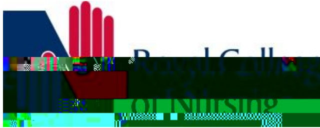

Survey of district and community nurses in 2013

Report to the Royal College of Nursing

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Executive summary

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

District nursing teams

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

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

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

Working hours

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

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

Caseloads

V@^Áæç^¦æ*^Á[¦cæ]Á}˘{à^¦Á[-Á•cæ-Á[}Áå˘cˆÊÁ[}Ác@^Á^•][}å^}c•qÁæ•cÁ[¦{æ]Á¸[¦\ã}*Áåæˆ ÊÁ¸æ•Á˦ÈÁæ)åÁ typically 14% of the total team were DNs, 49% community nurses (with no DN qualification), 6% community matrons, 2% nurse specialists, 18% HCAs and other support workers and 8% administrative/clerical staff.

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

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

Role and division of time

Direct care accounts for the largest proportion of time spent by nurses in district nursing teams, but nurses do not spend as much time on this activity as they would like. On average 37% of time is spent [illegible]

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

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

Quality of care and caseloads

When asked about the care on their last shift, 19% described it as excellent, 61% as good, 18% as fair, [illegible] *there are not enough staff to get the work don* .

The reported quality of care is significantly correlated with the number of patients seen. Nurses rating [illegible] ents in their last shift. Despite differences in average caseloads between staff groups, the correlation between numbers seen and assessment of quality holds true for each group . those with higher caseloads are more likely to have described the quality on that shift as [illegible]

77% report c@ææÁc@^ãÁ±[¦\|[æåÁãÁ{[Á@^æç^dÊÂ HÃ Á•æê Ác@¦^Áæ¦^Á}[cÁ•ˇ~ã&ã^}cÁ}ˇrses to get the work done, and 75% report specifically that there are not sufficient district nurses on their team.

Many of the frustrations for nurses working in district/community nursing are interlinked. The most frequently cited sources of frustration, often described in language expressing considerable distress, are: excessive and unpredictable caseloads and workload; poor staffing levels and inadequate skill-mix (exacerbated by work related sickness absence and recruitment and retention difficulties), lack of administrative support, poor IT resource to support work, and concern about the effect insufficient staffing/time is having on the quality of care and health and wellbeing of nurses themselves and other team members. How others understand the district nursing service the cr min

1. Introduction

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

1.1 Context

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

1.2 Method

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

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

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

All those without an email address were contacted by post and sent a paper copy of the survey (1,783 { ^{ à^¦•DĚÝ@Á[•œþÁ˘¦ç^ˆÁ‡ æ&\ ǽ&[}ææ̃ ^åÁææ&[ç^¦ã *Á|^œ^¦ÊÁæ• &¦^^} ã *Á æ̃ ^ÁÇ[Á㌠^} cã ˆ Áwhether or not potential participants were currently working in a district nursing service) and an eight-page A4 questionnaire (with free-post envelope). The paper survey was mailed on 27th November and closed on 17th December 2013 (with no reminders).

1.3 Response rate

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

The eligible population that could be reached and met the study criteria was therefore 7,246. A total of 1661 eligible nurses (worki

2. Profile of nurses working in district/community nursing

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

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

Figure 2.1 Job title: percentages (weighted data)

