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Ideas that change
health care

Understanding quality in district nursing services

Learning from patients, carers and staff

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Key messages

District nursing services provide a lifeline for many people and play a key role in helping them to maintain their independence, manage long-term conditions and treat acute illnesses. At their best, they deliver an ideal model of person-centred, preventive and co-ordinated care, which can reduce hospital admissions and help people to stay in their own homes.

Although limitations to national data make it difficult to establish a robust account of changes to activity and staffing, there is evidence of a profound and growing gap between capacity and demand in district nursing services.

- Our research, together with national surveys, indicates that activity has increased significantly over recent years, both in terms of the number of patients seen and the complexity of care provided.

- While demand for services has been increasing, available data on the workforce indicates that the number of nurses working in community health services has declined over recent years, and the number working in senior 'district nurse' posts has fallen dramatically over a sustained period.

Our research suggests that these pressures are compromising quality of care. We found examples of an increasingly task-focused approach to care, staff being rushed and abrupt with patients, reductions in preventive care, visits being postponed and lack of continuity of care.

This is having a deeply negative impact on staff wellbeing, with unmanageable caseloads common and some leaving the service as a result. We heard of staff being 'broken', 'exhausted' and 'on their knees'.

It is worrying that the people most likely to be affected by this are often very vulnerable and among those who are also most likely to be affected by cuts in social care and voluntary sector services. It is even more troubling that this is happening 'behind closed doors' in people's homes, creating a real danger that serious failures in care could go undetected because they are invisible.

District nursing shortages risk adding to pressures on other parts of the health and care system: other recent research by The King's Fund has found this is already having an impact on caseloads in general practice and social care. There is also a risk of this contributing to the growing number of older people requiring acute hospital admission, and to delayed transfers of care for older people being discharged from hospital.

The dissonance between the frequently stated policy ambition to offer 'more care close to home' and the apparent neglect of community health services over recent years is striking. Resources, monitoring and oversight remain stubbornly focused on the acute hospital sector.

We suggest the following as immediate priorities to address the issues revealed in this report:

- system leaders must recognise the vital strategic importance of community health services in realising ambitions for transforming and sustaining the health and social care system

- there is an urgent need to create a sustainable district nursing workforce by reversing declining staff numbers, raising the profile of district nursing and developing it as an attractive career

- robust mechanisms for monitoring resources, activity and workforce must be developed alongside efforts to look in the round at the staffing and resourcing of community health and care services for the older population.

It is also essential to develop a robust framework for assessing and assuring the quality of care delivered in community settings. Our research suggests that staff, patients and carers have a strongly aligned set of beliefs about the components of 'good' district nursing care, valuing a 'whole-person approach' to care with a focus on relational continuity, involvement of family and carers, patient education and self-management support, and care co-ordination. This would provide a strong foundation for developing a new quality framework suited to the distinctive characteristics of this care.

1 Introduction

District nursing services are a vital part of the NHS for many people, often making the difference between people being able to stay well at home or moving into residential care settings. A growing older population and related increases in the prevalence of frailty and long-term conditions, together with a policy ambition to shift more care out of hospitals and into community settings, mean that district nursing is a key part of the health service both now and in the future (Ham *et al* 2012).

However, we know very little about demand for district nursing services nationally, what capacity there is within the workforce, what level and type of care is provided and still less about the quality of this care. The distinctive features of district nursing care, particularly the fact that it happens 'behind closed doors' in people's homes, make most existing quality measures used in the hospital sector a poor fit and scrutiny a real challenge.

This study focused on care for older people who receive district nursing services in their own homes. It asked the following questions.

- What does good-quality care look like in this context from the perspective of people receiving care, their carers and district nursing staff?

- How does that compare to their experiences?

- What factors support 'good care', and what is getting in the way?

To answer these questions, we:

- conducted a review of existing policy and research literature

- had scoping conversations with national stakeholders

- conducted focus groups with senior district nursing staff (n=40)

- carried out interviews with patients, carers and staff in three case study sites (n=50).

Each 'site' was the area covered by one district nursing service. (For details *see* the Appendix.)

While our work was originally focused on drawing together evidence to set out a framework for understanding the quality of district nursing care, during the course of our research we found evidence of a profound gap between demand and capacity within district nursing services. Moreover, we identified concerning evidence of the impact this was having on staff wellbeing and on the quality and safety of care delivered to patients. Therefore, we present the findings of this report in two parts.

- The first part sets out our framework for what 'good care' looks like in district nursing services, providing an evidence-based foundation to inform quality assurance and improvement work by frontline teams, provider organisations, commissioners and regulators.

- The second part outlines evidence of the demand–capacity gap in our case study sites – together with national data indicating that this is a much wider problem – and sets out examples of the ways in which this is damaging staff wellbeing, and pulling care away from the features of good-quality care outlined in our framework.

2 Background

District nursing services

District nursing services deliver a wide range of nursing interventions to people in their own homes (*see* the box below) and play a key role in supporting independence, managing long-term conditions and preventing and treating acute illnesses. These services are required for many reasons, but are commonly needed by disabled adults, older people living with frailty and long-term conditions, and those who are near the end of their life (Cornwell 2012; Imison 2009). According to the most recent *NHS reference costs* release for 2014/15 (containing data from just over half of trusts), approximately 20 per cent of NHS spending on community health services was spent on district nursing (about 2 per cent of the total NHS budget) (Department of Health 2015).

Services commonly provided by district nursing services

- Advice and support
- Bowel care
- Continence management
- End-of-life care
- General nursing care
- Health education
- Injections (intramuscular/intravenous/subcutaneous)
- Intravenous therapy, including chemotherapy
- Medication administration
- Medication reviews
- Monitoring/screening
- Nasogastric (NG) tube feeding (artificial feeding through a tube inserted into the nose)

- Pain control

- Percutaneous endoscopic gastrostomy (PEG) feeding (artificial feeding through a tube inserted directly into the stomach)

- Phlebotomy (blood taking)

- Prescribing

- Pressure area care (to prevent the development of pressure ulcers)

- Referral to other services

- Risk assessment

- Skin care

- Urinary catheterisation and ongoing catheter care

- Wound care

Source: Adapted from The Queen's Nursing Institute 2009

The terminology used for these services is not always consistent; the terms 'community nursing services' and 'district nursing services' are often used interchangeably. For the purposes of this report, we use the term 'district nursing services' to distinguish these services from nursing care in other areas of community services.

Definitions of 'community nurse' and 'district nurse' are outlined in the box below; however, again, these terms are also often used interchangeably in practice. Throughout this report, we refer to qualified nurses working in district nursing teams as 'community nurses' (who include some staff with a district nursing specialist practitioner qualification), and to senior frontline staff with team leader roles as 'district nurse team leaders'. We refer to other staff working in these teams, including health care assistants and assistant practitioners, as 'support staff'.

Staff who commonly work in, or closely with, district nursing services

Community nurse - a registered nurse working in the community with or without a specialist practitioner qualification. Registered nurses work at varying levels of seniority within community teams, depending on their level of experience and pay banding. It is possible for nurses without the district nursing qualification to hold management positions.

District nurse - a registered nurse with a district nursing specialist practitioner qualification recordable with the Nursing & Midwifery Council. The specialist practitioner qualification focuses on topics including: case management; clinical assessment skills; care co-ordination; autonomous decision-making; advanced clinical skills; leadership and team management. These nurses often hold senior or management positions within community nursing teams. In practice, the term 'district nurse' is often used to refer to nurses working in district nursing teams who do not have a specialist practitioner qualification, but occupy a 'district nurse' post.

Nursing support staff or health care support workers - staff working in clinical roles in district nursing teams who are not registered nurses, for example health care assistants and assistant practitioners.

Community matron - introduced in 2004, the community matron role combines advanced clinical practice with active case management. Community matrons work to improve the care of people living with long-term conditions in the community through: education, support for self-management, close surveillance and co-ordination of health and social care services. Community matrons often work with patients with multiple long-term conditions and complex needs.

Clinical nurse specialist - an advanced practitioner with expertise in a particular condition or set of conditions. Clinical nurse specialists may work in acute or community settings, they may visit patients at home and they may offer support and advice to community nursing teams. Specialty areas include: tissue viability, continence, palliative care, chronic obstructive pulmonary disease and heart failure.

A survey of Royal College of Nursing (RCN) members working in district nursing services found that a 'typical' district nursing team covers a population of slightly more than 5,000 people and includes:

- two district nurses

- five registered nurses (without a district nursing qualification)

- one community matron

- two health care assistants/other support workers

- one member of clerical/administrative staff

- 0.5 'other' staff.

This survey found that, on average, 75 per cent of staff in community nursing teams were registered nurses, 17 per cent were band 1–4 health care support workers and 6 per cent were administrative and clerical staff. The survey also revealed significant variation; for example, 43 per cent of teams had no community matrons, 38 per cent had no administrative or clerical staff and 16 per cent had no district nurses (**Ball** *et al* **2014**).

There is also significant variation in the organisational configuration of district nursing services (and all other community health services) following the Transforming Community Services policy (**Foot** *et al* **2014**; **Lafond** *et al* **2014**):

- some are provided by standalone community NHS trusts

- some are provided by combined community and acute or mental health trusts

- some are provided by charities, social enterprises or private sector providers.

(For a potted history of the frequent reforms to and restructuring of community health services, *see* **Foot** *et al* **2014** and **The Queen's Nursing Institute 2009**.)

Compared with other areas of NHS care, the independent sector is now a significant provider of NHS-funded district nursing and other community health services. In 2012/13, 69 per cent of NHS spending on community health services went to NHS providers, 18 per cent to the independent sector and the remaining 13 per cent to social enterprises and voluntary organisations – this compared with the acute hospital and mental health sectors, where the proportion of 2012/13 spending that went to NHS providers was 96 per cent and 81 per cent respectively (**Lafond** *et al* **2014**).

Demographic changes and the policy drive to shift care closer to home

The nature of the care provided by district nursing services, and the fact that these services are usually reserved for patients who have difficulty leaving their home,

means that a large proportion (but not all) of the people who receive this care are older patients living with multiple complex long-term conditions, limited mobility and frailty.

Between 2005 and 2014, the number of people in England aged 65 and over increased by almost a fifth, with the most marked growth in the oldest age groups; in the same time period, the population aged 85 and over increased by just under a third. This trend is predicted to accelerate; from 2015 to 2035, the number of people aged 65 and over is expected to increase by almost half and the number aged 85 and over to almost double (Mortimer and Green 2015; Office for National Statistics 2015). As people age, they are increasingly likely to live with chronic disease, multiple health conditions, disability and frailty (Health and Social Care Information Centre 2014; Oliver et al 2014).

An important policy response to these demographic changes has been an ambition to shift more care for older people out of hospitals and into community settings, including into people's own homes (Edwards 2014). In recent policy history, this drive dates back 10 years to the 2006 White Paper *Our health, our care, our say* (Department of Health 2006) and has taken various forms, including: running outreach clinics from hospitals; up-skilling primary care doctors and nurses to undertake more specialist work in the community; and more pro-actively identifying and supporting people living with long-term conditions who may be at risk of hospitalisation.

Providing care in the community rather than in hospitals has been seen as a way of both improving patients' experiences of care and also reducing pressure on hospitals and costs to the taxpayer. The evidence for whether these aspirations are realised in practice is mixed (Monitor 2015), but the policy direction is clearly set, most recently by the *NHS five year forward view*, which promised 'far more care delivered locally' (NHS England et al 2014). This might lead us to expect an expansion in these services in terms of the available funding and workforce; however, in recent years this has not been the case (Addicott et al 2015).

Managing quality in district nursing services

Compared with data on care delivered in hospitals, relatively little data on community health services is collected and collated at a national level. In the case

of hospital care, every patient episode has been recorded and collated nationally since the development of Hospital Episode Statistics in the late 1980s, but there is no equivalent, nationally mandated, data collection on activity in community health services. However, work is ongoing to develop the Community Information Data Set (CIDS). Similar to Hospital Episode Statistics, this is intended to provide robust, comprehensive, nationally consistent and comparable, patient-level information for community services (**Health and Social Care Information Centre 2016b**). The CIDS is currently in use for local data collection and extraction; it remains unclear when national collection and publication of this data will be realised.

There is also much less information available on the quality of care provided in community settings, including the nature of patient and carer experiences of that care. A previous report by The King's Fund on managing quality in community health services (**Foot *et al* 2014**) described the limited range of national and local quality data that is collected in this area and summarised some of the particular barriers to developing a more robust information base for community services, including:

- the diversity of services provided by the community care sector

- the large number of service providers

- the multiplicity and complexity of data flows required to cover the numerous and diverse services, settings and client base covered by community care

- the comparatively weaker information infrastructure in community care compared with the primary care and hospital sectors where information technology is better developed

- intrinsic difficulties in monitoring the quality of care provided in people's own homes.

A limited number of the quality measurement and assurance systems that apply to hospital care also apply to district nursing care, some of which focus on patient and/or staff experience. These include:

- the Friends and Family Test, which asks patients to give their views on the NHS care or treatment they have received

- Care Quality Commission inspections

- the Commissioning for Quality and Innovation (CQUIN) framework, which rewards health care providers for achieving local quality improvement goals

- NHS complaints data

- incident reporting

- the NHS Safety Thermometer, a tool to measure whether patients are at risk of harm in the care environment

- the annual NHS Staff Survey.

Commissioners and provider organisations also collect data at a local level, which they may or may not make available, for example through their quality accounts. Other initiatives to collect data on community health services include the following:

- the national indicator development project for community services – this is funded by a group of providers with the aim of developing a range of meaningful quality metrics for community settings, with an emphasis on patient-reported outcome measures and experience

- the NHS Benchmarking Network – this is a member-led organisation that collects data from some 80 per cent of NHS community service providers, including information on activity, funding, the workforce, access to care and the quality of care (Foot *et al* 2014).

