

The Queen's Nursing Institute champions and supports all community nurses in England, Wales and Northern Ireland. We promote best practice and innovation in primary care by providing professional and financial assistance for community nursing projects; and, by our commitment to welfare, maintaining the independence and dignity of community nurses in need.

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Supporting
Community
Nursing

Vision and Values

A call for
action on
community
nursing



The Queen's
Nursing Institute

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We would like to thank all the community nurses who contributed to this project by participating in the focus groups or sending in their comments independently.

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We would also like to thank the Association of District Nurse Educators for all their help.

Vision

and A call for
action on
community
nursing

Values

Foreword

This report comes at an opportune time for nurses working in the community. Never before has the spotlight shone quite so brightly on the role of community nurses and on the part it is anticipated they will play in helping to deliver primary care reforms set out in the Government's White Paper, 'Our Health, Our Care, Our Say'.

The White Paper spells out the changes needed in primary and community services so that they can better meet the needs and preferences of today's patients: more personalised care and greater choice, care closer to home and easier access, better co-ordination between health and social care and more emphasis on health promotion and staying well.

As I have travelled around the country meeting many of you, I am aware that these aims resonate with the ambitions you hold for your own patients.

This report has captured some of the positive experiences of the last few years, such as success in serving on professional executive committees, as well as some of the difficulties faced, for example, a higher demand for your services.

The report shows you are also thinking about what needs to be done and how to position your profession to take advantage of the opportunities currently presented. I welcome such initiative, not least because, as the theorists tell us, change is easier to handle when one gets involved and can help to shape the outcome of one's own destiny.

There will be even greater prospects for nurses to play a part in helping to improve services for patients. They may take part in practice-based commissioning, work more collaboratively along patient pathways or even become entrepreneurial providers themselves.

With all the developments in community and primary care it is vital that the profession challenges itself and begins to explore what we need to do to ensure our profession can fulfil its own aspirations, those of commissioners and enable us to offer even better care in the future for the patients who depend on us. This QNI Report provides a helpful and timely contribution to this process.

Professor Chris Beasley

Chief Nursing Officer England, Department of Health

Preface

The decision at the beginning of 2005 to produce a follow-up report to *The Invisible Workforce* was a straightforward one. The original report was already three years old, and based on work undertaken four years before. The fact that regular orders were still being placed for copies of the report was also a factor: it seemed important to make available an updated report, with a new account of the views and ambitions of district nurses.

Then came the changes to primary care announced in *Commissioning a Patient-led NHS*, including mergers of primary care trusts and the proposal to encourage new provider organisations to employ community nurses. Although it became clear later that primary care trusts could continue to employ their nurses and provide community nursing services, the sense of anxiety and organisational upheaval remained.

It was suggested that this was not a good time to ask district nursing teams about their future; that they might be too focused on the immediate concerns to consider the longer-term future of their branch of the profession. We took the opposite view. We believed that it was more important than ever to give district and community nurses an opportunity to identify their place in the future, based on what is core and essential in their nursing role, rather than wait to be told what that future might be. We wanted them to trace the line between the changes to practice over the last five years, the needs of their patients in the future, and the route they will need to take to connect those things.

This report records what happened at the eight practitioner focus groups that were held in England, Scotland and Wales, with contributions from similar work already undertaken in Northern Ireland. It includes the contributions from a group of educators, and 10 groups of district nursing students, facilitated by members of the Association of District Nurse Educators.

From each of these important perspectives we hear the voice of professional, caring nurses laying claim to the work, values and vision of caring for people in their homes and communities. Undoubtedly there are major anxieties and some disillusionment amongst these nurses. But there was also much evidence of their robust principles, values and sheer determination to turn change into practical opportunity and to get on with delivering the services their patients need. While they call for national leadership and action, they also challenge themselves and their peers to change, taking responsibility for their own and the next generation of community nurses.

This work has been a very positive and exciting experience. The report does not offer a strategy for community nursing, or make recommendations to anyone about employing or deploying community nurses. But it does suggest some actions that might be needed, from the QNI and others – including community nurses themselves – to support community nursing into the future.

We hope that this report will generate a much wider dialogue, with nurses and others, about the key issues it raises. Later in the year we will draw together the threads of that dialogue, and decide how The Queen's Nursing Institute can best support community nurses in the future.

In the meantime, I would like to thank everyone who took part in the groups, and who helped to facilitate the process. I am delighted that we can now offer this new report on the views and aspirations of district and community nurses.

