

Trends over ten years in the primary care and community nurse workforce in England

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Summary

1. Introduction

This paper provides the key points in the ten year trends in primary care and community nursing workforces in England. The analysis builds and expands on previous work completed for the Department of Health (England)¹. It draws on secondary data analysis of public domain information from the Department of Health Information Centre and the Office of Manpower Economics as well as grey literature sources e.g. unpublished local area workforce reports. Each key point given in this summary is supported by a detailed paper, with full data source references.

2. Background

A new UK wide programme on modernising nursing careers² has identified work streams to ensure the development of a component, flexible nursing workforce able to adapt to changing health care systems and environments. One work stream is the review the career pathways and educational preparation for nursing in the community focusing on public health, long term conditions and acute care³. This paper is one of two⁴ providing an analysis of current trends in the organisation, deployment and configuration of the nursing workforce in primary care and community settings to support this work stream.

The summary key trends are presented in the following order:

- The overall nursing workforce,
- The nursing workforce in adult community services,
- Nurses employed in General and Personal Medical Services,
- The nursing workforce in community contraception/family planning services,
- The primary care nursing workforce for children, young people and families.

3 Key Trends: The overall community and primary care nursing workforce

Detailed information is given in Paper 1

3.1 Qualified nurses. In 2006, 23 % of the total qualified nurses employed in the NHS in England were employed in community services, general practice and NHS Direct (a head count [hc] of 87,863).

3.2 Support to nursing. The 16,968 (hc) staff in support to nursing roles (nursing auxiliaries, health care assistants, nursery nurses) formed approximately 24% of the nursing workforce in the community services (compared to 28% in the acute, elderly and general hospital areas of work).

3.3 The largest groups of nurses were:

- The 'other' (i.e. not with specialist practitioner qualification for health visiting, district nursing or school nursing) registered nurses (RNs) in community services (headcount 35,179),
- Practice nurses (i.e. those employed in general practice , headcount 23,797),
- Health visitors in community services (headcount 12,034),
- District nurses (headcount 10,008 first level RNs).

3.4 Of the 'other' registered nurse full time equivalent (fte) resource it is estimated that:

- 89% are employed in adult community nursing services,
- 5% in school nursing services,
- 3% in health visiting services,
- 3% in contraceptive/family planning services.

Between 1996-2006 growth was most noticeable in:

- The qualified nurse fte resource in general practice and community services rose by 48% and the 38% respectively (compared to a 29% increase in the acute, elderly and general hospital services).
- The nursery nurse, nursing auxiliary and health care assistant resource in community services grew by 118% (compared to 73% in the same groups in the acute, elderly and general hospital services).

4 Key Trends: The nursing workforce in adult community services

Full details given in Paper 2

4.1 Total nursing resource. It is estimated that in 2006 there was a qualified nursing resource of 48,840 full time equivalents (fte) deployed in primary care ambulatory and home care services for adults (includes general practice and NHS direct).

4.2 In the **community services for adults** (ambulatory and home care), it is estimated that there was a qualified nurses and support to nursing resource of 38,867 fte (and a headcount of 53,902) in 2006.

4.3 From 1996-2006 there has been a 47% overall growth in the fte resource of qualified nurses and support staff to nursing, most noticeably in the increase of registered nurses. The nursing auxiliary and health care assistant fte resource has also grown over this period, while registered nurses with district nurse qualifications have decreased.

Population growth. In the same time period (1996-2006), there has been an increase of 486,000 person aged 65 and over in England.

4.4. Distribution of nursing resource. There is a regional range in the ratio of this nursing resource to population from 57fte/10,000 people aged over 65 (North West Strategic Health) to 28fte/10,000 (South West Strategic Health Authority). The regional distribution appears to mirror the range of percentage of older people in income deprived households with the exception of London Strategic Health Authority, which has the highest percentage of such older people but falls mid-way in the ranking of StHA fte/10,000 over 65 populations.

4.5 Full time and part time posts. Part-time working is more common than in the hospital sector but it is not possible to quantify the number of part time posts. The ratio of headcount to fte has decreased in some groups and increased in others suggesting an overall increase in part time posts and part time hours worked by individual nurses.

4.6 This workforce is **predominantly female**, with men comprising just over 4% of these staff groups in community services in comparison to 9.9% of RNs in acute, elderly, general hospitals and 31% of RNs in community psychiatry.

4.7 The age distribution of the qualified nurses and support to nursing staff in the community workforce is skewed towards the older age bands, although more so in some groups than others: 72% district nurses, 69% RNs, and 71% nursing auxiliary and health

care assistant (HCA) aged over 40 in community services compared to 43% in the acute, elderly and general hospital sector.

From 1996-2006, there was a 9% increase in District Nurses (DN) aged over 50, compared to a 3 % and 4% increase in the 'other' RN (registered nurse) staff group in community services and the general hospital staff group respectively.

4.8 Ethnicity. Of the registered nurses (first and second level) with district nursing qualifications, whose ethnicity is known 9.1% are of minority ethnic origin compared to 19.1% of all qualified nurses. This is an increase on the 4% reported in the 1996 (although it should be noted that there is a caveat with these figures that there may be inaccurate recording).

4.9 Turnover. There are limited national level indicators of turnover in the nursing groups within these services. Those that exist suggest this is a workforce increasingly sensitive to the fluctuations in the supply and demand in the wider nursing labour market. Evidence suggests that the district nurse group have had higher retirement rates (as their age profile would indicate) but lower leaver rates than qualified nurses (as an aggregate group across all sectors) until 2005, at which point the rates appear very similar. The rate of retirement is higher than all other qualified nurses, although similar to health visitors, as would be expected from the age profile. The rate of three month vacancies (i.e. posts unfilled for three months or more) for these groups remained relatively static (between 1.5 and 3.0 %) from 2001 until the marked decrease in 2006 although there are regional variations (0%-4.6%).

Unanswered questions and issues raised. This analysis raises a number of unanswered questions on all aspects of this workforce, career trajectories, educational and professional development requirements which are listed in Paper 2.

5 Key Trends: Nurses Employed in General and Personal Medical Services

Full details in Paper 3

5.1 Size of the workforce. At September 30th 2006 there were 23,797 qualified nurses employed in general practice (a nursing resource of 14,616 fte). It is not possible to quantify the nurses working as nurse practitioners or the health care assistants. In 2005, 268 fte qualified nurses from community services were seconded to PMS pilots⁵, compared to 130 in 2001.

5.2 Growth. From 1996 to 2006 the full time equivalent (fte) workforce grew by 23%. However, the growth has not been linear: the fte increase 1997/1998 was only 0.2% compared to 4% growth in 1998/1999 and 6% in 2005/2006. The growth is more marked in some parts of the country region than others. The North East region shows a decrease 2004-2006. Possible explanations for the growth in some years are the introduction of general practice contract financial incentive schemes such as the introduction of local development schemes from April 1998, the introduction of the new GMS (and PMS) contract in 2004 with quality and outcome framework.

5.3 Part-time working. The ratio of headcount to fte suggests greater part-time working than other groups such as the registered nurses in the community adult nursing, although this appears to be changing in some regions.

5.4 Distribution. The distribution of practice nurse resource has always varied across England. In 2006 the range was 22 fte/10,000 in the London StHA area to 66fte/10,000 in South Central StHA in 2006.

5.5 Demographics. There is no nationally collected demographic but local surveys in 5 parts of England since 2000 suggest this group of nurses are female and predominantly over the age of 35 with the majority aged 40 to 55.

5.6 Turnover. There is no nationally collected data on turnover but local surveys since 2000 indicate a very stable workforce in some areas, with less than 1% planning on leaving or retirement in the following year. Estimates suggest a 2006 drop in three month vacancy rates, in keeping with trends demonstrated across nursing but there are regional variations notably in London with estimates of higher vacancies.

Unanswered questions and issues raised. This analysis raises a number of unanswered questions on all aspects of this workforce, career trajectories, educational and professional development requirements which are listed in Paper 3.

6. Key Trends: The nursing workforce in community contraception/family planning services

Full details given in paper 4

6.1 Size and growth. It was estimated that the fte resource in community contraceptive/family planning services was 728 in England in 2006. A Faculty of Family Planning and Reproductive Health Care census of this workforce that included staff from Brook clinics (charity sector for under 25 year olds) reported a fte resource of 845.2. This was an increase by over 200 fte from a 2004 census. This increase was not uniform across England, and some regions reported a decrease rather than a growth.

6.2 Distribution. The ratio of fte nurse resource in community family planning and contraceptive services to population of women aged 15 -44 years ranges 1fte per 10,610 women in the North West Region to 1fte per 28,864 women in the East of England Region.

6.3 Part-time working. The very high headcount in comparison to the fte in this nursing group suggests a preponderance of sessional staff, although changes between 2004-2006 suggest that there may be a trend in some areas to employ a smaller number of staff for more hours.

6.4 Demographic and turnover data. Not available at a national level for this workforce.

6.5 Unanswered questions and issues raised. This analysis raises a number of unanswered questions on all aspects of this workforce, career trajectories, educational and professional development requirements which are listed in Paper 4.

7 Key Trends: The primary care nursing workforce resource to children, young people and families

Full details are given in Paper 5

7.1 Size. It is estimated that there was a qualified nursing and support to nursing resource of 14,708 full time equivalents (fte) and 19,581 staff (i.e. by headcount) in services for children, young people and families across England in 2006.

7.2 Growth. The overall trend has been of an estimated 18% growth in full time equivalents in this service: 12,053 fte in 1996 compared to 14,779 estimated fte in 2006. The rate of growth was most marked between 2002 and 2004.

7.3 Changes in the staff composition by service Within the overall growth, there has been changes indicative of a different staff composition:

- The largest increases have been in the nursery nurse and registered nurse resource,
- From 2004 to 2006 there has been a reduction health visiting resource in fte and numbers,
- The nursing resource to school health demonstrates growth overall as well as an increased growth in all staff groups,
- The employment of registered nurses- children in community services shows a decline over the past 10 years in community services (compared to an increase in paediatric services, perhaps suggestive of more outreach into the community).

7.4 Part time working. It is not possible to quantify the volume of part time posts but the ratios of headcount to full time equivalent suggest there is a higher rate than in the acute, elderly and general hospital sector. It appears to be more common in some groups of staff than others e.g. school nursing service, possibly because of the use of term time contracts.

Reduction in the under 16 population. This has been a reduction by 264,000 children under 16 (232,000 aged under 4) between 1996-2005.

7.5 Distribution. There is a regional range in the ratio of this nursing resource to population from 5 fte/10,000 children aged 0-16 to 16fte/10,000. Comparisons with regional percentages of children under 16 living in income deprived households suggests the distribution may demonstrate the inverse care law, however, this may not be accurate when analysed at primary care organisation level.

7.6 Demographics:

This workforce is **predominantly female**, with men comprising just over 1% in comparison to 4% of registered children nurses in paediatric services and 31% of RNs in community psychiatry. There have been only small increases over the past ten years.

