which varies considerably by pay band, job title and type of qualification. Nurses on pay band 5 do spend a larger proportion of their time on direct care; 44% of all time spent by band 5 nurses is on this activity, compared to 34% of the time spent by nurses on band 6 and 27% of the time of band 7 and higher nurses. Two fifths (43%) of the time of community staff nurses is spent on direct care compared to 35%

of the time of district nurses and 30% of the time of community matrons. Just 27% of the time of case managers and team leaders is spent on direct care.

Table 6.1 Proportion of time spent on different activities by job title and pay band: percentage

	Care planning	Direct care	Management	Admin	Travel	Other	*Base N=100%*
District nurses	20	35	14	18	11	1	*331*
Community nurses	18	43	5	19	14	1	*601*
Community matrons	28	30	13	17	11	2	*96*
Case/Team Leader/Managers	18	27	25	18	10	2	*148*
Nurse specialists	22	32	11	20	13	1	*65*
Other	26	29	15	16	8	7	*9*
Band 5	18	44	4	19	14	1	*588*
Band 6	21	34	14	19	11	1	*341*
Band 7/8	22	27	22	17	10	2	*254*
Neither SPQ nor Prescriber	18	41	6	19	14	1	*661*
Prescriber only	23	36	10	19	12	1	*106*
SPQ only	21	35	14	18	11	1	*83*
Both SPQ and Prescriber	21	31	18	18	11	2	*401*
All respondents	**20**	**37**	**11**	**19**	**12**	**1**	***1251***

Source: RCN/KCL District Nurse Survey 2014

The other area where there are significant differences between the roles and pay bands, is in the amount of time spent on management and leadership activities. In particular, case managers/team leaders and those in other leadership roles spend a quarter of their time on management and leadership activities, almost twice as much time as any other role in district nursing teams. District nurses spend 14% of their time, community specialist nurses 11% and community matrons 13%. Nurses with no DN qualification working in district nursing teams spend just five per cent of their time on management and leadership activities.

There is no difference in the division of time between nurses working for different types of employer.

Some 140 respondents gave details of other activities that they spend time on, with many using the space to provide more detail on the types of activities that contribute to their typical workload. A number of respondents mentioned activities such as administration and management issues that they often do at home, while off duty because there is no time during the working day due to planning and providing direct care.

Other activities referred to were: liaising with other professionals and agencies, mentoring, teaching/training and development, meetings, dealing with referrals, student/new recruits support/supervision, own study time, liaison (telephone) between patients/GPs and others and audits etc.

More specifically, respondents were asked about time spent on travel and administration on the last shift they worked. Nurses spent a total of 85 minutes on average travelling and 145 minutes on administration during their last shift. This amounts to approximately 40% of the total working time and more than half of the scheduled working time.

Table 6.2 Average working time (day only)

	Cases				Percentiles				
	N=	Missing	Mean	Median	10%	25%	50%	75%	90%
Length of shift (mins)	1391	6	449.6	450	450	450	450	450	480
Additional mins worked	1390	7	71.5	60	0	30	60	90	130
Total mins worked	1385	12	521.2	510	450	480	510	570	600
Total mins travel last shift	1306	91	84.9	70	40	60	70	120	150
% time travelling	1296	101	16.4	14	7	11	14	21	27
Total mins administration	1311	86	145.3	120	60	90	120	180	240
% time on administration	1301	96	27.9	25	11	17	25	35	47

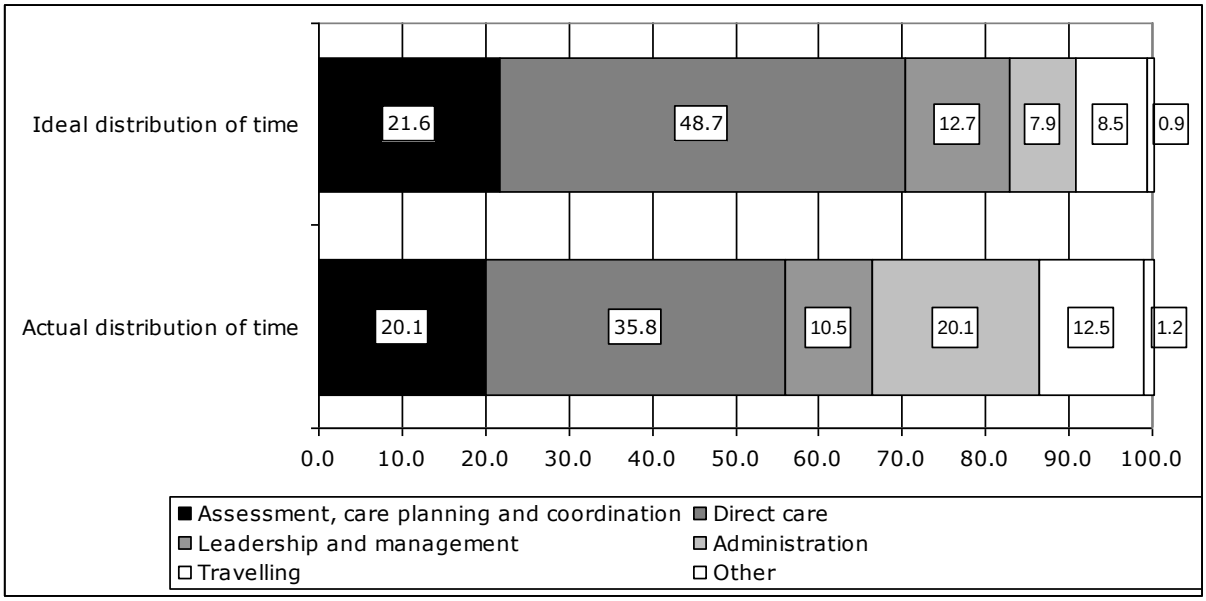
Source: RCN/KCL District Nurse Survey, 2014

6.2 Satisfaction with division of time

Very few respondents (20%) are satisfied with the distribution of their time between the core activities listed above, with 80% indicating they are not satisfied with how their time is divided. District nurses are most likely to express dissatisfaction with how their time is divided (88%, compared to 79% of staff nurses, 67% of community matrons, 74% of case manager/team leaders and 79% of advanced/ specialist nurses).

To explore this further, respondents were asked to show how they would ideally like their time to be divided across these same activity areas. Figure 6.2 shows the difference between the ideal and actual division of time reported. The largest differences are in nurses wanting to increase time spent in direct care of patients, ideally around half their time should be spent on direct care and less time on administration, ideally less than 10%, compared to 20% in their actual roles and also less time travelling (9% of their time compared to 13% at present). In terms of leadership and management, planning and coordination and other activities there was less difference between the current division of time and what nurses would ideally like.

