



# Vision

*Focusing on the future  
of district nursing*

**DN150**

150TH ANNIVERSARY OF DISTRICT NURSING  
1849-2009

# 2020 Vision

## *The Queen's Nursing Institute's vision of the future of district nursing*

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“We have recruited and consulted a large group of experienced district nurses who have helped us in our deliberations.”



## Introduction 2020 Vision

The Queen's Nursing Institute is delighted to be celebrating 150 years of district nursing in 2009. The Institute itself was set up in 1887 to train, supply and support nurses to care for people in their own homes. We continue to improve nursing care in the home today, by providing support not only to district nurses, but all other nurses working outside hospitals.

We plan to mark this anniversary year by leading the celebrations of district nurses' immeasurable contribution to patient care; by developing our support to them and their successors in years to come; and by addressing the very important question of the role of district nurses in the health services of the future.

This report is our first contribution to this latter commitment. We have called it '2020 Vision' because we have tried to take a clear and focussed look at what district nursing is and what it does. We have also tried to take the longer view, to see how district nurses might best contribute to primary health care in the next decade, towards the year 2020.

In preparing this report, we have talked to many district nurses about their working lives today. We have recruited and consulted a large group of experienced district nurses who have helped us in our deliberations. We have also carried out a survey of district nurses with the help of the British Journal of Community Nursing. And some of our professionally-qualified trustees have contributed a valuable non-district nursing perspective.

We have also looked carefully at Government policies on primary care and community-based services across England, Wales and Northern Ireland, mindful that no service or specialism should develop in isolation from the context in which it is delivered. Our sister organisation, QNI Scotland, has provided briefing on developments affecting district and other community nurses north of the border. From these different sources, we have tried to assess the state of district nursing today, and to visualise its future in the next decade.

I hope that policy makers, service commissioners and managers, and district nurses and their teams, will find this report a useful starting point for thinking about the future role of the district nurse.

150 years on, and in a very different world, it is time to reflect on and re-evaluate the vital contribution of nurses who specialise in caring for people in their own homes.

Rosemary Cook CBE  
Director, The Queen's Nursing Institute

“It is time to recognise the significant difference between nursing in clinics, surgeries and other clinical premises in primary care; and nursing in patients’ homes.”



## Executive summary

- The values and beliefs that inspired district nursing from the beginning still drive district nursing today: the importance of keeping people at home where they want to be; the relationship between nurse and patient as the prime therapeutic tool; the need to work with the whole family and their carers as a unit; the importance of expert assessment and care, both clinical and social; and the need to promote coping and independence, both practical and psychological.
- District nursing work remains both preventive and supportive. It can also be highly technical, risk-taking, intensive and practical. The nature of the work is unpredictable and changeable; it requires district nurses to be responsive, flexible and adaptable. There are inherent contradictions: district nursing is autonomous, but highly dependent on its networks and contacts; it is responsive to demand, but has to be proactive in managing both long-term and short-term patients; district nurses are intensely proud of their specialism, but also keen to integrate with other teams on a day to day basis.
- The volume of district nursing work undertaken makes it a significant contributor to health services, especially given a growing older population and increasing prevalence of long-term conditions. Even if caseload reviews have reduced current work by a percentage, the contribution to reducing hospital costs and improving people’s lives is enormous. Support for carers, not counted in the official figures, is another significant dimension of district nurses’ work in the home. Both patients and carers greatly value the support of district nurses.
- District nursing services are currently being diluted by loose use of the title, wide variations in pay banding and career structure, reduction in leadership opportunities and lack of recognition of the value of their specialist education.
- It is time to recognise the significant difference between nursing in clinics, surgeries and other clinical premises in primary care; and nursing in patients’ homes. Each needs different skills, training, aptitude and leadership. We should celebrate and develop the home as a setting

“There is no need to ‘reinvent’ the district nurse. It is however time to reinstate the district nurse.”

for health care in the future. Technology will radically change the nature of care that can be delivered in the home, but it will only be acceptable and successful if it is matched by relationship-based, expert nursing care. Both the basic IT infrastructure and investment in developing nurses’ confidence in technology is currently lacking in many cases.

- There is no need to ‘reinvent’ the district nurse. It is however time to reinstate the district nurse. Neither political expediency (enthusiasm for new roles and titles) nor political correctness (integration at the cost of specialisation) should obscure the fact that:

- o there is a huge and growing need for nursing in the home, as both politicians and patients want more care to move out of hospitals

- o nursing in the home is fundamentally different to nursing in clinical-type settings, in hospital or in primary care, and district nurses are specifically qualified to do it; and

- o the principles of district nursing that have lasted 150 years still fit the bill today: in today’s terminology, they are known as ‘better care, closer to home’, ‘patient choice’, ‘integrated care’, and ‘co-production’.

- The current sense of confusion about district nursing’s role can be set aside if district nurses are recognised as ‘practitioners, partners and leaders’ of care in the home, with contributions from specialists as required; while many other nursing colleagues deliver their expert services in the clinical settings of practices, health centres and community hospitals.

- It would be wrong to isolate and protect district nursing from the trend towards commissioning and staffing services on the basis of patient needs and service pathways. It would also be foolish to ignore the opportunities arising from new types of organisation delivering nursing in the home. Instead, district nursing should be seen as a body

“The next decade of primary care expansion ... is uniquely suited to district nurses' specialist skills.”



of specialist knowledge and practical skills that can contribute to many of these pathways – particularly acute care in the home, care of long term conditions and palliative care – as part of an integrated service designed around patient needs.

- The next decade of primary care expansion, which will include much more care in the patient's home supported by information and care technologies, is uniquely suited to district nurses' specialist skills. They should have confidence that they have what primary care needs: the trust of patients and families, the unique skills to nurse in domestic settings, and the vision to lead others in this most challenging of territory.

“Sometimes, great good can arise from tragic circumstances, and this is certainly the case with the origins of district nursing.”

## Chapter 1: District nursing beginnings

Sometimes, great good can arise from tragic circumstances, and this is certainly the case with the origins of district nursing. In 1859, Lucretia Rathbone was dying, just a few days after the birth of her fifth child. Her husband William, a wealthy Liverpool merchant, employed a private, hospital-trained nurse to care for her, and was greatly impressed by 'the great comfort and advantage derived from trained nursing, even in a home where everything which unskilled affection could suggest was provided'. This experience provided the impetus for philanthropic activity which lasted throughout his lifetime, and the lives of his successors for four generations.

After his wife's death, Rathbone decided to engage the nurse *'to go into the poorest districts of work Liverpool and try, in nursing the poor, to relieve suffering and teach them the rules of hygiene.'* The nurse was shocked at the poverty and misery she encountered, and wanted to leave after only one month. However, she was persuaded to stay, and provided with some assistance. Her employer reported that *'she was able to do great and certain good... patients who had been given up as hopeless by the doctors; patients who, without the assistance of skilled nursing, would have been hopeless even in well-provided homes, were restored to health by the aid thus afforded.'* From this beginning, a system of organized home nursing was born.

### Training

When it became apparent that all Florence Nightingale's well-trained nurses were required for hospital work, Rathbone paid for the building of a training home in Liverpool, to prepare nurses for work in people's homes. For administrative purposes, Liverpool was divided into eighteen districts based on the parish system and so the nurses became known as 'district nurses'. Their work was to be strictly non-sectarian and each district had a voluntary Ladies Committee, which decided the scope of the work to be undertaken. It also raised the necessary funds to employ the district nurse and maintain the nurses' home. The day to day management of the nurses' work was undertaken by a Lady Superintendent (not a nurse) who would also decide whether or not to provide any aids or appliances which the patient might need.



“Queen Victoria decided that the money collected ... to celebrate her Golden Jubilee should be directed to support the nursing of the sick poor in their own homes.”