The age distribution of the qualified nurses in the community services is skewed towards the older age bands in comparison to those working in the hospital sector. 80% of health visitors are aged over 40, compared to 72% district nurses and 69% of other RNs in community services.

Over the past 10 years the percentage of health visitors over the age of 50 has increased from 30 -37%. Of the health visitors and school nurses whose ethnicity is known 10% and 7% respectively are of minority **ethnic origin** (the same as in 1996) compared to 19.1% of all qualified nurses.

7.7 Turnover. Data is not readily available at an aggregate level of recruitment, retention and leaver rates in this workforce. There is some evidence that that the rate of health visitors leaving their post was higher than that of all qualified nurses since 2004 and had a higher rate of exiting from the NHS altogether. The rate of retirement is higher than all other qualified nurses, although similar to district nurses, as would be expected from the age profile. The rate of three month vacancies (i.e. posts unfilled for three months or more) for health visitors and school nurses (only collected from 2003) remained relatively

static (between 2.2 and 3.2%) from 2001 until the marked decrease in 2006 although there are regional variations (0%-4.6%).

Unanswered questions and issues raised. This analysis raises a number of unanswered questions on all aspects of this workforce, career trajectories, educational and professional development requirements which are listed in Paper 5.

8. Conclusions

There is growth in all of these nursing workforces over ten years, both in size and in the types of staff employed in nursing services (i.e. skill mix). However, it is analysis at a regional level where the differences in the rate of growth and diversity in staff groups becomes apparent. This presents challenges in offering a national picture of career pathways and opportunities in primary care and community settings.

There is a great deal of similarity between all the nursing workforces in the different primary care services and they contrast to the hospital and acute sector workforce: an older age profile, predominantly female and more likely to be in or working with colleagues in part time posts.

There are deficits in our knowledge of specific groups: most notably the nurses employed in general practice. There are also deficits in our knowledge by service area. Given the trend to not commission particular forms of qualification such as the specialist practitioner district nurse, our knowledge will become more incomplete about the workforce in some service areas. One suggestion would be that consideration is given to categorisation of staff in the Department of Health workforce census by the service patient speciality (e.g. community adults home care) rather than by qualification and broad categories e.g. community. This type of categorisation is likely to offer better opportunities for analysis to inform educational and workforce development planning.

Paper 1.

The overall size and growth of the nursing resource in primary and community services in England

This paper examines:

- The overall size of the qualified nurse workforce,
- The distribution of qualified nurses by work area or title,
- Identifying the work area of 'other' registered nurses,
- Support posts in the nursing workforce,
- Growth in the overall nursing resource.

* For ease of reading 'nurse' is used in this text referring to nurses and health visitors

The workforce data has then been analysed in more detail by service. This together with the questions and issues it raises are been reported separately in companion papers:

- The nursing workforce resource to adults. Paper 2,
- The nursing workforce in general practice. Paper 3,
- The nursing workforce in community contraceptive services. Paper 4,
- The nursing workforce in services for children, young people and families. Paper 5.

1. The overall size of the qualified nurse workforce.

At September 30th 2006 there were:

- 47,338 full time equivalents (fte)⁶ qualified nurses (including nurse managers) employed in the NHS community services,
- 14,616 fte nurses in general practice⁷
- 1,194 fte nurses in NHS Direct (see Chart A1.1).

These 3 groups total 63,148 fte and represent 20% of the fte qualified nurses employed in the NHS. The total number of qualified nurses (i.e. the headcount) in these groups was 87,863⁴. This represents 23 % of the total qualified nurses employed in the NHS i.e. 1 in 5 NHS employed nurses work in primary and community health services.

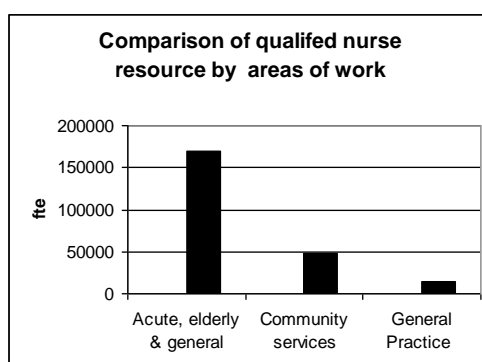


Chart A1.1

Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census. 2007⁶

Workforce data is not collected by service area e.g. district nursing but by a combination of employer (e.g. general practice), qualification groups (e.g. health visitor) and some generic post titles (e.g. nurse consultant).

2. The distribution of qualified nurses by work area or title

The qualified nurse resource is distributed across a range of services (Chart A1.2). The largest groups of nurses are:

- The 'other' registered nurses in community services (headcount 35,179⁶,
- Practice nurses (i.e. those employed in general practice, headcount 23,79⁷),
- Health visitors (12,034 headcount),
- District nurses (10,008 headcount first level RNs with district nursing qualifications and 1,262 headcount second level RNs with district nursing qualifications).

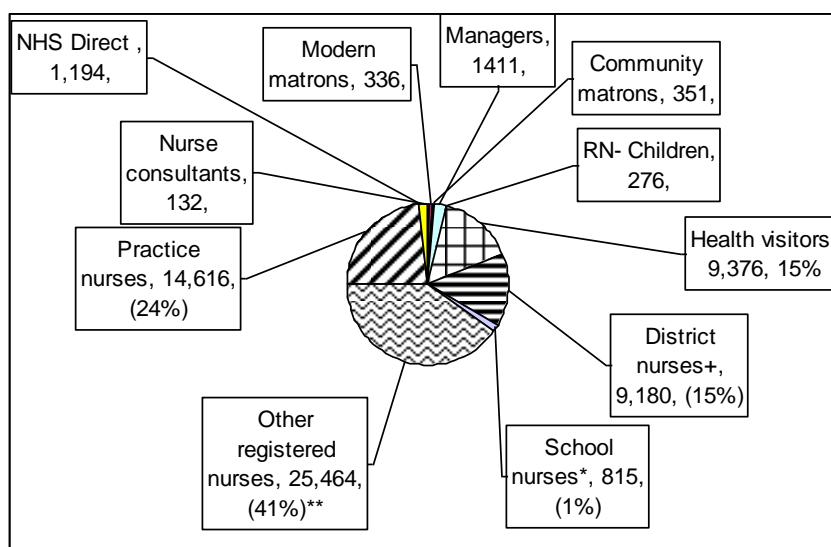


Chart A1.2. The distribution of qualified nursing resource (fte) in primary care services
Data sources: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census.
Information Centre for Health and Social Care. General and personal medical services in England: 30
September 2006- Detailed Results Table 4.

*Refers only to those with specialist practitioner qualifications

** Includes 1,285 2nd level nurses (previously known as enrolled nurses)

+ Includes 980 2nd level nurses with district nursing qualifications

The smaller staff groups such as the nurse consultants in community services have seen a year on year increase since their introduction. The headcount for nurse consultants was 36 in 2002⁸, 100 in 2004⁹ and 132 in 2006⁷. However, data is not available to distinguish which service or patient population they are associated with.

3. Identifying the work area of 'other' registered nurses

Registered nurses in the school nursing service account for 1,201 fte of the 'other' registered nurses shown in Chart A1.2. The work areas of the 'other registered nurse' group are not specified. In order to estimate which services these nurses work in a range of unpublished reports and grey literature from Strategic Health Authorities and PCTs were explored.

Analysis of the workforce census document from the Faculty of Family Planning and Reproductive Health Care¹⁰ with that from the Department of Health¹¹ reveals that on average (mean and mode) the qualified nurse fte in community family

planning/contraceptive services is 3% (of the total qualified nursing fte calculated at a Strategic Health Authority Level). The range is from 2% (East Midlands, South Central and South Coast StHA) to 7% (London StHA).

An analysis of 8 publicly available PCT documents (from different strategic health authorities) on the workforce resource in health visiting revealed the range of registered nurse fte in health visiting teams (Table A1.1) with a median of 3% of the HV fte.

PCTs (n=_)	RN fte as a % of the HV fte
3	0
2	3%
1	4%
1	7%
1	26%

Table A1. 1 The range of registered nurse resource in health visiting teams

Using these assumptions, it is estimated that about 89% of the other registered nurse fte resource is deployed in adult community and home care nursing (chart A1.3).

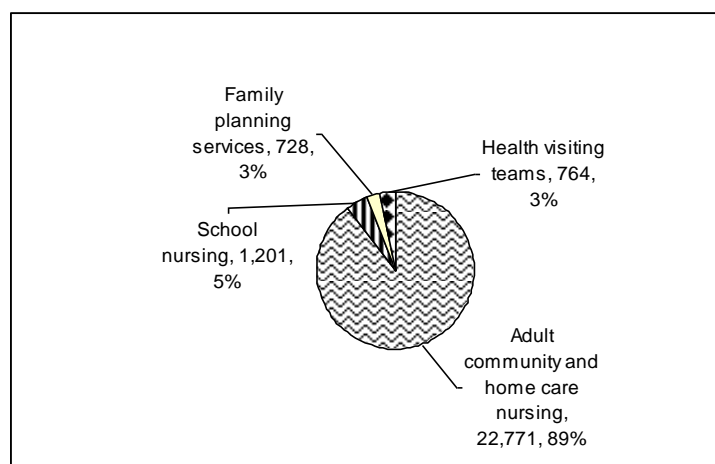


Chart A1.3 Estimated Distribution of 'Other' Registered Nurses between Service Areas. Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census.

4. Support posts in the nursing resource.

The support staff resource to primary care and community nursing is most easily identifiable in three groups: nursery nurses, nursing auxiliaries and health care assistants. It is not possible to separate administrative and clerical staff support to nursing from support to other staff groups. In 2006 there were 16,968 employees (i.e. headcount) in these groups in community health services.

This comprised a total support to nursing resource of 11,738 fte:

- 1,899 fte nursery nurses,
- 8,305 fte nursing auxiliaries,
- 1,567 fte health care assistants (NB Some of the HCA will be in support of other staff groups e.g. therapists but the majority will be in support of nursing).

Together this constitutes 24% of the total fte nursing resource (n=59,076 fte) in community services, a smaller proportion than the same groups in the acute, elderly and general hospital areas of work, who form over 28% (Chart A1.4)⁶.

It is not possible to separately identify support staff to nursing in general practice or in NHS Direct.

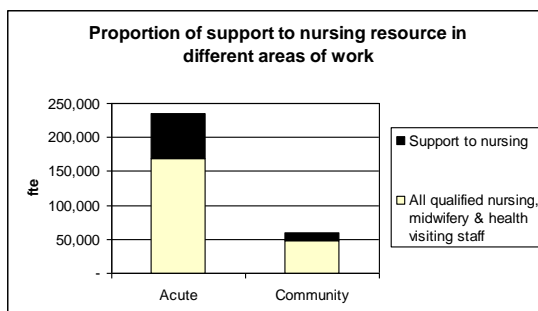


Chart A1.4

Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census.