Figure 6.2 Proportion of time spent on key activities (ideal and actual distribution of time): percentages, all respondents



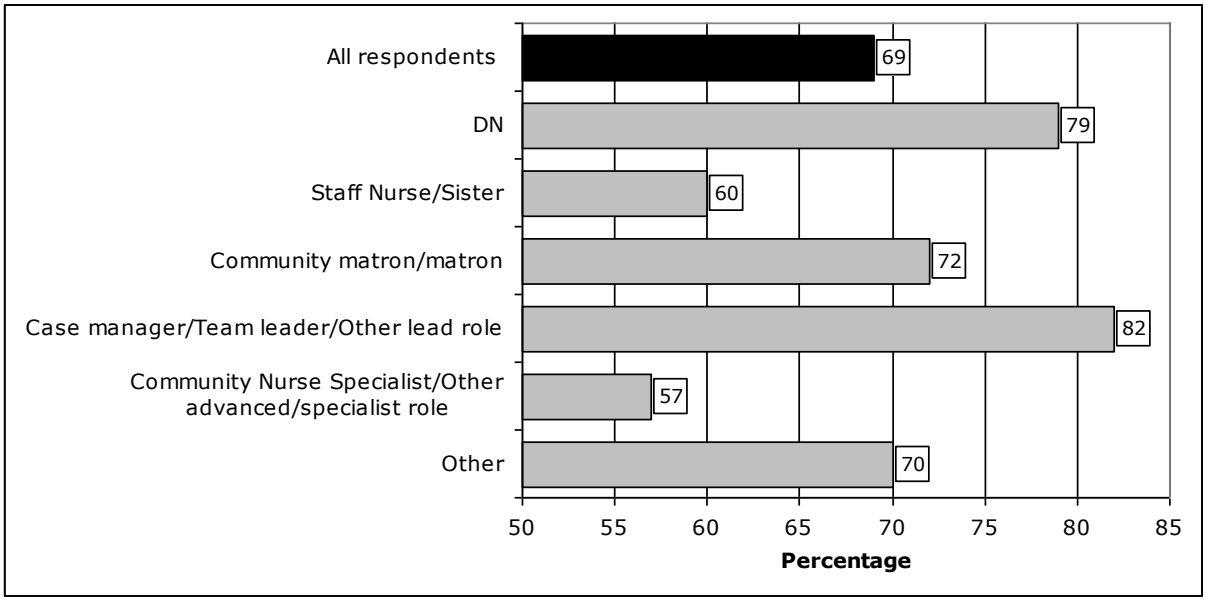
Source: RCN/KCL District Nurse Survey, 2014

Whilst all staff groups share a desire to reduce time spent on administration., there are some differences by role. District nurses would like spend more time on direct care (42% compared to 34% at present on average) and would also like to increase the time spent on leadership and management (more so than other groups). Case managers and team leaders are most likely report that they spend too little time on care planning, assessment and coordination, and would also like to spend more time on leadership and management. Community matrons, more than other groups of nurses, would like to increase the time they spend on direct care (up from 29% to 45% of their total work time).

6.3 Activities that should be done by other staff groups

Respondents were asked to say whether or not they felt there were activities they (or their staff group) currently undertake that should be being done by other staff. Two thirds (69%) of all respondents feel that there are activities that they or their staff groups currently undertake that would be better done by other staff. Again job title is a key factor correlated with response to this issue. However, a number of other variables are also correlated strongly, including whether or not respondents are qualified to prescribe, the length of time respondents have worked in district nursing teams and, perhaps crucially, whether or not respondents had to work additional hours beyond their scheduled hours on their last shift. Figure 6.3 shows the differences between nurses with different roles.

Figure 6.3 Activities that should be undertaken by other staff groups: percentages indicating 'yes' by job title



Source: RCN/KCL District Nurse Survey, 2014

Amongst district nurses specifically, more of those who are qualified prescribers (85%) feel there are activities they currently do that should be undertaken by other staff, than DNs who are not prescriber qualified (65%). This difference is not apparent for the other staff groups individually. There is also a link with length of time respondents have worked in district nursing; those who are more experienced are most likely to indicate that there are tasks they do in their jobs that should, ideally, be done by other staff (76% of those with 15 years or more experience compared to 55% of those with up to 5 years experience in district nursing teams). This perhaps indicates that their greater level of experience is not being fully utilised.

Nurses who worked additional hours on their last shift are more likely (73%) to say that there are activities they do that should be done by other staff groups (compared to 49% of those that did not work additional hours). This might suggest that doing tasks that are not seen as within the role is a factor contributing to the amount of excess hours worked.

Those nurses who indicated that there were tasks they currently do that they consider should be done by other staff groups were asked to detail the nature of the tasks and who, in their view, should be delivering them. These tasks were coded into five broad themes. More than a half of all respondents indicated that administrative/clerical activities should be undertaken by other groups and one in five also thought there were care procedures that would be better, or more efficiently/cost effectively, done by other staff groups[24].

[24] Note that many respondents listed several specific tasks within each broad activity group e.g. 'administration, tidying up caseload on computer systems, sorting out supplies, re-stocking equipment, faxing requests, ordering equipment, EMIs, registering new patients/schedules etc.' and these have only been coded once under 'administrative/clerical tasks'.

