

**National Quality Board**



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**Safe, sustainable and productive staffing**

**An improvement resource  
for the district nursing service:  
Appendices**

This document was developed by NHS Improvement on behalf of the National Quality Board (NQB).

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# 1. Appendix 1: People with learning disabilities

All healthcare providers must strategically plan for an interdisciplinary workforce that is able to meet the often complex needs of people with learning disabilities within resources available. It is a legal requirement that reasonable adjustments are made to ensure that people with learning disabilities have equal opportunities for their health needs to be met (Equality Act 2010). People with learning disabilities are more likely to have undiagnosed or wrongly diagnosed health needs and die prematurely from preventable causes.<sup>1</sup>

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

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

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<sup>1</sup> Department of Health (2008), Blair et al (2013).

## 2. Appendix 2: Case studies

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

#### 2.1.1 Rotherham, Doncaster and South Humber NHS Foundation Trust

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##### What was the problem?

Staff reported pressures on their service as demand increased:

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

##### What was the solution?

Sourcing appropriate workload and complexity tools and engaging staff to agree a way forward.

Every day the adult community nursing service's admin support team uses the tools to match predicted capacity and demand. Each patient has a five-minute complexity assessment that places them in one of five complexity categories. A dependency

score of 1 unit equates to 15 minutes of care. Patients with multiple straightforward care plans are assigned a maximum of 4 units.

### **What were the results?**

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

### **What were the learning points?**

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

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

### 2.2.1 Sheffield Teaching Hospitals NHS Foundation Trust

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#### What was the problem?

Ensuring sufficient staff for community nursing caseloads.

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

#### What was the solution?

Developing a caseload classification system to group patients' nursing needs and levels of complexity and allow the tracking of activity associated with each group.

Nurses classify patients' nursing needs by type of care required and level of complexity, defined by social situation and clinical interventions. The electronic patient record captures all the data.

The trust can now analyse activity data to identify trends, define resource requirements and inform skill mix. Team leaders can review their caseload by patient need and assess the appropriateness of treatment against evidence-based guidelines.

### **What were the results?**

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

### **What were the learning points?**

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



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

### 2.3.1 Whittington Health NHS Trust

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#### What was the problem?

District nurses identified that:

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

#### What was the solution?

E-Community – a fully hosted and supported system that aligns patients' needs with available resources.

The aim was to:

- improve capacity and demand management in district nursing, with all patients seen on time and no visits unallocated
- reduce incidents related to allocation errors
- reduce bank and agency usage

- maintain the district nursing vacancy rate below 10%
- complete a training needs analysis based on identified skills deficits
- reduce staff sickness by managing workload more effectively and reducing stress.

The system helps by:

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

### **What were the results?**

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

### **What were the learning points?**

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

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

### 2.4.1 NHS South Cheshire Clinical Commissioning Group

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#### What was the problem?

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

#### What was the solution?

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

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

### **What were the results?**

Staff morale has improved, but as the CCG has only recently recommissioned the service it is too early for concrete results.

There has been a shift to clinicians understanding and explaining to patients the reason for a change, rather than relying on a protocol-based (pathway) solution.

### **What were the learning points?**

- Working methods in community services are efficient but are not valued by the system.
- Understanding and quantifying them across a health economy shows where to invest.
- When quality markers are focused on patients, staff confidence grows and morale improves.
- Demand management and secondary care methods appropriate for a small population are difficult scale up, in the context of community care for a larger population.
- True person-centred care provided by skilled staff working with continuity in small teams is efficient, and patients with complex conditions value it.
- Understanding a patient's goals and giving them appropriate information supports patients to make their own decisions, rather than implementing pathways.

## 2.5 Case study 5: Review of community nursing and therapy and intermediate care bed services

### 2.5.1 Norfolk Community Health and Care NHS Trust

#### Contact

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#### What was the problem?

Community services such as intermediate care beds and community nursing and therapies (CN&T) are pivotal to care, particularly for the frail and elderly. While we have significantly changed our delivery of these services over the last five years – greater use of technology and remote working, improved scheduling and route planning, adoption of productive community services principles – this has not been enough to bridge the widening gap between funded capacity, acuity and increased demand, and further change is needed.

#### What was the solution?

A systematic review between provider (NCH&C) and commissioners (Central Norfolk CCGs) explored current CN&T and intermediate care beds services. We were not aiming to 'solve' the system's problems, rather to provide evidence to inform local stakeholder decisions about the future of these two community services.

Phase 1 answered three questions about existing design, delivery and demand using a range of quantitative and qualitative techniques:

- What are we seeing in terms of demand? (nature, volume and acuity of demand, and how these relate to service demand and opportunity for change)
- How are these services delivered? (how effectively do we deliver these services as measured against commissioner requirements and peers?)
- How are CN&T and inpatient services commissioned and designed? (in terms of method of delivery, performance, payment and outcome measures).

Phase 2 modelled service change options for the near future and longer term.

### **What were the results?**

- Focus groups generated over 100 improvement ideas. These clustered into four groups: getting closer to primary care; supporting a shift from hospital to community; making the most of our resources; prevention and self-care.
- Conversation within and external to the trust shifted from 'more of the same' to ideas about change that were backed by evidence and an understanding of how the different aspects of service delivery are linked.
- By understanding demand and modelling through to capacity the evidence was of sufficient weight to directly affect local 2017-19 contract negotiations.
- A shared commitment to explore new ways of commissioning and delivering these services, and of monitoring performance.

### **What were the learning points?**

- Presentation of findings needs to be carefully considered: staff must be able to navigate all aspects; otherwise they instinctively gravitate to those they have some familiarity with.
- An evidence review needs to be done by a team with the right skills and behaviours to complete it, helped by 'top cover' to prevent derailment by other agendas.
- Expectations need to be realistic: such a review is unlikely to solve everyone's problems, but it can reframe the debate and from this solutions can emerge.
- Modelling demand must precede modelling capacity, as any change in capacity should be based on change in demand.

## **2.6 Case study 6: Integrated community team workload, acuity and dependency tool (BRAVO)**

### **2.6.1 Derbyshire Community Health Services NHS Foundation Trust**

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#### **What was the problem?**

The time community staff spend with their patients is under increasing pressure because patients with complex needs are being discharged earlier into the community, and staff need to fulfil new agendas such as completing more detailed patient documentation and carrying out more safe care assessments for the elderly. To improve workforce and workload planning, better data on clinical activity and patient profiles was needed.

#### **What was the solution?**

BRAVO (baseline recording activity for valued outcomes) – an Excel-based tool – was developed to consistently capture clinical activity (including clinical procedures, travel, breaks) in 10-minute slots. This tool can be adapted for use across any clinical service, and has now been rolled out beyond the community nursing service to include community therapy and community matron services.

#### **What were the results?**

BRAVO captured a comprehensive data resource that identified workload by individual, team, locality and discipline. The data was used to demonstrate acuity and dependency trends, identify where skill mix could be reviewed to support more equitable and appropriate workload management, and identify duplication of patient care and treatment activity between disciplines.

A shift to patients with higher dependency being cared for in the community was confirmed – for example, for community nursing, patients with dependency level 4 made up 11.6% of patients in July 2014 but 19.6% two years later.

### **What were the learning points?**

- Engage with frontline clinicians to ensure clinical activity is correctly coded in the tool.
- Keep the activity coding simple to prevent confusion aligning activities with codes.
- Prepare staff for the introduction of the tool with a clear communication plan and appropriate lead-in time for training.





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