5. Growth in the nursing resource.

The fte qualified nurse resource in general practice and community services rose by 48% and the 38%, respectively, from 1996-2006. This a comparatively greater rate of increase than in the acute, elderly and general hospital areas of work in the NHS, which experienced a 29% increase in the same period(Chart A1.5)¹².

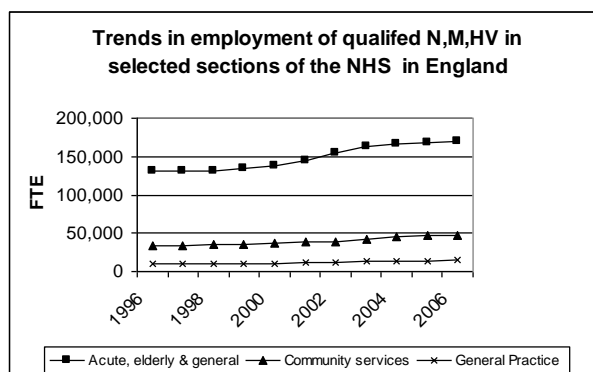


Chart A1.5

Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census for the years 1996, 1998, 2000, 2002, 2004 and 2006.

The growth in qualified staff is also mirrored in the growth of staff in posts in support to nursing. Community services have increased the employment of nursery nurses, nursing auxiliaries and health care assistants by 118% over 10 years compared to a growth of 73% of the same groups in the acute, elderly and general hospital sector (see chart A1.6).

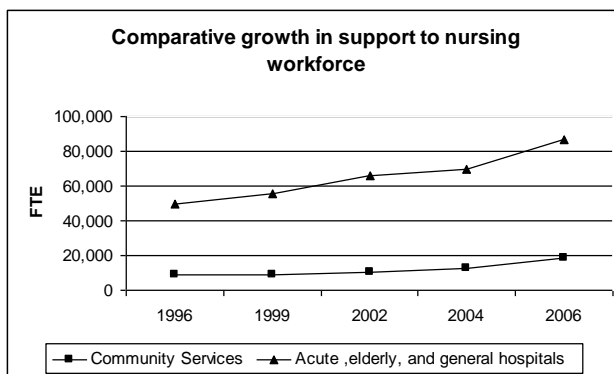


Chart A1. 6

Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census for the years 1996, 1998, 2000, 2002, 2004 and 2006.

6. Conclusion

This is workforce that has seen year on year increase. In order to understand if this growth is uniform the accompanying papers look at each patient service area in more detail.

Paper 2.

The primary care nursing workforce resource to adults (Ambulatory and home care services)

This paper examines:

- The total primary care nursing workforce for adults,
- The size and growth of the community services nursing workforce for adults,
- The distribution of this workforce,
- The ratios of full and part-time working,
- The demographic changes in this workforce,
- Indicators of change in turnover in this workforce.

It raises questions and issues as part of the discussion of each of these items.

1. The total primary care nursing workforce for adults

Using data assumptions outlined in Paper 1, there is an estimated qualified nursing resource of 48,840 full time equivalents (fte) deployed in primary care ambulatory and home care services for adults (Chart A2.1).

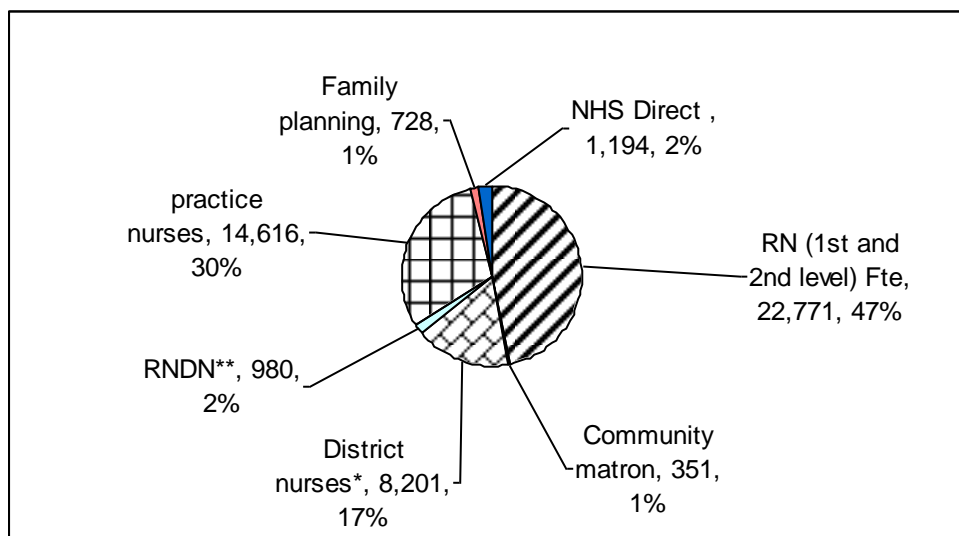


Chart A2.1 Distribution of the nursing resource (fte) between adult services

Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census & Information Centre for Health and Social Care. General and personal medical services in England: 30 September 2006- Detailed Results Table 4.

* RN (first level) with district nursing qualification

** RNDN (second level i.e. formerly known as enrolled nurses) with a district enrolled nurse qualification

Practice nurses are included in this calculation as evidence suggests the majority of their work is with adults¹³ although a proportion of their time is given to children e.g. for the childhood immunization programme. Paper 3 considers the practice nurse workforce in more detail.

Estimates are made of the resource for family planning based on assumptions described in Paper 1. The nursing workforce in community family planning/contraceptive services are explored in Paper 4.

While some health visitors in some areas work with older people rather than (or as well as) children with their families, it is not possible to quantify this resource although previous activity data would suggest it is small¹⁴. The health visiting workforce is therefore discussed in Paper 5.

The remainder of this paper considers only those employed by Community Health Services working in services for adults (ambulatory and home care).

2. Size and growth of the nursing workforce in adult community services (ambulatory and home care services)

This group of staff include the district nurses (first and second level RNs with district nurse qualifications), 89% of the 'other' registered nurses, community matrons, and 89% of nursing auxiliaries and health care assistants employed in community services. Together these form a nursing resource of 38,867 fte (and a headcount of 53,902)¹⁵.

Growth.

The adult community nursing resource has grown over the past ten years nursing resource. Since 1996 there has been a 47% overall growth in the fte resource of qualified nurses and support staff to nursing (Chart A2.2), most noticeably in the increase of registered nurses. The nursing auxiliary and health care assistant fte resource has also grown over this period, while those registered nurses with district nurse qualifications have decreased.

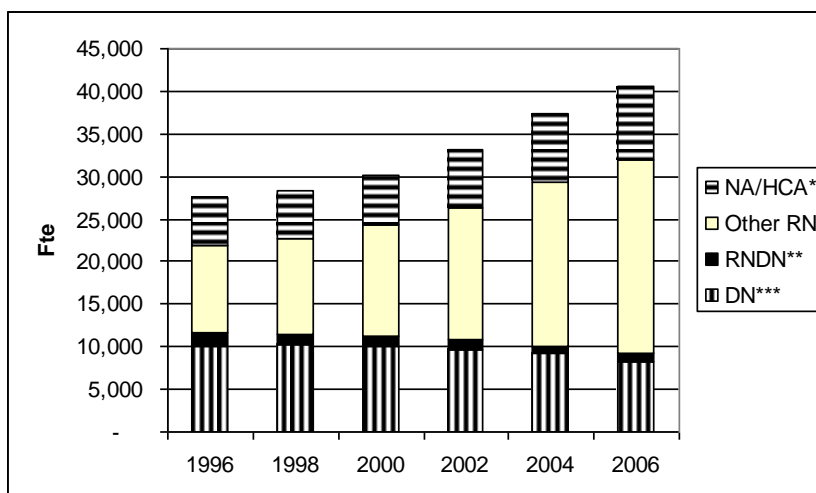


Chart A2.2 Comparison of estimated size and staff groups within adult community nursing services 1996-2006

*Nursing Auxiliaries and HCAs (89% of total in community Services)**RNDN are second level RN with district enrolled nurse qualification. NB The District Enrolled Nurse course ceased in the late 1980s/early 1990s
 ***First level RN with district nursing qualification

Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census for the years 1996, 1998, 2000, 2002, 2004 and 2006.

The headcount for first level nurses registered nurses with district nurse qualifications in 1996 was 12,350 compared to 10,008 in 2006.

To help put this in context in 1996 there were 8,895,000 persons in England aged 65 and over, rising to 9,381,000 in 2005¹⁶. This was an increase of 486,000 persons in this age group. While these nurses in adult community nursing services do not work exclusively with one age group, every study¹⁷ from the nineteen sixties onwards has demonstrated the majority of their patients to be over the age of 65.

Questions and Issues

1. To what extent is the overall growth taking place in the generic district nursing/home care service or in other types of teams e.g. intermediate care teams, rehabilitation teams?
2. Is the nursing staff growth the result of greater financial investment or an increased grade and skill mix in the nursing teams with the same financial resource or a mixture of both?
3. The focus on data gathered by qualification and the absence of data on those in team leader roles (or Agenda for Change bands) makes it difficult to interpret the organisational structures and scale of potential career pathways.
4. The numbers of those with district nursing qualifications has declined in part from a decline in NHS employer commission and sponsorship in the one year programme. What has this qualification (benchmark) been replaced with and is it in a portable form between employers?

3. The Distribution of the Workforce

The population of people over 65 has been used to calculate the ratio of community nurses (fte) in each Strategic Health Authority. Table A2.1 demonstrates that this ranges from 57fte/10,000 people aged over 65 to 28fte/10,000. The ranking by highest StHA fte/10,000 population seems to follow the StHA ranking for percentage of older people living in income deprived households except for London StHA and the South West StHA although comparison of resource distribution at primary care organisation level may offer a different picture.

Questions and Issues

5. To what extent does the ratio of adult community nursing resource reflect the other services in that locale e.g. the numbers of hospital beds or the size of the practice nurse workforce?

Strategic Health Authority	Population over 65 ¹⁸ (% older people living in income deprived households ¹⁹)	Ratio of estimated nursing resource FTE** to 10,000 population aged over 65
North East SHA	496,289 (19.65%)	57 fte/10,000
North West SHA	1,283,597 (18.51%)	54 fte/10,000

West Midlands SHA	1,013,461 (18.65%)	52 fte/10,000
Yorkshire and the Humber SHA	952,342 (17.9%)	45 fte/10,000
London SHA	1,025,145 (20.9%)	44 fte/10,000
East Midlands SHA	817,422 (15.21%)	38 fte/10,000
East of England SHA	1,076,293 (12.65%)	37 fte/10,000
South East Coast SHA	866,903 (11.02%)	36 fte/10,000
South Central SHA	706,637 (11.02%)	28 fte/10,000
South West SHA	1,098,328 (12.59%)	28 fte/10,000

Table A2.1 Ratio of estimated community nursing resource to 10,000 population over 65 by Strategic Health Authority (SHA).

**Includes DN (both 1st and 2nd levels), other RN (89% of total), community matrons, nursing auxiliaries (89% of total), and health care assistants (89% of total)²⁰.