The national NHS patient experience survey programme does not extend to people receiving district nursing care in their home. However, the Care Quality Commission (2016) is currently consulting on extending the programme to community services.

❸ What is 'good care'?

A quality framework for district nursing

This section sets out a framework for understanding the components of 'good care' for older people receiving care from district nursing services in their own home. The framework is derived from interviews with people receiving district nursing care, their unpaid carers and staff; and focus groups with staff. It is supplemented with findings from our review of the literature. Our analysis most often drew on discussions of positive experiences and the values and preferences of interviewees, but it sometimes also drew on discussions of negative care experiences and what the hypothetical inverse of these would look like.

The strongest message we heard from older people receiving care from district nursing services and their unpaid carers was one of gratitude. Although there was a considerable range in the severity and complexity of the health conditions these older people and their families were living with, most of the people receiving care were unable to leave the house independently and some had not left their home except in medical emergencies for some years. It is difficult to overstate the value that our interviewees placed on having health professionals visit them to provide the care that they needed, helping them to continue to live at home rather than to be compelled to move to a hospital or a care home.

The first three characteristics of good care that were most commonly described, and often the most intensely felt, by all three interviewee groups were:

- caring for the whole person

- continuity of care

- the personal manner of staff.

In addition, people receiving care and their carers spoke of:

- the importance of visit times being predictable and reliable

- being able to contact services between appointment times.

Additional characteristics that were important to all participants, but to a lesser degree, were:

- valuing and involving carers and family members

- nurses acting as co-ordinators and advocates

- clinical competence and expertise.

Staff also emphasised the importance of their role in supporting and educating patients to manage their own health and care needs. The subsections that follow outline the features of each of these characteristics in detail.

At their best, district nursing services can offer a model of co-ordinated, person-centred, prevention-oriented community care. They exemplify the principles of good care for people living with long-term conditions described by national policy leaders in the *NHS five year forward view* (**NHS England** *et al* **2014**) and the recent nursing and midwifery strategy *Leading change, adding value* (**NHS England 2016**), as well as in consensus documents from patient organisations such as the Richmond Group of Charities (**Foot and Maybin 2010**).

The three characteristics of good care, **caring for the whole person, continuity of care** and **personal manner of staff**, described below, were the features most commonly described, and often the most intensely felt, by all three interviewee groups.

Caring for the whole person

What does this involve?

- Taking a holistic, person-centred approach to care rather than a task-focused approach

- Seeing the person, not the need

- Considering the person's other health conditions, social issues and wider circumstances, not just a particular condition

Quality of care improves because:

- The root cause of a problem can be understood and addressed

- Undiagnosed health problems, including acute illness, can be identified

- Care can be adapted to the person's needs, helping to put them at ease

- The person receiving care and their carer feel supported

- Care is an important source of social interaction for the person receiving care

Who is it a priority for?

- Older people receiving care

- Informal carers

- Staff

Good care was commonly described in terms of staff caring for the whole person and providing holistic, person-centred care rather than taking a task-focused approach. Our participants described a number of key benefits and gave examples, and these were very similar for patient and staff interviewees. They included the following.

- The root cause of a problem can be understood and addressed.
  I had a patient that had a leg ulcer that wouldn't heal. We tried everything. And I was just starting, so I was still very task-oriented. So I would go in… do the leg and leave. But it got to the point that I started saying to myself, 'Why is that not healing, what's happening?'… So I spoke with her… The wounds kept opening, because she was alone, and she was trying to reach a top cupboard… and every time she had to prepare her meals, she would re-open the wound. So, it was such a simple thing. I just had to go into the kitchen, remove the stuff that was up high, I talked with her, and we put it lower… The wounds got better… you just need to sit down and talk.
  (District nurse team leader)

- Undiagnosed health problems, including acute illness, can be identified.
  A number of people receiving care and their carers gave examples of occasions when their nurse had observed that they were unwell and had arranged further medical attention. Examples included an individual with early pneumonia, another with early signs of deep vein thrombosis (DVT) and another who had fallen and sustained a head injury. These individuals all went on to receive investigations and treatment from their general practitioner (GP) or in hospital,

and all reported that they would not have sought medical attention without the support of their nurse.

- Care can be adapted to the person's needs, helping to put them at ease.
  I went to administer medication to a very confused lady… she lives with her daughter but her daughter was out of the house at that point… So my popping in to give her an injection was very scary [for her]… I ended up having to stay half an hour instead of 15 minutes, just to calm her down. Because I don't believe in just administering medication without having the patient's total consent… she explained that she was very stressed, because I looked too young to be giving injections. So after that, I managed to calm her down, explaining to her what the injection was for, and why she needed it. She calmed down, she understood, so I was able to give the injection.
  (Community nurse)

- The person receiving care and their carer feel supported.
  They just seem to go that little bit further to help, I mean, just being asked: 'Are you feeling okay?'
  (Male patient, 60s)

- Care is an important source of social interaction for people receiving care, particularly those experiencing loneliness and social isolation.
  The social aspects of the care often appeared to be valued more than its clinical components:

  They're always social. You can talk to them, like I'm talking to you. And I look forward to them coming… They come twice a week at the moment and they'll scale that down to once and then out… I dread them signing me off.
  (Male patient, 90s)

  Loneliness is one of the problems. So if you spend time talking to [people you are caring for], even five minutes makes a difference to them… And the more you talk to them, that's when they also open up and tell you some things that you don't know… they're in the house, housebound, they don't get that socialising from their family. So the more you walk in there, spend five, ten minutes, spend time, talk to them, you'll bring them back where they are.
  (Support staff)

  I think it's just the time we spend with them… not administering the medica-tion, or doing the wound care. It's just being with them, and knowing that they

have some support; someone that will be coming in and checking on them, and making sure that they're safe… They're not so socially isolated… They have something to aim for, when they wake up in the morning. There is a change in their day.
(District nurse team leader)

Caring for the whole person requires professionals to engage with people receiving care as individuals with a collection of problems, preferences and needs – including other health conditions, social issues and wider circumstances – rather than narrowly focusing on a particular task or condition. One focus group participant expressed this as 'seeing the person, not the need'. It also requires staff to enquire after their patients' health and general wellbeing. A key moment for this is at the initial assessment or during re-assessments, but staff also described continuously making assessments during routine visits:

Just being there and chatting with the patients, because while you're doing that you're also doing an assessment of them, and there can be things that crop up while you're chatting.
(District nurse team leader)

Because I took the time to sit down with him, he opened up. Because he said: 'You're the first person who actually, instead of just writing, writing, writing, took the time to speak with me'… Just that, it's enough for them to open up and tell us what's happening… sometimes it just takes asking.
(District nurse team leader)

The nature of district nursing care facilitates a 'whole-person approach' – visiting people in their own homes helps staff to gather critical information about the wellbeing, needs and preferences of the person through seeing them in their home environment and speaking to formal and informal carers and family.

We get the correct view on them. We get to see them in their own environment. So it's not forced, they are not telling us what we want to hear, they are not masking their lives, they are being themselves, in their houses. They are showing us who they are, in reality, and they are letting us help them in their own environment… you have the chance to make a difference.
(District nurse team leader)

Whenever the patient is on the ward, you don't know the real person. You know the patient, you know the sick person who's there, but then whenever you visit them at home… you get to know the person in their comfort zone… And you get to know a lot of their personal history, you get to know their families. And, sadly, you get to know a lot of what scares them, or a lot of what is not quite right.
(District nurse team leader)

Having it done in my own home [means that] even if I'm not feeling well, which often happens, they still come. And they take it on board if I don't feel well – they ask me about it and it's in my notes.
(Female patient, 80s)

Caring for the whole person also features as a prominent theme in the literature regarding patient, carer and staff experiences of community nursing care, and other types of care delivered in home settings, including from social carers and community matrons (Randall *et al* 2014; Skilbeck 2014; Hanratty *et al* 2013; Ellins *et al* 2012; Manthorpe *et al* 2012; The Queen's Nursing Institute 2011; Williams *et al* 2010; Brown *et al* 2008; Reed and Gilleard 1995).

Continuity of care

What does this involve?

- The same nurse, or the same few nurses (who communicate information effectively) seeing each individual receiving care

Quality of care improves because:

- Staff are able to monitor progress and see how effective the treatment is

- Staff can detect improvements or deteriorations in the person's condition

- The person receiving care does not have to repeat information

- The person has confidence in the abilities of a known and trusted nurse

- Continuity supports and enables a 'whole-person approach' to care

- Continuity facilitates the development of relationships and trust

- Continuity can enhance the relational and social benefits of care

Who is it a priority for?

- Older people receiving care

- Informal carers

- Staff

Our interviewees highlighted a number of benefits of regularly seeing the same nurse or few nurses.

- Staff are able to monitor progress and see how effective the treatment is.
  This often helped to guide decisions about changes to treatment, and was valued by people receiving care and their carers as a source of reassurance:

  You get a reassurance… They say it's getting better, so you feel better. Whereas a complete stranger can't say what it's like, if it's getting better, because they've never seen it before so they can't compare it with anything.
  (Male patient, 60s)

- Staff can detect improvements or deteriorations in the person's condition.
  Again, this could help to guide decisions about treatment, and sometimes helped staff to identify new health problems and acute illness promptly.

- The person receiving care does not have to repeat information.
  The person does not have to repeat information (which may be personal) about their condition or background, or their preferences about care (for example, a preferred style of wound dressing or favoured injection site, or preferences regarding appointment timing, access to their home and equipment storage). For some people receiving care it can be difficult to make these preferences clear, particularly if they experience confusion or have communication difficulties.

- The person has confidence in the abilities of a known and trusted nurse.
  This can significantly reduce anxiety associated with receiving care, particularly for personal care or uncomfortable procedures:

  I think what it was, she used to change your catheter and you used to have a lot of faith in her that it would be all right, but if somebody else came you always got a bit worried.
  (Male carer, 70s)

- Continuity supports and enables a 'whole-person approach' to care.
  Interviewees described how a nurse undertaking a one-off visit is much more likely to focus on the task at hand compared with a 'regular' nurse, who knows the individual and their wider situation.

- Continuity facilitates the development of relationships and trust.
  This is particularly important in the context of care delivered in people's homes:

  > *I think they need a friendly face, and a regular friendly face to build up that relationship with someone they can trust. I think trust is a major issue, especially because it's in the community and you are going into these people's homes, they feel very vulnerable.*
  > (Community matron)

- Continuity can enhance the relational and social benefits of care.
  Many people receiving care and their carers placed huge value on the opportunity to build a lasting relationship with a nurse, particularly those experiencing isolation and limited social contact.

A number of interviewees suggested that continuity could be achieved through a patient experiencing the 'continuity of a team'; that is, seeing a small number of nurses who work together to ensure the continuity of the treatment plan and case management.

A number of staff interviewees also highlighted that continuity should always be balanced by input or review from other staff members to make sure that there is appropriate quality assurance in place and senior members of staff are involved.

It was evident in our interviews that the relative importance of continuity varies depending on the situation of the person receiving care and their condition. One person receiving care explained that continuity had held a different weight for two different district nursing interventions. When receiving visits from district nurses for the administration of intravenous antibiotics through a peripherally inserted central catheter (PICC) line, she had been satisfied with any qualified staff member completing this quick and discrete task. However, when she subsequently received district nursing care to heal a complex and painful wound, she described the huge value of continuity in helping the treatment plan to be followed and the wound progression to be monitored. Across all our interviewee groups, wound management consistently came up as a key area benefiting from continuity.

A further area where continuity was particularly valued was in end-of-life care, where the building of relationships and anticipatory planning are key. As one staff member described:

> *If you've known the person when they're well, you build up that rapport and that relationship with the patient and the family. Then when they begin to decline you've got more of a feeling for what they need, and then you know what they're going to need and you can – to a certain extent – anticipate it. Just the little things like when to approach the hospital bed scenario that might look incongruous in their house, when to talk about the syringe driver so that it doesn't come as a huge shock to them when those things need to be put into place.*
> (Community nurse)

Continuity is also one of the strongest and most consistent themes in the existing research literature on patient, carer and staff experiences of community nursing care and other types of care delivered in home settings. The literature highlights similar benefits (Randall *et al* 2014; Hanratty *et al* 2013; Goodman *et al* 2010; Williams *et al* 2010; Brown *et al* 2008; McGarry 2008; Sargent *et al* 2007), including:

- the building of relationships and psychosocial support

- better understanding of the patient's condition, circumstances and preferences

- regular nurses being able to detect improvements or deteriorations in a patient's condition and responding accordingly.

There is also evidence from previous research that continuity is associated with improved patient outcomes, including a reduced chance of hospitalisation and improved functioning in activities of daily living (Russell *et al* 2011).

The personal manner of staff

What does this involve?

- Caring and compassionate attitudes

- Polite and respectful attitudes

- Not appearing to rush

- Effective communication and the building of trust

- Staff appearing to be professional and confident

Quality of care improves because:

- The person receiving care feels at ease and more confident in the care

- Polite and respectful attitudes are particularly important in the context of nurses delivering care in people's homes

Who is it a priority for?

- Older people receiving care

- Informal carers

- Staff

A number of aspects of the personal manner of district nursing staff were highlighted as key to good care. While many of the features described apply to nursing care generally, many interviewees told us how they take on a particularly strong significance in the context of professionals going into people's own homes.