Source: RCN/KCL District Nurse Survey, 2014

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

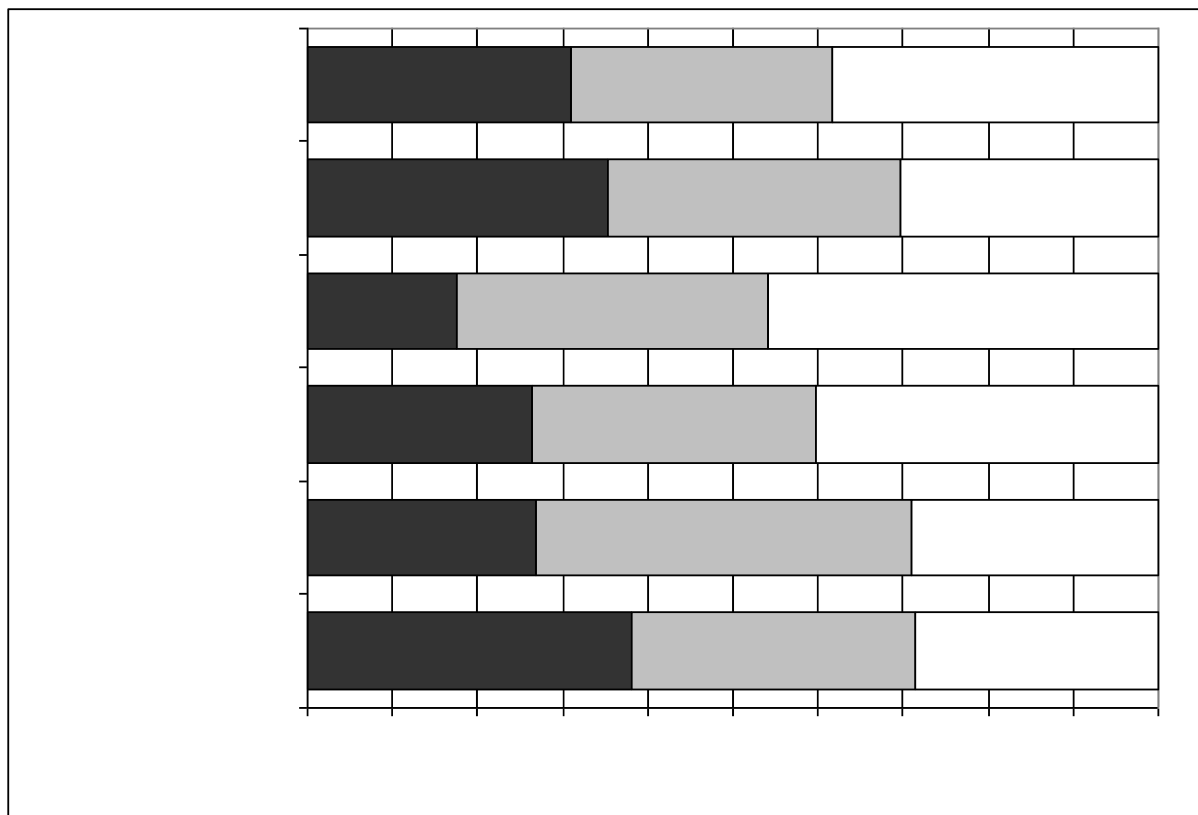
2.2 Qualifications

Nurses were asked two questions relating to qualifications . specifically which academic qualifications in nursing they held, and a more general question asking about all their nursing qualifications. Just under a half of respondents hold a nursing degree (48%) and 47% hold a diploma in nursing. Six per

2.3 Demographic profile

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

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



Source: RCN/KCL District Nurse Survey, 2014

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

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

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

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

	District Nurse	Community staff nurse	Community matron	Case manager/Team leader	Nurse specialist	Other	All respondents
Years worked in district/community nursing							
< 5 years	9	37	8	9	12	18	23
5-9							

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

	District Nurse	Community staff nurse	Community matron	Case manager/ Team leader	Nurse specialist	Other	All
Band 5	16	95	1	0	16	58	51
Band 6	65						

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

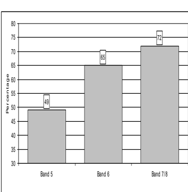
3. Working patterns and hours

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

3.1 Full or part-time working

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

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



Source: RCN/KCL District Nurse Survey, 2014

More than half (56%) of all respondents work 37.5 hour weeks. One in five (20%) of respondents work less than 23 hours per week, one in five (21%) work between 23 and 32 hours per week and three in five (59%) work more than 33 hours per week. Again, stage of career is strongly correlated with those in the later stages of their careers most likely to work the shortest working weeks e.g. a third (33%) of those respondents more 4(n)-9(de)4(n)-9(ts)-4(fJr5.-3(po)4t9(4(n)-9(dN)4t9(ryT-.79 TmM(ryT-.79 TmM(ryT-.79 TmM(-