Source Data: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census Table 2,2b NHS Hospital and Community Health Services: Qualified nursing, midwifery and health visiting staff by Strategic Health Authority area.

4. Full and part time working

For all groups of staff the headcount is greater than the fte indicating that part time posts are present. It is not possible to quantify the volume of part time posts but it would appear to be more common in some groups of staff than others. For example for district nurses the ratio is 1 headcount to 0.8 fte compared to a ratio of 1 other registered nurses (RNs) to 0.7 fte (see Chart A2. 2). This ratio has remained the same for district nurses since 2003 but increased for other RNs (ratio of 1 head counted nurse to 0.6 fte²¹). The ratio for registered nurses in the acute, elderly and general hospital is 1 nurse by headcount to 0.8 fte.

Questions and Issues

6. Has the level of part-time posts developed as a response to the available workforce and is it now changing as the supply of nurses from the wider nursing labour market increases?

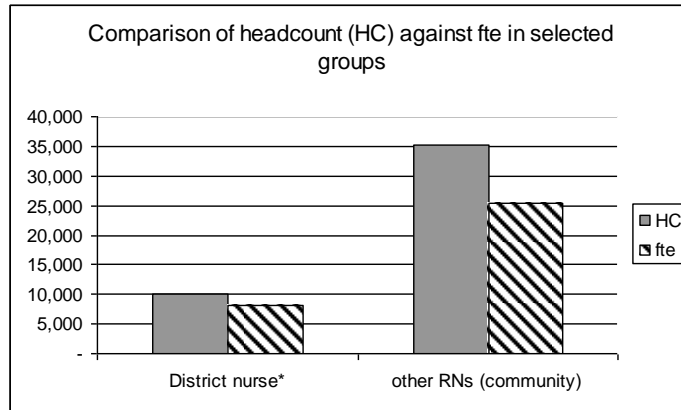


Chart A2.5

*First level RN with DN qualification

Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census Detailed Results. Table 2. 2.

5. The demographic profile of this workforce

Gender

This workforce is predominantly female, with men comprising just over 4% of these staff groups in community services in comparison to 9.9% of RNs in acute, elderly, general hospitals and 31% of RNs in community psychiatry (Chart A2.6). There have been small increases in the percentage of male nurses working in these services but less than in the RN staff group in the hospital sector. This increase also contrasts with the community psychiatry nursing group which has seen a decrease in male nurses over 10 years. The staff who are in community nursing auxiliary and health care assistant posts demonstrate a similar gender distribution with just over 4% men²².

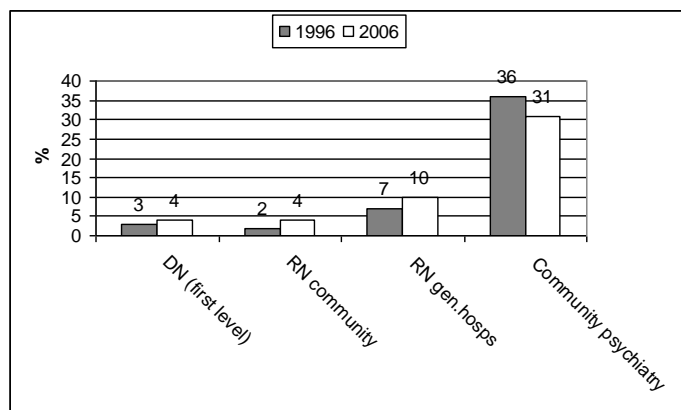


Chart A2.6 Percentage of male qualified nurses in selected staff groups 1996 and 2006.

Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census Detailed Results. Table 3.2.

Questions and Issues

7. Why are there not higher levels of male nurses in adult community nursing services, given the increased numbers of male nurses registered with the Nursing and Midwifery Council ²³ ?
8. To what extent does the seemingly higher level of part-time RN posts in the adult community nursing service attract female nurses rather than male nurses?
9. Are male and female nurses retained in the adult community nursing services to the same extent?
10. What is the gender balance in the registered nurse posts with higher responsibility and salary scale posts, given that 19%²⁴ of qualified nurse manager posts are held by men? Has this changed over time or with the introduction of the NHS Knowledge and Skills Framework linked to salary banding?

Age

The age distribution of the qualified nurses in the community workforce is skewed towards the older age bands in comparison to those working in the acute, elderly and general hospital sector (Chart A2.76). 72% of those with district nurse qualifications (and known age) are over 40, compared to 43% of those in the acute, elderly and general hospital sector. The staff in community nursing auxiliary and health care assistant posts demonstrate a similar age distribution with 71% over the age of 40²⁵.

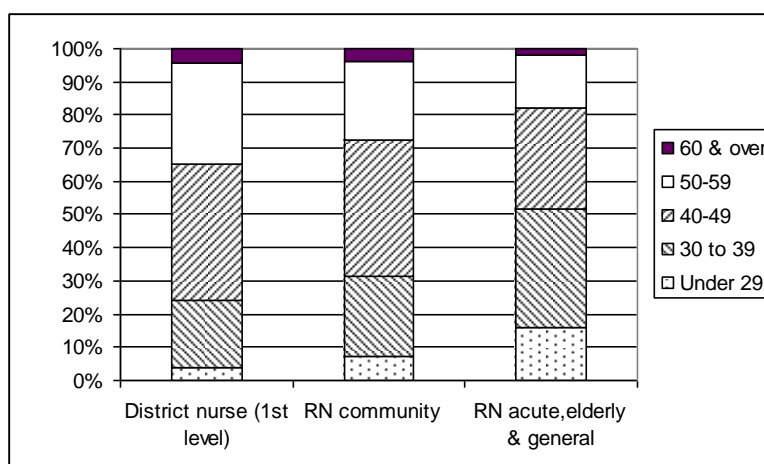


Chart A2.6 Comparison of age band distribution between selected groups of qualified nurses
Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census Detailed Results. Table 4.2

The comparatively greater numbers of older nurses in community services has long been recognized²⁶. It is apparent that the trend for increased percentage of the staff group to come from those aged over 50 is not confined to the adult community services (Chart A2.7). However, that it is apparent that there has been a 9% increase in proportion of District Nurses (DN) aged over 50 in the last ten years, compared to a 3% and 4% increase in the 'other' RN (registered nurse) staff group in community services and the general hospital staff group respectively.

Questions and Issues

11. Given the decline and change in nursing education and qualifications for adult community nursing, what is the age banding of those nurses in higher salary bands , which reflect higher levels of responsibilities and skills?

12. What are patterns of age of entry into adult community nursing posts? At what point in nurses career trajectories, does entry into this service area occur?

13. Are previously identified local initiatives²¹ which are designed to encourage more nurses to consider careers in adult community nursing, changing patterns and age of entry?

Ethnicity

Of the registered nurses (first and second level) with district nursing qualifications, whose ethnicity is known 9.1% are of black and minority ethnic (BME) origin²⁷, compared to 19.1% of all qualified nurses. This is an increase on the 4% reported in the 1996 (although it should be noted that there is a caveat with these figures that there may be inaccurate recording).²⁸ 5.8% of the community matrons are of BME origin. Data is not available separately for the other staff groups working in adult community nursing services.

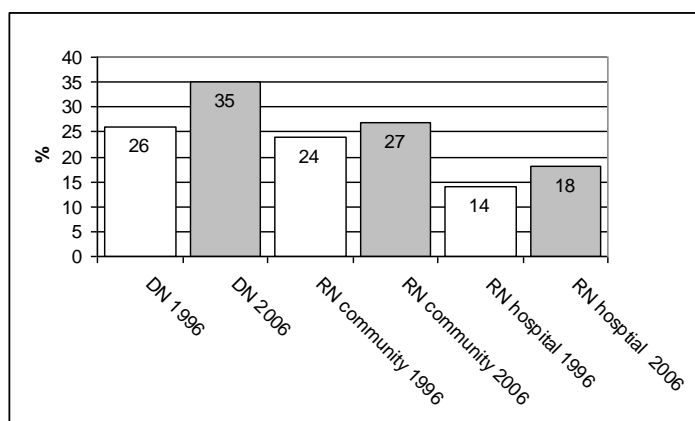


Chart A2.7. Percentage of nurses (HC) in selected staff groups aged over 50 1996-2006
Data source: Information Centre for Health and Social Care (2007). 2006 and Department of Health 1996
Non-Medical Workforce Census Detailed Results Table 4.2

Questions and Issues

14. Does local data demonstrate different levels of nurses of BME origin, more reflective of local communities? Does the national aggregated data mask the extent of representation in some services?

15. Are nurses of BME origin reflected equally through all types of posts and salary scales in adult community nursing (professionally qualified and support posts)?

16. Since the enlargement of the European Union, to what extent are nurses from EU countries represented in adult community nursing services?

6. Staff turnover indicators

Data is not readily available at an aggregate level of recruitment, retention and leaver rates in this workforce. Information on those with the district nurse qualification is most readily available. Data from the Office of Manpower Economics (OME) survey of matched PCT samples²⁹, suggests that the movement in this workforce reflects the wider nursing labour market influences of supply and demand. In the OME survey, the rate of district nurses leaving their post would appear to be generally lower than that for all qualified nurses (chart A2.8). However this has fluctuated and drawn closer to the higher leaver rates of all qualified nurses in 3 out of the past 7 years (Chart A2.8).

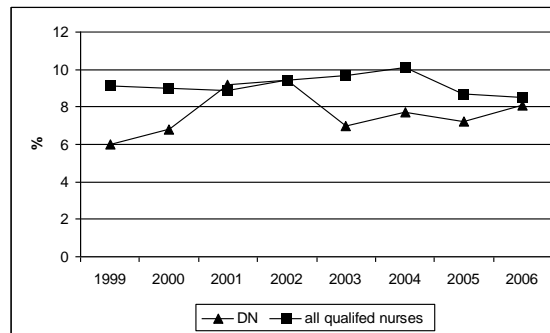


Chart A2.8. Rate of district nurses 'leavers' in matched sample PCTs 1999-2006.

Data Source: The Office of Manpower Economics Workforce Surveys for the Review Body on Nursing and Other Health Professions 1999-2006

Given the age profile of nurses with district nurse qualifications it is not surprising that the rate of retirement is higher than all qualified nurses. It is noteworthy that the rate has decreased in 2005 and 2006 to match that of all qualified nurses (Chart A2.9). This may be an indication of the effect of the wider nursing labour market on decisions to retire. Although the rate of three month vacancies (i.e. posts unfilled for three months or more) for nurses with district nurse qualifications has remained relatively stable until the marked decrease in 2006 (Chart A2.10).

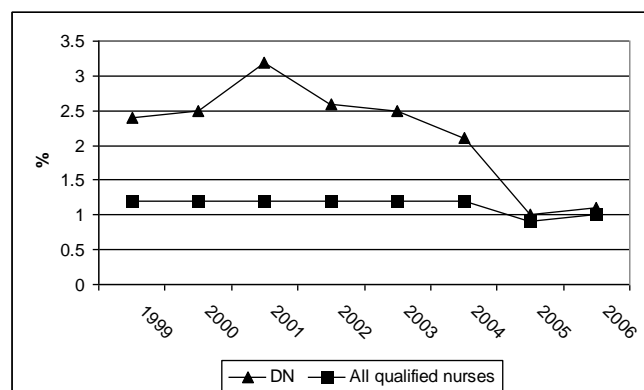


Chart A2.9. Retirement rate of district nurses in matched sample PCTs 1999-2006.