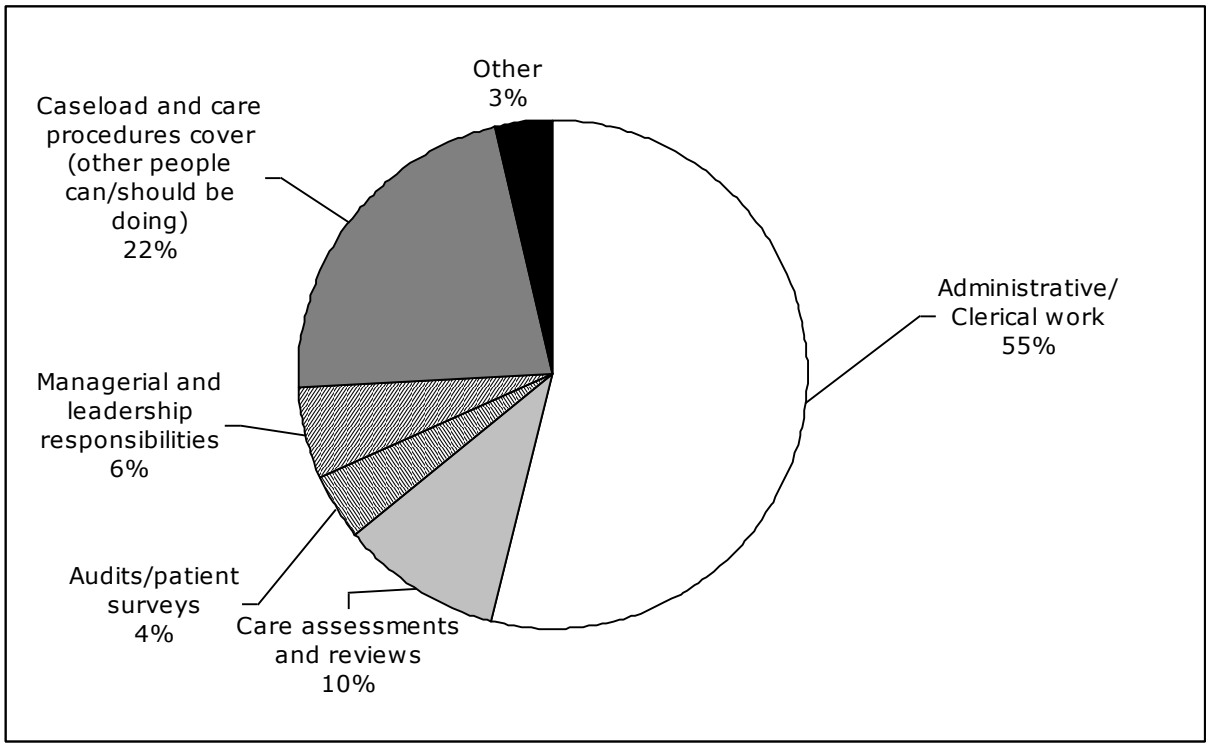
Table 6.3 provides examples of activities that respondents would like to delegate, under the five broad headings.

Table 6.3 Tasks within each broad activity group

Broad heading	Tasks/activities included:
Administrative/ clerical work	Computer/IT work, data processing, e-rostering, paperwork, booking training and various other activities, telephone work, contacting patients, making appointments, recording activities and mileage, completing patient records/entering onto system, taking messages, diary management, stock/equipment/dressings - ordering, unpacking and storing, scanning forms, accounting for time, photocopying, faxing, filing, RIO, chasing referrals and sorting misdirected referrals, organizing prescription sheets.
Care assessments and reviews	Continuing healthcare assessment and attending panel, assessing alcohol problems, complex/initial care assessments, continence assessments, mental health assessments, assessing social care needs, falls assessments, bed assessments.
Audits/patient surveys	Auditing patient records, QOF work, patient satisfaction surveys, form filling, collecting statistics (general)
Management/ leadership	HR/recruitment, job adverts/interviews, devising job descriptions, team planning, monthly (and other) meetings, off duty rotas, sickness reviews, work allocation, organising/management of caseload, social care reviews, root cause analysis, staff management, co-ordination of social care activities,
Caseload and care procedures	Administering insulin, bloods, clinic patients, venepuncture, phlebotomy (non urgent), ear irrigation, medication prompts, supporting nursing homes with syringe drivers and end-of-life care, any non housebound patient, visits to assess need for GP (doing GP visits), IV antibiotics, dealing with inappropriate referrals, DST assessments, dressing care, simple wounds, social care, general medication, washes/creams/eye drops/foot care etc., immunisations/ vaccines, palliative support.

Source: RCN/KCL District Nurse Survey 2014

Figure 6.4 Activities that should be undertaken by other staff groups: percentages



Source: RCN/KCL District Nurse Survey, 2014

Table 6.4 looks at these activities and shows which staff group respondents feel should be doing the task[25]. Across all activities, nurses responding to the survey feel administrative and clerical staff should be picking up much of the work. Specifically, nine in ten (87%) report administrative work should be done by clerical/administrative staff and two thirds (64%) also feel audits and patient surveys should be done by clerical/administrative staff.

Four in ten (44%) of those who felt their care assessments should be done by other staff groups indicated that other nursing staff/teams should be doing the activity and one in four (24%) felt other healthcare/MDTs should be doing them. There were similar patterns of response from nurses when considering particular caseload activities.

[25] The correlation between task and staff group is not exact as respondents did not always link particular tasks to staff groups.

Table 6.4 Activities respondents feel should be done by others and who should be doing the activity: percentages

	Admin/ Clerical	Care assessments	Audits/patient surveys	Management	Caseload activities	All activities
Healthcare support workers	5	4	3	2	11	**6**
Other nursing staff/teams	8	44	13	29	41	**20**
Other care services	<1	9	3	6	23	**7**
Other healthcare profs/MDT	2	24	13	2	22	**9**
Admin/clerical staff	87	8	64	25	12	**55**
Management	1	2	10	27	3	**3**
DN	2	2	0	13	6	**3**
Other	6	29	15	13	9	**11**
Base N=	*479*	*98*	*39*	*48*	*199*	***927***

Source: RCN/KCL District Nurse Survey 2014

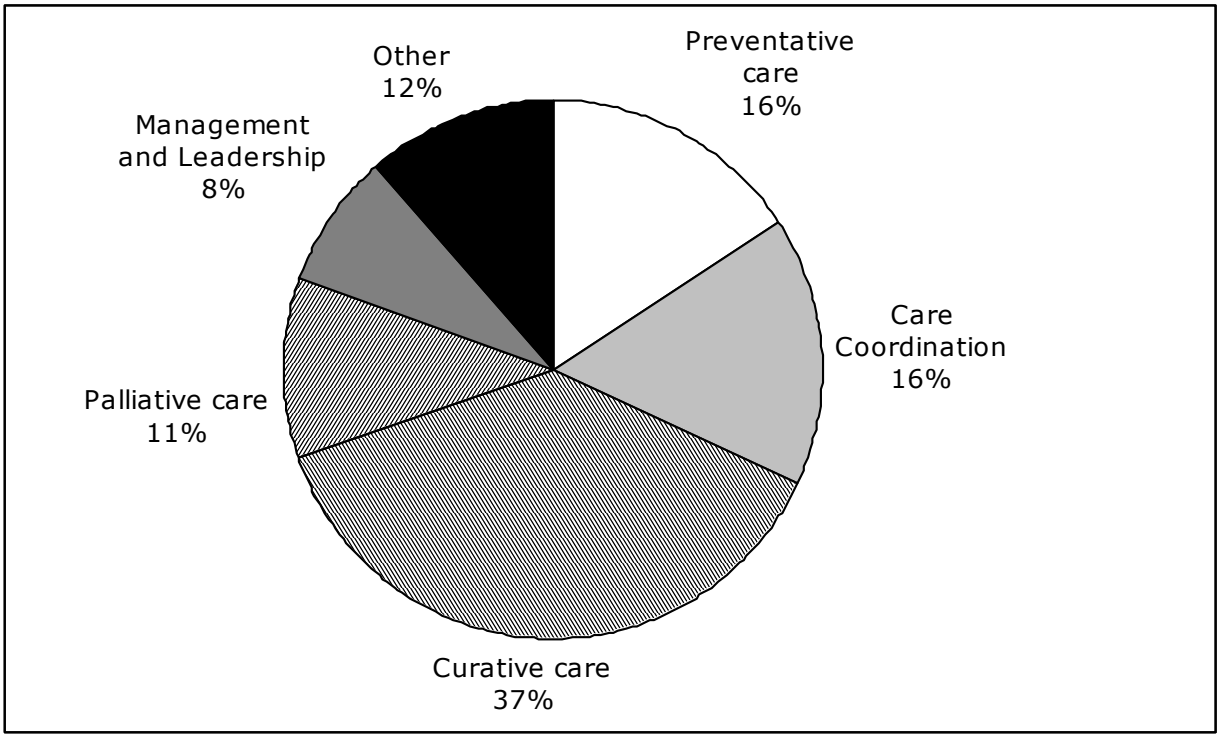
6.4 Activities would like to do (currently done by others)