### **Spreading the model**

Rathbone's organisational model of district nursing spread rapidly, and Nursing Associations were set up in towns and major industrial cities rife with overcrowding, poor sanitation and epidemic disease. Some included private nursing to boost their funds, while others placed more emphasis on sanitary reform or religious missionary work, through the work of 'bible nurses', particularly in London, where the Ranyard Mission was the largest employer of district nurses well into the 1920s.

Florence Nightingale, who had been acting as an advisor to the Liverpool experiment, wrote to Rathbone in 1867: *'I rejoice that your District Nursing is likely to be imitated in the East of London, you know I shall never think that we have done anything in London until we have nursed not only all the hospitals and all the workhouses, but have divided London into convenient districts for the sick poor.'*

The next major step forward was taken when Queen Victoria decided that the money collected by the women of England to celebrate her Golden Jubilee should be directed to support the nursing of the sick poor in their own homes. A committee was set up in 1874 to explore how this could be accomplished. By this time Rathbone was a Member of Parliament, and, given his experience in Liverpool, he was seen as the obvious choice to lead developments in the capital.

### **Origin of the Institute**

Rathbone and his fellow trustees proposed that the best use of the endowment was to set up an Institute for the training, maintenance and supply of nurses for the sick poor. The Queen Victoria Jubilee Institute was founded in 1887, and ultimately became responsible for the whole of the district nursing service. In the ensuing decades, the Institute changed its name several times, becoming the Queen's Institute of District Nursing in 1928, and known today as the Queen's Nursing Institute (QNI). William Rathbone X, the great-great-grandson of the founder, is a trustee of the QNI today.

Steered by Rathbone and Florence Lees (later Mrs Dacre Craven), who was a nurse colleague of Nightingale, the Institute developed a rigorous programme for the training and examination of district nurses,

“The nurses were more than attendants on the sick poor, they became social reformers and regenerators of the homes of the poor.”

and inspection of the services which they provided. Miss Lees' stated motivation was to raise the quality and standard of education and training for nurses to make it 'a profession fit for women of cultivation'. This was no mean feat in an era when nurses and nursing had a poor reputation. In Liverpool, for example, when a review of hospital nursing proposed to raise the salary of nurses, William Rathbone concluded that *'Any ordinary nurse of that time, if paid more than the usual salary of £10, would most probably have incurred dismissal for drunkenness after the first quarter day.'*

#### **'Queen's Nurses'**

It is testament to the foresight and determination of Florence Lees that the quality of the training and inspection regime devised by the Institute became nationally and internationally recognised, and that the title of Queen's Nurse became synonymous with a high quality service. Archibald Williamson said in an address to the Jubilee Congress on District Nursing held in Liverpool in 1909: *'the nurses under Mr Rathbone's careful guidance were more than attendants on the sick poor, they became social reformers and regenerators of the homes of the poor.'*

The district nursing role expanded in the early decades of the twentieth century in response to changes in society brought about by the First World War, and the state registration of nurses in 1919. In addition to their intimate work with the sick, district nurses were increasingly to be found as community midwives, in mother and baby clinics, visiting schools and assisting GPs with major and minor surgery in the home. Nursing handbooks well into the 1930s give detailed instructions on how to set up and prepare a room in the home for major operations such as amputations, mastectomies and nephrectomies.

During World War II, district nurses across Britain nursed air raid victims and injured service personnel in addition to their routine duties in homes and clinics. Until this period, all district nurses were female and unmarried (although this latter restriction had been removed during wartime) so the decision of the QNI to offer training to male nurses in 1947 was groundbreaking.

“The 150th anniversary provides an important opportunity to draw lessons from the past, and prepare for the future, of what William Rathbone called *'the story of a successful experiment'*.”



The next major change came with the advent of the National Health Service in 1948 when local authorities became responsible for the provision of a home nursing service. Councils could directly employ district nurses, or continue to use district nursing associations as agents, but in either case they became funded by public rather than voluntary monies.

With the rising cost of the health service becoming apparent, the subject of post-registration education for district nurses became contentious, reflecting opposing views on the need for professionalism and specialism. A report by the Ministry of Health in 1953 which discussed the concept of the 'domiciliary team' raised questions about the nature and length of training, with many familiar arguments. The Armer report which was finally accepted by Government considered that there was no need for a statutory body to control training, but a central body (The General Nursing Council) was to be set up to issue a syllabus and a national certificate, with the QNI and local health authorities responsible for training. This situation continued until 1967 when the QNI withdrew from training.

In 1973, the NHS Reorganisation Act saw district nursing come into the health service, under the remit of area health authorities. The three decades since have been characterized by regular organizational restructuring, and continued debates about appropriate education and training for district nurses.

We are now once again in a situation where public health issues are to the fore, and the role and title of the district nurse is under scrutiny. The 150th anniversary provides an important opportunity to draw lessons from the past, and prepare for the future, of what William Rathbone called *'the story of a successful experiment'*.

“The report also made clear that the district nurses’ approach and attitude in delivering care to the individual was crucial to the quality of the patients’ experience.”

## Chapter 2: Patients’ and carers’ views

After 150 years of change and development, and with the growing recognition of the importance of listening to patients, what do patients and their families think about modern district nurses and the care they provide in the home?

There is surprisingly little research specifically on this question. More than 2.6 million people receive care from district nurses each year, in England and Wales alone, according to the most recent statistics gathered nationally (1). One in four people over the age of 75, and one in two of those aged over 85, will receive care from a district nurse (2). Many other services to the public of comparable size would be the subject of regular and intensive consumer research. However, recent national studies of healthcare outside of hospital have focused on services provided by general practice and nurses employed by general practitioners, rather than community nursing services (3).

The last major national survey of district nursing services, including patients’ and carers’ views, was carried out by the Audit Commission, and published in 1999 (2). ‘First Assessment’ summarises the impact of district nursing services on patients and families with these words:

*‘All patients valued the relationship with the nurses. However, being able to establish a ‘one to one’ relationship beyond the ‘professional’, and liking and trusting the person who comes into your home and on whom you are dependent, are perceived by patients to be particularly important to the quality of their care. They felt that they got personal attention at home which was lacking when they visited a clinic and also felt that the nurse knew more about them and their needs.’*

### What patients say

The reassurance and sense of safety provided by district nurses was summed up by patients who said:

*‘I love the fact that they’re there and they’re available if we needed them. I think it’s vital to have that freedom.’*

*‘Well, the most important thing is that I’m not being neglected. I’ve got*

“Patients who were alone talked about the value of this relationship for its social contact.”



*something that is not right and they will come and do something about it.'*

The report also made clear that the district nurses' approach and attitude in delivering care to the individual was crucial to the quality of the patients' experience:

*'If someone comes into your house, and it's come on do that or do this ... you're made immediately to feel a stranger in your own home.'*

*'I had a nurse come a few years ago and she didn't seem to care about you ... she just come in and poked the needle in and that was that you know, and she didn't talk or make you feel comfortable, and she never used to ask how you were (4).'*

Overall, the research undertaken for the Audit Commission report identified what was special and important about nursing provided by district nurses in people's homes:

*'For patients and carers the district nurse was the health professional they saw most frequently. Kindness and professional skills were highly valued and the nurse as an approachable member of the health care system also had a role as advocate, confidante, and liaison person with other services. This was 'their nurse' who knew them and they felt cared for them. Patients who were alone talked about the value of this relationship for its social contact, patients who were in pain or worried about their condition talked about the value of the professional knowledge and skills. Carers talked about the value of professional knowledge and emotional support.'*

### **Changing context of care**

A more recent and much smaller study in Northern Ireland (5) identifies the context in which district nursing (and other forms of community nursing) is undertaken today as:

'... a power shift away from the health professional towards the consumer that is characterised by:

- Choice as a fundamental ideology

“ Nearly half [of patients] said they felt more comfortable dealing with their community nurse than their GP. ”

- An increase in well-informed, assertive consumers
- An increase in perceptive questions from the public about provision of health and social care
- Increasing individual access to health information that was previously held by professional gatekeepers
- The challenging of professional autonomy and increasing empowerment of consumers; and
- Increased access to best evidence through the Internet and other media’

Questioned about the nature of community nursing services they received, the patients in this survey had some interesting ideas about what they wanted: nearly half said they felt more comfortable dealing with their community nurse than their GP; 86% agreed that the concept of the nurse being able to prescribe medication within a GP practice is very appealing to members of the public; and 71% agreed that *‘members of the public prefer one type of nurse to visit them at home rather than a variety of different nurses’*.