Data Source: The Office of Manpower Economics Workforce Surveys for the Review Body on Nursing and Other Health Professions 1999-2006

While the overall mean rate for vacancies for district nurses and other registered nurses was 0.7%, the range reported in the Strategic Health Authorities (as at March 2006) was 0% -4.4% for district nurses and 0% -3.5% for other registered nurses³⁰. This indicates that in some primary care organisations there has been a higher vacancy rate as indicated in previous years²¹.

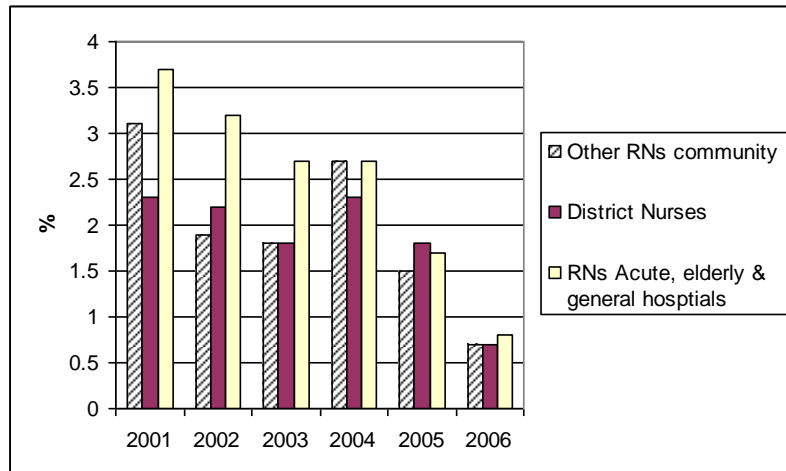


Chart A2.10 Comparison of 3 month vacancy rate between groups 2001-2006
 Data Source: Department of Health Vacancy Surveys 2001, 2002, 2003, 2004, NHS Health and Social Care Information Centre Vacancies Survey, 2005 and 2006.

Conclusions

The past ten years has seen a growth in the numbers and full time equivalents employed in NHS adult ambulatory and home care community nursing services in England. The greatest increase has been within the registered nurse group, although there is no means of identifying career trajectories, experience or professional education prior or at their entry to this service area. Organisational boundary changes make it difficult to assess whether the increase has been consistent across the country over this time period. The ratio of fte nursing resource to the over 65 population shows a regional variation that requires further investigation to establish whether it reflects other resources in the local health economy or a continuation of historical variation. This workforce remains predominantly female with greater numbers in older age bands and in part time posts than equivalent staff groups in the NHS acute, elderly and general hospital sector. There are few nationally aggregated staff turnover indicators. The few indicators that are available suggest that this is a workforce increasingly sensitive to supply and demand factors in the wider nursing labour market.

Paper 3

Nurses Employed in General and Personal Medical Services

General and personal medical services are the primary care services provided through the NHS under either a GMS (general medical services)³¹ or PMS (personal medical services)³² contract between mainly general practice and a local primary care organization. This paper examines:

- The size and growth of the practice nursing workforce,
- Full and part-time working,
- The distribution of this workforce,
- The demographic changes in this workforce,
- Indicators of change in turnover in this workforce.

NB Some PMS contracts are held by provider arms of PCTs for patient groups such as the homeless, a small number are now held by independent companies, while a very small number are held by general practice professionals other than GPs.

In comparison to other groups of nurses in community services, there is relatively little data available on nurses working in general practice. A national survey is currently underway through the Working in Partnership Programme due to report later in 2007³³. For the purposes of this report grey literature (i.e. unpublished reports) was drawn on from previous work³⁴ and sought from Workforce Development Sections of every Strategic Health Authorities, practice nurse e-groups, and the RCN Practice Nurse Forum.

1. The size and growth of the nursing workforce in general practice

At September 30th 2006 there were 23,797 qualified nurses employed in general practice (a nursing resource of 14,616 fte³⁵). Within this total number it is not possible to quantify the nurses working as nurse practitioners. While anecdotally the numbers of health care assistants employed in general practice are growing it is not possible to extrapolate the numbers either. In 2005 268 fte qualified nurses from community services were seconded to PMS pilots³⁶, compared to 130 in 200³⁷.

This fulltime equivalent workforce has grown by 23% between 1996 and 2006 (Chart A3.1). However, the growth has not been linear over this period. The fte increase 1997/1998 was only 0.2% compared to 4% growth in 1998/1999 and 6% in 2005/2006.

Possible explanations for the marked growth in some years are the introduction of general practice contract financial incentive schemes such as the introduction of local development schemes from April 1998³⁸, the introduction of the new GMS (and PMS)³¹ contract in 2004 with quality and outcome framework (annually amended)³⁹ amended 2005 and 2006).

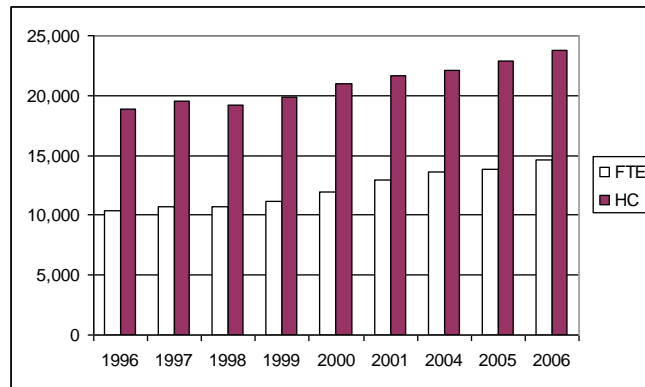


Chart A3. 1 The number and fte of qualified nurses employed in general practice
Data source: The Information Centre for health and social care and the Department of Health. General and Personal Medical Services England Detailed Tables. Table 4 for the years 1996 -2006.

The rate of growth of the fte nursing resource also varies between Government Office Regions (Chart A3.2) with the South East (i.e. South Central and South Coastal Strategic Health Authorities) showing the greatest rate of increase while the North East has a small decrease.

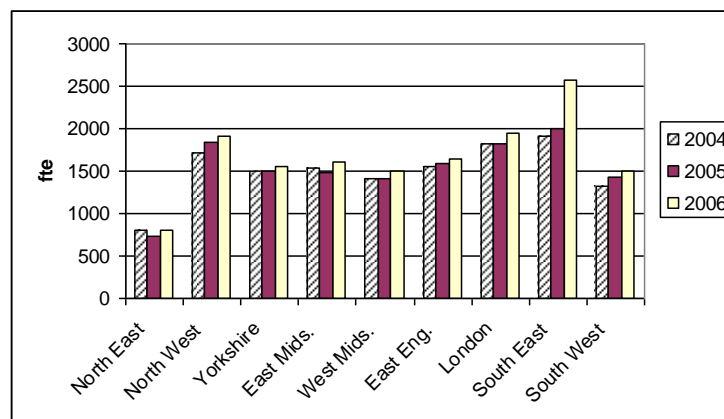


Chart A3.2 The qualified nursing resource (fte) in government regions 2004-2006
Data source: The Information Centre for health and social care and the Department of Health. General and Personal Medical Services England Detailed Tables. Table 4 for the years 1996 -2006.

Questions and Issues

1. Does the growth in numbers reflect a growth a skill mix and grade mix in nursing in general practice or not ?
2. To what extent can career progression occur within one practice employer or does career progression require changing employers?
3. Has the 2004 new GMS contract influenced the types of work the nurses are undertaking and as consequence the type of clinical and professional education required?
4. Following the 2004 new GMS is there greater demand for nurse practitioners?
5. Will the regional trends for growth continue or has the impact of the new 2004 GMS contract on demand for practice nursing peaked by 2006?
6. What is the career trajectory into practice nursing in the areas with increased demand? Is it different from those areas for very low demand for practice nurses?

2. Full and part time working

As Chart A3.1 indicates the number of qualified nurses by headcount is much greater than the fte, indicating a substantial amount of part time working. It is not possible to specify the amount of part time posts but the ratio of 0.61 nurse by head count to each fte gives some indication of the level of part time working. In 1996 the ratio was 0.55 nurse by headcount to each fte, suggesting the number of hours worked by individual nurses has increased.

Overall the ratio of headcount to fte suggests greater part-time working than other groups such as the registered nurses in the community adult nursing (See Paper 2). However, there is some evidence that employment practices in some areas may be changing. Table A3.1 compares fte and hc between Government regions between 2003 and 2006. It suggests that in some areas the growth in the nursing resource results in an increase in employment hours of individual practice nurses. For example in the Yorkshire Region there is an increased fte of 64 but only an increase in headcount of 13. Other areas appear to continue with very part-time employment e.g. the South West Region has an increase of 164 fte but the number of nurses employed has increased by 269.

Questions and Issues

7. Will the trends towards greater hours per nurse continue and the demands for nurses decrease or will the level of part time posts continue with the demand remain the same?

Government Regions	Change in FTE 2004-2006	Change in HC 2004-2006
North East	-7	43
North West	186	200
Yorkshire	64	13
East Midlands	78	392
West Midlands	89	25
East of England	90	87
London	137	-8
South East	663	630
South West	164	269

Table A3.1 Comparison of change in practice nurse workforce by Government Regions
Data source: The Information Centre for health and social care and the Department of Health. General and Personal Medical Services England Detailed Tables. Table 4 for the years 1996 -2006.

3. The distribution of the practice nurse workforce

The distribution of practice nurse resource varies across England with a range of 22 fte/10,000 in the London StHA area to 66fte/10,000 in South Central StHA in 2006. The South East Region has had a higher ratio of fte practice nurses to population than other regions for some time³⁴.

Strategic Health Authority (StHA)	Practice nurse fte* /10,000 population all ages**
North East	32
North West	28
Yorkshire and The Humber	31
West Midlands	30
East of England	27
London	22
South East Coast	46
South Central	66
South West	30

Table A3.2 Ratio of practice nurse fte to population

*Data source: The Information Centre for health and social care . 2006 General and Personal Medical Services England Detailed Tables. Table 4.

** Data Source: Office of National Statistics. 2004 mid-year estimate - resident population based on the ONS National Population Census 2001

Questions and issues

8. How is the ratio of practice nurses to population affected by other elements of primary care service delivery or contracting? Is it affected by, for example, the availability of GPs, or the levels of primary care organization contracting for locally enhanced services in general practice?