Respondents were also asked to consider if there are any activities currently done by other staff groups that should be done by themselves (or someone from the same staff group as them). As might be expected given the long working hours and heavy workload of this group of nurses, only 15% of all respondents suggested that there are activities currently done by others they thought should be taken by themselves.

Again there is some variation by pay band and by job title. Nurses on band 5 were less likely to indicate that there are activities done by other groups that they feel should be done by them (11% compared to 20% of band 6/7 respondents). Whilst DNs (21%) and community nurse specialists/nurses in other advanced/specialist roles (25%) were more likely than other respondents to suggest activities that they felt should be done by them rather than the staff group currently undertaking the work.

The activities that respondents (not forgetting it is only 15% of all) feel they should be taking on are curative care activities (37% of relevant cases), preventative care (16%), care co-ordination (16%), palliative care (11%), management and leadership (8%) and other (12%). Mostly, the activities that some nurses would like to be doing are currently being done by other nursing staff (26%), other care services (19%), healthcare support workers (19%), other healthcare professionals and MDTs (11%), administrators (11%) and managers (6%). The numbers are not sufficient to cross tabulate against the activity or by job title.

Figure 6.5 Activities respondents should take on from other staff groups: percentages



Source: RCN/KCL District Nurse Survey, 2014

6.5 Key points

Direct care accounts for the largest proportion of time spent by nurses in district nursing teams, but not as much as many staff would like. On average 37% of time is spent on direct care activities, 20% on assessment, care planning and coordination, and 13% of all time is spent travelling. About a fifth (19%) of each day is spent on administration.

Nurses on pay band 5 spend a larger proportion of their time on direct care (44% compared to 34% of the time spent by nurses on band 6 and 27% of the time of band 7 and higher nurses).

Nurses spent a total of 85 minutes on average travelling and 145 minutes on administration during their last shift. This amounts to approximately 40% of the total working time and more than half of the scheduled working time.

Very few respondents (20%) are satisfied with the distribution of their time between the core activities listed above, with 80% indicating they are not satisfied with how their time is divided. All staff groups share a desire to reduce time spent on administration. District nurses would like to spend more time on direct care (42% compared to 34% at present on average) and would also like to increase the time spent on leadership and management (more so than other groups).

Two thirds (69%) of all respondents feel that there are activities that they or their staff groups currently undertake that would be better done by other staff. More than a half of all respondents indicated that some administrative/clerical activities should be undertaken by other groups and one in five also

thought there were care procedures that would be better, or more efficiently/cost effectively, done by other staff groups.

Not surprisingly, given the already packed working day of most nurses working in district nursing teams, only 15% of all respondents suggested that there are activities currently done by others that they thought should be undertaken by themselves. In the main these were specific elements of care delivery.

7. Sources of job satisfaction and frustrations

The survey provides an opportunity to capture the views of nurses working in community/district nursing – highlighting the shared sources of satisfaction and common frustrations as well as exploring differences between distinct groups of staff within the field.

7.1 Overall views

Respondents were presented with a series of 20 statements covering issues including: workload, staffing levels, quality of care, training and development, resources and job satisfaction. Table 7.1 below summarises the overall responses to the statements.

Table 7.1 Nurses views of their working environment (percentages)

		strongly disagree	disagree	agree	strongly agree	*N*=
Career related issues:						
1	My employer provides me with the opportunity to keep up with new developments related to my job	5	28	56	11	*1259*
7	I have access to the professional training and development I need	5	26	57	12	*1247*
19	It will be difficult to progress my career in district /community nursing	8	37	39	17	*1233*
11	I am satisfied with my present job	10	34	48	9	*1250*
15	I would leave this job if I could	21	39	29	11	*1234*
Role related issues:						
2	My role is clearly defined	6	36	52	7	*1259*
4	A high level of autonomy is required in my role	1	3	37	59	*1253*
10	I feel well prepared/trained for this role	1	15	69	15	*1253*
17	I have access to the clinical supervision I need	18	30	44	7	*1246*
20	I am satisfied with the support I have from my manager	12	31	45	13	*1252*
Resource related issues:						
5	I am given the support I need to manage my workload	12	48	36	4	*1256*
6	I have the resources I need to do my job well	14	50	33	3	*1253*
8	My workload is too heavy	4	19	49	28	*1248*
12	There are enough staff to get the work done	34	49	15	3	*1252*
18	Care is often compromised due to low staffing levels	5	29	45	21	*1243*
Service related issues:						
3	There are sufficient district nurses in my team	33	42	21	4	*1248*
9	We have the right skillmix where I work	11	43	41	4	*1250*
13	The team I work in provide good care for patients	1	6	59	34	*1250*
14	Public expectations are difficult to meet	2	17	53	29	*1251*
16	In general, GPs, social services and hospital providers make appropriate use of district nursing services	20	42	35	3	*1246*

Source: RCN/KCL District Nurse Survey, 2014

Working in the community requires a high level of autonomy with almost all respondents agreeing that 'a high level of autonomy is required in their job'. Most (84%) 'feel well prepared/trained for their role' and more than two thirds (69%) indicated that they 'have access to the professional training and development that they need' in their jobs and similarly, two thirds (67%) said that their 'employer provides opportunities to keep up with new developments related to their job'. A slightly smaller percentage (57%) indicated that they are 'satisfied with the support they receive from their manager', with 43% expressing dissatisfaction. 59% said they feel their role is clearly defined. Respondents are fairly evenly divided on whether they have access 'to the clinical supervision they need', with 52% agreeing and 48% disagreeing.