Rosemary Cook
Director, The Queen's Nursing Institute

Introduction

Nursing in the community has a long and honourable tradition. District nursing was established in Liverpool nearly 150 years ago. Its success there led to the development of the Queen Victoria Jubilee Institute for Nurses, established to extend the provision of district nurse training schemes. Later it became known as the Queen's Nursing Institute. Today the Queen's Nursing Institute supports and develops the work of community nurses so that patients receive the best possible care in their own homes, and seeks to influence innovation and best practice in community nursing.

In 2002 we published a discussion document that reported on the state of community nursing as seen by district nurses.¹ Since then a number of new health and social care policies have emerged which have had a considerable impact on their work. We decided it was time to look again at the experience of district and community nurses to better understand their role in contemporary health care and to help inform our work.

We met with groups of district and community nurses in a number of locations in England and with district nurse educators.² Meetings also took place in Northern Ireland, Wales and Scotland.³ We owe a special debt of gratitude to the colleagues who kindly convened these meetings and to the many nurses who so willingly contributed their time. We also received written comments from individuals and groups, including students currently undertaking district nurse training.⁴

We asked these nurses to draw on their community nursing experience to identify changes that had occurred over the last five years, to consider what they thought would change in the next five years and what was needed to enable them to deliver high quality care in the future. We do not claim any scientific rigour for the approach we adopted but we are confident that the nurses we met were able to express their views freely and that their experience is broadly representative of the wider district and community nursing workforce.

This publication reports what we heard. It highlights the major themes and issues that emerged during our discussions with this important group of health professionals – not policy makers, strategists or managers, but frontline practitioners. Our report paints a picture of a profession in transition. It describes how district and community nurses view their work today and how they see it developing over the next few years. It highlights the obstacles they encounter, the challenges they face and the frustrations they experience in carrying out their duties – but it also celebrates the crucial work they do and the vital role they play in the modern health service.

We hope this report will begin a debate within the profession and more widely. A debate about how we and others can work together to help better prepare, support and develop district and community nurses for the future. For us it represents the start of a process that we hope will galvanise action to ensure that district and community nurses are able to continue to give the best possible care to people in their own homes and other community settings.

Looking back

The context in which district and community nursing takes place has been changing. We asked those who participated in our discussions to reflect on their experience and to identify the main changes that have had an impact on their work over the last five years.

Demand and complexity

The need for home and community care has increased.⁵ In recent years government policies have been explicit about shifting more care and treatment into the community and keeping older people and those with long term conditions out of hospital. Many of the patients who now receive care in the community have complex needs and requirements. Without exception the groups of nurses we spoke to highlighted growing demand as one of the most obvious changes to have occurred over the last few years.

One of the most frequently cited examples of this concerned early discharge. Patients are spending less time in hospital and being sent home or into the community much sooner. Many are more acutely ill, less mobile and require more intensive nursing than used to be the case. As a consequence home visits are required more frequently, take longer and demand clinical skills previously associated only with in-patient care. Some groups referred to the enormous pressure to 'work smarter' and one nurse summed this up by saying that:

"...the patients emerge quicker and sicker so we have to work faster and slicker."

It was clear from our discussions that district and community nurses recognise the therapeutic benefits of earlier discharge from in-patient care and are committed to developing the skills needed to deliver home-based care to patients who are more acutely ill. The groups we consulted cited intravenous anti-cancer chemotherapy, blood transfusion and the management of central lines as illustrations of some of the more demanding clinical activities that have become a routine part of home care. Nurse prescribing was identified by most groups as an example of how nurses were acquiring advanced knowledge and exercising extended skills but, perhaps surprisingly, little was said about how widely it was practised or how it had improved patient care.

In line with the changing profile of the general population, many of our respondents referred to higher levels of dependency associated with a rise in the number of very old patients as an important feature of their changing workload. Indeed recent figures show that 57% of first contacts with the district nursing service were people aged 85 years or more.⁶ Increasing numbers of very old patients present a significant challenge because many have several illnesses and wide-ranging needs. Some nurses referred to the passivity and dependency of older patients while others observed that expectations amongst this group are often very high, noting that many are all too ready to question their care:

"...these [patients] are the 'new' old – they challenge and ask 'why aren't we getting this or that?'"

This more assertive approach was not just confined to discussion about older people. Most groups said that public expectations about services and care had increased and that many patients, and especially their carers, were now much better informed and more astute than in the past. However a few groups noted that some patients were still quite willing to be the passive recipients of care, especially where doing so meant that they could avoid taking responsibility for personal behavioural change to improve their health. This contrasted with the experience of some nurses caring for those with long term conditions who spoke of the positive impact of the expert patient programme. Publicity about choice of hospital and consultant was identified as another

change that was beginning to feed through too, with patients seeking advice from district nurses.