9. To what extent does the ratio of practice nurses to population reflect other population factors such as the Department of Health's indicators of additional need?⁴⁰

4. The demographics of the workforce

There is no national demographic data on this workforce. Local surveys in 5 parts^{41 42 43 44 45} of England suggest this group of nurses are female and predominantly over the age of 35 with the majority aged 40 to 55. A national practice nurse survey is currently being undertaken as part of the Working In Practice Partnership (WIPP)³³ and may provide an update on the 1992 practice nurse census figures⁴⁶.

Questions and issues

10. To what extent do the practice nurse workforce reflect the age profile and career trajectories of the adult community nursing workforce or do these two different groups have different profiles?

11. What is the percentage of male practice nurses, do male nurses consider it a career option and is there any demand for male practice nurses for specific populations or GMS/PMS services?

5. Indicators of change in turnover in this workforce.

Like most nursing groups in primary care there is little aggregate information on indicators of turnover such as rates of staff leaving or retiring.

There are indicators of a very stable workforce in some areas e.g. three local surveys report that a high proportion of nurses have been in post 10 years or more^{42 43 45} and less than one percent planned to leave or retire in the coming year⁴¹.

The Department of Health has included practice nurses in its annual general practice vacancy sample survey since 2005. The survey report estimated from the sample of practice returns that there was a 0.6% three month vacancy rate of practice nurse posts per 100,000 populations in 2006⁴⁷. The authors calculate this was a 0.2% reduction from the previous year's estimate. They estimated that 6 Strategic Health Authorities (as at March 2006) had a 0% vacancy rate e.g. Dorset and Somerset and that those with the highest levels were in London and Essex. This reflects the regional variation in vacancy rate and reduction in recent shown in the wider nursing workforce as well as adult community nursing (see Paper 2).

Questions and issues

12. Given the apparent stability of the workforce, do practice nurses mainly only leave posts on retirement? Are the patterns of practice nurse post movement in different types of areas e.g. rural, suburban, inner city, GMS additional need areas?

6. Conclusions

The England nursing workforce in general practice continues to grow year on year, although there are regional variations and steady state in one region. The introduction of the 2004 new GMS contract and subsequent changes to the incentivised quality and outcomes framework may have had a direct impact on the demand for practice nurses in many areas. Changes in ratios of headcount to full time equivalents over time suggest that, while part-time working predominates, there is a shift to more hours being worked by individual nurses in many areas. The little that is known about the demographics and turnover of this workforce suggests it is predominantly female, middle aged workforce with stability in post. Estimates suggest a 2006 drop in three month vacancy rates, in keeping with trends demonstrated across nursing, but there are regional variations, notably in London. Data on this workforce is very limited. In the light of the continued growth of this sector, many questions are raised concerning career trajectories and the associated education and training.

Paper 4

The nursing workforce in community contraception / family planning services

1. The size of the qualified nurse workforce

The estimated fte resource in the 'other' registered nurse staff group was 728⁴⁸ across England from the Department of Health Non Medical workforce Census September 2006, using assumptions described in Paper 1. However, specific workforce census undertaken by the Faculty of Family Planning and Reproductive Health Care reports higher numbers although they include some Brook Clinics in their figures. They report the fte nursing resource for community service contraception/family planning clinics (including Brook clinics) has increased to 845.2 from 630.32 fte across England between 2004⁴⁹ and 2006⁵⁰. NB. Brook Clinics are part of the Brook Advisory Centres for people under 25, run by an independent charity www.brook.org.uk. In many areas the NHS commissions Brook Advisory Centre Clinics rather than provide separate NHS clinics targeted at young people.

On further analysis, it is apparent that the increase is not equally distributed and masks reductions in the nursing resource into this type of provision in three regions (Chart A4.1). This does not necessarily equate to a reduction in service as it may be provided differently e.g. through general practice and have a direct impact on that segment of the nursing workforce.

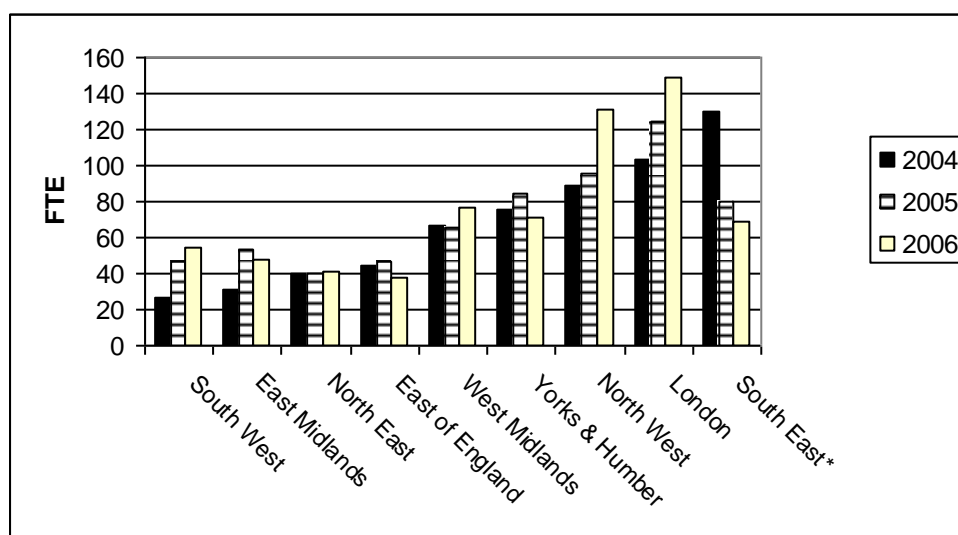


Chart A4. 1 Regional trends in fte nursing resource to contraceptive/family planning services
Data source: Faculty of Family Planning and Reproductive Health Care Workforce Census 2005⁴⁹ and 2007⁵⁰.

* combines South East Coastal and South Central Strategic Health Authorities

The ratio of fte nurse resource in community family planning and contraceptive services to population of women aged 15-44 years ranges 1fte per 10,610 women in the North West Region to 1fte per 28,864 women in the East of England Region (Chart A4.2).

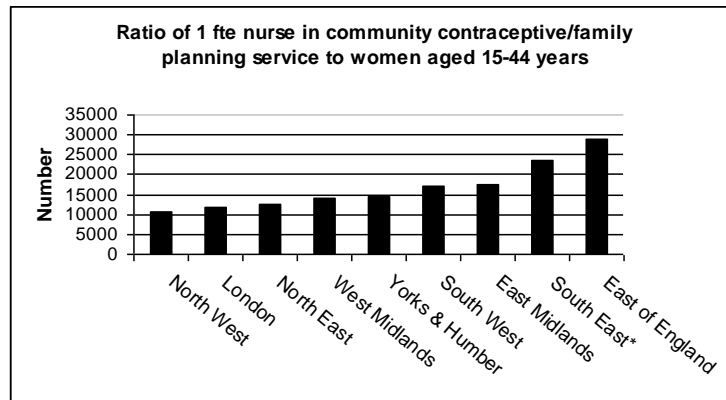


Chart A4.2

Data source: Faculty of Family Planning and Reproductive Health Care Workforce Census 2007⁵⁰ and the Office of National Statistics Census 2001⁵¹

* combines South East Coastal and South Central Strategic Health Authorities areas

2. Pattern of Working

The nursing resource in these services has a preponderance of sessional staff as demonstrated by the very high headcount in comparison to the fte (Chart A4.2). It is noticeable that between 2004 and 2006 there has been a reduction in the headcount of nurses in comparison to an increase in FTE suggesting a trend of a greater number of hours worked by a smaller number of staff.

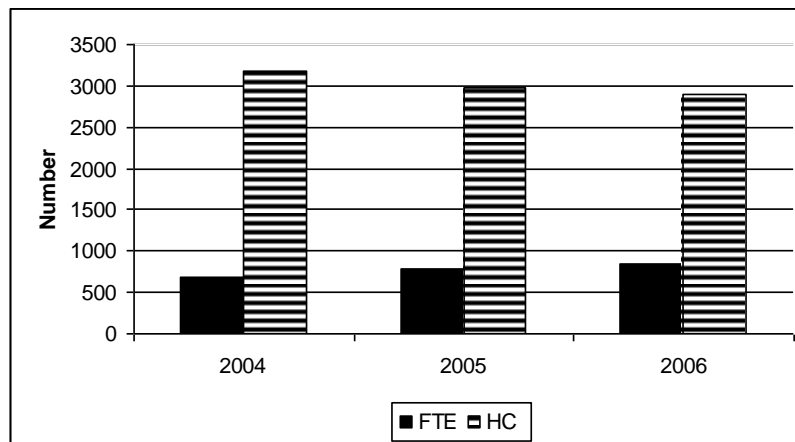


Chart A2.4 Nurses in family planning/contraceptive services England 2004-2006.

Data source: Faculty of Family Planning and Reproductive Health Care Workforce Census 2005 and 2007.

3. Other demographic and workforce data.

There is no other data available to describe the demographics or workforce trends in this group of nurses.

Questions and Issues

1. What is the career trajectory for nurses into sessional work in contraceptive/family planning services?
2. Do sessional nurses in these services work in other NHS services (and if so what services) or have multiple part-time contracts with other contraceptive or independent sector services?
3. What are the career pathways of those nurses working sessionally for multiple employers, and how is their professional development supported?
4. What is the demographic profile of these nurses?
5. What are the turnover levels?

Paper 5.

The primary care nursing workforce resource to children, young people and families

This paper examines:

- The total primary care nursing workforce for children, young people and families,
- The trends in the community services nursing workforce for children, young people and families,
- The distribution of this workforce,
- The demography of this workforce,
- The trends in full and part-time working,
- Indicators of turnover in this workforce.

It raises questions and issues as part of the discussion of each of these items.

1. The total primary care nursing workforce for children, young people and families

Using data assumptions outlined in Paper 1, there is an estimated qualified nursing and support to nursing resource of 14,708 full time equivalents (fte) and 19,581 staff (i.e. by headcount) deployed in services for children, young people and families across England (Chart A5.1).

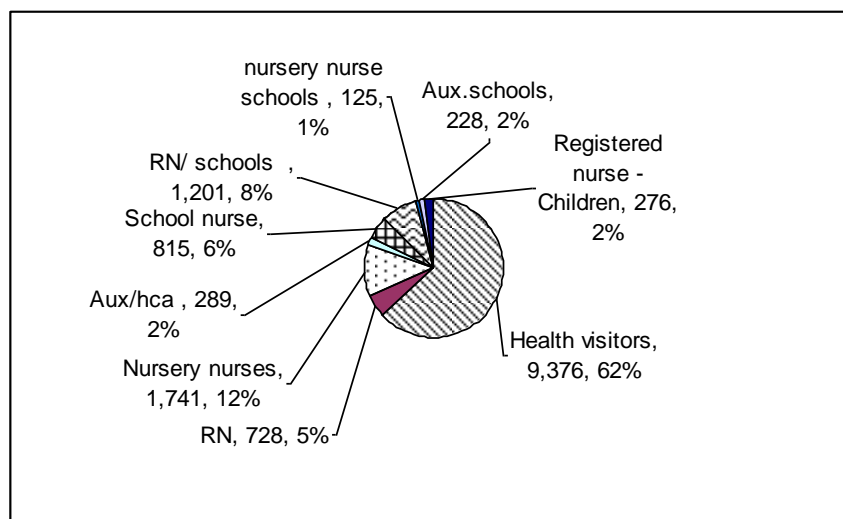


Chart A5.1 Distribution of the nursing and support to nursing resource (fte) in community children and family services

Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census & Information Centre for Health and Social Care. General and personal medical services in England: 30 September 2006- Detailed Results Tables 1.2 and 1.5 .