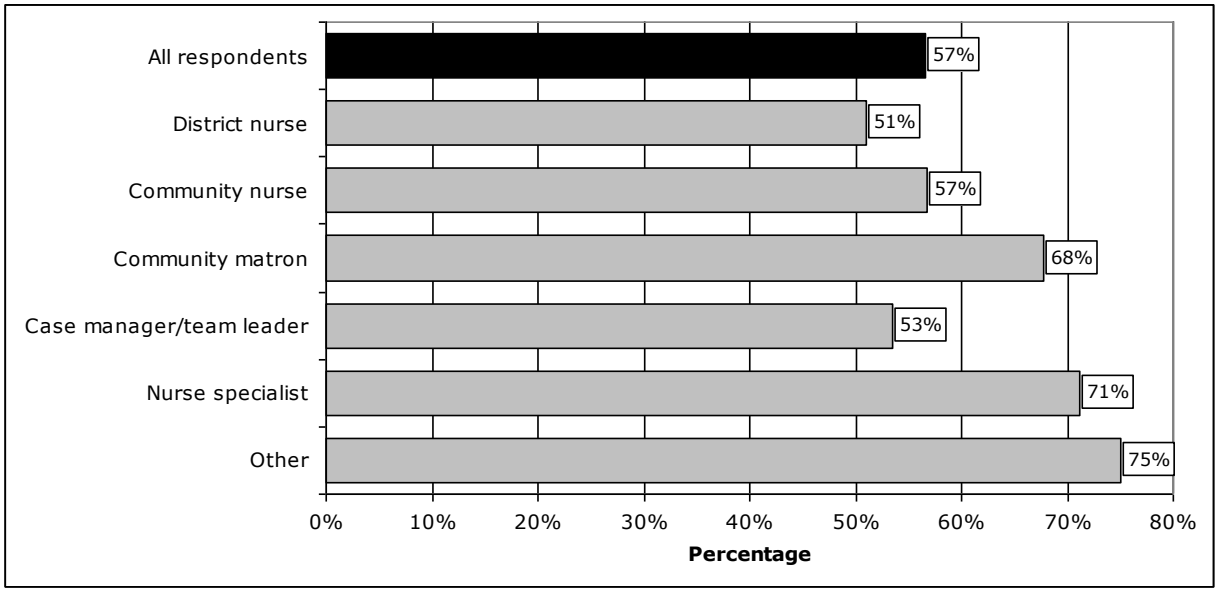
Almost all (94%) feel that where care is delivered 'the team provides good care for patients'. However this appears to be achieved at a cost to the individual in terms of workload pressure with three quarters agreeing their 'workload is too heavy'. Two thirds (66%) report that 'care is often compromised due to low staffing levels'. Chapter 3 showed that 80% of respondents worked additional hours (typically in excess of an hour per shift) and this is reflected in their views on workload and staffing. Eight in ten (83%) disagreed with the statement that 'there are sufficient nurses to get the work done' and, similarly, three quarters of all nurses (75%) disagreed with the statement 'there are sufficient district nurses on my team'.

Perceived staff shortages and workload pressure is exacerbated, at least in part, by a sense of unmet public expectation. Four fifths (83%) of all nurses working in district nursing teams responding to the survey agreed that 'public expectations are difficult to meet'. Six in ten (60%) disagreed with the statement 'I am given the support I need to manage my workload' and two thirds (64%) said they disagreed with the statement 'I have the resources to do my job well'. Six in ten respondents (62%) do not think that 'GPs, social services and hospital providers make appropriate use of district nursing services'.

In terms of the potential impact of this mismatch of unmet demand, public expectations and large workload, although more than half of all respondents (56%) say that they are 'satisfied with their present job', 40% of nurses employed in district nursing teams said they 'would leave their current job if they could'.

District nurses are least satisfied with their jobs. Figure 7.1 shows that just 51% of district nurses agreed 'I am satisfied with my present job' compared to 71% of nurse specialists and 68% of those in community matron roles. Nurses who have been working in district nursing for 10 years or more are also less likely to feel satisfied in their current jobs (53% compared to 61% of those who have been working in district nursing less than 10 years).

Figure 7.1: I am satisfied with my present job by job title (weighted data)



Source: RCN/KCL District Nurse Survey, 2014

To allow exploration of differences in the views of respondents, the themes used in Table 7.1 were used to create scales[26]. Working additional hours was associated with lower levels of satisfaction across the scales. For example, in relation to 'resources', nurses who had worked additional hours scored a significantly lower (i.e. more negative) score than those who had not (2.0 out of 4, compared with 2.4). However, generally, there was little significant difference in scores between groups of nurses by pay band, job title, length of service, employer or age; when it comes to their views of working life, nurses working in the community have more in common with one another than they have differences.

7.2 Satisfaction in working as a community nurse

Respondents were asked in an open section of the questionnaire to describe what they find most satisfying about working in the community. Nearly three quarters (72%) of all respondents gave details of sources of satisfaction, providing nearly 2400 individual comments. These were categorised into themes, and the results are presented in Table 7.2.

Four fifths (83%) referred to a specific aspect of their community based role as a satisfying aspect of their work, such as treating people in their own homes and keeping them out of hospital. Many respondents mention their enjoyment of providing direct nursing care and the patient contact this entails and more specifically helping patients at the end-of-life, in providing good palliative care. The relationships fostered with patients and their families in the course of providing care in their homes are also cited as a key source of satisfaction for many (29%).

[26] This involved reversing the scoring on items framed negatively e.g. 'My workload is too heavy' the score is reversed. This ensures that all items are scored in the same direction. The responses for each item in the group are summed and divided by the number of items to give a composite result for the group of items ranging between 1 (a negative score) and 4 (positive).