- Caring and compassionate attitudes.
  Patients and carers clearly appreciated nurses who appeared caring and compassionate: 'He seemed to care. And his professional manner of course… there was that thought, not just like "I'll do my job and go"' (female carer, 60s).

- Polite and respectful attitudes.
  This was often raised in relation to the general manner of nurses, and

sometimes in relation to specific actions such as removing shoes when entering a person's home, or clearing up thoroughly following a procedure.

- Not appearing to rush.
  It was important for people receiving care and carers that staff did not seem to be rushing their care. This did not always relate to the amount of time taken, but rather their approach and manner during the visit. Some staff spoke of how 'just being a bit more human when you're there goes a long way'.

- Effective communication and the building of trust.
  Patients and carers also spoke of the importance of their nurses communicating effectively with them:

  > [Good care is] communication, more than anything. Discuss what you're doing, step by step – 'I'm here now, my name is… I'm going to take this bandage off now… I'm going to clean, now I'm going to put on a new bandage…' And tell him everything you're doing, so that he's not so fretful. Communication and bedside manner.
  > (Female carer, 50s)

  Interviewees also thought that it was key for nurses to be able to quickly develop relationships and trust: 'We are in their home so building up trust quickly with people that you don't know is very important' (community nurse). A number of staff discussed the importance of effective communication in difficult circumstances, for instance during sensitive conversations regarding end-of-life care, and with people who experience significant cognitive impairments.

- Staff appearing to be professional and confident.
  A number of patients and carers described their preference for nurses who display a professional manner and appear at ease when explaining and performing procedures.

Previous research into community nursing care and other types of care delivered in home settings supports these findings (Randall *et al* 2014; The Queen's Nursing Institute 2011), often highlighting the importance of:

- a caring and compassionate approach

- friendliness

- communication skills

- professional and positive attitudes

- respect for individual preferences and home environments.

The following two features of good care, **scheduling and reliability of appointments**, and **being available for patients and carers to contact between appointments**, were of high importance to people receiving care and their carers. While they were rarely mentioned by staff as key components of good care, when we asked staff what aspects of care they thought patients most value, they were almost always mentioned. Thus, while staff did not prioritise these characteristics to the same extent, they recognised them as important to patients and carers.

Scheduling and reliability of appointments

What does this involve?

- Advance warning of appointment timing

- Reliable/predictable timing

- Information and updates when scheduling is disrupted

Quality of care improves because:

- Predictable appointment timing helps people to plan and maintain routines

- People are able to plan hospital appointments or other care visits

- People are able to maintain social networks and contact

Who is it important to?

- Older people receiving care

- Informal carers

Who else recognises its importance?

- Staff

Most people receiving care and their carers expressed a preference for appointment windows to be as narrow as possible, and for nurses to reliably arrive within that timeframe. Where changes were necessary, they wanted to be informed about this and updated as to when the likely appointment time would be. This was important for a number of reasons.

- Predictable appointment timing enables people to plan and maintain routines. This includes meal preparation and eating, food shopping, washing, dressing and even going to the toilet. Unpredictable appointment timing could have a profound impact on the ability of people receiving care and their carers to plan and maintain routines.

- People are able to plan hospital appointments or other care visits. For people who also received home care from other professionals or had to attend hospital appointments, reliable timing helped them to plan these around the nursing visit.

- People are able to maintain social networks and contact. This included being able to invite people to visit, going out to see friends and family and attending day centres. Nurses arriving at unpredictable or unsociable hours could increase social isolation for people who were already finding it difficult to maintain social networks due to poor health or mobility.

A very small number of interviewees disagreed with the above sentiment, with one suggesting that it did not matter because 'we're going to be here all day' (female patient, 80s). However, this was not a common opinion, and the notion that appointment timing matters less for 'housebound' individuals was repeatedly challenged through our interviews. Most patients and carers appreciated the obstacles to regular appointment times being given, and were often quick to caveat their preferences with a recognition that this is difficult for nurses.

Previous studies focusing on the experiences of older people living with frailty (Skilbeck 2014; Nicholson *et al* 2012) highlight the importance of daily routines for: general wellbeing; maintaining a sense of purpose; helping people to have a sense of connection to wider society; and distracting people from thinking about physical dependency and decline. They emphasise the significance of the loss of social contact that frailty can bring.

Being available for patients and carers to contact between appointments

What does this involve?

- Services being available to be contacted between visits for information, advice or support or in case of emergency

Quality of care improves because:

- Patients and carers are able to contact the service in the event of a deterioration, a sudden worsening of a problem or other issue, and receive helpful intervention and support

- Being able to contact the service for information and advice can support people receiving care and their carers to manage between nurse visits

- The knowledge that this support is available is reassuring and alleviates anxiety for people receiving care and their carers

Who is it important to?

- Older people receiving care

- Informal carers

Who else recognises its importance?

- Staff

People receiving district nursing care and their carers spoke highly of the benefits of being able to contact district nursing services between appointment times to obtain advice or arrange additional visits. The services we visited had measures in place to manage calls, including emergency numbers and messaging services. People receiving care and their carers described a number of benefits.

- Being able to contact the service for information and advice supported people receiving care and their carers to manage between nurse visits. This could involve practical advice on how to manage care, reassurance regarding a symptom or signposting to and support for contacting another service.

- Even when the need to contact the service between appointment times did not arise, the knowledge that this source of support was available was reassuring and alleviated anxiety for people receiving care and their carers. One person described the comfort she took from being 'always able to ring them up if something [isn't] right' (female patient, 60s).

- Patients and carers were able to contact the service in the event of a deterioration, a sudden worsening of a problem or other issue, and receive helpful intervention and support.

- We heard a number of examples from patients and carers of times when the nursing service had supported them in a moment of crisis, and had either made an unscheduled visit or supported them to access other emergency medical care.

The importance of community nursing services as a point of contact and support features prominently in existing research literature, and has been highlighted as particularly important for carers and for people living alone (**Skilbeck 2014**; Manthorpe *et al* 2012; Brown *et al* 2008).

The three characteristics of good care outlined below, **valuing and involving carers and family members, nurses acting as co-ordinators and advocates**, and **clinical competence and expertise**, were commonly described by all three interviewee groups, but were not as highly valued as the features listed above.

Valuing and involving carers and family members

What does this involve?

- Offering practical support to carers in their role

- Involving carers in care planning and decisions

- Valuing and recognising carers' contributions and expertise

- Addressing carers' own needs and personal wellbeing

Quality of care improves because:

- Carers feel supported and reassured, and more confident in their caring role. Carers feel valued and recognised

- Carers may also be able to help nurses with treatment and support them to better understand the person's preferences and needs

- Some nursing tasks can be handed over to carers

- Patient experience and outcomes are improved

Who is it important to?

- Informal carers

- Older people receiving care

- Staff

The involvement of informal carers and family members was most often raised by carers, but was also commonly mentioned by staff and people receiving care. Involvement (where this is what the person receiving care wants) was perceived to be important on a number of levels.

- Offering practical support to carers in their role.
  There was significant variation in carers' preferred level of involvement, depending on their needs, preferences and abilities. Common examples of the types of input and support they wanted included:

  - updates and information about treatment progress and changes to the person's condition

  - clinical information and education to help them better understand the condition or treatment

  - training in clinical skills and caring tasks

  - signposting to other services, or help to navigate the health and care system

  - support to identify deteriorations in the person's condition so that they may anticipate a crisis and seek prompt help and advice on what to do if a crisis were to occur.

This type of input helps carers to feel supported and reassured, and can increase their confidence and alleviate anxieties about their ability to fulfil the caring role:

> *[If they tell me what to do when there's a problem then] when it happens I'm not going to panic – I feel like I know what I should be doing because I was told to do that, rather than thinking I can't leave it like that, I'm going to have to make my own mind up, and I might do something stupid.*
> (Female carer, 50s)

- Valuing and recognising carers' contributions and expertise.
  It was clearly important to many carers that nurses respected and valued their role, and the knowledge and expertise they have about the person's preferences and needs:

> *He spoke to me like I was important. I wasn't just there… Being my Mum's full-time carer I was very important… and I felt like he respected that…*
> *He was constantly involving me.*
> (Female carer, 60s)

- Carers assisting nurses with treatment.
  Carers may be able to help nurses with treatment and support them to better understand the person's preferences and needs:

> *If we are struggling with a patient, I will turn to the family most of the time and say 'encourage him to do that'… they tend to listen to them… they try to implement it for us.*
> (Support staff)

> *You have to get a good relationship with the family. Because the family know the patient more than you do… We go to some patients once, the carers can go to them four times a day. So they have that relationship, so if you make a relationship with them then you get to know the patient more and you'll be able to deliver good care.*
> (Support staff)

> *I have a patient who has dementia, she can't understand what you tell her. So the carer wants the feedback so she can keep reminding the patient that we are the nurses… they keep giving the feedback to the patient whenever she gets a bit confused.*
> (District nurse team leader)

- Handing over nursing tasks to carers.

  Sometimes we would educate carers to do the care themselves [for example, how to check pressure areas, how to give medications or how to administer a PEG feed]… if we're happy that the carers know what they're doing and they've been educated then we would basically leave our number and say to them: 'Look, this is what you need to look for and if you find this then you escalate it to us'… It's great, because if the carers are very involved then we don't have to go in so often.
  (District nurse team leader)

  Whether handing over nursing tasks to carers is appropriate depends on the needs, preferences and abilities of individual carers, and we heard a range of opinions from carers regarding the extent to which they felt they would be willing or able to take on more caring responsibilities. It is therefore important that this is assessed on a case-by-case basis and tasks are only delegated where appropriate and with adequate ongoing support. If done appropriately, this can be beneficial to people receiving care and their carers by enhancing their independence.

- Addressing carers' own needs and personal wellbeing.
  We heard a number of examples of nurses paying attention to the needs and wellbeing of the carer as an individual. This was particularly valuable as a number of carers who participated in the interviews (particularly those caring for their partner or spouse) were themselves experiencing frailty and multiple, complex health problems.

Previous studies highlight the importance of staff concerning themselves with carer wellbeing in this context, and show how this can indirectly affect patient wellbeing (**Ellins** *et al* **2012**; **The Queen's Nursing Institute 2011**). Carers are often recognised as playing a vital role in the success and sustainability of service interventions (**Age UK 2014a**).

Nurses acting as co-ordinators and advocates

What does this involve?

- Supporting patients and carers who are in contact with multiple services

- Advocating on the patient's or carer's behalf.

Quality of care improves because:

- Other professionals are alerted to problems and appropriate intervention can be made

- The need for other services can be identified and brought into the home. This is particularly important for people with multiple and complex health and care needs, who may be in contact with many professionals and services

Who is it important to?

- Informal carers

- Older people receiving care

- Staff

Community nurses often have a valuable role in co-ordinating care from other professionals and services, and may advocate on behalf of patients and their carers. Our interviewees highlighted a number of benefits.

- Supporting patients and carers in contact with multiple services.
  People receiving community nursing care often have multiple and complex health and care needs, and may be in contact with many services. Common examples from our interviewees included:

  – GPs

  – specialist nurses (particularly continence, tissue viability and diabetes specialist nurses)

  – hospices

  – occupational therapists

– palliative care teams

– physiotherapists

– social services

– podiatry

– equipment and wheelchair services.

A lot of these elderly patients with complex needs are being seen in different departments within different hospitals, and everything gets very confusing for them. A lot of them are on their own, so I think [district nurses] being the patient's advocate and the co-ordinator of their care is really important because a lot of people struggle with that.
(Community matron)

They're so on the ball. I told her I need antibiotics from the GP – off she trots and a couple of days later I've got my antibiotics… I've got an ulcer on my heel – they told the podiatry people and now they see me every month… she arranged the ambulance to pick me up for my appointments. They really are on the ball.
(Female patient, 80s)

• Alerting other professionals to problems and ensuring appropriate intervention. We heard a number of examples of nurses detecting acute problems – such as a wound or a urine infection – and requesting antibiotics from the GP, or in more serious cases asking the GP to do a home visit. In some instances, nurses were able to alert the GP to problems or concerns that the person would not have reported themselves:

Some of the patients won't call [the GP], either because they can't call, or they have no one who can call for them. We tend to be the only health care professional they see on a regular basis.
(District nurse team leader)

A number of staff interviewees regularly attended local GP practice meetings, and spoke of the benefits of being able to discuss and co-ordinate patient care and develop closer working relationships with practice staff. Some people receiving care also reported benefits from their nurses being in regular contact with their GP.

Staff also discussed their role in identifying and addressing safeguarding issues:

> *We managed to get all the services involved on board, and get together and discuss what went wrong, and what we could do to improve it… to create the conditions for [the patient] to be safely at home.*
> (District nurse team leader)

- Identifying the need for other services and bringing them into the home. We heard examples of community nurses referring people to other services, helping them to access services by providing information or arranging transport, ordering equipment and, in one case, arranging a period of respite for a carer. Interviewees described how 'if you've got them on your side it does push things along quicker' (male carer, 70s) and that 'things get moving a bit more' (male patient, 60s). Community nurses are often in a unique position to be able to identify the need for services: 'You pick up so much about what they want and what they need, and can liaise with others, and bring services into the home' (community nurse).

Existing literature also highlights the role of community nurses as co-ordinators of care and as advocates to articulate and champion their patients' needs (The Queen's Nursing Institute 2014, 2011; Goodman *et al* 2010).

Clinical competence and expertise

What does this involve?

- Knowledge, experience and expertise

- Clinical skills and advanced technical skills

- Skills in assessment and care co-ordination

Quality of care improves because:

- Procedures are completed to a high standard without causing harm or avoidable discomfort

- This increases patients' and carers' confidence in the care they are receiving

Who is it important to?