There are some limitations and omissions to this calculation including:

- There are some nursing resources not included in this calculation e.g. practice nurses who may be involved in children and family work such as immunisation programmes but as only part of their work. Paper 3 considers the practice nurse workforce in more detail,

- Groups such as nurse consultants and modern matrons in community services are not included as it is not possible to discern from national figures which service they are working with,
- Some children's nursing services in the home may be provided as outreach from a hospital and therefore impossible to disaggregate that resource from the total hospital resource,
- While some health visitors in some areas work with older people rather than (or as well as) children with their families, it is not possible to quantify this resource although previous activity data would suggest it is small⁵².

2. Trends in the nursing workforce to children and families in community services

Using assumptions outlined in Paper 1 it is possible to estimate the overall nursing resource trends for children and families (Chart A5.2). The overall trend has been of an estimated 18% growth in full time equivalents in this service: 12,053 fte in 1996 compared to 14,779 estimated fte in 2006. The rate of growth was most marked between 2002 and 2004.

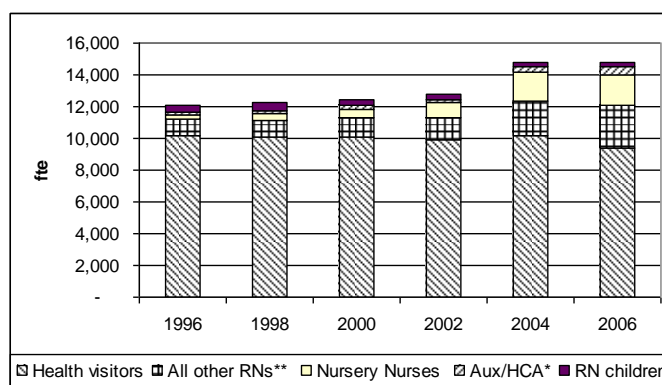


Chart A5.2. The nursing resource in children and family community nursing services 1996-2006
 * Aux/HCA= Nursing Auxiliaries and HCAs (estimated as 3% of total in community services). **All other RNs (excludes registered children nurses and is estimated as 8% of total in community services). Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census in England for the years 1996, 1998, 2000, 2002, 2004 and 2006.

NB. The attribution of other registered nurses to working with families and children needs to be treated with some caution as some areas may have employed RNs as part of the health visiting service to work with older people.

Data on staff in the school nursing service have been collected separately only since 2003 and for the purposes of the calculations for Chart A5.2 included in the other groups.

Within the overall growth, there have been changes indicative of an increased skill mix with the largest increases in the nursery nurse and registered nurse resource. From 1996-2004 the fte resource in health visiting has been static although the numbers by headcount increased (Chart 5.3). This has been accompanied by a small growth in registered nurses in these services but more noticeably by a growth in the numbers and fte resource of nursery nurses, particularly since 2002. From 2004 to 2006 there has been a reduction health visiting resource in fte and numbers.

One contextual element that should be noted is that in 2005 there were 9,721,000 children under 16 (of these were 2, 893, 000 were aged 0-4) in England compared to 9,985,000 in 1996 (of these 3,125,000 were aged 0-4)⁵³. This is a reduction of 264,000 children under 16 (232,000 aged under 4).

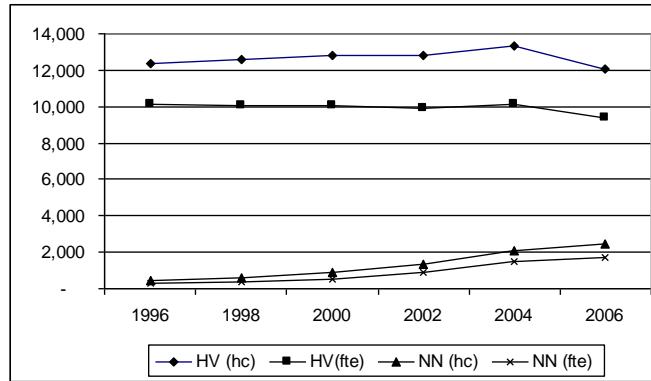


Chart A5.3 Health visitors and nursery nurses 1996-2006

Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census in England for the years 1996, 1998, 2000, 2002, 2004 and 2006.

The nursing resource to school health demonstrates growth overall as well as an increased growth in all groups (Chart 5.4) over the period that the Department of Health non medical workforce census has categorise staff in school nursing separately.

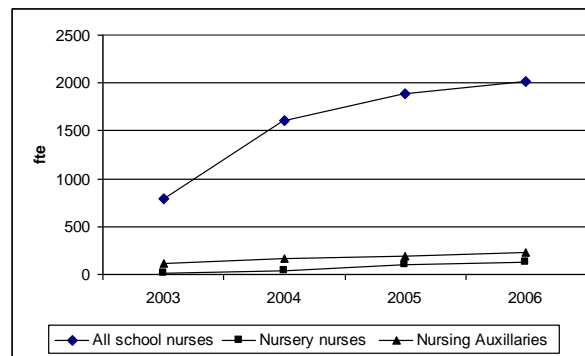


Chart 5.4 Qualified nurse and support to nursing resource in school health 2003-2007

Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census in England Detailed Tables for the years 2003, 2004, 2005 and 2006.

The employment of registered nurses- children in community services shows a decline over the past 10 years in community services (Chart A.5.5) but this may be a result of greater outreach from or growth in paediatric hospital services.

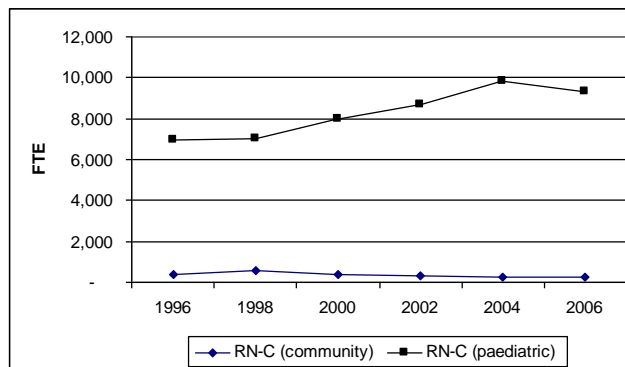


Chart A5.5. The Registered Nurse- children resource in community and paediatric services 1996-2006

Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census in England Detailed tables for the years 1996, 1998, 2000, 2002, 2004 and 2006.

Questions and Issues

1. To what extent is the overall growth taking place in the generic health visiting and school nursing service or in other types of teams e.g. Sure Start and Children's Centre initiatives, youth offending teams, looked after children teams?
2. Is the growth the result of greater financial investment or an increased grade and skill mix in the health visiting and school nursing teams with the same financial resource or a mixture of both?
3. The focus on data gathered by qualification and the absence of data on those in team leader roles (or Agenda for Change bands) makes it difficult to interpret the organisational structures and scale of potential career pathways.
4. What educational qualifications do those in senior clinical roles leading teams of others have in these services? Given the decline in NHS employer commission and sponsorship in the one year programme of specialist community qualifications, what has this been replaced with? And is it in a portable form between employers?
5. Given the growth in nursery nurses in community children and family services, what are the career routes and options for this group?
6. Has paediatric services outreach replaced community services paediatric nursing? Has this influenced education and training of these groups? Has it helped develop clearer career routes for registered children's nurses?

3. Trends in full and part time working

For all groups of staff the headcount is greater than the fte indicating that there are part time posts. It is not possible to quantify the volume of part time posts but it would appear to be more common in some groups of staff than others e.g. the ratio of 1 RN in school nursing by headcount is to 0.68fte compared to a health visitor ratio of 1 by headcount to 0.77fte. (NB Many areas use school term time only contracts for school nurses). There are however, this ratio has changed over time for some staff groups. In 1996 in health visiting the ratio was of 1 headcount to 0.81 fte compared to 2006 when it had changed to 1 head count to 0.77 fte indicating greater part time working. The ratio for nursery nurses had changed in the other direction in the same time period, from 1 to 0.64 to 1 to 0.70 fte (Chart A5.6), indicating a greater number of employment hours to individual nursery nurses. Overall these figures suggest a greater amount of part time working when compared to the acute, elderly and general hospitals where the ratio for registered nurses is 1 nurse by headcount to 0.8 fte.

Questions and Issues

7. Has the level of part-time posts changed as a response to the available workforce or a demand for physically more people to respond to requirements for partnership working with many other organisations? Is the level of part-time posts changing again as the supply of nurses from the wider nursing labour market increases?

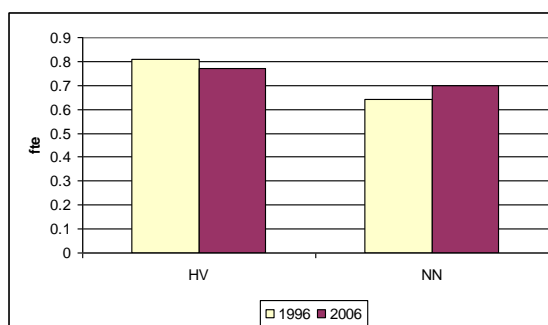


Chart A5.6 Health visitors and nursery nurses 1996-2006
 Data sources: Information Centre for Health and Social Care and Department of Health Non-Medical Workforce Census in England for the years 1996, 1998, 2000, 2002, 2004 and 2006.

4. The Distribution of the Workforce

This group of staff work across children, young people and families but it is difficult to quantify families at English population level. The child population 0-15 (n= 9,721,000 as at 2005⁵³) has been used to calculate the ratio of children and families community nursing resource (fte) across government regions. Table A5.1 demonstrates that this ranges from 5 fte/10,000 children aged 0-16 to 16fte/10,000. Comparison with indicators of deprivation suggest that the distribution may reflect an inverse care law⁵⁴ (i.e. higher resource levels in areas of lower need) although comparison of resource distribution at primary care organisation level may offer a different picture.

Questions and Issues

8. To what extent does the ratio of community nursing resource to population of children and young people reflect the other scale and activities of other services in that locale e.g. practice nurses, children's centres, local authority young people's services, paediatric services?

9. Does this resource ratio to population reflect additional population indicators such multiple indicators of deprivation?

Government Region/Strategic Health Authority	Population aged 0-15 ⁵⁵ n= (% children living in income deprived households ⁵⁶)	Ratio of estimated nursing resource FTE** per 10,000 0-16 population
North East	475,100 (26%)	5
North West	1,337,900 (23%)	14
West Midlands	984,600 (21%)	10

Yorkshire and the Humber	822,400 (21%)	8
London	1,067,100 (28%)	11
East Midlands	1,077,800 (18%)	11
East of England	1,490,000 (15%)	15
South East (Includes both South East Coast & South Central SHA)	1,580,500 (14%)	16
South West SHA	926,400 (16%)	10

Table A5.1 Ratio of estimated community services nursing resource to 10,000 population 0-16years by Government Region /Strategic Health Authority (SHA) 2006.