Table 7.2 Satisfying aspects of work as a community nurse: percentage of cases[27]

Broad theme	Details/examples	% cases
Role content	Treating patients in their own homes/keeping patients out of hospital	35%
	Providing direct general nursing care/direct patient contact (love treating patients)	19%
	Providing end-of-life/palliative care (a good death)	16%
	Educating/informing/empowering/guiding patients to achieve self management of their condition/promoting independence/health promotion	5%
	Staff training/mentoring/supporting team/training opportunities	5%
	Using skills/knowledge/adjusting care to best suit patient	3%
	Specific task/activity – i.e. ulcer, dressing clinic	1%
	Gaining skills/knowledge/always learning	1%
	Developing/adapting the clinical care/service for patient benefit	1%
	Total (role content)	**83%**
Enjoy way of working	Autonomy/independence/responsible for own caseload	20%
	Variety/diversity of role and environment/vast array of ages and needs	10%
	Liaising with agencies/team members (GPs/hospice/nursing homes etc.)	4%
	Assessing and making decisions/problem solving	2%
	Challenge/dealing with complex cases	2%
	Flexibility	1%
	Having responsibility/influence in policy/guidelines/changes, etc.	<1%
	Working hours	<1%
	Total (enjoy way of working)	**40%**
Impact / making a difference	'Making a difference' – improved health/wellbeing/ready for discharge	14%
	Give people time/individual care/complete care/personalised care planning	11%
	Feeling valued/appreciated from patients/families	5%
	Privilege of treating patients in their own homes/welcomed into homes	3%
	Working with and supporting families/carers	2%
	Being part of the community/contribution to community	1%
	Total (impact/making a difference)	**33%**
Relationships	Relationship with patients/families; having contact/working with; one to one; ongoing relationship/continuity of care	29%
	Being part of wider team/good relationships with colleagues/other professionals	10%
	Working/meeting with variety of people	1%
	Respect from patients/families	<1%
	Total (relationships)	**43%**

Source: RCN/KCL District Nurse Survey 2014

[27] Total sums to more than 100% as respondents could provide more than one answer.

In terms of the nature of the role, many respondents mention the autonomy and independence they have in their work (20%) and one in ten respondents highlight the diversity and variety of work they do.

Some nurses get satisfaction from developing their staff and team and the variety of the role. Many nurses working in the community love their jobs and there are many aspects of the work that give great satisfaction and pride in the service provided.

7.3 Frustrations of working as a community nurse

Whilst most nurses cite several aspects of their work that give great satisfaction, enable pride in their work and sense of contributing positively to individual patients, their families and indeed the wider community, there are also a number of significant frustrations in the work, the job and the structures that surround district nursing teams.

In the same format as the 'satisfaction' section above respondents were asked to give details of what they find frustrating about working in the community. The strength of response is demonstrated in that a similar number of nurses (72%) provided comments on the frustrations of their jobs but they expressed these using more than 46,000 words, whereas when commenting on what they find satisfying 24,000 words were used.

Most respondents stated multiple issues. As mentioned above, 40% of all community nurses would leave their job if they could, suggesting in itself that for many nurses there is a high level of frustration in their work. Most issues are interlinked and many nurses cited four or five, and up to eight different factors contributing to their frustration. All responses were coded and the main themes identified are listed in Table 7.3 below. In summary, workload and caseload were most frequently mentioned by respondents (69%), second was staffing and workforce issues mentioned by 50% of respondents, then administration, paperwork and IT systems (42% of nurses), followed by concerns about the quality of care delivered (36% of respondents mentioning this broad theme). Agency interface issues were cited by 29% of respondents and management and leadership issues were raised by 28% of community nurses and aspects of role and expectations by one in four community nurses (26%).

Table 7.3 Frustrations in working as a community nurse: percentage of cases

Broad theme	Details/examples	% cases
Workload/ caseload	Excessive workload/caseloads/not enough time/unpredictable workloads	26%
	Travel time	9%
	'No limits' on taking cases	8%
	Overtime (working hours)	8%
	Work pressure/stress	6%
	Lack of resources	6%
	Meeting targets	4%
	Lone working/isolation	2%
	Responsibility with little authority	<1%
	Total (Workload/caseload issues)	**69%**

Source: RCN/KCL District Nurse Survey 2014

Table 7.3 (cont.) Frustrations in working as a community nurse: percentage of cases

Broad theme	Details/examples	% cases
Staffing/ workforce	Staffing levels	35%
	Skillmix issues	6%
	High sickness levels	3%
	Day to day staff shortages	2%
	Use of bank/agency staff	1%
	Recruitment problems	1%
	Staff leaving/poor retention of staff	1%
	Other staffing issues	1%
	Lack of input from other staff/agencies	<1%
	Total (Staffing/workforce)	**50%**
Admin and IT systems	Too much paper work/administration	27%
	Poor IT for patient records	7%
	Lack of office space/poor old computers/poor mobile network	7%
	Other general IT problems	<1%
	Other administrative/IT issues	<1%
	Total (IT systems)	**42%**
Quality of care	Lack of patient contact time	13%
	Task focused care	7%
	Not having right equipment/dressings, lack of resources	6%
	Poor attitude from DN	4%
	No time to fast track patients when really busy	4%
	Poor communication re: patient	3%
	Better for some patients to still be in hospital/patients discharged too early	2%
	Lack of continuity of care	1%
	Cutting costs	<1%
	Not enough direct advice for medical queries	<1%
	Total (Quality of care)	**39%**
Agency interface issues	With GPs or with practice staff	8%
	With other professional services (general)	7%
	With hospitals	6%
	Patients are not house bound	4%
	With social care	3%
	Other interface issues	1%
	With nursing homes	<1%
	Total (Agency interface)	**29%**

Source: RCN/KCL District Nurse Survey 2014

Table 7.3 (cont.) Frustrations in working as a community nurse: percentage of cases[28]

Broad theme	Details/examples	% cases
Management/ leadership	No support from managers	10%
	Poor management	5%
	Not informed of developments/constant changes	5%
	Generic other	5%
	Involvement in decision making	4%
	Not valued	3%
	Lack of coordination/planning	2%
	Lack of resources	<1%
	Total (management/leadership)	**28%**
Role	Public/patient/carers expectations	13%
	Inappropriate referrals	8%
	Lack of understanding of role	5%
	Complexity of care	<1%
	Total (Role)	**26%**
Career & CPD	Lack or CPD/training	6%
	Poor career structure/opportunities	2%
	Too much mandatory training	1%
	Other career/CPD issues	<1%
	Total (Career & CPD)	**9%**
Pay/banding issues	Insufficient mileage/payment of parking fines	3%
	Pay levels	1%
	Inappropriate pay band	1%
	Lack of job security	<1%
	Total (Pay/banding issues)	**5%**

Source: RCN/KCL District Nurse Survey 2014

As stated above, most responses concerned work/case-overload, with the main cause of this seen to be understaffing, sometimes described as chronic, including poor skillmix in teams and excessive administrative tasks with no support. These issues are very much interlinked; understaffing and inefficient systems leading to stress and pressure of workloads, pressure to deliver more care, rushing from case to case and the attendant problems in delivering good quality of care. This causes staff to be absent with sick leave, again causing more problems for management in covering shifts; a vicious cycle of frustration.