## Carers’ views

The views of informal carers – members of the family or others who have an unpaid role in caring for a sick person at home – are equally important to an understanding of the role of district nursing today. Almost six million unpaid carers are estimated to provide care worth £87 billion a year which would otherwise have to be provided by publicly-funded services (6). Every day, another 6,000 people take on caring responsibilities (7). The district nurse’s role in enabling and supporting carers is essential to the maintenance of this network of care.

The Audit Commission report (2) notes that:

*‘Carers also had needs ... for psychological support. They value the nurses’ attention to the patient for whom they were looking after and also value the time the nurse gave them to listen to their own concerns – they needed to trust her judgement and rely on her confidentiality. The feeling that resources were available for when they just couldn’t manage any longer helps them to carry on and to feel cared for.’*



“District nurses are the face of the NHS for many patients outside of hospital.”



A large survey of 5,000 carers (8), carried out by the Carers National Association (now Carers UK), was unequivocal in its message about the importance of district nurses to carers' ability to cope. The survey asked which NHS staff had the most power to improve their life as a carer, which had been most effective in providing them with help and information, and which had given the most practical support.

District or 'community' nurses came second only to GPs in their ability to make a difference to the lives of carers, and in providing help and information. They were ranked alongside GPs as the most important staff in giving practical support. More than half of carers who had not had visits, help or advice from a district nurse believed that they would have found it helpful.

One nurse, writing about the experience of care at home for her father, put it more starkly: '*...the skilled, knowledgeable nurse is a godsend to those of us who have been burdened by the work of monitoring the performance of a rag bag of unskilled, unknowledgeable or demotivated workers (9).*'

## Summary

It is clear from both published research and individual feedback from patients that district nurses provide an essential and much-valued service. They help huge numbers of people to manage at home instead of going to hospital. They support the enormous and crucial network of informal carers that saves the health service millions of pounds. Their professional knowledge and skills encompass the technical and practical, analytical and facilitative, emotional and psychological. And their approach and attitude is as important to the quality of care as their professional repertoire of skills.

District nurses are the face of the NHS for many patients outside of hospital: the most frequent contact, the most important in providing practical support, and a key confidante and support for both patients and carers. In short, as 'First Assessment' puts it: 'this was 'their nurse ...'.

“She has a way of making you feel at ease with her. We have often been reassured by her when we have been concerned about something.”

<p><b>Patient feedback on district nurse for Queen's Nurse application</b></p>	<p><i>'We trust her judgement completely. She has a way of making you feel at ease with her. We have often been reassured by her when we have been concerned about something. She is always very positive and caring - we know we can talk to her about absolutely anything that we are worried about.'</i></p>
<p><b>Patient feedback on district nurses for Queen's Nurse application</b></p>	<p><i>'I used to be left here, I didn't seem to be going nowhere, some week the doctor could be here 3-4 times but since [the district nurse] has come I am better and not so ill. We get a straight answer out of her, she listens to our side, she doesn't push her opinions, she helps us to choose what we want. She has never judged me. She doesn't push her views, she listens she asks to do things before she does them which shows respect.'</i></p>
<p><b>Nurse's comment on case of her father at home</b></p>	<p><i>'Do we need expert nursing care? Yes. It has improved the lives and wellbeing not just of my father but of my siblings and our families as the terror of watching the inept do their worst resulted in the need to police them so that harm to Dad was kept to a minimum and so that he could receive barely good enough care.'</i> (9)</p>
<p><b>Carer's comment on night nursing service</b></p>	<p><i>'We had so much support during the day but it was very frightening during the night, as my husband was in so much pain. If it had not been for the [nurses] visiting during the night, I could not have coped.'</i>(10)</p>

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“She has never judged me. She doesn't push her views she listens she asks to do things before she does them which shows respect.”



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“Other common aspects of district nurse work today include clinical work that would once have been carried out only in hospitals or by doctors.”

## Chapter 3: District nursing today

### Who they are

The qualified district nursing workforce in England today numbers just over 10,000 (1). In Scotland there are around 1,000 district nurse specialist practitioners. There are just over 1,000 district nurses in Wales and the same number in Northern Ireland. In England, there has been a decrease of 23% over the last decade, though there has been overall growth of 38% in the full time equivalent resource of qualified nurses in community services in this period. This compares to 29% growth in the hospital sector (2). Including support posts, there has been a 47% growth of total resource (2) with more than 31,000 'other' Registered Nurses and more than 15,000 support posts in adult community nursing services. District nursing is a 96% female workforce. 72% of district nurses are aged over 40 (compared to 43% in the acute sector), and 71% of support post holders are over 40. Between 1996-2006, there was a 9% increase in those aged over 50. Nine per cent of district nurses are of minority ethnic origin (2).

### What they do

The patients that district nurses care for can be categorised by the nature of their needs (3): regular; short-term (which may mean very intensive support); limited involvement (assessment only); phlebotomy only; or additional – including those who attend clinics, need annual flu jabs,

#### **Box 1: Services provided by district nurses in County Durham and Tees Valley (3) (apart from assessment):**

- Advice and support
  - Phlebotomy
  - Injection
  - Wound care
- Monitoring/screening
- Contenance management
  - Pain control
  - Pressure area care
- Administration of medicines
  - Bowel care
  - Peg feeding
  - Equipment
- General nursing care
  - Skin care
  - Health education

or receive proactive 'outreach' services. A study of district nursing workload across County Durham and Tees Valley (3) found that the most common diagnostic categories for district nurses' patients were anaemias and other deficiencies, continence problems, cancer and health threats such as hypertension. Diabetes, heart conditions, abscesses and ulcers, wounds, and mental health and addiction problems, also featured. The services most frequently provided by these nurses are shown in box 1.

“Caseload management is important to ensure that workload is reasonable, risks to patients are minimised, and scarce resources are used to best effect.”



Other common aspects of district nurse work today include clinical work that would once have been carried out only in hospitals or by doctors: prescribing, urinary catheterisation, intravenous therapy including cancer chemotherapy, and end of life care. Medication reviews, risk assessment, bereavement care, inter-agency referral and patient advocacy are key skills (4). Teaching, mentorship and preceptorship, data collection and audit, and leadership of a team of nurses and support workers, are also part of the role (5). Delivering this package of skills and knowledge well builds confidence in patients and families that can keep them at home when they would otherwise have needed a hospital admission or an ambulance transfer to an accident and emergency department (6).

Asked to describe the three main elements of the DN role, respondents to the QNI/BJCN survey offered these summaries:

1. 'Holistic assessment of patients and their families
2. Enabling complex care to be organised and provided at home
3. Working with patients, multi-disciplinary team and families to provide unique care for individuals.'

And:

1. 'Managing complex healthcare within patients' own home
2. Managing a team of staff working unsupervised
3. Liaising with many different services.'