4. Populations served, services and workforce

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

This survey addresses these issues by examining the size and skill-mix of community/district nursing teams in order to identify how much variation exists in team compositions and according to where services are based. This section of the report looks at the communities where services are provided and the nature of those services[21]

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

4.2 Service provided

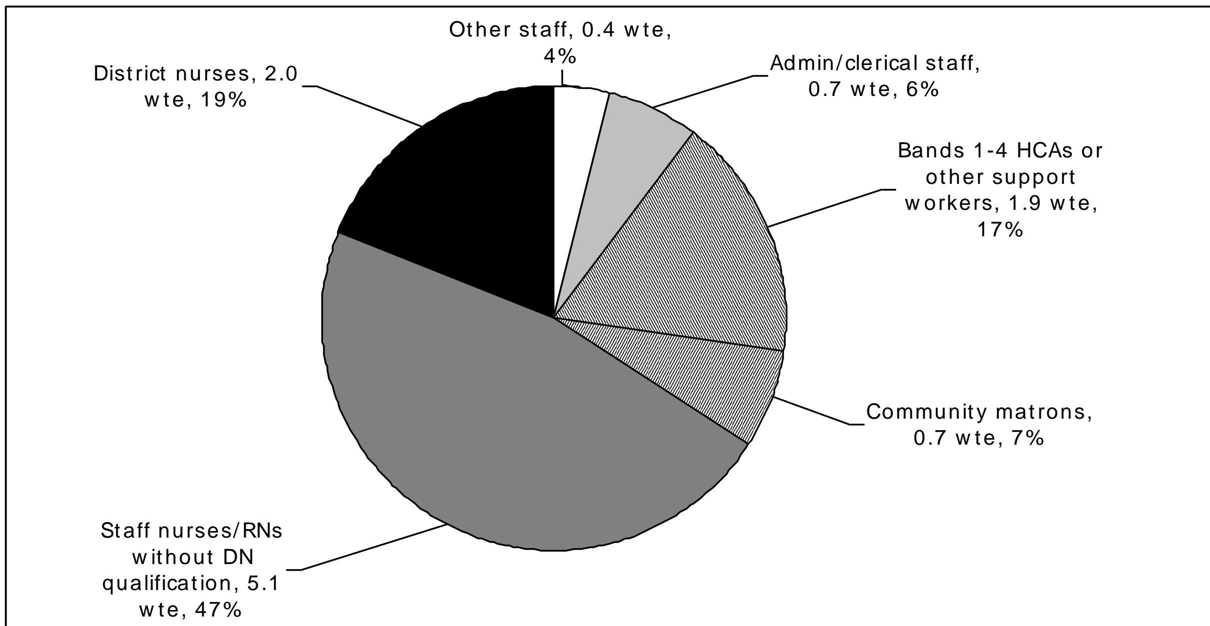
Nearly all community/district nurses responding indicated that the service in which they work is available seven days a week, and 69% said it was available 24 hours a day. Services in urban environments are more likely to be available 24 hours a day (72% reporting 24 hour services available compared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

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

Source: RCN/KCL District Nurse Survey, 2014

4.3 Team composition (size and mix)

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



Source: RCN/KCL District Nurse Survey, 2014

The typical team composition is: approximately two district nurses, five community staff nurses (with no DN qualification), one community matron, two HCAs/other support workers, one clerical/administrative [illegible] five (19%) of all staff in the team being district nurses, while staff nurses make up approximately a half (47%) of staff on the team.

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

[illegible] contribution of district nurses, registered nurses and healthcare support workers (HCSW) (Table 4.1).