The knock-on effects of staffing issues are important too. Many describe how they regularly work overtime and miss lunch breaks. This may, in theory, be compensated for through time off in lieu, but generally does not seem to be an option, as there are insufficient staff to provide appropriate cover.

Many also mentioned unpredictable workloads and 'constant changes' made by management to the team. This may be an affect of staff absence where nurses have to cover each other's patch but there is

[28] Total sums to more than 100% as respondents could provide more than one answer.

also mention of a lack of co-ordination and poor planning with large areas to cover for visits. It is also difficult to plan for absenteeism on a daily basis.

Skillmix is another issue highlighted by many nurses, with a feeling that there were too many newly qualified staff and a lack of team leaders. The pay banding and skillmix of posts was not felt to have taken account of the skills required to meet the needs of increasingly complex patients (for example those who are terminally ill).

Inadequate planning and poor co-ordination of staffing are a frequent cause of concern. Community nurses are pulled into teams across wide areas to compensate for understaffing and many raise concerns about the constant changes they are facing.

Nurses also comment on the implications that work and case overload have on the quality of patient care. Rushing to complete visits to patients not only affects care but puts further strain on communication between team members and a lack of time for meaningful handovers. Many see lack of resources as impinging on nurses' ability to provide holistic care, and the danger of overlooking important factors affecting patients' health. Many respondents also highlighted the impact of poor handovers due to lack of time, lack of resources and lack of appropriate equipment as all having a negative impact on patient care.

Four in ten of respondents mentioned administrative tasks (and the disproportionate time spent on them) as a major source of frustration. Poor office equipment, lack of computers, small work-spaces, poor access to printers, mobile devices which do not work, outdated, slow computers, all contribute to the frustration of respondents and the inefficient context in which they do their work. Many are completing administrative tasks outside their normal working hours, which leads to greater frustration if they cannot complete them efficiently and quickly. Duplication of writing notes in the patient's home and then inputting data onto the computer is also seen to be onerous.

Some argue that there is very little administrative support, stating that non-nursing staff could take up more of the administrative burden. This was especially the case for ordering supplies. Different systems (such as ROI) were criticised. On a slightly different note, some feel that having a laptop can be a barrier between nurse and patient. There would also appear to be a lack of co-ordination through the linking up of computer systems between different professional bodies (social care, GP surgeries etc.).

Also linked to the interface with agencies, nearly a third of respondents mentioned a lack of a clear working relationship with other professionals and agencies (such as GPs, social care and hospitals) and the problems associated with the role not being fully understood. There is a general feeling that the capacity of the team can never fill up and other professionals and agencies take advantage of this. The relationship between community nurses and other professions is crucial and issues of role boundaries also affect workloads. Nurses comment that they feel they have to pick up where other professionals leave off.

Many feel they are perceived as the 'catch all' that must be available when no other service is available (particularly at weekends). The public perception that community nurses are (or should) always be available, and at very short notice, adds to the challenge in meeting demand and the sense that the

demand is a ‘bottomless pit’. Respondents also refer to the impact of inappropriate referrals and poor discharge planning by hospitals, and the time spent chasing up records. The lack of support for district nurses to ask about specialist medical issues concerning the patient, especially at weekends, is of concern to many too.

Lone working and travelling, while a fundamental part of the role, can cause some community nurses to feel isolated and some miss the communication of working in a team, leading to stress and dissatisfaction. The impact of many miles on the car and also the recently changed mileage allowance is a concern to a number of nurses.

Some 40% of respondents commented about patient care and the quality of care. Again, these issues are rarely cited independently, but in conjunction with discussions of staff shortages, work overload and too much time spent on administrative tasks, as outlined above. Poor handovers, isolated working, rushing to get to the next job all contribute to poor communication about patients’ needs, leading to poor quality care if the nurse is not able to compensate by working additional hours.

The task focused nature of working could have implications for missing out on other factors affecting the patient. Poor planning and discharges by hospitals, especially at the weekends, were also cited as having a detrimental impact on patient care. In addition, the complex nature of patient needs when receiving care in the community is viewed as different to 10 years ago. There is a perceived need among some community nurses for more training on certain issues (e.g. palliative care, UVs).

Underpinning many comments is a sense of being undervalued and a lack of investment, which is exemplified by the fact that when staff leave they are not replaced leading to increased pressure being placed on existing staff as absences are uncovered, and it is felt this is disregarded, exacerbating the sense of not being valued.

Over a quarter of respondents aired their frustrations about the way in which they or their services were managed. In particular, they related to a lack of awareness of the district/community nurse role, the daily tasks, and a perceived lack of support in a variety of different ways. Nurses also challenged managers’ ability to provide effective leadership. There was a feeling that managers were powerless to change much, partly due to the relationship between the Commissioning Group and GP.

7.4 Key points

Nurses working in district nursing teams are generally positive about their work lives. Almost all (94%) feel that where care is delivered ‘the team provides good care for patients’ but at some cost:

- Three quarters (77%) agreeing their ‘workload is too heavy’.
- Two thirds (66%) report that ‘care is often compromised due to low staffing levels’.
- Eight in ten (83%) disagreed with the statement that ‘there are sufficient nurses to get the work done’
- Three quarters of all nurses (75%) disagreed with the statement ‘there are sufficient district nurses on my team’.

- Four fifths (83%) of all nurses working in district nursing teams responding to the survey agreed that ‘public expectations are difficult to meet’.
- Six in ten (60%) disagreed with the statement ‘I am given the support I need to manage my workload’.
- Two thirds (64%) said they disagreed with the statement ‘I have the resources to do my job well’.
- Six in ten respondents (62%) do not think that ‘GPs, social services and hospital providers make appropriate use of district nursing services’.

Although 56% of respondents say that they are ‘satisfied with their present job’ four in ten (40%) of nurses employed in district nursing teams said they ‘would leave their current job if they could’.

There are many things nurses like about their jobs. In particular, the role content, feeling a part of the community and their enjoyment of providing direct nursing care and the patient contact this entails and more specifically the helping patients in end-of-life, in providing good palliative care and in patient homes. Many nurses also gain satisfaction from the autonomy and independence of the role.

However, there is a significant downside, with nurses reporting many frustrations in their work in district nursing teams, most of which are interlinked with nurses citing several different issues. The most frequently mentioned are:

- Excessive and unpredictable caseloads and workload; 69% mentioned aspects of this including no limits on the number of cases, long working hours, excessive travel time;
- This is caused partly by poor staffing levels; 50% mentioned this and related issues including skillmix problems, high sickness levels and poor recruitment and retention.
- Adding to excessive workload are frustrations with volumes of administration and paperwork and IT issues (42% mentioned this broad issue) and a lack of administrative support.
- Many community nurses are concerned about the quality of care delivered as they have to rush from case to case, having insufficient contact time which results in task focussed care rather than holistic care.
- Public expectations of the role, inappropriate referrals, used as a ‘catch all’ by other agencies who do not understand the role of district nursing teams and lack of support from management were all cited by many nurses as causes of frustration in their jobs.