The workload generated by each nurse's caseload of patients is a product of the frequency of visits, length of each visit, and duration of the period of engagement with the patient (3). Caseload management is important to ensure that workload is reasonable, risks to patients are minimised, and scarce resources are used to best effect. A multi-phase caseload management exercise in Northern Ireland showed that, as definitions of caseload activity can vary greatly between teams in the same areas, and sometimes bear no relation to population size or characteristics, a large caseload does not necessarily mean a high workload (7). Individual working styles and perverse incentives to maintain patient numbers,

“The district nurse uses good clinical assessment skills and confident decision-making, together with accurate feedback from her community nursing team, to ensure that the right people get the right care at the right time.”

amongst other factors, impact on workload - see box 2. The district nurse, as the caseload manager, uses good clinical assessment skills and confident decision-making, together with accurate feedback from her community nursing team, to ensure that the right people get the right care at the right time.

**Box 2: Factors impacting on caseload and workload of district nurses (7)**

- Needs of the local population
- Time out for nurses, such as attending courses
- Patient dependency
- Caseload management - clinical decisions about patient care/visits, planned reviews and when a patient should be discharged
- The medical practice of the GP, influencing the number of referrals received and the reason for them, especially one-off referrals.

**How they do it**

Thirty years ago, research began to be published that articulated the unique characteristics of community nursing (8):

- The complexity of working with people over whom the nurse had no authority
- The uncertainty of home environment, where the nurse is a guest with no right to enter or remain
- The centrality of the development of inter-personal relationships in order to undertake work and overcome lack of authority
- The challenge of maintaining boundaries of a paid professional delivering service in domiciliary settings, while keeping interpersonal relationship at a level to allow work to be undertaken
- The nurse provides a small amount of care, health maintenance and health promotion activities in comparison with patients and carers
- District nurses undertake activities at margins of their work role in order to maintain and continue relations with patients

“District nurses are the only professionals with no limit to their workload.”



- The assessment and care planning process is complex, using relationship building, detailed knowledge of local systems and contacts and internalised experiential knowledge.

The skills needed to work in this way are summarised in box 3.

### **Box 3: Skills needed as a nurse in primary care (9)**

- Developing networks of contacts through reciprocity and consciously creating working relationships
- Interpersonal skills and relationship building with patient, their family and networks
- Confident decision making in the absence of other professionals
- Creativity in problem solving in absence of specified care pathways and pre-determined infrastructure
- Learning from experience and acquiring internalised mental checklists

The district nurses who responded to our survey were clear about the skills they needed in their day-to-day work. These included:

- Clinical skills: holistic assessment and holistic care; wound care; palliative care; ability to cope with a range of illnesses; managing complex healthcare within the home; prescribing
- Management skills: delivery of care based on expressed need; ability to work autonomously; managing diversity; being flexible and adapting to changing situations; caseload management and care co-ordination (or, as a survey respondent summarised: 'communication, organisation, observation')
- Leadership skills: clinical leadership; providing education to staff and patients

“It is such a privilege to nurse and support patients at the end of their lives and often to have built up a relationship with them ... throughout their healthcare journey. I could ‘burst with pride’ being called a district nurse.”

- Strategic skills: knowledge of the local community, need and current services; being the patient’s advocate.

**In their own words** *‘District nurses are the only professionals with no limit to their workload; we do not have appointment slots or beds limiting the number of visits we are expected to see in a day. This is both a strength and a weakness because it means we risk taking on too many visits for the number of staff available.’*

*‘We do not put referrals to the ‘panel’ once a week. We give an answer immediately and fit in extra visits (to an already full day) as the need arises. On a ward, nurses become expert in one area of care and can easily get a second opinion or expert advice. In the community we are experts at getting the information needed to support our patients. To me, this means that we need a higher percentage of experienced nurses than might be expected. District nurses also learn a huge amount from most of their patients, many of whom have developed an extensive knowledge of their condition.’*

*‘Practical skills can be taught and transferred but to be a community nurse you need to be able to take risks and be prepared to be flexible and think laterally to enable patients to be cared for holistically and individually.’*

*‘I love the variety of my daily work. Over the past two years I have been visiting an elderly patient with cancer, being there to support both the patient and his wife as he has had several treatments including chemo. A week ago following hospital discharge he rapidly deteriorated and I ordered all relevant equipment – hospital bed mattress etc and arranged a care package to meet his needs. I liaised with GPs over MacMillan nurse and two days ago had set up a syringe driver. Today my patient sadly died. I was able to be there to support his wife and give last offices to my patient who died pain free with privacy and dignity in his own home.’*

“The expert clinical work of district nursing, broad as it is, provides only part of the picture.”



*His wife and family will remember the care he received for the rest of their lives. We only have one chance to 'get it right' it is such a privilege to nurse and support patients at the end of their lives and often to have built up a relationship with them over days weeks and sometimes years throughout their healthcare journey. I could 'burst with pride ' being called a district nurse.'*

*'I guess it is about making a difference. We sometimes walk into complete chaos and confusion. To be able to gradually support the patient and family, develop trusting nurse patient relationships and help turn chaos and confusion into comfort and hope. My experience over the years has enabled me to initially prioritise and solve the problem ... It is impossible to tackle everything in the first few visits, its about making the situation safe and manageable and empowering families to care for their loved ones at home if this is their first wish.'*

*'A day in the life ... 21 patients – 55 miles travelled. Skills involved: bowel care, diabetic care, eye care, dermatology, tissue viability, wound care, phlebotomy, Peg feeding, Portocath flushing. Liaison with GPs, and dealing with patient discharged from hospital without his medication or a signed medication form. Worked 8am -6pm. 2 hours over due to poor hospital discharge. How would the patient have coped without someone to sort out his problems with discharge if no district nursing service?'*

#### **Letter from a relative**

*'Thank you especially for all you did for Carol, and myself, and our family over the last few months. You got so many difficult balances just right. Efficient without being officious, cheerful and cheering without being brisk or matter of fact or ever hitting a false note, knowing when we needed help and when you could boost our morale by showing us how to help ourselves. Every time we had a problem you provided us with a means of coping with it. Always having time for an extra word with me or Carol's mother or other members of the family... We could not have wished for a better nurse or a better friend. You were really super. Thank you a thousand times.'*



“District nursing also requires management, strategic and leadership skills, and is built on inter-personal skills.”

## Summary

The expert clinical work of district nursing, broad as it is, provides only part of the picture. District nursing also requires management, strategic and leadership skills, and is built on inter-personal skills. It requires the assessment of a patient's whole situation, co-ordination of a network of care and support for the individual and their family, then re-assessment and flexible response over time. It builds the patient's and family's trust and confidence in the community services while fostering the individual's ability to self-care and cope. And in achieving this, district nurses every day '*help turn chaos and confusion into comfort and hope*'.

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“How did district nursing ... arrive at this state of anxiety and uncertainty?”



## Chapter 4: What is happening to district nursing

In 2006, the Queen's Nursing Institute published *Vision and Values – a call for action on community nursing* (1). This was designed to update a previous report, *District nursing – the invisible workforce* (2), which had been published by the Institute with the English National Board for Nursing, Midwifery and Health Visiting in 2003. The Invisible Workforce had reported on a service that felt its contribution was often unrecognised, and its practitioners were demoralised.

The findings in the Vision and Values report came from focus groups of district nurses, students and educators, held around England, Wales and Northern Ireland. There were some in the groups who saw interest and opportunity in the changes in the health service and in society - *'an opportunity to shift from demand-led to needs-driven provision'* – and believed in district nurses' capacity to do this: *'DNs are creative and adaptable – because we have to be.'* Many felt that they were not currently in a good position, however: *'we're not in control of the service we provide – we only do what others want us to do'* and *'we're an afterthought ... always last in the queue for resources'*. One acknowledged that *'the trouble is, traditionally, district nurses have refused to let go of things they should let go.'*

Overall, the groups described a district nursing profession in transition, concerned about its future and looking for support in four key areas:

- Professional and role identity
- Vision and leadership
- Influence and engagement
- Image and profile.