- Informal carers

- Older people receiving care

- Staff

Patient, carer and staff interviewees sometimes mentioned community nurses' clinical skills and expertise. However, many interviewees did not mention this at all, and when it was discussed it was rarely at the top of their list of what makes for good care. This was reflected in the findings of our literature review, where this characteristic received less attention than the other aspects of care mentioned above. In some ways, it is surprising that this theme did not feature more prominently. This may in part be a question of expectation: people assume that it is beyond question that a qualified nurse should have relevant clinical expertise and may not think to mention this in response to an open question about what they value or would like from a service (Qureshi and Henwood 2000; Reed and Gilleard 1995). It is notable that where both clinical expertise and psychosocial support did appear in responses, they were given a similar weighting by people receiving services, although a number of people commented that clinical expertise is of secondary importance.

Where clinical expertise was mentioned, this often related to procedures being completed to a high standard, without causing harm or avoidable discomfort. People receiving care and their carers also valued nurses' assessment and care co-ordination skills, and their ability to explain conditions, tests and treatments. A number of staff also highlighted this as important, pointing to the need for a combination of knowledge, experience and communication skills. Some staff highlighted the value of advanced clinical skills, and cited examples where these can improve patient outcomes, such as using Doppler assessments to guide appropriate leg ulcer treatment. A handful of patients and carers also mentioned the importance of staff displaying basic clinical good practice such as maintaining hand hygiene and using sterile approaches to procedures. A similar list of skills is highlighted in previous research (The Queen's Nursing Institute 2011).

The final characteristic of good care, **patient education and support for self-management**, described below, was emphasised by staff interviewees, but did

not feature prominently in our interviews with older people receiving care or their carers.

Patient education and support for self-management

What does this involve?

- Supporting and educating patients to self-manage their health and care needs

- Involving people in decisions about their own care

Quality of care improves because:

- People can be supported to manage their own health and care needs as far as possible, which promotes independence

Who is it important to?

- Staff

Who else recognises its importance?

- Older people receiving care

- Informal carers

Many staff interviewees felt that a key aspect of good care is to support and educate people to manage their own health and care needs as far as possible, and to involve them in decisions about their care.

Community [nursing] is about empowering them, so educating them about what they should do in terms of their own health.
(Support staff)

[We should be] giving patients empowered choices, yet helping them understand their health needs and how to access [care] appropriately… so they can get a better understanding and it's done more in partnership.
(Professional development lead)

It is less 'doing to' and more of a partnership.
(Focus group participant)

Nurses often highlighted this as one of the most rewarding aspects of their role:

It's about allowing them to maintain their dignity and their independence in their own home. I find that really rewarding… A lot of what we do is health education and trying to get people to care for themselves and maintain independence… It's rewarding when that works.
(District nurse team leader)

The maintenance of independence has been highlighted as a key priority for older people in a number of previous research studies (**Age UK 2014b**), and there is evidence that greater patient engagement and 'activation' is associated with better clinical outcomes, lower hospitalisation rates and higher satisfaction with services (**Hibbard and Gilburt 2014**).

Defining quality: an evidence-based foundation for service improvement

The criteria set out in this report provide a positive, evidence-based framework to inform local and national work on quality assurance and improvement in district nursing services. This framework focuses on what makes for good care experiences in this context and, as such, it complements the existing 'I statements' on care for older people (*see* the box below), which emphasise the care outcomes that are important to people receiving care. Together these two sets of resources can provide a reference point for policy-makers, managers and staff engaged in: developing external oversight of care; internal governance processes; or quality improvement initiatives. The resources will help them to understand which aspects of care should be included and prioritised.

The I statements

Independence

- I am recognised for what I can do rather than assumptions being made about what I cannot

- I am supported to be independent

- I can do activities that are important to me

- Where appropriate, my family are recognised as being key to my independence and quality of life

Community interactions

- I can maintain social contact as much as I want

Decision-making

- I can make my own decisions, with advice and support from family, friends or professionals if I want it

Care and support

- I can build relationships with people who support me

- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me

- Taken together, my care and support help me live the life I want to the best of my ability

Source: Adapted from National Voices *et al* 2014

Terms such as 'continuity' and 'co-ordination' are now used so commonly in the policy, management and research literatures that they are at risk of losing their meaning. By including first-person accounts from people receiving care, the detail of our framework draws attention to why these things matter to people, and the impact they can have on their care experience, health and wellbeing. The framework also means that the characteristics of good care can be prioritised; it describes which characteristics had the most support across all three interviewee groups and the intensity of feeling that surrounded them, and offers some insight into which

characteristics were more or less important for certain types of health conditions and care.

Our research found broad agreement among older people receiving district nursing care, their unpaid carers and district nursing staff about what constitutes good care in this context. In the few cases where staff did not share the same priorities as people receiving care and their carers (for example around the scheduling of appointments), they nonetheless knew that the particular aspect of care was important to those they cared for. That there is such a close alignment between the most important characteristics of care quality for staff, patients and carers in this context makes for a compelling and positive foundation for quality improvement. A particular strength of the framework is that it includes the views of staff working at a range of levels in the health service, as well as the experiences and views of people receiving care and their carers. Evidence from quality improvement programmes in health care suggests that initiatives that engage the intrinsic motivation of staff are often the most successful at embedding positive changes in practice (Herzer and Pronovost 2013).

Although we focused specifically on district nursing services, similar care characteristics are described in the research literature on what matters to older people about social care services they receive at home (*see* the box below). As such, the framework presented here can serve more broadly as a starting point for better understanding and improving the quality of care provided to older people in their own homes, whether the professional involved is a home carer or a member of another community service.

What is 'good care': findings from the social care literature

Research evidence about what is important to older people when receiving social care services in their own homes identifies a very similar list of characteristics to that for what is important to older people receiving district nursing services. The characteristics include:

- continuity of care worker

- opportunities for social interaction and positive social relationships

- the manner of staff: not appearing rushed, respecting people's homes and showing caring and compassionate attitudes

- timing and reliability of care worker visits

- availability and accessibility of services between appointment times

- co-ordination of services (Gridley *et al* 2014; Skilbeck 2014; Francis and Netten 2004; Patmore 2002; Qureshi and Henwood 2000; Sinclair *et al* 2000; Henwood *et al* 1998; Qureshi *et al* 1998).

What can this model of care achieve?

The type of care described above exemplifies an ideal model of person-centred, preventive and co-ordinated care for older people living with multiple or complex conditions in their own homes. As well as improving patient experience, we heard examples demonstrating that when done well, this kind of care can prevent deteriorations in health, reducing the need for undesirable and costly hospital admissions, and helps people to remain living independently in their own homes, avoiding the need for long-term institutional care:

I think district nurses will always pride themselves in giving end-of-life care, they will always pull out the stops. Someone dying at home and who aims to die at home will get really good hands-on care from the district nursing service but they'll also be able to bring [other services and equipment]… I think they're very good now at keeping older people at home.
(Senior manager)

He had been stuck in hospital [for months] and the family were really, really, frustrated. [We agreed to support him at home] and I can just see that he has grown back into himself… He absolutely stepped back into home, it was so familiar to him, he is living his life in a really full, independent way… and that's just fabulous.
(Community nurse)

The example below describes how taking a whole-person, co-ordinated and supportive approach to the care of a patient being visited for insulin injections ultimately helped the patient to self-manage her health needs and regain her independence:

In discussion with her, it seemed that actually there were more issues than just her own diabetes – it was around social aspects… Her daughter had mental health

problems, so we linked with the mental health team. She had a grandchild in her care and was involved with social services [so we linked with them too]. We tried to ensure that this lady had support. When she felt supported… she felt able to manage her own diabetes… [We gave] the responsibility back to her; rather than her saying, 'well it's your diabetes district nurse', [we were saying] 'actually it's your diabetes, but we will support you to manage it'. And ultimately she's gone on to self-care… just spending a bit of time with her, and sometimes just parking the diabetes part of it, and talking more about what else was happening, it made her realise that she could manage the diabetes.

(District nurse team leader)

During our interviews with people receiving care and their carers, we were often struck by their immense sense of gratitude for the care they were receiving from district nursing teams, helping them to continue to live at home. Age UK highlights the maintenance of independence as a key priority for older people in a number of its publications, and emphasises primary and community health services as key to supporting this (Mortimer and Green 2015; Age UK 2014b).

Is 'good care' consistently being delivered?

Although in general terms, most people receiving care and their carers were very positive about and appreciative of the care they received, when talking in detail about their experiences, they described how in practice the reality of the service often differed from the descriptions in this report of what good care ought to look like. Meanwhile, staff interviewees raised strong concerns about barriers to the quality of care.

The type of care described above was not being consistently delivered, and in fact performance against the criteria set out here was described as under threat and deteriorating as a result of current pressures on the service. The next section describes:

- the nature of these pressures

- how district nursing services were responding to them

- the impact of the pressures on staff

- the examples that staff, patients and carers gave of the negative impact of the pressures on the quality and safety of patient care.

4 Pressures in district nursing

What gets in the way of 'good care'?

Barriers to high-quality care raised by staff interviewees included:

- a challenging working environment, for example where a patient had cramped or unclean living conditions

- unpredictable travel time between appointments

- unpredictable appointment lengths due to an unexpected deterioration in a patient's condition

- poor planning by or communication from hospitals or other professionals, particularly surrounding discharge (Ball *et al* 2014).

But by far the most significant obstacle to delivering good care, which was raised by patients, carers and staff, was the gap between the demands on the service (in terms of the number and complexity of patients referred to it) and its capacity to meet those demands given the number of staff in post and their level of skills and experience.

This demand–capacity gap is not a new problem in district nursing (*see* for example Stuart *et al* 2008), but in our case study sites it was a problem that had become more acute in the past few years, and looked set to get worse rather than better in the immediate future.

Increases in the number of people needing district nursing care

Staff across all three sites reported a significant increase in the number of patients on their caseloads in the past few years, and even months. At all sites, staff noted that increasing numbers of people living into old age with frailty and multiple long-term health conditions were contributing significantly to their caseloads. This reflects the

wider demographic changes towards an ageing population and more people living with multiple, long-term health conditions, described in section 2 of this report.

There is no nationally published activity data with which to assess changes in the size of district nurse caseloads. However, national surveys have reported increases. For example, a survey of community nurses for the RCN conducted in 2012 found that the vast majority (89 per cent) of respondents reported an increase over the previous 12 months, and almost two-thirds (62 per cent) described that increase as 'significant' (Royal College of Nursing 2012).

Increasing complexity of care delivered in the community

As well as seeing an increase in the number of people they were caring for, staff also described 'dramatic' increases in the complexity of the conditions that these people were living with and the extent of the specialist knowledge and technical expertise required to care for them. Examples of complex care that the staff in our study are now routinely providing are:

- caring for people with multiple, complex conditions

- managing chemotherapy (including drug administration, managing PICC lines and monitoring patients for the complications of therapy)

- managing specialist medical devices (including PEG tubes, nasogastric tubes, wound drains, tracheostomies, medication pumps and chest drains).

Staff described that they were providing care to people in their own homes that would previously have been delivered in hospitals or care homes: 'I think what people used to do was a kind of basic nursing, whereas now we're almost like hospitals at home' (district nurse team leader) and 'as generalists we are being asked to work at a specialist level across different disciplines' (community nurse). Our interviewees attributed this to a strategic shift to deliver more care closer to home, through earlier hospital discharge, admission avoidance and a move away from long-term institutional care. Staff highlighted end-of-life care as a particular area of growth, as there is now an emphasis on helping more people to die at home should they choose to.

The Queen's Nursing Institute (2014, 2006) has recorded increases in the complexity of care provided by district nursing services and, in the RCN's 2012 survey of

community nurses (Royal College of Nursing 2012), 92 per cent of respondents agreed that their services were dealing with patients with more complex needs than in the past.

Staff shortages and a significant capacity gap

In our case study areas, a significant shortfall in the workforce was making the pressures that these changes have created for district nursing services worse. Rather than increases to staff numbers and skills in response to rising demand, our interviewees reported that staff numbers had been static or falling:

• In site one, managers told us that they only have a full team for about two to three months in a year before people leave again. A senior manager described this 'numbers game' as the main challenge facing that service.

• In site two, staff numbers had halved in the past three years because of cuts to posts and difficulties with recruitment and retention. Because of these shortages, temporary reductions in staffing numbers resulting from parental or sickness leave or training were creating significant capacity problems. A senior manager reported that they had been given a poor rating for safety in their Care Quality Commission inspection, which the inspectors had attributed directly to the gap between their demand and staffing levels.

• In site three, where gaps between available staff and the activities to be performed prompted an 'escalation' process, an interviewee told us that they were now using that process almost every week.

In two of the sites, a number of patients and carers were aware of these shortages. They commented on nurses leaving the service, and how they were seeing more agency staff or nurses being brought in from other teams to provide their care.

Recruitment, retention and high staff turnover were described as a 'massive challenge' by staff:

• a senior manager in site one described how recruitment could easily have been her 'life's work for the last year'

• a manager in site two described how it demanded huge amounts of time and work from team managers who were already overburdened with clinical work

- an interviewee in site three described how they were in an 'extended period with our recruitment ongoing', which was having a negative impact on staff morale

- managers in site two had to make a case for replacing anyone who left due to funding constraints, and even where the post was secured, it was difficult to find suitably qualified staff interested in it.

Causes of staff shortages

Interviewees described the development of a vicious cycle in which staff are working under a great deal of pressure, which results in people leaving district nursing, which makes the demand–capacity gap even bigger, making it even harder to recruit and retain staff as the service becomes an unattractive prospect for would-be recruits.