Some of the groups we spoke to were keen to tell us about their achievements in providing intermediate care, in taking action to reduce falls and in helping to prevent admission or readmission to hospital. They described rigorous risk assessment, anticipatory care, early intervention and rapid response as having helped many older patients who until recently would have been admitted as in-patients, with all the attendant dangers associated with hospitalisation. Some of our respondents noted that the significant cost savings resulting from this proactive work tended to go unrecognised. In contrast some nurses said that pressure of work prevented them from doing observation visits to the most vulnerable, and that they were concerned that these people were then lost to the system.

Palliative care and care of the terminally ill were other areas that district and community nurses said had increased over the last few years in both volume and complexity. They told us that more and more people wanted to die at home and that district nurses were expected to provide high quality palliative care – something that requires specialist skills and that can be very time consuming. Some nurses were concerned that they were not always able to provide care to the standard they wanted.⁷ Providing support to patients, relatives and other informal carers can be especially challenging in a busy work schedule, and as one nurse observed:

"...palliative care is an area that's not really recognised or targeted."

Most of the groups that identified a higher workload and greater complexity as major changes also said that these pressures had not been reflected in enhanced levels of staffing. Along with other developments which have placed greater demands on the community nursing workforce, district nurses said they felt they had absorbed additional pressures without proper recognition, increased resources or appropriate remuneration for extended roles and responsibilities:

"...we're sponges, always taking on new referrals."

Others were ready to acknowledge their part in this state of affairs, one nurse noting that:

"...the trouble is, traditionally, district nurses have refused to let go of things they should let go."

Some said a lack of recognition or reward had been compounded by the new pay arrangements for NHS staff that were beginning to take effect. We heard about real terms pay reductions and cases where district nursing posts were apparently being downgraded, which our respondents felt called into question the value of the specialist district nursing qualification.⁸

In some cases nurses spoke of significant staff shortages. Many expressed a good deal of frustration about the apparent lack of understanding amongst their managers regarding workload pressures. Some were moved to express genuine concern about the continuing viability of local district nursing services, summed up by one nurse who said:

"...we're so understaffed we're just running on goodwill."

Yet some of the nurses we spoke to were remarkably phlegmatic about staff shortages. They told us that traditionally district nurses have assimilated new and more demanding work without challenge. Many of these nurses seemed to express a perverse sense of pride in being able to deliver care under less than optimal circumstances. Some referred to the autonomy but relative

isolation of district nursing as both attracting and creating a 'just get on with it' mentality and many seemed resigned to the idea that district nursing is rarely considered a priority in service planning:

"...we're an afterthought – we're always last in the queue for resources."

Influence and leadership

Nearly every group we spoke to highlighted their concern that a district and community nursing voice was absent from local policy and planning groups. We were struck by the growing sense of disempowerment evident in some of the groups we met. In many cases this appeared to be linked to an insidious decline in professional leadership in the organisation. It was clear from what we heard that in many primary care organisations there is currently no expert community nursing input to strategic decision making.

It seems that this state of affairs can be traced to successive structural reorganisations and service reconfigurations, each introducing cost saving measures by amalgamating or stripping out posts and in so doing diluting professional representation and leadership, especially at the more senior levels. We were told that in some cases integration with other organisations had compounded the problem because non-clinical and social care staff had been appointed to key leadership roles without the appropriate clinical experience.

Many groups also decried what they perceived as an absence of professional leadership at a national level. Reflecting on the last few years they commented that the district and community nursing voice seemed to have disappeared from government policy making, from the regulatory body and from professional associations. They cited changes including the introduction of community matrons, the new nursing register, and the absence of a meaningful critique of health policy coming from the main professional organisations as evidence of what they perceived as a failure to advance district nursing as a vital element of a modern health service. A number of the groups highlighted what they saw as the contradiction between government rhetoric about primary care and the absence of vision or national leadership for district nursing, one nurse observing that:

"...we just haven't got any champions anymore."

In contrast we also met groups where local professional leadership remained strong. We were struck by the extent to which this was evident from their knowledge and understanding of current health issues and the way in which these groups expressed themselves. They were generally more positive and forward looking and spoke with a confidence absent from others we met. If proof were needed that professional leadership can have a profound impact on the culture and effectiveness of an organisation, we observed it in the way these groups conducted themselves.