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

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

Table 4.1 Summary statistics for size and composition of teams (WTE) 8.88.8Tot 1 f* 417.36 721.185g [(8)-

	Cases				Percentiles [22]				
	N=	Missing	Mean	Median	10%	25%	50%	75%	90%
Total team	991	24	10.9	8.8	4.0	5.7	8.8	13.6	20.0

5. Staffing and workload

A key aim of this research was to not only describe the workforce in terms of the staff employed and composition of the teams (covered in Chapter 4), but to examã ^Á•æ-ã * Á^ç^|•Áæ) åÁ ¸ [¦\|[æå•Á[} Áthe *¦[˘ } å to capture the reality of staffing and caseloads on a typical shift as reported by individual staff, as opposed to simply looking at establishments and posts.

To do this we asked respondents to answer a series of questions about the staff on duty and patients seen on the last shift/day they worked. These responses are used to describe staffing levels on duty (as opposed to planned or in post) and look at the caseloads based on the individual, and for the whole team. Anticipating that workloads vary from day to day, a follow up question asked staff if they felt the |æ• cÁ• @ãºcÁ@^Á ¸ [¦\^åÁ ¸ æ• Á c] ãæ|Áæ) åÁ[Á ¦[çãå^Á@^Á c] ãæ|Á} ˘ { à^¦Á[-Á] æcã^} c•Á@^Á ¸ [˘ |åÁ}[¦{ æ||^Á see during a shift.

5.1 Staff on duty and patients seen by the team

All respondents were asked about the last shift they worked; how many patients they themselves saw and the staffing and number of patients seen by the team. Table 5.1 summarises the staff numbers on å˘ c Á[¦Á^•] [} å^} c•q|æ• cÁ}[rmal working day, showing also the range of responses. The total number [-Á• cæ-Á[} Áå˘ c ÊÁ[} Á@^Á^•] [} å^} c•q|æ• cÁ}[¦{ æ|Á ¸ [¦\ã * Áåæ ÊÁ¸ æ• ÁÌ ÈÎ ÁV@^Á c] ãæ|Á^æ{ Á[} Áå˘ c Á ´• ã * Á mean results from all nurses) consisted of 1.2 DNs (14% of the total team), 4.2 registered nurses (without DN qualification) (49% of team), 0.5 community matrons (6% of team), 0.2 nurse specialists (2% of team), 1.5 HCAs and other support workers (18%) and 0.7 administrative/clerical (8%). The ‡ c@^¦qÁ[|^•ÁŠ[} •ã c^åÁ[-Áæ|Á ç ˛æ|ãã c Á[-Á ursing and other professions linked to healthcare.

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

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

Source: RCN/KCL District Nurse Survey, 2014

In 29% of cases there was no district nurse on duty during th^Á^•][}å^}c¶Á|æ•cÁ}[¦{ æ|Á¸[¦\Áday, in 63% of cases there was no community matron and in a half (53%) of cases there was no administrative/clerical staff available.