How did district nursing – a service so well appreciated by its clients, providing so much clinical, psychological and emotional support to more than 2.6 million people a year, and sustained for 150 years by the simple commitment to care for people in need in their own homes and communities – arrive at this state of anxiety and uncertainty?

There have been many external influences on district nursing in the last

“Within the profession, changes to pre-registration education have put more emphasis on preparation for the community.”

20 years. They include:

**Influences on district nursing**

- flagship Government policies on moving care out of hospitals that have increased the volume and complexity of work in the community
- numerous re-organisations of national health service bodies that have repeatedly changed nurses’ employers, managers, titles and ways of working
- devolution in Wales, Scotland and Northern Ireland, leading to increasing diversity in service delivery and commissioning models
- periodic financial pressures on service commissioners leading to vacancy freezes and increased work pressures
- the introduction of a national pay system, with discrepancies in assimilation into new pay bands for district nurses
- the demographics of a growing older population (and NHS workforce) with more long-term conditions
- improvements in out-of-hospital monitoring and treatment technologies, impacting on the scope and nature of care
- recent ‘productivity studies’ of community services carried out by private sector companies on behalf of employers; and NHS ‘productive community hospitals’ and ‘productive community services’ programmes, focusing attention on the detail of working practices.

Within the profession, changes to pre-registration education have put more emphasis on preparation for the community. A new review is again considering the best way to prepare nurses for both hospital and community careers. Protracted debates about post-registration specialist education and levels of practice beyond registration have created uncertainty about career paths and routes to progression.

**Developing roles**

The development of nursing roles, notably but not only prescribing, have opened up new areas of practice. Meanwhile, employers have developed the skill mix in district nursing teams, with major growth in general registered nurse (rather than DN-qualified) and health care assistant

“Amongst all these influences, both positive and negative, there is no single point of origin for the sense of decline described by many district nurses.”



numbers in primary care. This has been matched by a sustained decline in the numbers of qualified DNs, and in the numbers of nurses seconded for the DN specialist practitioner course.

There is now a growing number of specialist nurses in areas such as wound care, continence, palliative care and specific long-term conditions who visit patients at home and support and advise district nurses on care. In addition, the explosion in practice nurse numbers to more than 24,000 in 2007, has provided another option in practice-based nursing for ambulant patients.

Work in the United States under the title of 'Evercare' sparked Government interest in the intensive, nurse-led case management in the community of the relatively small number of patients most likely to be admitted to hospital. This led to the introduction of community matrons in England which in some places has been seen as taking away some of the district nurses' caseload and duplicating their role. However, some district nurses welcome this role both as a career option for themselves, and because of the support that community matrons offer with very complex patients.

## Reports on district nursing

Amongst all these influences, both positive and negative, there is no single point of origin for the sense of decline described by many district nurses in both *The Invisible Workforce* and *Vision and Values*. But one report could mark the starting point for the approach of many external observers of district nursing. The report of the Department of Health's Value for Money unit, published in 1992, looked at district nurses' tasks in their daily work. It recommended that more of this work could be delegated to other nurses, with higher grade district nurses becoming managers of care, and therefore that fewer qualified district nurses would be needed. This report has been criticised for focusing on tasks undertaken rather than knowledge deployed, '*result[ing] in qualified DNs being valued as managers rather than as providers of care*' (4) but workforce figures show that its recommendations have been implemented. An Audit Commission report in 1999, *First Assessment – a review of district nursing services in England and Wales* (5), also

“It would be a mistake to think that district nurses feel that all criticism of their service is unjustified.”

looked at the way that district nursing work is identified, managed and delivered. It identified a mismatch between resources, skills and demand. Both this report and a report from the Royal College of Nursing in 2006 recommended measures to control referrals to district nurses, including setting strict criteria to be used by the referrer to reduce demand, and identifying the nursing need before referral. Many district nurses would agree that inappropriate referrals can be a problem, particularly if the DN is used simply as a point of contact for community services, rather than the referral being for their specialist skills. Much time can be wasted by the need to return or redirect inappropriate referrals. However, systems that control referral have been criticised because they take the initial assessment of need – a core district nursing skill – away from district nurses and *'may serve to exclude the majority of patients who would benefit from their interventions and reduce the referrals community nurses will accept to a list of nursing tasks ... it also excludes the opportunities for community nurses to intervene proactively in health promotion activities.'* (7)

In short, district nursing has been judged on its daily tasks, rather than its whole role, as over-qualified for some of its work; and criticised for being too referral-driven and reactive. Attempts to control referrals to DN teams may have reinforced the reductionist view that their work consists only of a list of common nursing tasks undertaken in the home rather than in hospital. Fewer DNs are being trained, and a range of other general and specialist nurses, and health care assistants, are taking on the work in the home that once defined district nurses.

### **How district nurses respond**

It would be a mistake to think that district nurses feel that all criticism of their service is unjustified. The Vision and Values focus groups recognised that some of the assessments about traditional district nursing practice were valid. Nurses acknowledged that *'district nurses have refused to let go of things they should let go'*, and that some colleagues were *'dragging their feet'*.

But there is also plenty of evidence that DN teams around the country have been introducing new ways of working and developing new skills,

“13% of respondents' employing organisations no longer use the title 'district nurse' at all.”



as demonstrated in the preceding chapter. There has been a 'District Nursing Renaissance' project, pilots of telecare and remote monitoring involving district nurses, the development of hospital at home and rapid response teams, and 'virtual wards' in the community. District nurses have demonstrated that they improve services and save health service money: in one project 'within the first five months staff reduced non-elective admissions by 17% and achieved savings of £668,000 (8).

So, given all these influences and district nurses' responses to them, what is actually happening to district nursing today?

#### **QNI/BJCN survey**

The QNI and the British Journal of Community Nursing carried out a postal and online survey in 2008, gathering information and views from district nurses in England, Wales and Northern Ireland about the state of their specialism. This small snapshot survey cannot be representative of any of these countries as a whole, but provides information on the status quo in some district nursing services.

#### **District nurse title**

The survey found that:

- 13% of respondents' employing organisations (more than 1 in 10) no longer use the title 'district nurse' at all
- In those organisations that still use the title, more than 30% do not limit its use to those with a district nurse qualification: some use it for team leaders or case managers, with or without the qualification; some for all community nurses; and one respondent reports that it is used for community health care assistants.

Nurses said:

*'There is a drive to not recognise a district nursing service in the interests of integrated and interdisciplinary working'*

*'District Nurses had to fight hard to retain the title: managers wanted to call us nurse as the add-on to case manager'*

*'It would appear some senior managers do not 'like' the title and feel*

“‘I have been so proud to be called district nurse, we are all devastated about the loss of our title.’”

*community staff should be 'brought into this century'.*

*'I have been so proud to be called district nurse we are all devastated about the loss of our title. Management have told us we can 'call ourselves what we want.'*

*'I think the title has slowly been devalued and will probably disappear as community matron and case manager become more common.'*

*'It is one of the few nursing titles that actually mean something to the people who matter most. That is the public we serve, most people have a reasonable understanding that DNs look after poorly housebound people.'*

## **Education**

On education:

- 29% of respondents' organisations no longer second nurses to study for the specialist practitioner qualification (SPQ)
- Only 48% of employing organisations continue to require district nursing team leaders to have the DN specialist practitioner qualification. Another 19%, who do so now, plan to discontinue this requirement.

Most use modular courses or in-house training for community nurses as an alternative to the SPQ course.