Some interviewees described the ageing workforce in their teams, and reported that older colleagues were reducing their working hours or taking early retirement. One interviewee predicted: 'You are looking in the next 10 years in community nursing at a mass exodus of expertise.' Nationally, the community nursing workforce has an older age profile than the rest of the nursing workforce (**Royal College of Nursing 2012**) and in 2014 The Queen's Nursing Institute reported that half of district nurses planned to retire within the following 10 years (**The Queen's Nursing Institute 2014**).

Staff were also leaving for roles as practice nurses in primary care, and for roles in specialist services such as heart failure or falls teams, which were perceived as having more manageable workloads and allowing more time for patient care. Some staff were leaving for roles in hospitals; as one focus group member described: 'We used to have a shift of staff from acute to community, now it's the other way around.' Health Education England has also stated that employers have reported that the post-Francis expansion in hospital-based nurses 'means that nurses are not moving from secondary to community care at the rate previously observed' (**Addicott *et al* 2015**; **Health Education England 2015b**, p 6). Our respondents suggested that the trend may even be reversing.

One senior manager attributed the recruitment problem to the government's recent drive to more than double the number of health visitors in post, which had led to newly qualified staff who might otherwise have joined district nursing teams going

into health visiting. In 2012, the RCN voiced concern that 'the intense current political interest in health visitors could have negative implications for other areas of the community workforce if nurses in other community roles… are "poached" in order to meet the only nationally set target'. The RCN also thought that it was 'highly probable' that the community matron role meant that a 'significant number may have crossed over into the role from that of being district nurses' (**Royal College of Nursing 2012**, p 13).

Our interviewees also cited inadequate numbers of training places for district nursing over recent years as a cause of the current shortfall, particularly in some areas where there had been periods during which no training places were offered. Teams were particularly short of experienced staff members, especially those with the national district nursing specialist practitioner qualification. Some areas are no longer requiring nurses to hold the district nursing qualification in order to be eligible for a district nurse banded role, but are instead focusing on whether people have relevant skills and experience (**Health Education England 2015a**, p 2). It was notable in one site in particular how relatively inexperienced team managers were; one interviewee had become an acting team manager nine months after entering the district nursing service.

High staff turnover made it difficult to keep up with mandatory and additional training needs for all staff, and left teams without enough skilled and experienced team members. It was frustrating for managers that they would invest in training and induction programmes for new staff, who would then leave soon after.

Workforce issues in district nursing are not unique to our case study sites. There is no nationally published data on vacancy rates by service type; however, an interviewee in a previous study by The King's Fund estimated a 15 to 20 per cent vacancy rate across all community nursing teams (**Foot _et al_ 2014**). NHS England recently reported that, in some organisations, more than 40 per cent of positions at band 6 and above were vacant (**NHS England 2015**, p 17). Meanwhile, in its 2012 survey of community nurses, the RCN found that more than half (61 per cent) reported that their staffing levels had decreased in the previous year. Of those respondents:

• nearly half (47 per cent) reported recruitment freezes and vacancies being left unfilled

- more than a third (37 per cent) described skill-mix changes in their teams

- a third (34 per cent) reported that roles were being expanded to cover wider areas (**Royal College of Nursing 2012**).

The box below outlines national workforce trends in this sector over recent years.

District nursing service staffing levels: the national picture

Community nurse numbers

The way that national workforce data is recorded means that it is not possible to extract a figure for the total number of registered nurses working in district nursing services from the wider community nursing workforce. In terms of the community nurse workforce as a whole, annual NHS workforce data shows that the total number of full-time equivalent nurses working in the community (excluding health visitors) increased by 53 per cent between 2000 and 2009, reflecting a period of growth in NHS budgets and corresponding expansion of the workforce. However, this trend has since reversed, with numbers declining by 8 per cent between 2009 and 2014 (**Health and Social Care Information Centre 2015**, **2011b**) (*see* **Figure 1**).

This picture is complicated by the Transforming Community Services policy (**Department of Health 2009**), which was launched in 2009 and officially came into force in March 2011, leading to a greater proportion of community health services being delivered by voluntary

Figure 1 Number of full-time equivalent qualified nursing staff working in community services (excluding health visitors) by year
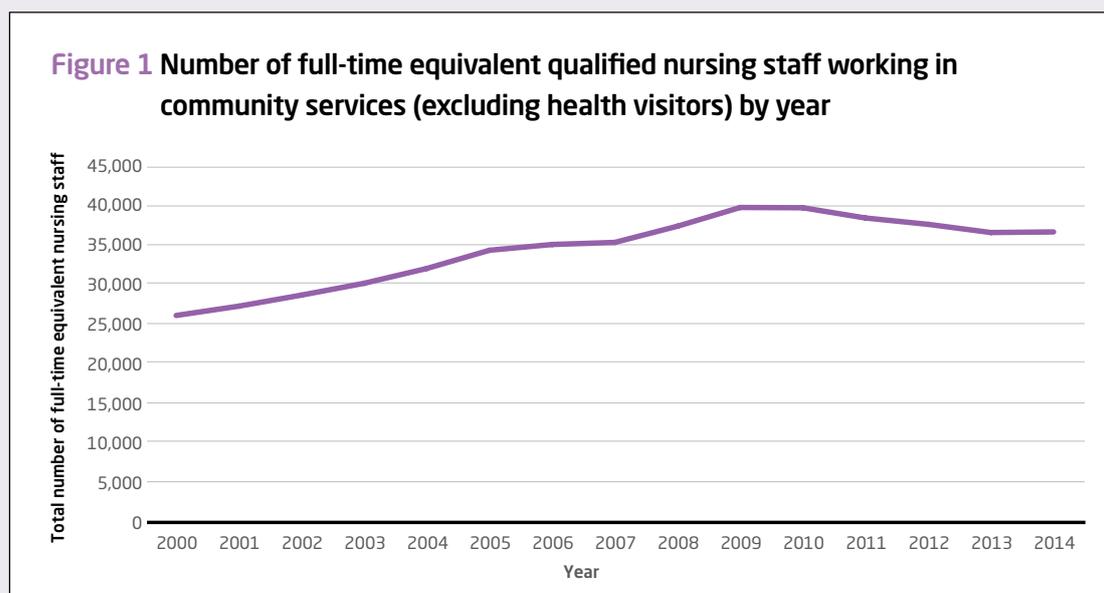
Source: Health and Social Care Information Centre 2015, 2011b

and independent sector providers. These organisations provide NHS-funded care but are not required to return workforce data to the Health and Social Care Information Centre. As a result, some of the apparent decrease could be accounted for by this organisational change; however, this is unlikely to be the sole cause of the fall, as it pre-dates the implementation of the policy (Addicott *et al* 2015).

District nurse numbers

The number of staff recorded as working in district nurse posts has fallen dramatically and consistently over the past 15 years (Addicott *et al* 2015; Royal College of Nursing 2012). Annual NHS workforce statistics show a 48 per cent drop in the number of full-time equivalent district nurses between September 2000 and September 2014 (Health and Social Care Information Centre 2015, 2011b) (*see* Figure 2).

Figure 2 **Number of full-time equivalent qualified 'district nurses' by year**
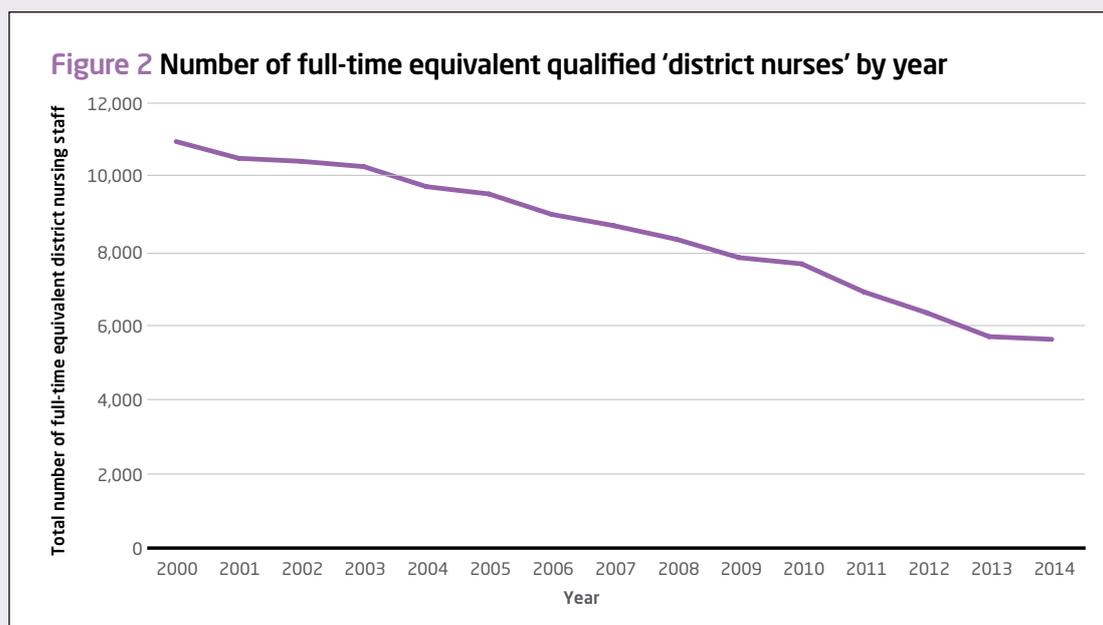
Source: Health and Social Care Information Centre 2015, 2011b

Monthly workforce releases suggest that this decline has since continued: the number of full-time equivalent district nurses fell by 13.6 per cent between March 2014 and March 2016 (Health and Social Care Information Centre 2016c).

Again, the Transforming Community Services policy is likely to have had an impact on these figures, effectively deflating the numbers as non-NHS providers formed or took over services. However, the decline in district nurse numbers pre-dates the policy. Furthermore, recent analysis by The King's Fund suggests that the impact on staff leaving NHS providers

was relatively time-limited: between April 2011 and September 2012, 25 per cent of district nurses who were leaving their posts but not transferring to another NHS trust were moving to non-NHS providers, but this fell to 7.6 per cent between September 2012 and September 2014 (**Addicott *et al* 2015**). The latest data from the Health and Social Care Information Centre shows no significant slowdown in the decline in district nurse numbers, meaning that we can estimate with some confidence that there has been a fall in the number of senior nurses working in district nursing teams.

Nursing support staff working in the community

National workforce statistics also detail the number of nursing support staff working in the community, including health care assistants, nursing assistants, auxiliary nurses, nursing assistant practitioners and other support staff. Overall, these staffing numbers fell by 1.5 per cent between 2009 and 2016 (**Health and Social Care Information Centre 2016c**). Again, it is not possible to extract a figure for the number working within district nursing services specifically.

Community nurses in training

It is the general 'pre-registration adult nursing training' that is the feeder course for community nursing staff, and for all other adult nursing roles across the health system. The number of training places commissioned by Health Education England for this course has increased by 17 per cent over the past six years, although this increase has tailed off in the most recent plan; the proposed increase in places between 2015/16 and 2016/17 is a very modest 2.5 per cent (**Health Education England 2016b**).

District nurse training numbers

Research by The Queen's Nursing Institute with universities found that a fifth of universities validated to offer a district nursing course did not run a cohort in 2012/13 and that many of those that did run one had only small numbers of students on their programmes (**The Queen's Nursing Institute 2013**). More recent research found that numbers of entrants to courses had increased by a third between 2012/13 and 2014/15; and forecast an increase of 14 per cent between 2014/15 and 2015/16 (**The Queen's Nursing Institute 2016**).

There has been wide geographical variation in the availability of district nurse training places. Some areas such as South West England had several years during which no district

training programmes ran. In some areas, despite programmes running, it has not been possible to fill the available places because of a lack of suitable applicants (The Queen's Nursing Institute 2013).

Data from Health Education England on the number of district nurse training places commissioned showed an overall increase of 26 per cent between 2013/14 and plans for 2016/17. However, that increase was focused in 2013/14 and 2015/16, and the latest plans indicate an increase in training places of less than 1 per cent compared with the previous year (Health Education England 2016b). The Queen's Nursing Institute has expressed concern about the apparent slowdown in the number of training places in the context of falls in district nurse numbers and the policy drive to provide more care in community settings (The Queen's Nursing Institute 2016). There are ongoing difficulties with recruitment; this year, 443 of the 502 planned district nurses have been recruited (a –12 per cent variance against the plan), with no further recruitment planned. Health Education England has cited 'a reduced calibre of students and availability of placement capacity' as contributing to this shortfall (Health Education England 2016a).

Survey data

Findings from national surveys of district nursing staff indicate that most are experiencing problems with capacity in their teams. In a 2014 survey of district nursing staff carried out by the RCN, 83 per cent of nurses reported that there were not enough nurses to get the work done, and 75 per cent that there were not enough district nurses on their teams (Ball *et al* 2014). A survey by The Queen's Nursing Institute the same year found that 60 per cent of staff respondents did not believe that they had enough appropriately skilled or qualified staff to deliver the patient care they thought was needed (The Queen's Nursing Institute 2014).

Variable provision of other community-based services

We heard from staff interviewees, focus group participants and national stakeholders that the range of activities that GPs and practice nurses provide to 'housebound' patients varies by area and has an impact on district nursing caseloads. Some interviewees described how pressures on primary care (described in Baird *et al* 2016) were having an impact on the district nursing workload; 'if one service has cuts it's just… like a domino effect… it increases our caseload'. Focus group participants and some interviewees described district nursing as an 'eternal sponge' that filled in the gaps left by other services.