We also heard from some district nurses about the positive and empowering experience of being involved in Professional Executive Committees. Despite what they referred to as a steep learning curve when first taking on the responsibility, they said that they quickly acquired the knowledge, language and tactical skills necessary to influence decisions and help shape local policy. One group stressed how important they thought it was for district nurses to be prepared to move out of their comfort zone to embrace new opportunities to influence policy and practice. One nurse said:

"I'm taking on board everything that is good about the change but I'm seeing a lot of my colleagues dragging their feet."

Many of the groups we met told us that they were rarely consulted about service changes, even where these directly concerned professional practice, patient care or their employment status. One recent example that was consistently cited was the introduction of community matrons, an initiative which it seems is being imposed in some places without sufficient consideration being given to the impact on the role and function of district nurses. Others spoke of rapid response teams and intermediate care services that were being established without proper connections to existing provision. A number of groups gave us examples of other changes that had been rushed through, had been poorly implemented or inadequately resourced, highlighting the costs associated with subsequent action to remedy the problems that followed. Some felt that even where it occurred, consultation was often cursory or disingenuous. It was clear that as a consequence many felt alienated from the organisations in which they worked:

"...we're not in control of the service we provide – we only do what others want us to do."

An ageing workforce

Concern about the absence of opportunities to influence policy and strategy at a local level also extended to workforce issues. A number of the groups we spoke to highlighted ineffective workforce planning as a particular worry, drawing attention to the ageing profile of the district nursing workforce, the number of imminent retirements amongst their colleagues, seemingly unplanned skill mix dilution and a drop in the number of commissioned places on specialist district nursing courses. We heard that in some areas student commissions had been stopped completely.

Many groups expressed concern that valuable experience and skills were being lost and that the pool of district nurses was not being replenished. While many of the nurses we spoke to acknowledged the potential benefits of the skill mix changes that had occurred, resulting in more and better trained health care support workers, they drew attention to the need to ensure that there were sufficient district nurses to train, mentor, supervise, assess and lead these staff. Many considered it short sighted to further reduce training commissions at a time when national policies emphasised more community care, when workload demands were increasing, the district nursing workforce was ageing and the demand for mentorship and supervision of junior staff had never been greater.

Role identity

A number of the groups we heard from questioned whether the specialist district nursing qualification had been devalued to the extent that it was now inevitable that it would just wither away. Changes to the professional register, expanded roles for health care support workers and community staff nurses, together with obsolete course content out of step with contemporary district nursing were cited as some of the reasons to doubt the continuing viability of the current post-registration training. Many also referred to the growing number of secondary care specialist nurses providing outreach services in the community and to the emergence of new roles – such as case managers, community matrons, advanced practitioners and consultant nurses – as impinging on and fragmenting the traditional district nursing role and function. Some referred to this as 'cherry picking', noting that district nurses were left to pick up what was left after new roles had been created. One nurse expressed her concern about the growing number of specialists and case managers saying that:

"...the people who are hands on are gone."

Others acknowledged that it was important to focus on workforce development and skill mix

initiatives to ensure that staff are deployed in the most effective way, one nurse noting succinctly that it is all about:

"...getting the right people to do the right job."

Role identity was an important issue for every group we met. Most made reference to changes during the last few years that had resulted in a blurring of roles within the community team, erosion of the district nursing role and as a consequence a lack of understanding amongst managers, professional colleagues and the public about what district nurses were and what they did. Some were concerned that the application of alternative titles such as care manager, key worker or team leader failed to convey the clinical background or nursing experience upon which their expertise was based. A number of groups told us that as a result referrals were often inappropriate, expectations about workload unrealistic and the contribution of district nurses unappreciated and undervalued. In an effort to emphasise their knowledge, skills and experience, some district nurse groups referred to themselves as specialist generalists, but they acknowledged that this idea was poorly understood by managers, service commissioners, general practitioners and the public. Many spoke of the growing confusion – even amongst district nurses themselves – about the core and enduring responsibilities that defined what it was to be a district nurse.

New team formations and structures were identified as important changes to have occurred over the last five years. We heard about a variety of models including integrated teams, co-located interdisciplinary teams, intermediate care teams, rapid response teams, outreach teams, zone, patch and cluster working. A number of changes seemed to be common to most areas we visited, including a greater diversity of roles within community nursing teams and a higher proportion of health care support workers than in the past. Some referred to the further imminent reformation of teams with the introduction of new models of case management. Others commented on positive developments where integrated working with secondary care organisations and with social services departments was helping to provide a more seamless service, where co-location increased the possibility of knowledge sharing, and where previously marginal issues such as mental health had been brought into the mainstream.