Nurses said:

*'By not supporting SPQ [there is a] reduced specialist service [and] no robust leadership and the consequence [is] a diluted service and in five years plus we will see effects of lack of clinical leadership'*

*'I can see the advantage of offering a module training scheme. In practice I feel it is devaluing the DN qualification.'*

*'Since the 52 week DN course ceased 2 years ago due to financial constraints morale is low, recruitment and retention dire, and remaining staff exhausted and confused as to their roles and responsibilities.'*



“94% of respondents’ teams’ work is measured by number of patient contacts.”



*'There seems to be a lot of regional variation which leads to an inequitable service'*

*'On the whole the community workforce is on the 'mature' end of the workforce we need to be seen to be encouraging younger nurses in this field. This has affected the whole team of district nurses and morale and self esteem we feel we are not wanted or valued and our qualification is not worth the paper it is written on.'*

## **Pay**

Team pay bands:

- DN team leaders (with or without SPQ) are banded between 6 and 8 on the Agenda for Change pay scale (one respondent said there were no team leaders in their organisation; in others teams were led by either nurses or therapists)
- DNs with the SPQ vary from band 5 to 8, with most on bands 5 or 6

## **Measuring district nursing work**

Measuring district nursing work:

- 94% of respondents’ teams’ work is measured by number of patient contacts; in addition, 44% say that whole time equivalent staff in the team is measured; 16% say they are developing 'delivery of packages of care' as a measure; and 17% are working on using 'patient outcomes' in this way.
- Other measures include a 'capacity' tool, patient 'units' of time, patient satisfaction surveys, prevention of admission to hospital and early discharge, weekly workload analysis tool, audits such as hand hygiene, and balanced score cards e.g. how many patient visits with multi-disciplinary team, how many patient compliments, days lost through absence, number of pressure ulcers healed, numbers of patients admitted to hospital, number of patients on continence caseload and number of terminally ill patients.

Nurses’ comments on measuring their work recognise the importance and the challenges of being able to demonstrate both inputs and

“DN team leaders (with or without SPQ) are banded between 6 and 8 on the Agenda for Change pay scale.”

outcomes:

*'We collect daily activities and record on computer database. Our flexibility, adaptability and problem solving is not known beyond those who have contact with us.'*

*'Meticulous performance data collected 4 times each year: no. of contacts , no: of indirect contacts etc.'*

*'As an organisation we have introduced a dependency score system which helps monitor business of a team but this is not used by commissioners.'*

*'Takes admin time out of the day in order to do this but has been useful tool in showing level of workload.'*

... and the failure for many years to find appropriate ways to do this:

*'This has always been very poorly done with minimal feedback, very labour intensive for DNs, poorly thought out and often changed so no long term statistics or any meaning.'*

*'Very inaccurate picture of all that they do. Data collection facilities very poor resulting in poor reporting on activities.'*

*'Our activity data system is very basic and does not capture what we do. The type of visit is very vague and open to individual interpretation. We do use dependency scoring.'*

*'So much work is unmeasurable. The system we use to record our weekly data (comcare) is not a true representation of the visits we do or the time we spend with out patients.'*

Overall, the mood of respondents to the survey was downbeat. It can be summed up by the nurse who wrote:



“Overall, the mood of respondents to the survey was downbeat.”



*'Newly qualified RN's are 'running' the DN service. They have neither the knowledge or expertise to do so effectively and it is positively unkind and destructive to expect them to do so. The result is service delivery without confidence and expertise - resulting in over visiting to compensate... no doubt things will go full circle and someone will invent a skilled knowledgeable practitioner who –again!- will hold her budget, manage, reassure and look to service development and provision according to local need. Until then what resources there are will be trying to chase this week's hot topic.'*

### **The emerging picture**

We have tested the findings of the survey with our district nurse consultation group, and reviewed them alongside published articles about district nurses' experiences. The picture that emerges of district nurses and district nursing today is a mixed one. It reinforces with additional urgency the issues that were raised in the Vision and Values groups, and identifies some new ones:

- Identity – the title of 'district nurse' is already out of use in some areas, and diluted to mean any nurse working in the community in other places. It no longer means someone with district nurse specialist training, or someone with experience of working in the home and the ability to lead a team.
- Skills and knowledge for nursing in the home – the specialist practitioner qualification is no longer greatly valued by employers or commissioners of education, and no longer required in some places to lead a district nursing team. Analyses of district nursing work that focus only on tasks bely the complexity of nursing people in their own homes.
- Leadership and career development – with team leaders no longer necessarily nurses, or qualified district nurses, and team members, team leaders and case managers sharing the same pay bands, it is difficult for DNs to see a career path that values their specialist skills.
- Scope of the role – district nurses are performing a wider range of clinical interventions than ever before, but there are also many more specialist and generalist nurses in primary care

“There has been an enormous increase in unregistered support workers providing care in the home that would once have been undertaken by the nursing team.”

providing care to the same communities. There has been an enormous increase in unregistered support workers providing care in the home that would once have been undertaken by the nursing team.

### **Positive signs**

There are also positive signs:

- Measuring DN work – attempts are being made to measure outcomes, patient experience, and improvements in care such as avoiding hospital admissions and healed ulcers. This will help service managers and commissioners to understand and value the contribution of district nursing to local health services.
- Modular education – specific modules are being developed so that individual nurses’ learning needs can be met, and long secondments avoided, rather than using a standard 32 week course for all. This flexibility may not only help nurses develop the specific skills they need, but also enable employers to release staff more easily for training.
- Direct entry to primary care – more newly qualified nurses are working in the community immediately after registration, bringing fresh enthusiasm and ideas, and indicating a better appreciation that community nursing can be as interesting and challenging as hospital nursing. However, these nurses need the support of experienced and skilled district nurse teachers and mentors.
- Integration with other professionals – some respondents saw this as an appropriate way forward, providing more flexibility than uni-professional services, and leaving behind the tendency to professional protectionism.

### **Summary**

It is understandable that many district nurses feel that their role has been subject to a campaign of attrition and neglect over the last two decades. It has changed from being the sole, recognised and respected role delivering nursing care in the home, to one of many community roles at a variety of levels. The meaning of its unique title and the value of its specialist qualification have been eroded, and qualified district nurses can no longer assume leadership of their own teams.

“District nurses are still deeply committed to the vision and values of the original home nursing service.”



And yet, many district nurses are still deeply committed to the vision and values of the original home nursing service, summed up by two who wrote:

*'District nursing to me means building up relationships and trust with my patients within my own community where I get to be involved with people's whole lives ... understanding of where they come from. [I] find it a privilege to use my skills and knowledge to endeavour to support and help them through often difficult times.'*

*'[Best things about district nursing:] To be able to deliver good quality nursing care to a person in their own home which improves their quality of life even if for a very short period of time. To give back to a person the right to choice, dignity and a say in how they want their care to be given.'*

District nursing has been under tremendous pressure from changes in society, in the NHS, and in nursing. District nurses, possibly more than any other nurses, have seen their role questioned, examined and eroded, even as they have increased their technical skills, and in the face of evidence about the complexity of competencies required for home-based nursing. The professional ground has shifted beneath their feet, and it is no surprise that they are looking for a clearer path to guide them to the future.

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“[District nursing] has changed from being the sole, recognised and respected role delivering nursing care in the home, to one of many community roles at a variety of levels.”

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“District nursing has been under tremendous pressure from changes in society, in the NHS, and in nursing.”



## Chapter 5: The vision for 2020

It is readily apparent that community nursing has become much more diverse. District nursing is no longer the automatic career choice for nurses wanting a clinical nursing role outside hospital. Nor do providers of community services always see qualified district nurses as natural team leaders in primary care nursing. So have other roles now made the traditional concept of the district nurse redundant? Is district nursing, as some believe, in terminal decline?

