NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline scope

Safe staffing for nursing in community care settings for over 18s

Topic

The Department of Health and NHS England have asked NICE to develop an evidence-based guideline on safe staffing for nursing in community care settings for over 18s.

Who the guideline is for

- providers of community nursing services for the NHS
- commissioners of community nursing services for the NHS
- boards responsible for providing community nursing services for the NHS
- community nursing staff
- managers of organisations providing community nursing services for the NHS.

It may also be relevant for:

- people using services, their families and carers, and other members of the public
- people developing toolkits and resources for assessing and determining safe staffing for community nursing services.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive.

Equality considerations

NICE has carried out an equality impact assessment during scoping. The assessment:

- lists equality issues identified, and how they have been addressed
- explains why any groups are excluded from the scope.

1 What the guideline is about

1.1 Who is the focus?

Groups that will be covered

Nursing staff who are part of the nursing establishment in community care settings for over 18s. This includes:

- registered nurses providing care for over 18s in the community; for example, district nurses, community matrons and nurses providing specialist care for specific conditions or diseases
- non-registered nursing staff providing care for over 18s in the community; for example, healthcare assistants and assistant practitioners.

The nursing establishment is defined as the number of posts for registered and non-registered nursing staff funded to provide community nursing care across a defined geographical location.

Groups that will not be covered

Nursing staff and other multidisciplinary team members who are not part of the nursing establishment in community care settings for over 18s. This may include:

- registered nurses who are or will be covered by other safe staffing guidelines, such as:
  - community midwives
  - mental health nurses
  - learning disability nurses.
- registered nurses who are not part of the nursing establishment in community care settings for over 18s, such as:
  - children's community nurses
  - health visitors

  - school nurses
  - practice nurses
  - dental nurses
  - prison and custody nurses
  - specialist nurses working only in inpatient settings
  - nurses working only in nursing care homes
  - nurses working in adult social care.
- non-nursing staff who are not part of the nursing establishment in community care settings for over 18s, such as:
  - therapists; for example, occupational therapists, physiotherapists, podiatrists, speech and language therapists
  - social care workers.

1.2 Settings

Settings that will be covered

- People's homes, community clinics and any other setting in which care is delivered by the community nursing team for over 18s.

Settings that will not be covered

- Inpatient settings.
- Community hospitals.
- Schools.
- Children's centres.

Although the guideline will not specifically cover these settings, the recommendations may be relevant to these settings.

1.3 Activities, services or aspects of care

Key areas that will be covered

The guideline will cover minimum numbers of nursing staff and the skill mix needed to deliver safe nursing care for over 18s in community care settings. To achieve this, the following key areas will be covered:

84 1 Outcomes and indicators associated with safe staffing for nursing in
85 community care settings for over 18s. These may include nurse-to-
86 patient/service user ratios, the minimum number of nurses and the skill
87 mix needed to deliver safe care.
88 2 Factors affecting safe staffing for nursing in community care settings for
89 over 18s. These may include:
90 – Patient/service user factors, for example: case mix and volumes,
91 population demographics, acuity (how ill the person is), prevalence of
92 chronic disease, availability of support (family or carers) and level of
93 dependency on nursing care
94 – environmental factors, for example: the nature of the geographical
95 area covered by community nursing teams (distance covered, urban
96 or rural, ease of access to people's homes and community clinics),
97 ease of access to key specialties and existence of other teams or
98 services
99 – staffing factors, for example: the division and balance of tasks
100 between registered and non-registered nursing staff (skill mix); staff
101 turnover; the range of services provided; availability of and care and
102 services provided by other multidisciplinary team members;
103 management and administrative factors; and staff and student
104 teaching and supervision arrangements.
105 3 Organisational factors affecting safe staffing for nursing in community
106 care settings for over 18s. These may include:
107 – organisational management structures and approaches
108 – organisational culture
109 – organisational policies and procedures, including those for staff
110 training and lone working.
111 4 Nursing care activities that should be considered when determining safe
112 staffing for nursing in community care settings for over 18s.
113 5 Approaches and toolkits that help assess and determine safe staffing
114 requirements for nursing in community care settings for over 18s and
115 how often these should be used.

116 See appendix A for a diagram summarising the main areas covered by the
117 scope and their relationship.

118 **Areas that will not be covered**

119 1 Service design or reconfiguration, and different service delivery models
120 or components of these models, such as different models of community
121 care delivery, and delivery of patient/service user care in the community
122 compared with inpatient care. However, the guideline will consider safe
123 staffing for nursing needed to implement the different models of care
124 used in community services for over 18s.
125 2 Safe staffing for other members of the multidisciplinary team in
126 community settings (for example, physiotherapists and social care
127 workers). However, the guideline will consider how the availability of
128 other multidisciplinary team members affects safe staffing for nursing in
129 community care settings for over 18s.
130 3 The effectiveness of:
131 – care delivered by nursing staff compared to other healthcare
132 professionals working in the community
133 – different treatment and management strategies and interventions
134 4 Workforce planning and recruitment at network, regional or national
135 levels.