District nurses said they were leading larger and more diverse teams than in the past and that they were spending more time on management and administrative duties and less time giving direct care to patients. Many felt saddened at the loss of patient contact – something which gave most of them the greatest job satisfaction. A number said they increasingly acted as a resource for others in the team and only got involved in the care of those patients with the most complex clinical needs. A small minority said they were involved in more public health focussed activity than they had been, working through day centres and cooking clubs, and running clinics to tackle obesity.

Virtually all groups highlighted the increasing administrative burden they had to contend with, referring to red-tape and form filling, many citing the single assessment process as something they took seriously but which could be time consuming. A number stressed how difficult it was to get access to a computer terminal. In addition, as management and leadership posts had disappeared, budgetary responsibilities had been devolved to the extent that most team leaders now faced the challenge of controlling expenditure in a climate of financial constraint.

Directives and targets

Developments such as clinical governance, audit, risk management, clinical practice benchmarking, national service frameworks, the single assessment process and guidance about clinical effectiveness were singled out as having had an impact on practice over the last five years. Many acknowledged that frameworks and targets had resulted in action to tackle important priorities and that this had resulted in benefits for patients. However most of those we consulted drew attention to the frustration of trying to get to grips with the latest development in the plethora of national and local policies that impinge on their work. They referred to what they saw as a deluge of directives, frameworks, guidance and targets and it was apparent that even the most avid followers of policy found it difficult to distinguish those of particular relevance to community nursing.

The groups we spoke to thought there was a lack of coherence and a number of contradictions in recent health policy and planning. In the last five years most had experienced several major changes to the primary care organisations in which they worked, leaving them with a sense that they had been delivering care in spite of rather than because of the organisations in which they were employed. Noting that further changes were on the horizon, several groups said that despite the considerable volume of guidance and directives that had been issued over the past few years, paradoxically the level of uncertainty about organisational structures and service priorities had never been greater.

Of the more recent developments, most groups referred to the new General Medical Services contract and to the way in which their work was being shaped by the need to earn points – and income – for the practices to which they were attached. Some felt this was in danger of skewing the district nursing role. Others were more sanguine and spoke of the way in which the general practice contract had improved their relationships with general practitioners. However none were under any illusion about why this had come about, one nurse noting wryly that:

"...it's as if GPs have been given new spectacles – suddenly we're seen and appreciated. We change our roles, they reap the benefits."

Some groups identified changes outside the health service. For example one drew attention to the impact of increasing levels of traffic over the last few years, the time it now took to undertake even relatively short journeys between patients' homes and the difficulty of parking close by. Others spoke of their growing concern about personal security, an issue they said that simply would not have arisen even as little as five years ago. One group spoke positively about the appointment of a Trust security officer who had been able to offer valuable advice and support, and a minority mentioned other improvements arising from implementation of the improving working lives initiative, singling out anti-bullying policies and the appointment of an anti-harassment officer for special mention.

Put simply, the nurses we met identified a raft of wide-ranging changes over the last five years, many of which had increased their workload and reduced their support. Many of the groups we heard from were critical of the succession of changes to organisational structures and the growing pressure to meet targets and implement new policies – policies which, at least from their perspective on the frontline, appeared to lack coherence. In the light of recent policy pronouncements about a patient-led NHS, it was ironic to hear them observe that:

"...the patient just isn't the focus any more."

Despite obvious and widespread change-weariness and a degree of scepticism about the prospect of imminent improvement, the majority of nurses we met managed to retain an exceptionally cheerful disposition and what appeared to be a remarkable resilience to the vicissitudes of primary care policy. Without exception they were highly professional in their attitude and totally committed to providing a quality service to the patients in their care.

The main changes that district and community nurses identified as having had an impact on their work over the last five years were:

- a higher demand for community and home care
- increased workload
- earlier discharge and more acutely ill patients with complex clinical needs
- more older and dependent patients
- better informed and more assertive patients
- a more proactive approach and anticipatory care to reduce admissions
- more palliative care and care of the terminally ill
- skill mix dilution and staff shortages
- a loss of professional representation from decision making groups
- a lack of community nursing leadership locally and nationally
- a positive experience of involvement in Professional Executive Committees
- disingenuous or non-existent consultation on important changes
- organisational restructuring and reconfiguration
- an ageing community nursing workforce
- devaluing of the district nursing qualification
- reduction in student district nurse commissions
- new and expanded nursing and other roles
- erosion and fragmentation of the district nursing role
- inappropriate referrals and work
- new and more diverse teams
- collaboration with social care agencies
- more policies, directives, frameworks guidance to follow and targets to achieve

Looking forward

As a way of helping participants in our meetings to consider the development and support they might need to enable them to provide high quality care in the future, we asked them to think first about what the service might look like in five years time. Most groups combined a realistic assessment of what they thought would happen with some aspirations for the future.