**Includes HVs, all RNs & N.Aux in school nursing, all nursery nurses in community and school nursing , 3% other RNs, N.Aux and HCA in community services.
Source Data: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census 2006 Detailed Tables 2.2and 2.5

5. The demographic profile of this workforce

Gender

This workforce is predominantly female, with men comprising just over 1% of these staff groups in community services in comparison to 4% of registered children nurses in paediatric services and 31% of RNs in community psychiatry (Chart A2.6). Over the last ten years there have been small increases in the percentage of men in health visiting (2006 n=157), school nursing (2006 n=28, 0.8%) and nursery nurse (2006 n=19). This increase contrasts with the paediatric services and community psychiatry which has seen a decrease in male nurses over 10 years.

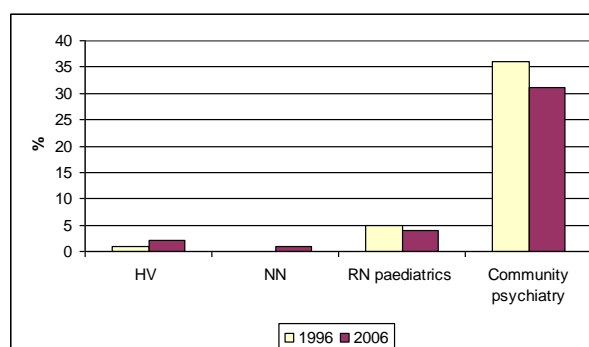


Chart A5.6 Percentage of male qualified nurses in selected staff groups 1996 and 2006.
Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census Detailed Results. Table 3.2.

Questions and Issues

- 11. To what extent does the seemingly higher levels of part-time RN posts in children and family community nursing service attract female nurses rather than male nurses?
- 12. Are male and female nurses and nursery nurses retained in the community nursing services to the same extent?

Age

The age distribution of the qualified nurses in the community services is skewed towards the older age bands in comparison to those working in the hospital sector. 80% of health visitors are aged over 40 (Chart A5.7) compared to 72% of district nurses and 43% of registered nurses in acute, elderly and general hospital sector.

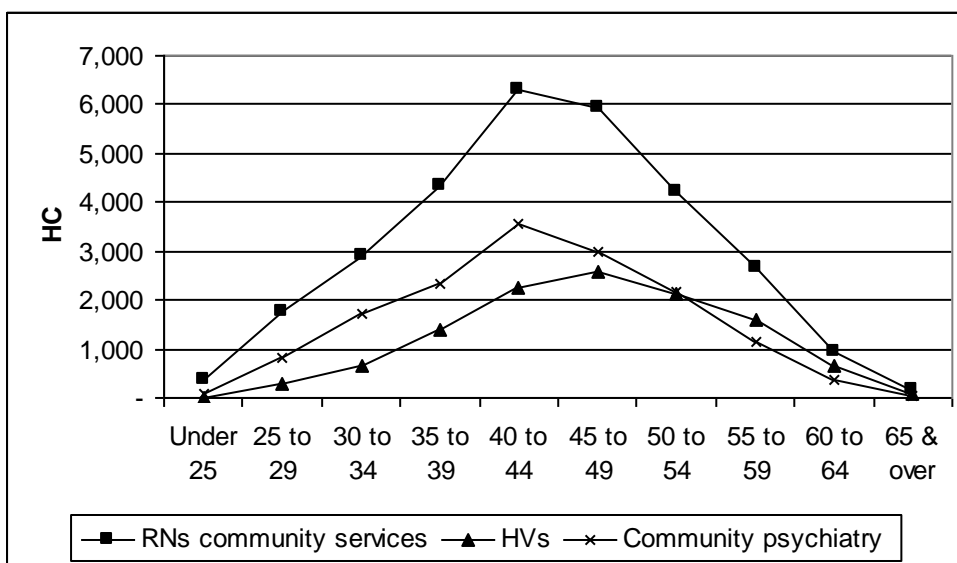


Chart A5.7 Comparison of age band distribution between selected groups of qualified nurses
Data source: Information Centre for Health and Social Care. 2006 Non-Medical Workforce Census Detailed Results. Table 4.2

The comparatively greater numbers of older nurses in community services has long been recognized⁵⁷. The trend for increased percentage of the staff group to come from those aged over 50 is not confined to the adult community services (see Paper 2 Chart A2.7). However, in the last ten years the percentage of health visitors aged over 50 has increased from 30% to 37% compared to a 3 % and 4% increase in the ‘other’ RN (registered nurse) staff group in community services and the general hospital staff group respectively.

Questions and Issues

- 13. What are patterns of age of entry into children and family community nursing posts? At what point in nurses career trajectories, does entry into this service area occur?
- 14. Are previously identified local initiatives²¹ which are designed to encourage more nurses to consider careers in children and family community nursing, changing patterns and age of entry?

Ethnicity

Of the health visitors and school nurses whose ethnicity is known 10% and 7% respectively are of black and minority ethnic (BME) origin⁵⁸, compared to 19.1% of all qualified nurses. This remains about the same for health visitors since 1996 (although it should be noted that there is a caveat with these figures that there may be inaccurate recording).⁵⁹ Data is not available separately for the other staff groups working in adult community nursing services.

Questions and Issues

15. Does local data demonstrate different levels of nurses of BME origin, more reflective of local communities? Does the national aggregated data mask the extent of representation in some services?

16. Are nurses of BME origin reflected equally through all types of posts and salary scales in adult community nursing (professionally qualified and support posts)?

6. Staff turnover indicators

Data is not readily available at an aggregate level of recruitment, retention and leaver rates in this workforce. Information on those with the health visitor qualification (or specialist practitioner health visitor) is most readily available. Data from the Office of Manpower Economics (OME) survey of matched PCT samples⁶⁰, suggests that the rate of health visitors leaving their post exceeded that of all qualified nurses in 2004-2006, although previously had been lower (chart A2.8).

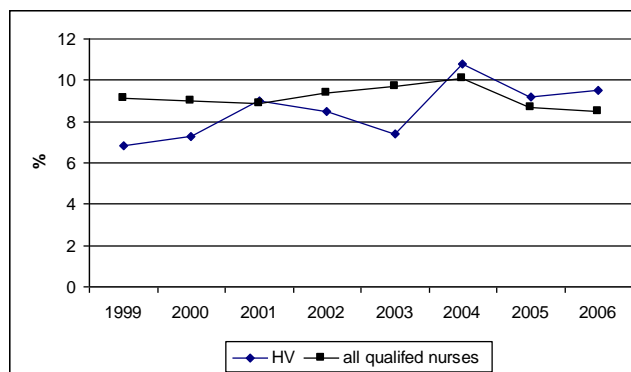


Chart A5.8. Rate of health visitor 'leavers' in matched sample PCTs 1999-2006.

Data Source: The Office of Manpower Economics Workforce Surveys for the Review Body on Nursing and Other Health Professions 1999-2006

Given the age profile of health visitors it is not surprising that the rate of retirement is higher than all qualified nurses (Chart A5.9). While there was a dip in 2005, the rate increased again in 2006. This may be an indication that the state of the wider nursing labour market does not have significant bearing on health visitors' decisions to retire. This is supported by some evidence from the same survey that leavers from health visiting are more likely to exit the NHS than other groups of nurses⁶⁰. There is no indication at a national level as to whether they move into other public sector workforces such as local authority children services or education.

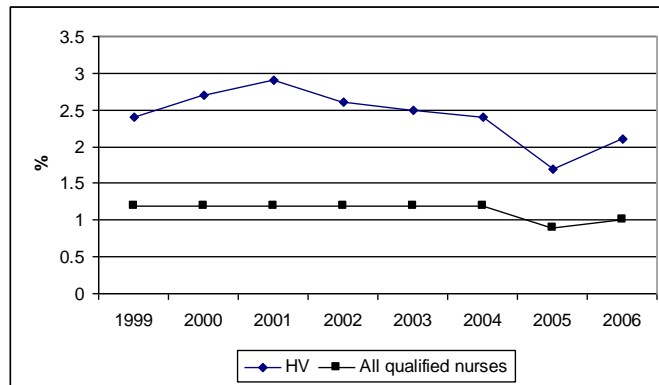


Chart A5.9. Retirement rate of health visitors in matched sample PCTs 1999-2006.
Data Source: The Office of Manpower Economics Workforce Surveys for the Review Body on Nursing and Other Health Professions 1999-2006

The rate of three month vacancies (i.e. posts unfilled for three months or more) for health visitors and school nurses (only collected from 2003) remained relatively static until the marked decrease in 2006 (Chart A5.10), a decrease in common with all nursing groups. The range reported in the Strategic Health Authorities (as at March 2006) was 0% -4.4% for health visitors and 0% -3.5% for school nurses⁶¹. This indicates that in some primary care organisations there has been a higher vacancy rate as indicated in previous years⁶².

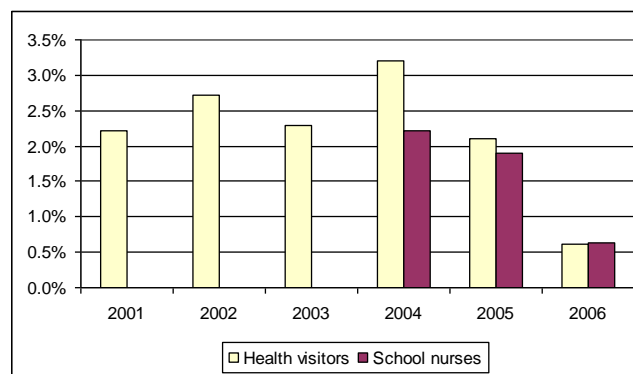


Chart A5.10 Comparison of 3 month vacancy rate between groups 2001-2006
Data Source: NHS Health and Social Care Information Centre Vacancies Survey, 2006 Table 8.

Conclusions

The past ten years has seen a growth in the numbers and full time equivalents employed in community children and family community nursing services in England. The greatest increase has been within the nursery nurse (a qualification outside of the remit of the Nursing and Midwifery Council) and registered nurse group. There is currently no means of identifying career trajectories, experience or professional education prior or at their entry to this service area. Organisational boundary changes make it difficult to assess whether the increase has been consistent across the country over this time period. The ratio of fte nursing resource to the 0-15 population shows a regional variation that requires further investigation to establish whether it reflects other resources in the local

health economy or a continuation of historical variation. This workforce remains predominantly female with greater numbers in older age bands and in part time posts than equivalent staff groups in the hospital sector or other segments such as community psychiatry. There are few nationally aggregated staff turnover indicators. The few indicators that are available relate to health visitors and suggest they are group exiting the NHS at a higher rate than other groups of qualified nurses.

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