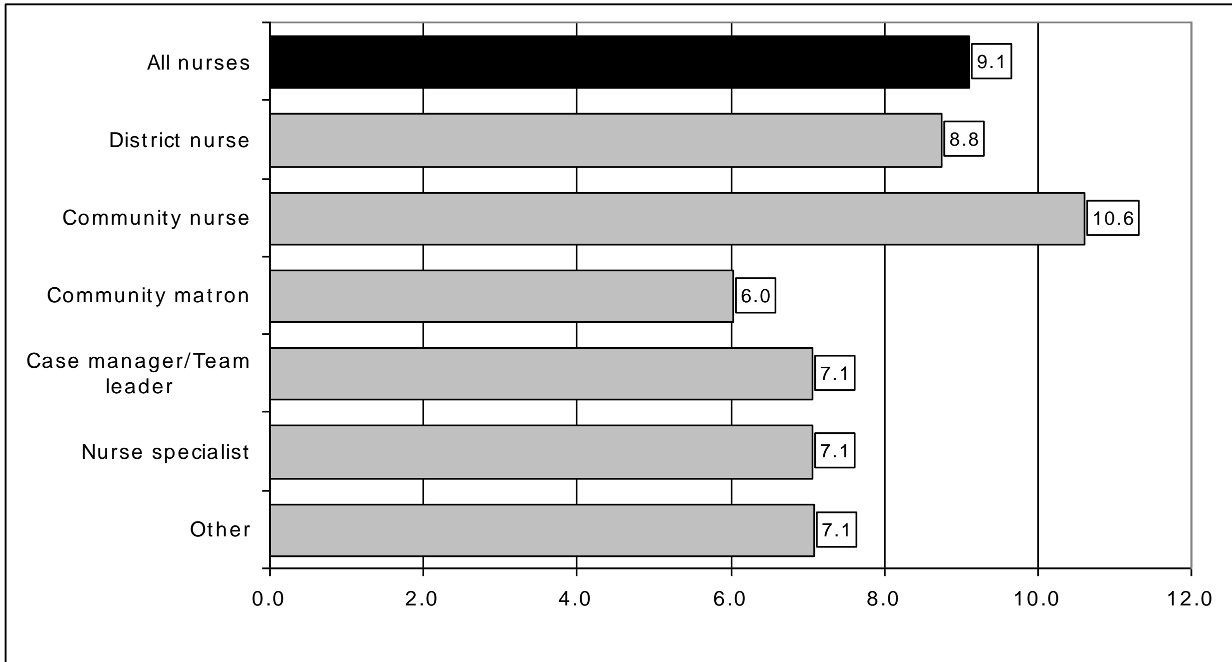
Respondents reported how many patients were seen by the team on their last shift, and the mean average was 11.5. An association is observed between the average number of patients seen and the team composition. Teams with a larger proportion of district nurses on duty tend to see slightly more patients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

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

Source: RCN/KCL District Nurse Survey, 2014

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

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



Source: RCN/KCL District Nurse Survey, 2014

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

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

Tabl

Although the average case loads are different for each staff group, the correlation between case load and quality of care holds true for each group with higher case loads among those nurses who indicated [illegible] r still among those who [illegible]

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

There are also relationships, albeit not quite as strong, between the quality of care provided and the total time worked on their last shift (including additional time) and with the average minutes per patient [illegible] on their last shift. This is an indication of the extent to which nurses in the community are over-stretched and trying to compensate for a lack of available hours by working beyond their contracted hours.

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

These findings suggest that nurses working extra hours beyond their shift length is not contributing