136 ## *1.4 Economic aspects*

137 We will take economic aspects into account when making recommendations.
138 We will develop an economic plan that states for each review question (or key
139 area in the scope) whether economic considerations are relevant, and if so
140 whether this is an area that should be prioritised for economic modelling and
141 analysis. We will review the economic evidence and carry out economic
142 analyses, using an NHS perspective, or wider perspectives as appropriate.

143 ## *1.5 Review questions*

144 While writing this scope, we have identified the following review questions:

1 What outcomes are associated with safe staffing for nursing in community care settings for over 18s?

- Is there evidence of a relationship between nursing staff levels or skill mix and increased risk of harm?
- Do nursing staff levels or nursing staff-to-patient/service user ratios affect outcomes?
- Which outcomes should be used as indicators of safe staffing for nursing?

2 What patient/service user factors affect nursing staff requirements for over 18s in community care settings? These might include:

- population demographics
- patient/service user acuity and dependency
- prevalence of chronic disease and frail older patients/service users
- availability of support (family or carers)
- safeguarding issues.

3 What environmental factors affect nursing staff requirements for over 18s in community care settings? These might include:

- the nature of the geographical area covered by community nursing teams (distance covered, urban or rural, ease of access to people's homes and community clinics)
- ease of access to key specialities
- existence of other teams and services

4 What staffing factors affect nursing staff requirements for over 18s in community care settings? These might include:

- the division and balance of tasks between registered and non-registered nursing staff (skill mix)
- the range of nursing services provided
- the availability of services provided by other multidisciplinary team members
- management and administrative factors
- staff and student teaching and supervision arrangements.

5 What organisational factors affect nursing staff requirements for over 18s in community care settings? These might include:

- organisational management structures and approaches
- organisational culture
- organisational policies and procedures, including those for staff training and lone working.

6 What core nursing care activities should be considered when determining nursing staff requirements for over 18s in community care settings?

- What key activities are currently carried out by nursing staff?
- Do the activities carried out by registered nurses and non-registered nursing staff (such as healthcare assistants and assistant practitioners) differ?
- How much time is needed for each activity, and does this differ according to the setting in which care is delivered (for example, a person's home [including care homes], or a community clinic)?
- Are activities that are carried out by nursing staff associated with outcomes?

7 What approaches for assessing and determining nursing staff requirements and/or skill mix, including toolkits, are effective in community care settings for over 18s and how often should they be used?

- What evidence is available on the reliability and/or validity of any identified approach or toolkits?

1.6 Main outcomes

The main outcomes that will be considered when searching for and assessing the evidence are listed below; however this is not a definitive list. Other outcomes may be included, depending on the evidence and the Committee's considerations. Outcomes of most relevance to this guideline will be those that are most closely linked to nursing staff levels.

1 Serious incidents

- Deaths and serious untoward incidents attributable to problems with the care provided by nursing staff in community care settings.

209 – Serious, largely preventable patient safety incidents that should not
210 occur if the available preventative measures have been implemented
211 by healthcare providers (also known as 'never events'), including
212 incorrect administration of drug treatments and serious safeguarding
213 incidents.

214 2 Delivery of nursing care

215 – Preventing avoidable deterioration.
216 – Preventing unnecessary admission to hospital.
217 – Preventing healthcare-associated infections.
218 – Early discharge.
219 – Improving the safety of discharge.
220 – Preventing medication errors.
221 – Preventing medical device errors.
222 – Preventing pressure ulcers.
223 – Preventing avoidable venous thromboembolism.
224 – Completing safeguarding duties.

225 3 Patient/service user and staff feedback

226 – Reported experience and satisfaction ratings related to community
227 nursing, such as complaints related to nursing care.
228 – Staff experience and satisfaction ratings.

229 4 Other

230 – Nursing staff retention and sickness rates.
231 – Nursing staff clinical appraisal and statutory review rates.
232 – Nursing vacancy rates.
233 – Current and up-to-date nursing staff training.
234 – Costs, including care, staff and litigation costs.

2 Links with other NICE guidance and NICE Pathways

2.1 NICE guidance

NICE guidance about the experience of people using NHS services

NICE has produced the following guidance on the experience of people using the NHS. This guideline will not include additional recommendations on these topics unless there are specific issues related to safe staffing for nursing in community care settings for over 18s:

- Safe midwifery staffing for maternity settings (2015) NICE guideline NG4.
- Safe staffing for nursing in adult inpatient wards in acute hospitals (2014) NICE guideline SG1.
- Patient experience in adult NHS services (2012) NICE guideline CG138.
- Medicines adherence (2009) NICE guideline CG76.