Future uncertain

In many groups initial reflections inevitably focused on the recent policy announcement about changes in primary care in England.⁹ There was considerable speculation about whether contestability would result in non-NHS organisations providing primary care services and discussion about what impact this would have on district nurses and nursing. The majority expressed concern about the possibility of being employed by a body outside the NHS, to which the great majority remained utterly committed, and the widespread uncertainty the policy had provoked. A minority predicted that district nurses would seize the opportunity to take charge of their own destiny, referring to a recent well-publicised example of a group of health professionals who had established a cooperative to sell back their services to the NHS.

A number of groups singled out another recent policy – practice based commissioning – as likely to have a significant impact over the next few years. However many were less clear about what that impact would be. Most groups were keen to emphasise the importance of ensuring that nurses got involved and some suggested that district nurses should use their knowledge of the local community to inform and influence commissioning, one group referring to it as:

"...an opportunity to shift from demand-led to needs-driven provision."

Others noted the potential shift of power towards community nurses, suggesting that:

"...in the future, whoever is managing that team will be involved in commissioning as well – you're going to have to know what resources you need to deliver."

A minority predicted that the introduction of contestability in primary care, coupled with practice based commissioning, would result in district nurses becoming much more business minded and entrepreneurial, with some becoming partners in general practices.

Some groups predicted a future in which there would be greater emphasis on health promotion and public health interventions. Few elaborated what role district and community nurses might play in this but some referred to health promotion activities with older people and to work to reduce obesity amongst the younger population. Others made reference to their local knowledge as a valuable epidemiological asset that could be used to inform service planning and proactive public health interventions.

A variety of views were expressed about service configuration and delivery with a number highlighting the goal of seamless services and care. Most groups predicted closer collaboration with social services departments and some envisaged total integration, with a single and larger organisation responsible for health and social care. Some groups spoke of virtual teams with both health and social services staff working from what were described as referral hubs. Each hub would provide a unified point of access for single assessments and also sift, assess and allocate new contacts to ensure patients were seen by the most appropriate professional. Many groups predicted the restructuring of teams and services into what were variously described as clusters, zones, localities or neighbourhoods but, with the exception of the group in Wales, very

few made reference to attachment to a general practice as a model for the future.

Most groups saw a continuation of current trends with more emphasis on case management, proactive assessment and early intervention to prevent hospitalisation. Earlier discharge following more complicated hospital treatments would result in more highly dependent patients being cared for in the community. A number made the point that hospital at home initiatives would need to be properly funded. It was predicted that there would be more advanced generalist clinicians to deal with these patients but there were mixed views about the role community matrons would play. Some saw them as pivotal to the case management approach while others thought district nurses would have the necessary knowledge and skills:

"...if district nurses were allowed to do what district nurses are trained to do, there would be no need for matrons."

A number of groups thought district and community nurses would undertake more chronic disease management and assume greater responsibility for patients with long term conditions. Others suggested the expert patient programme would result in higher rates of self-care and that all patients would be better informed, more empowered to care for themselves and more knowledgeable, one nurse noting that:

"...nurses need to be prepared to find out things with the patients – to say 'you know more about this than I do, what else do we need to find out?'"

Some groups highlighted the opportunity to choose appointment time, consultant and hospital as an illustration of patient power, yet few speculated about the way in which patients might exercise greater choice in primary care. The more pessimistic amongst the groups we spoke to linked patient empowerment to predictions of increased litigation.

Most groups we met predicted that these and other developments would result in pressure to provide district nursing services twenty-four hours a day, seven days a week, or that at the very least there would be more extensive out-of-hours nursing services in the future. Some envisaged that all district and community nurses would have to work shifts around the clock. Others suggested that the current General Practitioner co-operatives and private out-of-hours agencies would expand to provide nursing services.

A digital dawn

Some groups aspired to work in an entirely paperless health service and most predicted significantly improved technology. Some thought patients and their carers would make much more use of on-line health information, suggesting that this could be further exploited to help reduce demand on other primary care services:

"...we can make more use of IT solutions that are already in place in some places."

Other predictions included universal adoption of electronic patient records and handheld computers or laptops for all community staff to access and record clinical and patient information. Some linked this prospect to other changes in primary care, suggesting that funding might come from outside the NHS:

"I can see it being sponsored by an IT company – why not? If we're commissioning."