8. Conclusions

For decades, regardless of the wider political or economic context, health and social care policy both in the UK and beyond has had two constant themes running through it: to shift more care from hospitals to the community, and to improve the integration of services in the community so that they are 'seamless'.

Whilst the policy messages have been strong and clear, the evidence of progress towards this goal remains scarce, and we know little about whether we have the infrastructure and workforce needed to make integrated community based care a reality. This study, the first large-scale cross sectional survey of nurses working in the community of its kind, has provided a unique opportunity to get a ground level view of community based care from the perspective of the community staff nurses, district nurses, community matrons and specialist nurses that provide these services.

Prior to this survey, little research had focused on the community nursing workforce, and even less had endeavoured to look at staffing levels and caseloads. Nationally collated NHS statistics provided a view of the total numbers of community based nursing staff but did not give insight into the composition of teams locally, how skillmix varied, and typical caseloads. We could gauge little from the data about how district nursing services are organised, when they are available, the geographical distances covered, what typical workloads look like, who is involved in delivering care, and the nature of the work undertaken. At a national level statistics indicate a steady and dramatic decline in the number of qualified district nurses employed. These data raise more questions than they answer; if district nurse numbers have fallen year on year since 1999, who is now undertaking the role that was once filled by this group? What effect has almost halving the number of district nurses had on workloads in the community?

Looking at previous cross sectional survey data allows us to see how district nurses compared with nurses in other settings. They are revealed to be one of the groups reporting most work-related pressure[29]. The same survey also showed that district nurses in particular, had not fared well in the transition to Agenda for Change (AfC) pay bands. Prior to the new pay system, 80% of district nurses were in G grade posts. By 2009, 65% were in band 6 posts, with just 19% on band 7 or 8. At the time of the transition in 2005, 53% reported they felt their banding was not appropriate given their role and responsibilities and 36% of district nurses applied for a review of their banding, more than any other group bar health visitors.

This survey has filled many of the knowledge gaps that existed about community/district nursing services. We know that a 'typical' district nursing service team is made up of two district nurses, five registered nurses (without DN qualification), one community matron, two HCAs/other support workers, a member of clerical/administrative staff and half an 'other' staff. But we also know that there are marked variations: one in six teams has no district nurses, and in two in five there is no community matron and/or no administrative/clerical support staff.

[29] Ball J, Pike G (2009) Past imperfect, future tense, Nurses' employment and morale in 2009, RCN, London

Nurses working in district nursing teams are generally positive about their work. Typically they report enjoying being able to care for people in their own homes, developing a good relationship with clients and their families and reducing the need for hospitalisation, particularly at the end of life. Many nurses also gain satisfaction from the autonomy and independence of the role.

However, there appear to be many frustrations for nurses working in district/community nursing related to workload and staffing levels. The challenge of excessive and unpredictable caseloads, inadequate staffing levels and skillmix and lack of administrative support, are made worse in many cases by poor IT resource and insufficient support from administrative or other staff.

Despite the satisfaction that can be gained in providing care in the community, and the fact that 94% consider that in general 'the team provides good care for patients', this is achieved through routinely working beyond their contracted hours (by an average of 70 minutes per shift) and daily workload pressure. Four fifths (83%) say there are not sufficient nurses to get the work done, and 75% report specifically that there are not sufficient district nurses on their team. The cumulative effect is that 44% are not satisfied with their job and 40% would leave it if they could.

The survey results suggest a service (and staff) that are stretched to their limits. 45% agree and 21% strongly agree that care is often compromised due to low staffing levels. Just a third indicated that this was not the case. And there is a strong and significant association between nurses rating of care quality and their caseload. Nurses rating the care provided as 'excellent' had seen an average of 8.1 patients on their last shift; those rating care as 'fair' or 'poor' had seen 11.0 patients in their last shift.

Several different factors emerge from the survey findings that contribute to the workload pressures, beyond the lack of staff in post. Lack of understanding of the role of district nursing teams among other agencies causes some of the workload strain and leads to inappropriate referrals. Nearly two thirds (62%) of nurses in the community think that other agencies do not make appropriate use of district nursing teams. This combined with no clearly defined capacity means that district nursing services can be treated as a limitless 'catch all'. Hospital wards monitor bed occupancy, and when all beds are full, can report that they are not able to take any further patients. There are no equivalent demarcation lines indicating when a service is 'full' in the community.

However, the need for additional community nursing staff is being recognised by workforce planners. In December 2013, HEE published its first full workforce plan for England[30], outlining the numbers of training places it plans to commission in 2014-15 and the trends it has identified within the existing workforce. Providers themselves had predicted an overall reduction in the community workforce by 1.5% in 2013-14 and by 2.1% in 2014-15. But HEE overturned this, saying: "We believe that the current forecast demand for nurses does not appear to sufficiently reflect the move towards more integrated care, with more services provided in a community setting, or the need to provide services that are more responsive to the requirements of vulnerable older people and those with mental health needs. It is therefore our collective judgment that we should not take these projections of future demand at face

[30] Health Education England (2013) Investing in people. Workforce plan for England 2014-2015. http://hee.nhs.uk/wp-content/uploads/sites/321/2013/12/Workforce-plan-interactive1.pdf

value. Our assessment is that because of this dissonance with national policy we will assume a higher degree of demand is likely."[31] A 7% increase in district nurse training numbers for 2014-15 is planned.

Increasing entrants into community nursing is clearly much needed. But if the new, and perhaps more importantly, existing staff in the community are to be retained (to create a net increase, rather than simply compensating for staff retiring and leaving), working conditions need to be improved. Services will need to address the other issues raised in the survey that lead to a misuse of community nursing services to enable this workforce to make full use of their skills and work more efficiently and effectively. Examples include, the provision of suitable IT for remote working, sufficient administrative support, delegation of activities that could be done by others (without specialist nursing skills), reducing duplication of assessment between agencies and members of the MDT and, above all else, to deal with the excessive caseloads reported so frequently (and the attendant care quality and staff wellbeing issues) will require robust patient dependency and workload management systems to assess demand and plan and review resources accordingly.

[31] Reported in Nursing Times, 20th January 2014. http://www.nursingtimes.net/nursing-practice/clinical-zones/management/news-special-nhs-workforce-plan-predicts-rising-demand-for-nurses/5067130.article

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