NICE guidance in development that is closely related to this guideline

NICE is currently developing the following guidance that is closely related to this guideline:

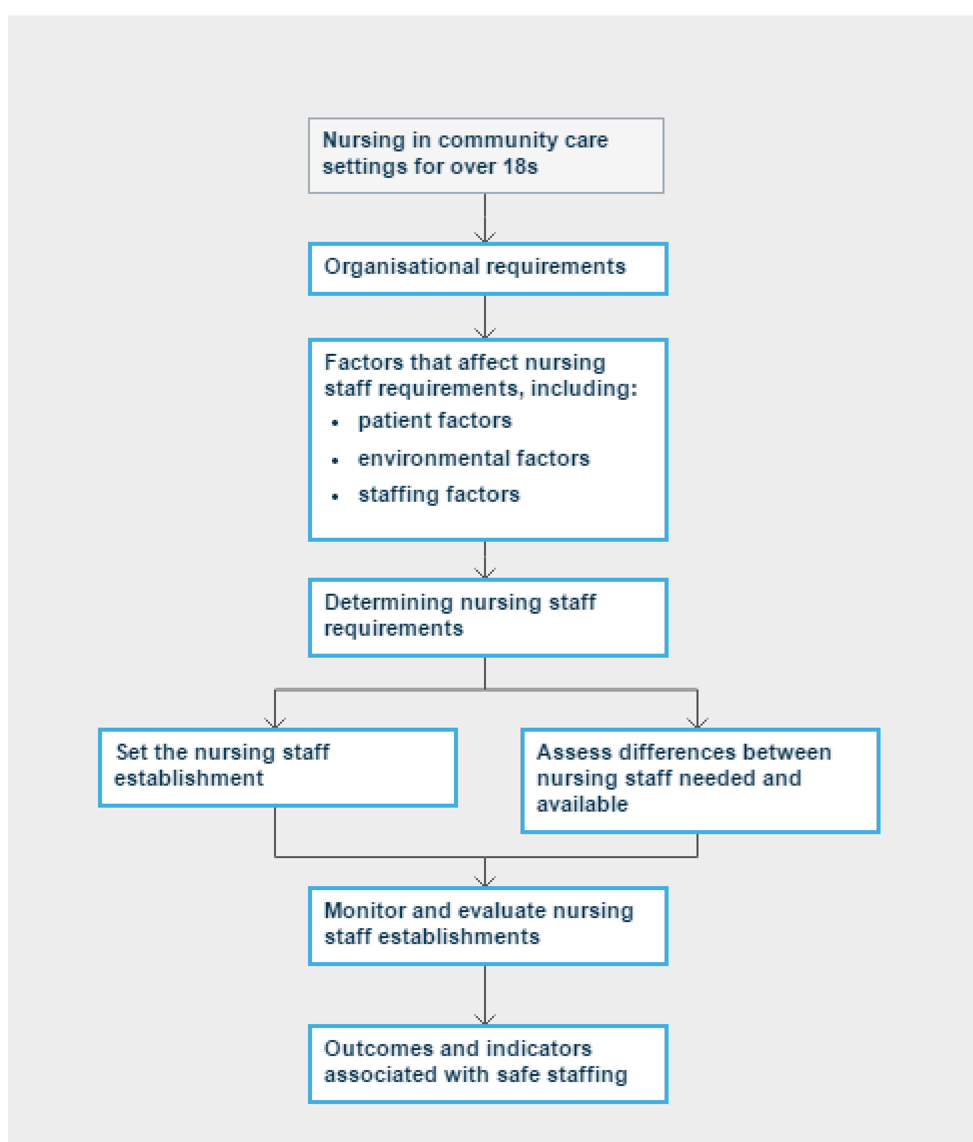
- Safe staffing for nursing in A&E departments. NICE guideline. Publication expected May 2015.
- Home care. NICE guideline. Publication expected September 2015.
- Safe staffing for nursing in inpatient mental health settings. NICE guideline. Publication expected October 2015.
- Management and organisational approaches to safe staffing. NICE guideline. Publication expected February 2016.
- Safe staffing for nursing in community mental health settings. NICE guideline. Publication expected May 2016.

2.2 NICE Pathways

When this guideline is published, the recommendations will be added to NICE Pathways. NICE Pathways bring together all related NICE guidance and associated products on a topic in an interactive topic-based flow chart.

A draft pathway outline on safe staffing for nursing in community care settings for over 18s, based on the draft scope, is included below. It will be adapted and more detail added as the recommendations are written during guideline development.

