

# Developing a workload benchmarking tool for community (public health) nursing.

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## Objectives

To outline the development of a safer staffing tool for use in community (public health) nursing **A workload-quality driven workforce planning and development model** was built and tested to enable community nursing teams to calculate their workloads and benchmark staffing levels and skill mix against high performing teams. This complements similar models built for inpatient areas (the Hurst Tools).

## Population and Setting

Community nursing staff in the UK typically visit and provide care for patients in their own homes. 449 community teams have entered data into the English Safer Staffing community workforce model since 2013 (Scotland and Northern Ireland have similar databases, appropriate to their context). Data are derived from more than **15053 patient care days** during which over 3,700 community staff contacted, on average, **nearly eight patients a day**.

## Data Collection Methods

### Step 1

Staff (all grades) keep a diary spanning 24hrs, Monday to Sunday, and record nursing interventions and patient dependency/acuity

### Step 2

An empirically derived workload index shows whether each full-time equivalent staff member (FTE) is under- or over-occupied. This index is calculated from patient numbers, case mix, direct care time and an 'overhead' (e.g., desk time)

### Step 3

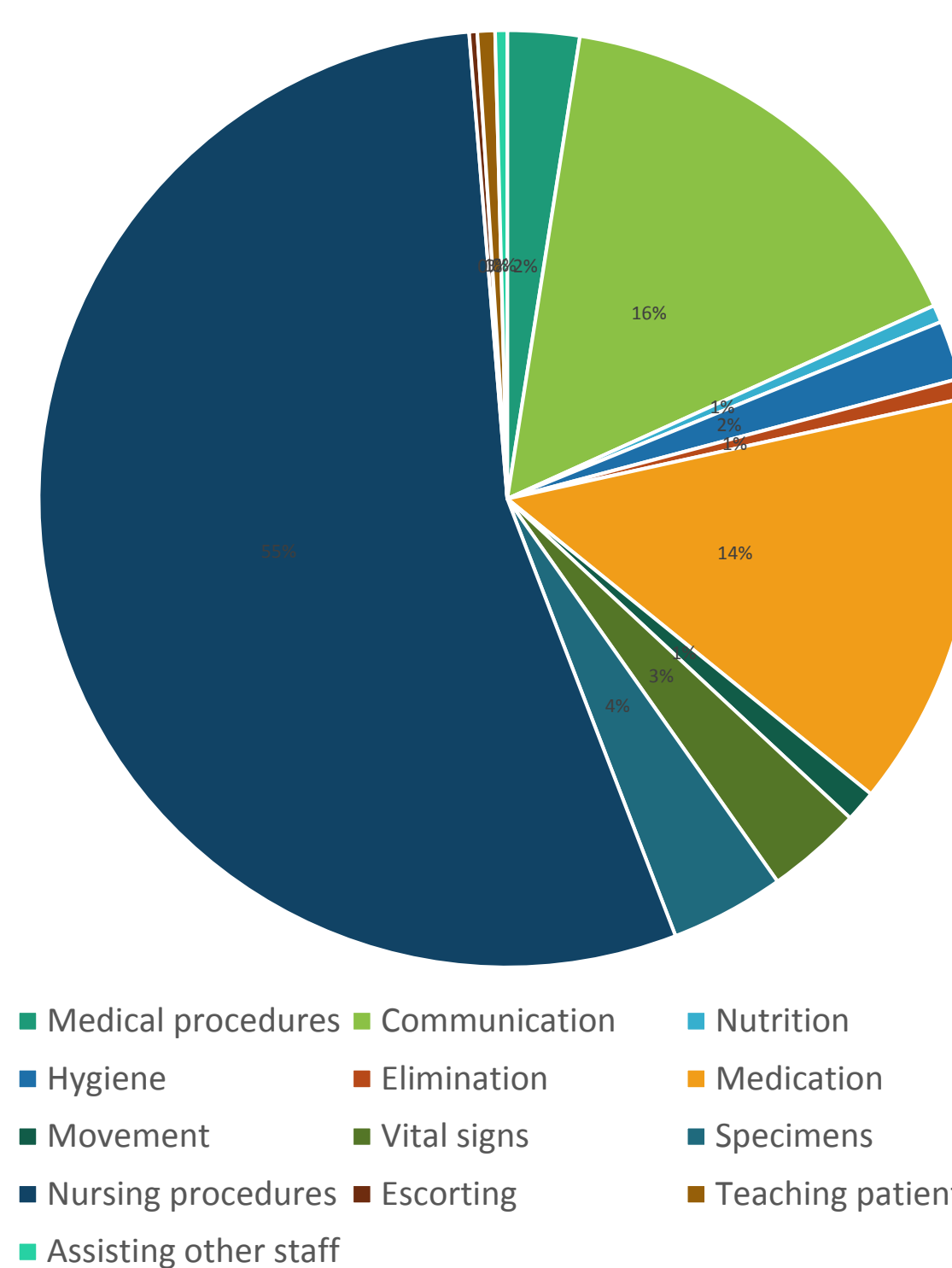
Only data from teams with acceptable service quality is admitted to the model