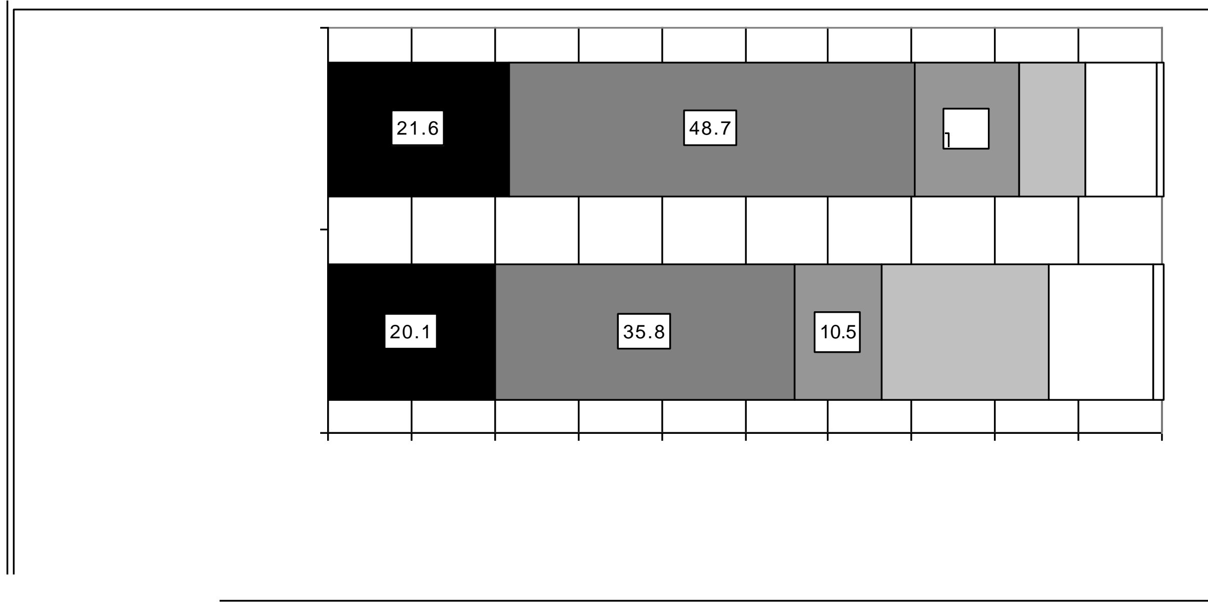
6. Roles and activities

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

of the time

More specifically, respondents were asked about time spent on travel and administration on the last

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



Source: RCN/KCL District Nurse Survey, 2014

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

6.3 Activities that should be done by other staff groups

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

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

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

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

Source: RCN/KCL District Nurse Survey 2014

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

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

Again there is some variation by pay band and by job title. Nurses on band 5 were less likely to indicate that there are activities done by other groups that they feel should be done by them (11% compared to

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

Source: RCN/KCL District Nurse Survey, 2014

6.5 Key points

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

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

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

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

Two thirds (69%) of all respondentnt on le n ds n dof) o than -5(tr)p/13 EMC C3S-cs-8() 2y83S-cs34(ov2[t)-14212[t)-1

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

7. Sources of job satisfaction and frustrations

The survey provi

Working in the community requires a high level of autonomy with almost all respondents agreeing that

development that they

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

Source: RCN/KCL District Nurse Survey, 2014

To allow exploration of differences in the views of respondents, the themes used in Table 7.1 were used to create scales[26]. Working additional hours was associated with lower levels of satisfaction across the

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

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

7.3 Frustrations of working as a community nurse

Whilst most nurses cite several aspects of their work that give great satisfaction, enable pride in their

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

Broad theme	Details/examples	% cases
Staffing/ workforce	Staffing levels	35%
	Skillmix issues	6%
	High sickness levels	3%
	Day to day staff shortages	2%
	Use of bank/agency staff	1%
	Recruitment problems	1%
	Staff leaving/poor retention of staff	1%
	Other staffing issues	1%
	Lack of input from other staff/agencies	<1%
	Total (Staffing/workforce)	50%
Admin and IT systems	Too much paper work/administration	27%
	Poor IT for patient records	7%
	Lack of office space/poor old computers/poor mobile network	7%
	Other general IT problems	<1%
	Other	

Table 7.3

also mention of a lack of co-ordination and poor planning with large areas to cover for visits. It is also

[illegible] iate referrals and poor discharge planning by hospitals, and the time spent chasing up records. The lack of support for district nurses to ask about specialist medical issues concerning the patient, especially at weekends, is of concern to many too.

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

Some 40% of respondents commented about patient care and the quality of care. Again, these issues are rarely cited independently, but in conjunction with discussions of staff shortages, work overload and too much time spent on administrative tasks, as outlined above. Poor handovers, isolated working, [illegible] quality care if the nurse is not able to compensate by working additional hours.

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

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

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

7.4 Key points

Nurses working in district nursing teams are generally positive about their work lives. Almost all (94%) feel that where ca[illegible]ut at some cost:

Three quarters (77%) [illegible]

[illegible]

[illegible]

Four fifths (83%) of all nurses working in district nursing teams responding to the survey agreed [illegible]

[illegible] I need to manage my [illegible]

Two thirds (64%) said they disagreed with [illegible]

[illegible]

[illegible]

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

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

Increasing entrants into community nursing is clearly much needed. But if the new, and perhaps more importantly, existing staff in the community are to be retained (to create a net increase, rather than

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