Staff at all three case study sites highlighted significant variation in support offered by social care providers. For example, in some areas, social care workers could prompt and support people to take oral medication; in other areas, they would only do so if the medication came in a blister pack; and in other areas, they did not offer any such support. Some staff reported that they are now undertaking work that was previously done by social care workers, because of significant cuts to local authority funding of adult social care. Nationally, public spending on adult social care for older people fell by approximately 9 per cent in real terms between 2009/10 and 2014/15, and the number of older people receiving local authority-funded social care fell by 25 per cent between 2009 and 2013/14 (with the steepest reductions seen in the numbers receiving community-based services) (**Association of Directors of Adult Social Services 2016**; **Health and Social Care Information Centre 2016a**, **2011a**; **Humphries** *et al* **2016**). The 2012 RCN survey of community nurses found that only 15 per cent agreed that patients in their care receive adequate support from social care services, and three-quarters (76 per cent) reported that social care cuts had resulted in increased work pressures in their teams (**Royal College of Nursing 2012**). Our interviewees also described other local authority spending cuts affecting their workload, including cuts to sheltered housing provision and funding for voluntary sector services.

Resourcing and commissioning of district nursing services

National stakeholders who we spoke to, and more senior staff and managers in interviews and focus groups, described how the increasing number and complexity of people requiring district nursing care, and the national policy drive to shift care out of hospital settings and into the community, had not been matched by a corresponding redirection of resources from hospitals to community services. Relatedly, a number of our staff and stakeholder interviewees commented that district nursing services are not recognised or well understood by national policy-makers; 'it is probably an unknown quantity to a lot of people'.

This is made worse by the fact that these services are commissioned using block contracts and there is a relatively limited range of data and analytical tools that managers can use to show to commissioners and others the increase in patient contacts they are experiencing and particularly the increase in the complexity of those contacts. A national stakeholder told us that over the past four or five years there had been a push to encourage teams to collect capacity and demand data but

that not all did so. Staff interviewees told us that demonstrating the complexity of patients' needs (and not just changes in numbers) was a particular challenge. Recent work by NHS England and The Queen's Nursing Institute has involved a review of those workforce planning tools that are currently being used by district nursing services in the UK (NHS England 2015; The Queen's Nursing Institute and NHS England 2014), and NHS Improvement and The Queen's Nursing Institute are currently undertaking work into developing 'safe caseloads' guidance for district nursing services.

But in our case study sites, even where commissioners could be persuaded of the reality of the existing demand and capacity gap, service managers were now coming up against restricted or reducing commissioning budgets as part of the wider financial pressures currently facing the NHS. Managers in one site described having to reduce their costs further in order to re-win a tender to provide services. Meanwhile in another site, the management team had gathered data to show that the financial value of the service they were providing was several million pounds over what they were being paid, but despite accepting the data, local commissioners simply responded that they did not have any more money to give.

Although there is a lack of robust national data to demonstrate the demand–capacity gap described above and how it has changed over time, it was undoubtedly a major challenge for the service in all three of our case study sites. The next subsection describes how staff and the provider organisations in the three sites were responding to this challenge in practice.

How are services responding to the demand–capacity gap in district nursing?

Staff had adopted a range of measures in response to the gap between demand and capacity. These included both considered, proactive strategies intended to introduce more efficient ways of working as well as more reactive practices that had developed as short-term survival strategies in the context of the pressures faced by the service.

We have grouped these strategies and reactions in terms of their potential impact on the quality of patient care. However, in many cases, that impact will vary significantly depending on the needs and preferences of individual patients and

carers, and the sensitivity and skill with which staff are able to make changes to ways of working.

The following approaches seemed to be principally positive in terms of their potential to sustain or improve patient care in the face of current capacity problems:

* using mobile technologies, new equipment and more efficient clinical pathways

* better co-ordination with other services – including other community health services, social care organisations and local voluntary sector organisations

* efforts to recruit and retain staff – for example by developing combined hospital and community nursing posts

* segmenting planned and unplanned work

* triage of urgent work by senior staff.

Other approaches had the potential to improve patient care and efficiency, but also risked damaging that care if they were pursued too far or without sufficient attention to their impact on patients and carers. These included:

* prioritising patient visits and care tasks – this ranged from positive, proactive initiatives to review caseloads and to discharge people who no longer needed care, to reactive decisions taken under pressure to delay visits and reduce their frequency

* engaging patients and carers in managing their own care – this holds the possibility of improving the experience of patients and carers, while also relieving pressure on the service, but a fine balance is needed to make sure that appropriate tasks are delegated and adequate levels of support remain in place

* using existing staff differently – for example:

    – allowing part-time and sessional staff to temporarily increase their contracted hours

    – developing an internal staff bank to avoid agency use

    – working across bigger geographical areas to spread workload and capacity between locality teams

- greater use of skill-mix within teams – having more assistant practitioner and health care assistant roles to undertake simple tasks, freeing up more senior staff to deliver care for patients with advanced or complex needs

- rejecting referrals that do not contain the required information about the patient – although encouraging high-quality referral information ultimately has the potential to improve patient care, it should be noted that rejecting referrals with poor-quality information may also delay patients receiving the care they need.

The following approaches unambiguously risked having a negative impact on patient care:

- increasing reliance on agency staff – agency use was particularly high at one of our sites, where managers described agency staff as 'propping up' the service, but following a number of quality and safety incidents, the service had developed protocols to try to mitigate the associated issues, for example:

  - using only a few trusted agencies with agreed training and competency requirements

  - offering additional training and competency assessment to agency staff working frequently within the service

- cutting back on non-clinical activities that promote and assure quality – including:

  - teaching and training

  - professional development

  - joint visits

  - quality audits

  - quality improvement and system redesign.

- staff routinely working significantly over their rostered hours.

A number of our interviewees described how some of these approaches – particularly those with the greatest potential for positive impact – were difficult to

realise in the context of current pressures on the service. For example, there was not enough time to undertake reassessment and review, which was a barrier to more proactive management of caseloads; and there was less time for patient and carer education, preventing full realisation of the potential long-term benefits and efficiencies of patients self-managing their health needs. Staff often felt that they did not have the time to reflect on and reform current working practices to make them more efficient, or the resources to adequately support approaches that held the promise of reducing workload in the medium to long term.

The next subsection of this report describes in greater detail the impact on staff and patient experience of the approaches that services are taking in their response to the demand–capacity gap.

What is the impact on staff wellbeing and the quality and safety of care?

In our case study sites, the demand–capacity gap was often having an impact on staff wellbeing and the experiences of people receiving care and their informal carers, despite significant efforts by local managers and teams to mitigate these effects. Because of the nature of our research, we do not seek to make generalisable claims about the extent to which this is the case nationally. However, the in-depth nature of our interviews has allowed us to demonstrate how pressures may manifest, and to show the impact this can have for the people concerned.

Impact on staff

In practice, much of the shortfall in capacity was being made up by the dedication and goodwill of individual staff. Almost all of the staff who we interviewed were routinely working significantly longer than their paid working hours and were working very intensely, often without breaks.

> *To make it work… it is constant run, run, run, run, run.*
> (Community nurse)

> *We usually just pile [patients] up; [staff] have way over their capacity but they somehow get the visits done.*
> (District nurse team leader)

I see the district nurse caseload and I don't know how they cope… no matter what their caseload is they manage to get through it, break or no break.
(Community matron)

[Staff are] getting in early and staying late, above and beyond to actually maintain a standard… It's relying on goodwill… on people to fulfil all the criteria and do an A1 job with not enough time to do it.
(Senior manager)

This was having a profound impact on staff wellbeing in a number of cases, leading to fatigue and stress, and in some cases ill health. In two sites in particular, the strain being taken by staff seemed unsustainable. Managers and nurses used the following phrases when describing the impact on their colleagues:

The impact is stress… [staff are] pushed to frazzle.
(Professional development lead)

Sheer exhaustion… People are just in tears, people are broken.
(Senior manager)

The nurses are on their knees… exhausted.
(Professional development lead)

[Staff] end up the day completely exhausted and drained.
(District nurse team leader)

We get lots more tears now, which we never used to.
(Professional development lead)

We've had [arguments between staff], things being thrown around the room and all sorts… that wouldn't happen in the past; they're just stressed and really tired.
(Professional development lead)

In terms of delivering the quality of care we'd like, there's just not enough time in the service and people are working a lot of unpaid extra hours and becoming very

stressed and very tired. And then because of that, we have a lot of sickness and we've had a lot of turnover.
(Senior manager)

This reflects national survey findings; 70 per cent of respondents to a recent survey by The Queen's Nursing Institute (2014) reported low morale in their teams.

Staff in two of the case study sites described how the situation was made worse by what they perceived to be a lack of adequate recognition of and response to the problems by managers: '[In exit interviews I've conducted, I've heard] people feeling that leadership and management weren't listening to them, weren't hearing what they were saying about the safety, so [they] therefore had no choice but to leave' (senior manager).

Many interviewees, including some patients, described nurses leaving the service, and even the profession, due to these pressures:

[They're leaving, because] they have just had enough.
(Senior manager)

One of the nurses that comes to me regularly, she's given up the job because she can't stand it any longer.
(Female patient, 60s)

Impact on the quality and safety of patient care

Many staff were concerned about the impact that pressures were having on their ability to provide good-quality and even safe care. Similar concerns were raised in a survey conducted for the RCN in 2013: of the 2,438 district and community nurses who responded, 45 per cent agreed and 21 per cent strongly agreed that care is often compromised due to low staffing levels (Ball *et al* 2014).

There appear to be a number of key areas where the quality of care is being compromised, indicated by the following:

• reduced visit frequency and delays to care

• increasingly task-focused approaches to care

• missed opportunities for prevention

- less continuity of care

- staff appearing to be abrupt, rude or uncaring

- greater uncertainty over appointment times

- less patient and carer education.

It can be difficult to determine the extent to which these are new or increasing problems or whether they are more longstanding. However, many interviewees suggested that a number of aspects of the quality of care have deteriorated in recent months and years due to increasing pressures on district nursing services. This often came through most strongly from staff who have been working in the service for many years rather than people receiving care or their carers, some of whom had only relatively recent experience of district nursing care.

Reduced visit frequency and delays to care

Across our case study sites, staff reported that they are increasingly having to postpone visits or reduce their frequency due to workload pressures. Some staff likened their current approach to the escalation process they would usually take in the event of severe adverse weather conditions. Many described having to take this approach on a weekly or even daily basis over recent months.

Staff from all three case study sites cited a similar prioritisation of the work: prioritised tasks included insulin administration, oral medication administration and palliative care; lower-priority tasks included wound care, pressure area care and assessment visits. While prioritisation may sometimes be in the context of appropriate and efficient caseload management, in some cases this was felt to be damaging patient care: 'I have seen that where you push [pressure area checks] back and back and by the time you get to see that patient they've got a pressure ulcer' (district nurse team leader).

Wound care was often cited as being deprioritised at busy times, with adverse effects on how effective treatment was and healing times. This was clearly a source of frustration for staff:

> *When we're understaffed it's always the wound care that gets pushed. So the frequency of changing the dressings or delivering that wound care becomes*

less because we have to prioritise the medications above the wounds… It is [frustrating], because if you're not changing the wounds regularly then obviously they start deteriorating and it means you have these people on the caseload for longer.
(District nurse team leader)

A number of people receiving care commented on reduced frequency of visits and delays to wound care: one person was confined to her bedroom for several days following a postponed visit as the leakage from her wound was so severe; another person, who was only able to shower on the day of her weekly nursing visit, was forced to delay this for a further three days when her visit was postponed over the course of a weekend.

Increasingly task-focused approaches to care
Staff reported having to reduce the time they spent with each patient, and many felt that they were having to rush through their visits and focus only on essential tasks in order to complete the required work:

When you have a big list of patients to see in the day, if you want to get through that list, you really need to rush… you end up going and doing whatever you're there to do, but fail, sometimes, to notice that that person is actually not herself today, or something's wrong. The workload is the main enemy for the patient-centred care.
(District nurse team leader)

What I'm finding quite difficult is that I find community nursing quite task-orientated… [if I'm] going in there to give them their medication, I have 15 minutes, that's what I'm there to do, and I do feel sometimes that part of it is sacrificed. You don't really get to be involved with the patient as a whole, the whole holistic side of assessing the patient you don't necessarily get to do… I feel like I'm missing a whole part of my job by not really knowing anything else about them.
(District nurse team leader)

Many people receiving care and their carers commented on the increasingly rushed and task-focused approach of nurses:

They come, do their job and go… They're friendly but you don't look forward to seeing them.
(Male patient, 60s)

It doesn't seem a personal touch there now. It's jim, jam, thank you ma'am, see you.
(Male patient, 60s)

They seem pushed because of their schedule. They haven't got that time to build that little bit of rapport.
(Female carer, 50s)

That's what it's all about these days – what you can get done, not the quality.
(Male carer, 60s)

Interviewees also felt that the changing skill-mix within teams was driving an increasingly task-focused approach:

If you send someone in just to be giving insulin at band 3 every single day, of course you teach them as much as you can to look holistically, but obviously it's not the same as sending in the nurse.
(Senior manager)

The nurse for the medication can't do the leg dressing or the catheter, so that means a different nurse has to come out to attend to these certain things… no one nurse can do all the items… if [his] bandage has come off or something, you might have to wait a couple of days.
(Female carer, 50s)

Staff interviewees expressed concern that a lack of time to talk and listen to patients could lead to important problems being missed:

There might be a patient who really wants to talk to you about something else. If they want to start that conversation but you tell them you need to go, that might be a very important message you are missing – it could be a safeguarding issue.
(Support staff)

What more can we do? We actually don't have any more capacity to offer. We actually don't have any more time in the day to spend, and to let people talk and listen to people.
(Community nurse)

Missed opportunities for prevention
Staff told us that in order to manage demand, they were completing less preventive work and fewer assessments and reassessments. We heard concerns that this was leading to problems occurring, which may have been prevented through proactive monitoring and preventive care:

We would aim to reassess everyone in the caseload every three months, and I know that isn't happening and we're not having reassessments for six months to a year… we may well miss something that we would have caught earlier if we were doing more regular reassessments.
(Professional development lead)

When you're using lots of agency staff, your patients don't get reviewed.
(Senior manager)

If we don't do [pressure area care or reassessments] they will create problems later on for people developing pressure ulcers or not being anticipatory in the care that we provide.
(Professional development lead)

As services struggle to meet demand, workload and caseload are managed in a reactive rather than a proactive way. As one focus group participant remarked: 'We're waiting for the frail elderly to have a crisis before we can intervene and do those caring things, whereas before we could keep them ticking over and prevent the crisis.'