### Benchmarks available

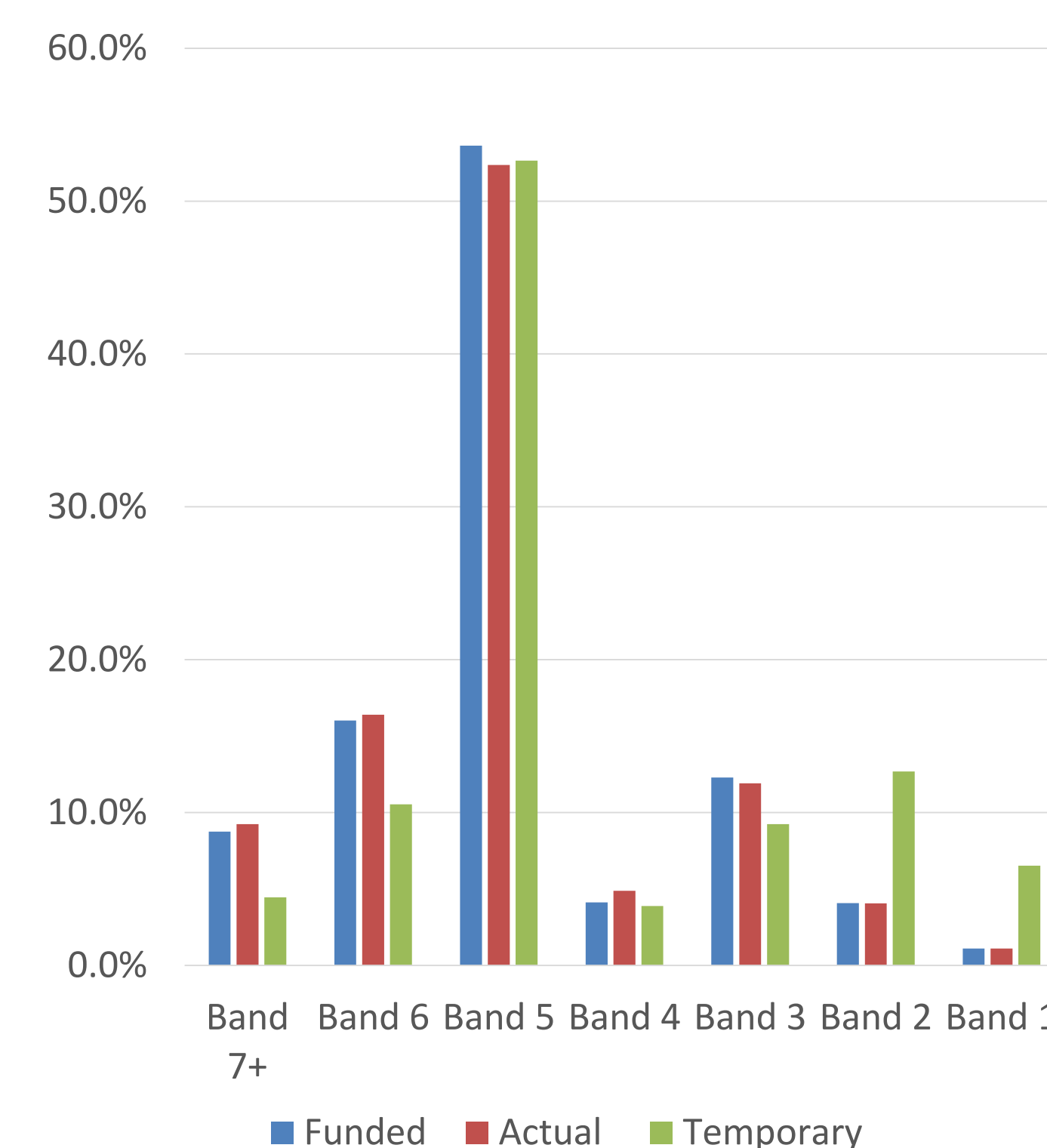
- Patient dependency per team
- Number of clinics offered per team
- Daily average nursing interventions by patient dependency/acuity category
- Travel time
- Direct Care time
- Indirect care time
- Associate work
- Unproductive time
- Nurse staffing by skill mix/banding

## Results

### Direct care activity



### Typical skill mix



### Typical workload by patient dependency/acuity

| Patient-based     | Dep.1 | Dep.2 | Dep.3 | Dep.4 | Clinics | Total |
|-------------------|-------|-------|-------|-------|---------|-------|
| Patients*         | 0.94  | 2.69  | 2.86  | 1.09  | 2.45    | 7.58  |
| Interventions*    | 3.63  | 2.05  | 2.51  | 4.49  |         | 12.67 |
| Patient mix       | 12%   | 26%   | 38%   | 14%   |         |       |
| Direct Care       | 36.3  | 20.5  | 25.1  | 44.9  | 60.1    | 1.10  |
| Indirect Care     | 31.8  | 16.6  | 17.4  | 39.7  |         |       |
| * (daily average) |       |       |       |       |         |       |

**64.5 %** of all activity is **patient focussed**: i.e., direct (face-to-face) care or indirect (patient-related) care. This is markedly higher than inpatient contact time. 35% of staff time is spent on activities not directly connected with patient care (e.g. general meetings travel and administration). **Unproductive time is negligible** (less than 1%) in comparison with inpatient areas (10%). The concurrent service quality audit (answered by patients, carers and staff) indicates that patients and carers **highly value the service** they receive from community staff, but community staff report stressful workloads.

## Conclusion

Results highlight that community care is efficient and effective, and is likely to reduce inpatient workload and costs significantly. Front-line staff report challenges with objective assessment of patient dependency and have, at times, been resistant to data capture. The approach has been rolled out for community mental health and learning disability workforces.