### District nurses and change

District nursing is far from declining: rather, it has a once in a generation opportunity to step into a future for which it is uniquely suited. Our discussions with working district nurses, the evidence from patients and carers, and scrutiny of trends in healthcare demand, all provide overwhelming support for the role of the district nurse as the hub of nursing that is provided in the home. District nurses are ably and essentially supported by colleagues working in practices, specialist teams and community hospitals: the volume, acuity and complexity of care outside of hospitals today demands such multi-disciplinary and nursing collaboration. But district nurses' core skills remain the essential foundation for successful care in the home for the majority of people who need it, providing:

- comprehensive assessment
- advanced clinical skills
- the ability to manage risk
- the networks and relationships to co-ordinate a variety of services
- expert relationship-building with patients and families
- the cultivation of trust, knowledge and confidence in patients and carers
- 'stand-back' accessibility, to promote self-care without abandoning the needy.

This does not mean that nothing should change in district nursing. Over-visiting, opaque caseloads protected from scrutiny, and regimented boundaries around specific tasks, all undermine the importance of what skilled district nursing, flexibly deployed, brings to community care.

“District nursing has a once in a generation opportunity to step into a future for which it is uniquely suited.”

**Patient pathways** Equally, it would be wrong to try to isolate and protect district nursing from the trend towards planning and staffing services( 1), (2), and educating nurses both pre and post-registration (3), on the basis of patient needs and service pathways. Professional protectionism is a both a career cul de sac for the individual, and a sure way to marginalise a specialism. Instead, district nurses should see themselves embodying specialist knowledge and practical skills that can contribute to many of these patient pathways – particularly acute care in the home, care of long term conditions and palliative care – as part of more integrated services that cross many outdated boundaries.

This may mean that employers, titles and ways of working change: but district nurses should face these changes with confidence in their abilities and conviction of their place in home-based care. In 150 years, district nursing has passed successfully through the dawn of two new centuries, two World Wars and the advent of the National Health Service. Major changes in the structure, culture and nature of their work are not new phenomena. They have always been challenged, questioned and moulded to suit the times, as has nursing as a profession.

District nurses will need to move with equal confidence through the 21st century's challenges. Titles, employers, education and colleagues have changed and will continue to change. The knowledge and expectations of the public, and their access to health information, is a world away from the society of even 50 years ago. Technology, treatments and approaches to illness are continuously developing, changing the therapeutic landscape in which all health professionals practice. An overview of all these changes has concluded that there is a need for a different kind of nurse in future, and for re-defining nursing care, with nurses as '*practitioners, partners and leaders*' (4).

**Strengths of district nursing** One of the key strengths of district nursing is that its values and principles have not changed over 150 years: the commitment to accepting people as they are in their real lives, and to meeting their needs in their own homes; negotiating not imposing care, by building relationships with families; understanding and working with individuals in the context of

“District nurses should see themselves embodying specialist knowledge and practical skills that can contribute to many of these patient pathways.”



their families and communities; helping them to do as much as possible for themselves; and handing back responsibility as soon and as far as possible. These principles need not change, whatever the future configuration of services, teams or technological developments. They provide a firm foundation for the new description of nursing, and the tripartite role of practitioner, partner and leader in primary care.

### **Towards 2020**

Government policy across the United Kingdom is focussed on treating more people outside of hospitals, for economic as well as ideological reasons. The demographics of a rising older population, and the increasing prevalence of serious, long-term conditions, mean that primary care must expand to meet increasing demand. Meeting this demand in hospitals is unaffordable, as well as inappropriate.

Commissioning and organising services on the basis of a headcount of particular kinds of specialist is increasingly being replaced by a focus on the patient's journey through healthcare and the right mix of skills to meet their needs. The education and preparation of many health care professionals is also changing to reflect this pathway approach. Across the UK, there is a new era of reflection on what nursing is, as well as what nurses do (4). In England, a new programme of work is specifically aiming to 'transform' community services, focussing on six service areas, six transformational changes, and the attributes for practice and leadership needed to do this (2).

As the expansion of care outside hospitals continues, it is clear that two complementary, but different, forms of primary care are developing.

- Primary care delivered in clinical settings, such as health centres, practices, community hospitals, walk-in centres and polyclinics, which have an administrative and practical infrastructure similar to hospitals, including large-scale equipment, multi-disciplinary teams, shared IT systems and shared records. People feel and are treated more like hospital patients, with travel, appointments, queuing, waiting and knocking on doors. Hospital-type procedures



“The demographics of a rising older population, and the increasing prevalence of serious, long-term conditions, mean that primary care must expand to meet increasing demand.”

(medical consultations, investigations, treatments, operations) take place in these settings.

- Primary care delivered in homes and residential settings, where the individual patient controls access and 'owns' the premises, the encounter is usually one-to-one, and portable equipment and records are brought in as needed. It is less visible, less protected and less predictable: it needs to be infinitely adaptable as every set of premises and every family within them is unique. The psychological contract with the patient is entirely different. This does not mean that it is less complex care, as developing information and care technologies bring 'acute' care into the home.

As more hospital-based staff move into primary care to work, the existence of the clinical settings will to some extent mask the enormous psychological gulf between hospital in-patients and people based at home. Clinical settings and their systems will feel familiar, and blunt the edge of the adaptation required between institution and home-based health care. Much of the growing primary care workforce will probably work in these clinical environments, which will require different skills, training, preparation and leadership from nursing in the home.

In contrast, district nurses are expert practitioners of the wholly different skills required to nurse people in their homes. They are already leading the transition to the use of new technologies within the home, including increasingly complex but portable medical and monitoring equipment, because of the trust and confidence people have in them. They are also leading and developing new primary care nurses, newly-qualified nurses, and the growing workforce of health care assistants and assistant practitioners who make up the home care teams. Both of these roles are essential to the future expansion of home care and home nursing.

It is here that the future for district nurses surely lies: in asserting their unique expertise as 'practitioners, partners and leaders' of the home-based acute, long-term and end of life care elements of the patient's



“District nurses are expert practitioners of the wholly different skills required to nurse people in their homes.”



pathway.

## Summary

In future there may not be 'district nursing teams' or a 'district nursing service'. This does not mean that there will be no specially-trained and qualified district nurses, leading nursing in the home. There may be teams commissioned to provide expert care in the home as part of a package of care and treatment for specific patient groups; and for which the expert district nurse is the best leader. Qualified district nurses may be employed in a variety of settings, including hospitals, by a range of employers to contribute to home-based care packages. None of this detracts from the fact that district nurses have a specific set of knowledge and skills which will always be required to nurse people outside of clinical settings. The professional engine remains the same, but the service vehicle it drives looks very different.

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“It is necessary to reinstate district nursing, recognising its centrality and expertise in a key arena for healthcare ... the patient's own home.”

## Chapter 6: Focusing on the future

**I**t is not necessary to 'reinvent' the district nurse. Currently, we still have district nursing.

**It is however necessary to *reinstate* district nursing, recognising its centrality and expertise in a key arena for healthcare over the next decade: the patient's own home.**

Acknowledging that expertise means also deciding how the advanced skills required should most effectively be taught and learned; and agreeing how best we can create leaders in district nursing who can model the role to other nurses. These are practical debates that should be led by district nurses themselves.

District nurses should be immensely proud of their heritage of 150 years, which gives them the enduring values they still bring to their work today. They should be prouder still of their everyday achievements, as reflected by patients, families and carers.