In one site, staff had reduced the help they previously gave to GPs in completing routine long-term condition management tasks. For example, a nurse visiting a patient to administer their insulin might in the past have also taken blood tests on behalf of the GP. The impact on the patient of this deflection back to the GP practice would depend on the capacity of the practice to send practice nurses out to visit

patients, but a single visit would be more efficient and may be less confusing or disruptive for the person receiving care.

Less continuity of care
Spreading teams across larger geographical areas and high staff turnover within teams were resulting in reduced continuity of care. At one site in particular, heavy agency staff use was also a significant barrier to continuity.

> *If you haven't got permanent staff constantly going in and you're using a lot of agency staff, sometimes the home notes aren't updated and patient assessments aren't always done. So you can often go in to a patient and the home notes are a mess, you can't understand people's handwriting, there isn't a care plan in place. So you'll go in there and you're like, what am I here to do? I don't really understand what people have been doing, and you have to work out what's been going on.*
> (District nurse team leader)

The changing skill-mix within teams was a further challenge to continuity: 'I can't send the same nurse to the same patient every single day, because I might need that nurse to visit a different patient, because of the skill-mix [and lack of experience] at the moment' (district nurse team leader). Poor systems and a lack of communication within teams often contributed to the problems associated with poor continuity. People receiving care and their carers often raised this as the main aspect of care they were dissatisfied with or would like to change, particularly for people receiving personal care, such as catheter changes.

Poor continuity had a negative impact on the experience of people receiving care and their carers in a number of ways.

- People having to repeat information to multiple staff members.
  Some people found having to repeat information frustrating, and others were anxious that staff were not adequately informed about their needs and background. This undermined their confidence in the service.

- Staff being unfamiliar with their homes.
  Patients and carers complained of having to repeatedly instruct and advise nurses, for example on equipment storage or access. One individual, who relies on nurses to gain access through an unlocked door as he is immobile and unable

to let them in, reported a number of occasions where staff had left without delivering his care as they tried to gain access by the incorrect (locked) door.

- Staff not knowing what care was required.
  'It happened a few times that they didn't know what they were doing. They thought they were coming to give eye drops, but obviously I could do that… There was no consistency at all. It all seemed a bit haphazard really' (female carer, 60s).

- Patient and carer anxieties about unfamiliar nurses being able to perform clinical procedures 'properly' and without causing unnecessary discomfort. The most common examples given were catheter changes and wound dressings.

- Inconsistent treatment, which had a negative impact on the effectiveness of the treatment and clinical outcomes.
  This was most often raised in relation to wound care:

  > One person will go in there and put one dressing on. Somebody else will go in there two days later and put another dressing on. So we tend to have people on our caseloads for longer than they need to be.
  > (District nurse team leader)

  > They started off with an iodine dressing and I'm supposed to have it for a certain length of time. But they would put the message down that they hadn't got any here and then they wouldn't come with it the next time. I'd say: 'Did you bring the iodine dressing?' [and they would say:] 'No, we never got a message about it'. They do put a dressing on which is passable, but not doing the job – it interrupts my treatment. It's not very nice, it's upsetting.
  > (Female patient, 80s)

- Not being able to monitor treatment progress.
  Again, this was particularly in relation to wound healing. People receiving care and their carers often commented on the lost benefit of a regular nurse being able to provide them with updates and reassurance regarding treatment progress.

- Concerns not being acted on or followed through.

  > A little while ago I had a nurse come, and because I'm getting a lot of headaches, she said: 'When I come on Friday I'll take your blood pressure, just to check it and everything'. Well then Friday comes, it's a completely different

nurse who knows nothing about it… it fell by the wayside. The information doesn't seem to get through to anybody else afterwards. They may think they're going to come the next time and they'll do it, but when that next person comes it's not the same person, and they just do the dressing.

(Male patient, 60s)

I always regret not having enough time to support informal carers as much as I would like to, and again, it's partly the lack of continuity… there is someone in particular I'm thinking of; I could see the patient's daughter was beyond breaking point really and I went back and handed over to her own team and then a couple of months later I saw them again and the situation hadn't changed.

(Community nurse)

Staff appearing to be abrupt, rude or uncaring
Some staff described how being under stress necessarily had an impact on the quality of the relationship they were able to form with patients: 'If we are not okay, it is difficult for us to establish that relation [with patients]. We need to establish [it], it's our duty, but it's harder for us' (district nurse team leader).

A number of people receiving care and their carers criticised the attitudes of some staff as abrupt, rude and, occasionally, uncaring. In the vast majority of cases, they attributed this to staff being rushed and under pressure. However, it was clearly distressing nonetheless:

Sometimes they can be very abrupt and maybe not as caring as they should be in the job that they do… mum's quite sociable so she likes people to be pleasant.

(Female carer, 60s)

Sometimes [he] might not be ready for his leg to be changed and it's like: 'Come on, come on, we haven't got this time'… [he] doesn't want it touched and they're going: 'Well come on we have to do this'. You can see sometimes they can get a little bit heavy-handed. It makes me cringe, but I've got to bite my tongue.

(Female carer, 50s)

On occasions they're huffing and puffing, and I know they're pressured, I know they're under pressure, but they're in front of the patient… the patient's in the worst position.

(Female carer, 50s)

Greater uncertainty over appointment times
Uncertainty over the timing of visits was a key frustration for people receiving care and their carers. While this is a longstanding issue in district nursing care, the problem is made worse when services are overstretched, as the impact of over-running appointments or unexpected events is magnified: 'If they get held up in any traffic or anything they're just in and out – it's like everything, all the services, are pushed and you're crunched up' (female carer, 50s).

This often had a significant impact on the daily lives of people receiving care and their carers:

> *[I can't get up until they've come, so] I'm just lying in bed waiting. You don't get a drink, you don't get anything to eat, and you're bored. And [if they come late], by the time you get up it's almost time to go back to bed again, the day's gone.*
> (Male patient, 60s)

> *I expect them to be there and I worry if they don't turn up; when it's getting near lunchtime then I do start panicking... I get all worked up.*
> (Female patient, 80s)

For people who were able to get out of the house, unpredictable appointment times sometimes limited their ability to make plans and maintain social contact. This was particularly significant for those who are visited by community nurses on a regular basis:

> *I've got a friend just a few houses down who comes up to see me and I go down to see her, but we can't do it on the days the nurse is coming... It's every other day and it's tying the whole day up... I don't seem to have any days.*
> (Female patient, 80s)

Less patient and carer education
Pressures on services were also limiting the time that staff had for patient and carer education:

> *Ideally, you would want to have enough time to support everyone to start to self-manage, or do some kind of supportive self-management. But what I worry happens is that because some of the nurses don't have enough time, it's easier to*

just give that person the injection.
(Professional development lead)

[They don't really involve me]… they seem to want to come in, rush his medication, and then go…
(Female carer, 50s)

Possible risks to patient safety
Worryingly, some staff were concerned that patient safety may be at risk:

[Staff who have left] felt their registration was at risk… they felt they were just working in unsafe conditions, that the demands and capacity were just ridiculous… they were just dashing round patients, missing loads out, they knew they were missing loads out, it was the only way they could get round people… They were saying, I love district nursing, I love my job, I just cannot continue in these circumstances, it's not safe.
(Senior manager)

We found people got to a point where they'd cut so many corners and became so task-orientated that they forgot where the corners were in the first place… even cutting the corners on safety.
(Senior manager)

What does this mean for district nursing care?

When taken together, the above examples strongly suggest that pressures on district nursing services are at risk of pulling care away from the model of high-quality care outlined earlier in this report. In our case study sites, this was sometimes having a profound effect on the wellbeing of staff, people receiving care and their carers.

⑤ Discussion

District nursing staff, older people receiving care and their unpaid carers appear to have a common understanding of what makes for 'good care' in the context of district nursing care delivered to older people in their own homes. The quality framework presented in this report provides an evidence-based foundation to inform quality assurance and improvement work by frontline teams, provider organisations, commissioners and regulators. But we found evidence that services are being pulled away from this model of care because of capacity pressures; the gap between the demand for district nursing services, and the number of suitably trained staff in post available to meet the demand, appears to be widening.

The demand–capacity gap: the impact on staff wellbeing and risks to the quality and safety of patient care

The limitations of national data collection in community services generally make it very difficult to give a robust national account of changes to activity and staffing in district nursing. However, available data from existing sources and our case study sites indicates a growth in the volume and complexity of the work over recent years, accompanied by a decline in the workforce and growing problems in recruiting and retaining suitably qualified staff.

The dissonance between the long-established and recently renewed policy drive to move more care out of hospitals into community settings, and the capacity problems being experienced in district nursing services, is striking. While the demand–capacity gap is acknowledged in national policy documents, the extent of its impact on staff wellbeing and the quality of care and support provided to patients and carers is not being adequately recognised or responded to. In all three of our case study sites, demand was exceeding capacity on a weekly or even daily basis, and services were kept running by staff routinely working over their contracted hours at a personal cost. We heard of staff being 'broken', 'exhausted' and 'on their knees', and leaving district nursing services for posts in other areas of community, hospital or primary care, which were perceived as offering a more manageable workload. Managers in one site described how in exit interviews nurses reported that they felt

unable to practise safely in the current conditions facing their teams. The remaining nurses were left with even more unmanageable caseloads as managers struggled to recruit suitably qualified replacements, leading to further stress, exhaustion and illness among staff, which in turn makes services unattractive to potential new recruits.

We heard from staff, patients and carers about examples of poor-quality and unsafe care, which some interviewees attributed directly to the impact of the current pressures, including: delays to treatment; less frequent visits; reductions in the amount of preventive care being given; a deterioration in the continuity of care; a reduction in the use of a person-centred approach to care and an increase in the use of a task-focused approach.

Each of these responses is an example of classic forms of 'rationing', which occur when resources are strained in health care (**Robertson 2016**; **Maybin and Klein 2012**; Parker 1967). Although our research does not report on the scale of such incidents, there is good reason to fear that poor quality will become more prevalent unless action is taken.

There is now an established evidence base demonstrating that staff wellbeing, particularly within the context of local teams, is an important prerequisite for positive patient experiences of care (**Powell *et al* 2014**; **Maben *et al* 2012**; Raleigh *et al* 2009). Work by West and Dawson (**2012**) shows that positive staff engagement can lead to improved outcomes for patients and organisations, highlighting associations between staff engagement and patient satisfaction scores, Annual Health Check scores, infection rates and mortality rates. Worryingly, some of the activities being deprioritised by district nursing services in order to manage demand are precisely those that are associated with positive staff wellbeing, and with assuring and improving the quality of care, including training, direct management support for staff and engagement in quality monitoring and improvement programmes.

Strain on district nursing services and its impact on the older people they serve, risk being compounded by concurrent pressures on other community-based services that support the same population group, including general practice, local authority-funded social care and voluntary sector support services:

- Recent research by The King's Fund found a 15 per cent increase in activity in general practice between 2011/12 and 2014/15, accompanied by a fall in the proportion of the NHS budget allocated to primary care over the same time period and problems recruiting and retaining GPs and practice nurses (**Baird *et al* 2016**).

- Cuts to local authority spending on adult social care in the past five years have resulted in a decrease in the number of people receiving this care, including domiciliary care; there is no national data to indicate what care (if any) people who are no longer eligible for funding are now receiving (**Humphries *et al* 2016**).

- Public funding for small- and medium-sized charities was cut by 44 per cent between 2008/9 and 2012/13 (**National Council for Voluntary Organisations 2016**). This was reflected by the local experiences of interviewees in our case study sites, who described support services for older people and carers in their area being reduced or withdrawn over recent months.

It is deeply worrying that this population of older people who are living with multiple or complex conditions, together with the unpaid carers who support them, are vulnerable to being affected by simultaneous pressures in these service areas. Even within district nursing services alone, it is clear that deteriorations in the availability and quality of services could result in severe consequences for the health and wellbeing of the people who rely on them.

Another potential consequence of the demand–capacity gap in district nursing services is increasing unmet need, in terms of people who would benefit from this type of care being unable to access it. Defining and measuring the extent of unmet need would be very challenging, and the nature of this research has not allowed us to do so.

District nursing services do not operate in isolation, and reductions in the quality or volume of care provided could also have significant implications for the wider health and care system. An important role and strength of district nursing is to support the health and wellbeing of people with complex and multiple health problems in a home setting, which is highly valued by people receiving care, and may also prevent the need for hospitalisation or residential nursing care. If the ability of district nursing services to deliver this much-needed care continues to be undermined,

we would expect consequences in terms of additional hospital admissions, delayed discharges and dependence on social care.