Many groups referred with relish to the prospect of an electronic single assessment process but an even bigger plea was for computer systems that could speak to one another. Many of the groups we heard from bemoaned the limitations of NHS, general practice and social services information technology systems that were unable to share information to support multi-disciplinary team working.

Some groups pondered the potential benefit of in-car satellite navigation and others suggested that community nurses would have web cameras attached to handheld computers able to transmit real-time pictures of patients to distant colleagues for advice. It was also predicted that new technology would enable nurses to monitor a patient's vital signs and other clinical measurements without having to visit the patient:

"...there'll still be consultations, just not necessarily in the home."

However in one area of the country nurses were particularly sceptical about the dawning of a new digital age – they were still being issued with mobile phones that had no network coverage in large parts of their patch.

Whatever their predictions, most groups were keen to emphasise that adequate resources were a necessary condition to deliver the services they envisioned. One group was concerned that services were already so stretched that speculations about the future were pointless. They highlighted the growing gap between policy rhetoric and the reality of their daily experience and argued that there would have to be a genuine and realistic national debate about resources if more care was to be shifted to the community. However, as one of the more optimistic participants observed:

"...the funding should be filtering down by then from acute trusts."

Roles revisited

There was considerable discussion about the workforce implications of these projections but little consensus about the future role of the district nurse or the shape of the nursing team. Some saw district nurses at the heart of primary care while others predicted the role and title would disappear, their work split into tasks and taken over by community matrons, specialist nurses and health care support workers:

"...there'll have to be changes around skill mix to maintain care in the community."

A number thought district nurses would become care co-ordinators, providing little if any direct care themselves, their current responsibilities transferred to vocationally qualified staff or to assistant practitioners prepared through one of the new foundation degrees. In this respect, a number of groups thought that in the next few years all health care support workers would be regulated, either by the Nursing and Midwifery Council or a similar body.

Some groups suggested that the care manager or co-ordinator was a generic role. They suggested that although it might well be filled by district nurses, a nursing qualification would not necessarily be a prerequisite. As a result of these changes a number questioned whether district nurses would become deskilled and devalued. Others predicted the introduction of mandatory revalidation which they asserted would ensure the continuing competence of any nurse who wished to remain on the register. It was acknowledged that:

"...the days are gone when DNs become DNs and then just stay – they will need to go on [developing]."

Others saw the district nurse as a team leader, still involved in direct care, leading a team of nurses and support workers, exercising advanced clinical skills, enjoying wider prescribing, diagnostic and referral rights and having direct access to secondary care:

"...the DN role will be much more complex than it is now – we're going to have to diagnose."

Variations of this model were sometimes supplemented by references to terms such as advanced and specialist practitioner, but with little explanation as to what it meant to apply these terms in this context. However a minority of the more optimistic singled out these titles in their predictions for the future, suggesting that there would be clarity about what it meant to be a specialist community nurse or advanced nurse practitioner, and that there would be an agreed and explicit competency framework locating these and other roles in a clear hierarchy of knowledge and skills. Related to this, some predicted evolution of a career framework based on the NHS Knowledge and Skills Framework and the new pay bands, suggesting that skills profiling, portfolio development and personal development planning would encompass the whole team and facilitate career progression from novice to expert. Others were more sceptical. They envisage a future in which there will be widespread downgrading of community nursing posts, an exodus of skilled staff as morale in primary care plummets and staff shortages in secondary care open up opportunities for career progression and greater job security.

One of the predictions cited by most groups concerned the emergence of comprehensive referral criteria for access to district nursing services. However it was clear that while some groups saw the universal application of referral criteria as a realistic expectation, others viewed it as more of an aspiration than a prediction. Similarly, some saw the control of MRSA within the next five years as a realistic proposition, while others mentioned infection control as an objective rather than an expectation. There was unanimity amongst those groups who emphasised the importance of standardising expectations about staff skills, care practices and quality in care agencies and nursing and residential homes, but again a divergence of views as to whether this was a realistic description of what would in fact be achieved. One group envisaged a future in which community nurses would be represented in policy making and planning at every level, and that as a consequence policy direction and strategic intentions would be much better communicated and understood by nurses.

All the groups we met took this exercise very seriously but a number made reference to the considerable uncertainties surrounding the direction of primary care policy and the difficulty of making meaningful predictions about the future. One group ended its deliberations by observing that there was at least one certainty about the next five years, that:

"...there will be a general election – so nobody can be certain of anything."