Safe staffing for nursing in community care settings for over 18s overview



3 Context

3.1 Key facts and figures

The need for a review of nurse staffing in community care settings was highlighted by the Queen's Nursing Institute report commissioned by NHS England: Developing a national District Nursing Workforce Planning Framework (2014). The report identified the need for a robust system to objectively assess population demands, determine the size of the workforce required to meet demand in a given locality, and deploy the available workforce efficiently.

There are a number of reasons why staffing for nursing in community care settings for 18s needs to be reviewed. These include:

- increasing demand for nursing care at home
- ageing population with more complex needs
- increased prevalence of complex long-term health problems
- earlier discharge and discharge of patients with more serious or complicated medical problems
- advances in healthcare techniques and technology allowing more complex care to be delivered at home
- decreasing numbers of qualified district nurses and community specialists.

NHS England's five year forward view noted that there has yet to be a shift from acute to community sector-based working, with just a 0.6% increase in the numbers of nurses working in the community over the past 10 years. In December 2014, there were 1264 community matrons and 5644 district nurses (full time equivalent) working in the community compared with 1545 community matrons and 7979 district nurses in December 2009 (Health and Social Care Information Centre). Community health services as a whole have around 100 million patient/service user contacts per year, and comprise approximately £10 billion of the NHS budget (King's Fund report). Over the age of 75, 1 in 4 people need a district nurse's care at home, rising to 1 in 2 people over 85. To meet this growing demand, home nursing services have

299 been changing and developing, but as a consequence there are fewer
300 community specialists (district nurses) with more nursing tasks being done by
301 healthcare assistants (Queen's Nursing Institute).

302 3.2 Current practice

303 The Queen's Nursing Institute report commissioned by NHS England showed
304 that decision-making around nursing staff levels is often decentralised and not
305 systematic, with district nursing establishments often derived from available
306 budgets, historical practice or overly simplistic and standardised caseload
307 sizes.

308 A King's Fund report on managing quality in community healthcare services
309 highlighted that nursing staff shortages were a recurring theme reported in
310 surveys and interviews. Providers were least positive about their performance
311 in the area of ensuring adequate staffing numbers, skill mix and caseload.
312 Monthly performance reports to boards showed that providers were failing to
313 meet targets for appraisal compliance, staff sickness and mandatory training
314 rates. Providers reported that planning and managing the workforce within
315 community services was challenging, largely because of the volume of
316 demand and increase in patient/service user acuity (how ill the person is), with
317 patients being discharged earlier into the community to relieve pressure on
318 acute services.

319 Nurse staffing levels in the community are typically captured as either a ratio
320 (for example, number of district nurses per 1000 head of population) or
321 through average caseloads (for example, number of patients/service users
322 seen per district nurse). There is no existing guidance on appropriate staffing
323 ratios, the required number of community nurses per population or
324 recommended maximum caseloads. National work has been undertaken to
325 benchmark nurse staffing levels in the community, but this does not determine
326 whether existing staffing levels are sufficient to ensure safe care.

327 ## 3.3 Policy, legislation, regulation and commissioning

328 **Policy**

329 Recent reports highlighted the need for safe staffing guidelines, such as the
330 Francis report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
331 and the Berwick report on improving the safety of patients in England. The
332 need for guidelines on safe staffing was also highlighted in reports produced
333 in response:

334 - How to ensure the right people, with the right skills, are in the right place at
335 the right time: a guide to nursing, midwifery and care staffing capacity and
336 capability (National Quality Board 2013).
337 - Hard truths: the journey to putting patients first (Department of Health
338 2013).

339 There are also some documents that are more specific to nursing in
340 community care settings and these are outlined below.

341 - Monitor (2015) Commissioning better community services for NHS patients
342 - King's Fund (2014) Managing quality in community health care services
343 - NHS England (2014) Five year forward view
344 - Queen's Nursing Institute (2014) Developing a national District Nursing
345 Workforce Planning Framework
346 - Department of Health (2013) Care in local communities: a new vision and
347 model for district nursing

348 **Commissioning**

349 In 2013 clinical commissioning groups took responsibility for commissioning
350 many community services, but local authorities became responsible for
351 commissioning certain community-based services, such as intermediate care
352 and some public health services such as sexual health services. NHS
353 England also became responsible for commissioning certain public health
354 services provided in the community, such as immunisations. Community
355 service providers can have more than 1 commissioner body and potentially
356 more than 1 clinical commissioning group or local authority commissioner.

357 The community services sector is more diverse than the acute or mental
358 health sector, and provider bodies can be NHS community trusts, mental
359 health or acute trusts, charities or social enterprises, or private sector
360 providers.

361 4 Further information

This is the draft scope for consultation with registered stakeholders. The consultation dates are 22 April to 20 May 2015.

The guideline is expected to be published in March 2016.

You can follow progress of the guideline.

Our website has information about how NICE guidelines are developed.

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364 # 5 Appendix A. Summary of the main elements of
365 the scope and their relationship

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