Recent research by The King's Fund into pressures in general practice (**Baird *et al* 2016**), and by The King's Fund and the Nuffield Trust into the effects of public funding cuts on social care services (**Humphries *et al* 2016**), has found that staff in these services describe how shortages in their local district nursing services have had a significant impact on their own workloads. District nurses also have an important role in educating and helping patients and carers to manage their own health and care needs. Supporting people in this way has the potential to enhance independence and reduce reliance on health services, but this potential will not be realised if services are unable to offer this support.

Knowing when patient care is being damaged

As The King's Fund has reported in past work on community services (**Foot *et al* 2014**), the infrastructure for quality measurement and oversight in community services is significantly under-developed compared with that for care delivered in hospital settings. The potential invisibility of the deterioration of the availability and quality of care delivered by district nursing services is extremely troubling. There is no equivalent of waiting time statistics, which are used as a barometer of the health of the hospital system, and grab headlines and political attention when they are in decline. This is also true for many other community-based services, including general practice, mental health and other community health services.

District nursing care takes place in what are often one-to-one interactions out of view of other staff or patients. The Care Quality Commission is still grappling with how to effectively 'inspect' this type of care in practice. Some people receiving care (or their carers) may be part of active, vocal and well-connected social networks, able and willing to share their experiences with others, including formal support groups, official scrutinisers of the health service and managers and staff in the service itself. But social isolation is more common in this older age group than any other, and the severity of the health conditions with which many district nursing patients are living means that they are less likely to be leaving their homes to visit local support groups. The impact of health conditions on the daily lives of these people also means that they can feel particularly dependent on the ongoing care and support offered by the service. Some of the older people and carers we spoke to

said they were reluctant to complain about their care in case doing so had a negative impact on the care they relied on from nurses.

A serious and urgent challenge for the system is to develop a meaningful form of oversight for care that is delivered in people's own homes, that is sensitive to the unique characteristics of care in this setting, supports the workforce and avoids crowding out the internal motivations of staff by creating perverse incentives and distractions in what is already an overloaded working day. This should be a priority of provider organisations, and national bodies responsible for the oversight of these services, particularly the Care Quality Commission. Our framework for what constitutes good care in this context should serve as a useful reference point for that work. Relevant, meaningful and robust quality assessment and assurance are particularly important at a time when services are clearly under immense pressure in order to identify deteriorations or failings in quality.

6 Recommendations

Match the stated intention to move care into community settings with greater attention to this service area.

It is striking how far at odds the current focus of policy-makers and regulators appears to be with the stated ambition to move care into community settings. Despite intentions to deliver 'care closer to home', the direction of resources, monitoring and oversight remains distinctly focused on the hospital sector. It is important that the system recognises the vital strategic importance of community health services in realising ambitions for the transformation of the health and social care system. Community services must be involved in, and central to, the development of new care models and Sustainability and Transformation Plans. National bodies responsible for approving the plans should make sure that they reflect the key role of community health services. Effective district nursing services are key to the health and social care system meeting the health and care needs of older people both now and in the future.

Involve district nursing service leaders in local plans for service redesign.

The voice of district nursing service leaders is often absent at the system level. Now more than ever, this important but pressured service needs to be part of discussions about future service redesign. District nursing should not be seen as a 'supporting' service that can be directed where others see fit, being pulled in different directions to meet the needs of acute care providers or primary care. It has a valuable role, and is of central importance to the wider system, enhancing the health and wellbeing of people living in their own homes (often people with complex and multiple health and care needs), and preventing deteriorations in health and the need for other services. Recognising district nursing professionals as partners who bring particular knowledge and expertise will be an important part of developing future services in the community.

Respond to the issues facing community health and care services, and the needs of people who depend on these, in the round.

Many of the problems identified in this report are not unique to district nursing – there are problems with workforce, capacity and demand in community-based services more generally. General practice, social care and the voluntary sector all face significant challenges of rising demand at a time of constrained resourcing and capacity. To address such wide-reaching problems, it will be necessary to look beyond each of these services in isolation, and instead respond to them together. We recommend that NHS England and Health Education England, together with local commissioners and providers, look in the round at the staffing and resourcing of community health and care services for the older population, taking into account the capacity of people receiving care, their unpaid carers and local communities.

Renew efforts to establish robust national data on capacity and demand in district nursing services.

The absence of robust national data on activity levels in district nursing services (including the complexity of work) and of a clear dataset on trends in staffing numbers, makes it very difficult to demonstrate, understand and monitor the demand–capacity gap within this service area. We strongly support the work that is under way by The Queen's Nursing Institute and NHS Improvement to establish a standard for demand–capacity and workload planning tools in this area, to make sure that they produce data that enables meaningful workload planning at a local level and feed data into regional and national data collections.

We also support efforts by NHS Digital (formerly the Health and Social Care Information Centre) to require independent sector providers of NHS-funded district nursing services to provide regular data returns on the numbers and skill level of their staff. We also urge NHS Digital to consider introducing more granular categories to the overall 'community nurse' and 'community nurse support staff' datasets, to make it possible to see how staff are distributed across different services within the community.

However, while this work is important and should be supported, we believe that there is already substantial evidence of a significant mismatch between capacity and demand in district nursing, and action to address this must not be delayed further while national data systems are developed.

Accelerate the uptake of digital technologies and support implementation.

District nursing stands to benefit significantly from enhanced digital support, if it is designed and works well. Technologies that enable remote working (for example, iPads with access to caseload lists and patients' notes) have the potential to improve efficiency and productivity, as well as enhancing quality and safety through timely access to notes at the point of care and supporting communication between professionals. It was striking that these technologies were only fully in use at one of our case study sites, while the others had not managed to implement them successfully because of issues such as poor internet connectivity.

Adopting new technologies should remain high on the agenda of providers and local service leaders as a strategic area for development. Implementation is not straightforward, and the extent to which efforts are successful will depend on investment and support to address barriers to adoption. There is a need for shared learning about 'what works' from services that have implemented them effectively through professional learning and support networks, together with robust technical and infrastructure support from NHS Digital. NHS England should support and fund local areas to make effective technologies available to district nursing services through their Local Digital Roadmaps and make sure that community health services receive enough attention in this agenda alongside primary and secondary care.

Develop a meaningful form of oversight for care delivered in people's own homes, which is sensitive to the unique characteristics of this care.

Our analysis has shown that a specific set of features define high-quality care in the context of district nursing care delivered in people's own homes. However, national mechanisms of quality assurance and accountability (largely designed to assess hospital care) are poorly suited to measuring quality in these terms. They may also fail to identify problems that are standing in the way of this type of care being delivered or to detect when the quality of patient care is deteriorating. National oversight systems need to be developed in order for their frameworks to meaningfully capture and reflect care quality. The evidence-based framework presented in this report should be a useful resource for this work.

Develop a sustainable district nursing workforce.

The shortage of suitably trained staff to fill roles in district nursing services is a major cause for concern. Services are increasingly unable to recruit and retain staff, and this situation looks set to worsen as many of the current district nursing workforce approach retirement age, and others choose to leave due to service pressures.

We support the work that NHS Improvement is doing to develop guidance on safe caseloads and recommend that, when complete, this should be used in such a way as to make sure that the staffing of teams is appropriate to the volume and complexity of work on their caseload. Providers need the resources to employ these staff if they are to close the current gap between capacity and demand, and local commissioners should recognise and respond to this.

Health Education England and other responsible organisations should take urgent action to reverse current trends in the workforce. This will require them to work with the profession and their representatives to develop attractive and sustainable careers in district nursing, with adequate training and support. This should involve: efforts to raise the profile of district nursing – for example through student nursing placements; consultation on ongoing support for the district nursing specialist practitioner qualification; and a particular focus on steps to retain experienced district nurses within the workforce.

The King's Fund will be working with leaders in this field to develop future research, improvement and policy work in this area.

Appendix: Methodology

The research for this report took place between April 2015 and May 2016 and comprised:

- scoping conversations with national stakeholders, commissioners and providers

- a literature review

- focus groups with senior district nursing staff

- interviews in three case study sites with older people receiving district nursing care, their unpaid carers and district nursing service staff.

Key findings from the research were discussed and further developed in conversation with national stakeholders.

Scoping conversations

We conducted 14 scoping conversations with a range of stakeholders, including providers, commissioners, third sector organisations, policy-makers, regulators and researchers. These conversations were used to identify the key issues and gaps in knowledge in this area, and to seek advice on our methodological approach.

Literature review

We undertook an extensive review of existing research evidence, data and policy. The review focused on a number of key areas, including:

- national policy, guidance and literature on the requirements for high-quality care for frail/older populations

- national requirements for measuring and managing quality of care in community settings

- existing research on what is important to older people receiving nursing care in their own homes, and to older people receiving other forms of domiciliary care

- existing research on what is important to carers of older people receiving nursing care in their own homes

- existing research on the experiences of nursing staff delivering care to patients in their own homes.

The databases searched included the Allied and Complementary Medicine Database (AMED), British Nursing Index (BNI), DH Data, Google, Google Scholar, The King's Fund database, PubMed and Web of Science.

Focus groups

We conducted three focus groups (with a total of 40 participants) in September 2015 with district nursing service team leaders, service managers, strategic leads and senior nurses, recruited via the National District Nurses Network. We asked participants about the challenges and rewards of caring for people who receive district nursing care in their own homes, and what they thought made for 'good care'. We used the findings from these sessions as primary data, and to inform the development of our interview topic guides.

Interviews

We conducted interviews in three case study sites, so that we could understand and relate the experiences of patients, carers and staff from the same district nursing service. We chose the three case study sites so that they varied in terms of:

- provider organisational type (two were combined acute–community trusts and one was a social enterprise)

- geography (London, a rural area in South East England and a city in North East England)

- deprivation

- ethnic mix.

We conducted semi-structured interviews with 50 people: 20 members of staff, 16 people who were receiving district nursing care and 14 unpaid carers. Interviews were audio-recorded and transcribed for analysis.

The project was classified as a service evaluation based on guidance from the Health Research Authority and it was registered with local governance departments.

Patient interviews

People aged 65 or over who were currently receiving care from district nursing services were invited for interview through a range of channels, including local third sector organisations, local online forums and via invitations distributed by the district nursing service. Potential interviewees were provided with an information sheet. They were then asked whether they would be willing for their contact details to be passed on to the research team, or they were invited to contact the team directly. Informed consent was checked before each interview, and researchers only went ahead if the person had capacity to consent. All interviews were conducted face to face in the person's home and lasted between 30 and 90 minutes. Interviewees were invited to have a relative or carer present if they wished.

Interviewees were asked about a range of issues, including:

- the nature of the care they receive from community nurses

- their experiences of the care

- what aspects of the care are most important to them

- what the service does particularly well, including specific occasions and examples

- what things about the service do not work so well or could be improved on.

Interviewees were given a £20 Boots voucher (or an alternative of their choosing) in recognition of their time and contribution.

Carer interviews

Carers were identified through the same methods as patient interviewees. Eleven of the 14 carers were carers of patient interviewees. One interview took place over the phone and the remainder were conducted face to face in the carer's home. A number of patients and carers chose to be interviewed together; these interviews were structured in two parts, focusing on each interviewee in turn.

Carers were asked about a range of issues, including:

- the nature of the care that their relative or friend receives from community nurses

- what is good about the care and what is less good or could be improved on

- the extent to which the community nurse involves them in the care

- what support the community nurse gives them as a carer and as an individual.

Interviewees were given a £20 Boots voucher (or an alternative of their choosing) in recognition of their time and contribution.

Staff interviews

Staff interviewees were identified through their employer. Service managers at each site sought consent from staff for their contact details to be provided to the researchers, and we then contacted staff directly to invite them to interview. Managers were not told which staff members had agreed to take part. The 20 members of staff consisted of four senior managers, seven team or deputy team managers, five community nurses without management roles, three nursing support staff and one community matron. Four were face-to-face interviews and the remaining 16 were conducted over the phone. They lasted between 30 and 90 minutes.

Interviewees were asked about a range of issues, including:

- the factors that make for good care in community nursing

- their views on what aspects of care patients value

- what helps them to provide good care

- what makes it difficult to provide good care.

Throughout the fieldwork, the researchers kept informal logs of observations and learning from the process of recruiting and interviewing participants.

Analysis

We conducted a thematic analysis of the data. Two members of the research team developed an initial coding framework based on a review of the transcripts from our first case study site and informed by our original research questions and literature review findings. We then revisited and revised the framework after interviews in the second two case study sites were complete. Transcripts were coded to the new framework in Dedoose (a web application for mixed methods research), and excerpts exported by theme were supplemented by findings from the literature review.

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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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Ideas that change health care

District nursing services provide a lifeline for many people and play a key role in helping them to maintain their independence by supporting them to manage long-term conditions and treating acute illnesses. But what does 'good' district nursing care look like and what gets in the way of this being delivered?

Understanding quality in district nursing services: learning from patients, carers and staff looks at the components of good care from the perspective of older people receiving care, unpaid carers and district nursing staff. These components, listed below, are combined to form a quality framework:

- caring for the whole person

- continuity of care

- the personal manner of staff

- appointment scheduling and reliability

- availability between appointments

- valuing and involving carers and family members

- staff acting as co-ordinators and advocates

- clinical competence and expertise

- patient education and support for self-management.

The report highlights that demand for district nursing care has increased significantly over recent years, both in terms of the number of patients seen and the complexity of care provided. But despite this, available data on the workforce indicates that the number of nurses working in community health services has declined and the number working in senior district nurse posts has fallen dramatically.

The report describes the pressures on the service resulting from this demand–capacity gap and uncovers the negative impact that these are having on staff wellbeing and – of concern – on the quality and safety of patient care.

Policy-makers, regulators, commissioners, system leaders and provider organisations need to take urgent action to address this and the report makes a number of recommendations on how to move forward.

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