**But they should also be ready to leave the past behind, and take the next steps towards a future in which district nursing means a flexible and adaptable body of skills and knowledge, rather than a service or a team; and is delivered in new kinds of multi-disciplinary services, tailored to the needs of patients in a much more diverse health service.**

Of course, regardless of how we describe care and teams in the future, for many people who need nursing at home, the district nurse will simply continue to be 'their nurse'. It is not necessary to sell the concept of district nursing to these people. They are clear about the value of the nurse who is available at short notice, can deliver and organise everything they need, and will continue to work with them and their family for as long as necessary. Other experts and specialists will contribute to the patient's journey through care in many settings: but the district nurse should remain the core of nursing in the home, the practitioner, partner and leader for home-based services, in the decade to 2020.

“Some of the conflicts experienced in developing community nursing ... can be explained by these different approaches to the essential nature of health care.”



## Chapter 7: Taking the debate forward

In preparation for the publication of 2020 Vision, the QNI brought together a group of its Trustees, Fellows, staff and Professional Advisory Panel members to debate the future of nursing in the home. Their thinking is summarized below, and will be the starting point for further debate and for action by the QNI.

### **What nursing in the home can deliver:**

The group reiterated the breadth of care that can be delivered in the home by nurses and their teams in partnership with the person, their formal and informal carers and other professionals.

This includes:

- palliative care
- care management plus technical interventions and care support for people with stable long term conditions (and their carers)
- care management plus technical interventions and care support for people with unstable and/or deteriorating long term conditions (and their carers)
- short term/one off technical health care (e.g. post operatively)

All including health promotion, self care support, and health and care teaching.

### **The delivery of nursing in the home:**

The key elements of a home-based nursing service will be seen differently depending how the health care context is viewed. Some of the conflicts experienced in developing community nursing, even in a primary-care focused policy environment, can be explained by these different approaches to the essential nature of health care.

“Professionals recognise that they give and receive.”

**Table 1: Different approaches to the essential nature of health care:**

<b>Health care as a set of transactions in the market economy</b>	<b>Health care with elements of the gift economy – where patient and professional are in a covenantal relationship</b>
Patient is cared for	Patient is cared about
Professionals seen as givers	Professionals recognise that they give and receive
Calculation and counting - objective	Judgement - subjective
Pre-determined protocols	Emergent creativity
Discourse and (hyper) activity	Wisdom and silence
Explicit knowledge	Tacit knowledge
Reflection on facts and figures	Reflection on feelings and ethics
Focus on efficiency and effectiveness	Focus on the quality of the moment
Dealing with the presenting problem	Keeping in mind the meaning of the encounter - for both parties
Competence called for on the part of the professional	Essence called for
Individuals have a relationship with the state and with the market	Individuals have a relationship with a community
Good policy ideas must degenerate as they are translated at every level in the system into a series of measurable, performance manageable actions and objectives.	Policy ideas can stay rich and be added to creatively, so that solutions are responsive, deeply humane, practical, flexible and adaptable.
The focus here is on being able to demonstrate the policy has been implemented	Here the focus is on solving problems.

“Lead rather than follow on plans for change.”



## Chapter 8:

### Recommendations

#### To district nurses:

- Demonstrate your expertise constantly by actions as well as explanations – make the invisible visible
- Be open to new ways of developing and delivering services, in terms of both different organisations, different pathways and different technologies
- Learn about commissioning so that you can influence it
- Challenge protectionism and encourage adaptability in your team
- Lead rather than follow on plans for change
- Raise the profile of expert district nursing through writing, speaking and teaching
- Take your case to local decision-makers rather than waiting to be invited.

*'A colleague presented to their Local Health Board, providing them with an impact analysis of the potential withdrawal of 1 million pounds worth of investment for District Nursing. If you withdraw this money, patients within their local communities will not be able to access District Nursing support post operatively, increasing length of hospital admissions. There would be no support to patients with long term conditions, necessitating hospital admission. Patients within the last days of life would not have the choice to remain at home.*

*We did a similar thing, as we have high levels of delayed transfers of care, and we secured additional investment - you can't transfer people to be cared for at home without the necessary resources!'*

Kay Jeynes, Chair of All Wales District Nurse Forum

#### To service and education commissioners:

- Value the less tangible outcomes as well as the obvious when deciding what courses to commission (good services need nurses with leadership and strategic planning skills, and understanding of the wider system, as well as ability to assess, treat and prescribe)
- Ensure all potential provider organisations recognise that the skills needed for nursing in the home are different from other

“The district nurse should remain the core of nursing in the home, the practitioner, partner and leader for home-based services, in the decade to 2020.”

forms of primary care nursing

- Investigate current local district nursing services to get a better understanding of their role and potential contribution to pathways for acute care in the home, care for long term conditions and palliative care
- Encourage measures of patient experience, care pathways and outcomes rather than staff numbers as contract currency
- Use the forthcoming community metrics and quality framework in England to ensure a focus on quality and consistency of services commissioned.

*'District nurses have often been "developed" to meet the needs of current policy most noticeably with the advent of the community matron role. This has often left a gap in clinical leadership and expertise in community nursing teams. This is now being recognised by education commissioners and service providers who are commissioning programmes for district nurses that are focused on experienced clinicians and develop the aspects of clinical leadership, management and expert practice necessary to support larger teams with a range of skill mix but are also practitioners who have the ability to respond proactively to new ways of working and challenges to traditional service provision.'*

Mary Saunders, Head of Department of Primary and Social Care, London South Bank University

#### **To employers and managers of district nurses:**

- Encourage district nurses to articulate their skills, for example in induction for new community staff
- Provide opportunities for district nurses to contribute to, or lead, practice improvement projects
- Develop the basic IT infrastructure that will make services more efficient, as well as putting new technology in the patient's home
- Link district nurses to key individuals in service development or commissioning, so that their role and potential contribution can be better understood
- Encourage staff to publish and make presentations about district

“District nurses cannot work in the same way as they did 150 years ago ... or even 5 years ago.”



nursing work and projects

- Make use of the leadership and strategic skills of district nurse specialist practitioners
- Encourage the development of leadership and strategic skills, as well as clinical and practical skills, through continuous professional development activities.

*'District nurses cannot work in the same way as they did 150 years ago, or 50 years ago, or even 5 years ago. The future is different – but district nursing's values and skills are as crucial as they ever were to improving community health by providing care in people's homes.'*  
Rosemary Cook, Director, QNI

## **Acknowledgements**

We would like to thank all the district nurses who contributed to our consultation group, and those who completed the survey. Thanks also to the British Journal of Community Nursing for their help with the survey.

Special thanks to all who contributed to the Nursing in the Home meeting. Thank you also to the 'Take it to the Limit Learning Set - October 2008' for the table on p44.



“We work to support community nurses and midwives in any specialty with project funding, professional development, information networks, publications and campaigns.”

## About the QNI

The Queen's Nursing Institute is a registered charity that traces its foundation to 1887.

We work to support community nurses and midwives in any specialty with project funding, professional development, information networks, publications and campaigns.

In addition we strive to represent the voice of community nurses at national policy level.

Through our financial and personal assistance department, we provide support for community nurses who are in difficulties through illness, injury, old age or disability.

There are over 100,000 community nurses in England, Wales and Northern Ireland, including district nurses, school nurses, practice nurses, nurse practitioners, community midwives, health visitors, mental health and learning disability nurses.

Community nurses in Scotland are supported by a separate charity, QNI Scotland.

As a charity, we rely on voluntary donations to fund our work.

If you would like to find out more about the QNI, please go to our website, [www.qni.org.uk](http://www.qni.org.uk).

To find out more about the 150th anniversary of district nursing please go to our dedicated website, [www.districtnursing150.org.uk](http://www.districtnursing150.org.uk) to explore our stories, galleries and films and find out how you can get involved in the celebrations.

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[www.qni.org.uk](http://www.qni.org.uk)

## **Putting community nursing at the forefront of patient care**

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