The main changes that district and community nurses think will impact on their work over the next five years are:

- practice based commissioning
- district and community nurses contributing to service commissioning
- new non-NHS organisations providing primary care services
- entrepreneurial and business minded nurses exploiting opportunities to provide community services
- more public health assessments and interventions undertaken by community nurses
- greater collaboration or full integration of primary care services and social care agencies
- integrated health and social care teams
- more case management, proactive and anticipatory care
- more responsibility for chronic disease management and the care of people with long term conditions
- better informed and empowered patients exercising greater choice
- round the clock district and community nursing services run by out-of-hours co-operatives and agencies
- integrated electronic information systems with handheld and laptop access
- electronic patient records, clinical data and single assessment process
- telemedicine used in home care for monitoring, consultation and advice
- in-car satellite navigation for community nurses
- resources flowing with the shift of care and treatment into the community
- clarity about the district nursing role and training
- an integrated career and competency framework for the community nursing team
- regulation of vocationally qualified health care support workers and mandatory revalidation of registered nurses
- unified quality standards for care agencies, nursing and residential care homes

Making the transition

Our final invitation to the nurses we consulted was to identify the things that need to happen to enable them to deliver high quality care in the future.

Focusing on the future

Many of the suggestions they made flow directly from the issues identified above.

Some are entirely realistic and achievable. Others are more aspirational. Some involve relatively small scale change at local level and could be achieved reasonably quickly. Others are longer-term goals that require large scale strategic intervention.

The changes that would make the biggest difference are self explanatory and can be summarised as follows:

- **unified and coherent national policy** – a number of groups argued for a single and definitive reference source to which they could refer to provide a sense of direction and overall purpose;
- **organisational stability** – most groups pleaded for a period of consolidation to bed-down and then to evaluate recent changes;
- **effective professional leadership** – all the groups consulted asserted that credible, committed and visionary professional leadership of community nursing was urgently needed, especially nationally and at senior levels within local organisations;
- **stronger representation** – many groups referred to the need for a higher profile on primary care and community nursing issues from professional associations and unions;
- **engagement and involvement** – district and community nurses want a voice in policy and strategic groups at every level, not for themselves but to better serve the patients and communities in their care;
- **genuine consultation** – the groups we heard from said that changes were more likely to succeed if there was proper consultation with professionals and service users and open two-way communication;
- **a national strategy** – specifically for district and community nursing to ensure that this field of practice is given sufficient attention in light of the policy to shift more care into the community;
- **role clarity** – a consensus is needed about the role, responsibilities and career opportunities for district nurses;
- **appropriate educational preparation** – a competency-based programme designed and delivered to equip nurses with the knowledge and skills needed for the district nursing role needs to be agreed;
- **protected time** – for continuing professional development and for the acquisition of advanced clinical skills;
- **clinical supervision** – time to train for and to provide clinical supervision, which many regard

as essential to maintain quality of care because district nursing is an autonomous and isolated field of practice;

- **reduction in red-tape** – fewer administrative tasks, less duplication of activity and paperwork;
- **compatible information technology systems** – underpinning an electronic single patient record and an electronic single assessment process;
- **referral criteria** – for access to district nursing services, agreed and universally applied to help manage and monitor workload;
- **referral rights** – to enable district nurses to get quicker access to consultants and secondary care for their patients;
- **better working conditions** – including mobile phones that work, better access to computers, improved personal security, greater flexibility over working hours and improved child care.

We recognise that presenting the areas for action in this way could be misleading. A list of this sort might be taken to imply that the district and community nurses we consulted were passive bystanders, unwilling to take responsibility for moving things forward, waiting for others to shape the future on their behalf and in their favour. This could not be further from the truth.

It is true that one of the overriding impressions we gained from our meetings was of an over-stretched workforce experiencing a growing sense of disempowerment, disengagement from the organisations in which they worked and alienation from the wider profession. Yet in every meeting this impression was trumped by the professionalism, dedication and enthusiasm that shone through. The nurses we heard from were confident about the part they could and should play in securing a viable future. As one nurse commented:

"...DNs are creative and adaptable – because we have to be."

The nurses we met were adamant that they would work to secure a sustainable future for district nursing and for the patients in their care. They were committed to taking charge of their destinies and welcomed the opportunity the meetings provided to discuss with their colleagues what steps they might take. A new sense of solidarity emerged in some groups:

"...we're the largest workforce in the Trust, we need to stick together and speak out."

Their suggestions amounted to what might be described as a personal and collective professional manifesto. Some of the commitments they made are summarised in the box opposite.

Among other things, district and community nurses said they needed to:

- stick together to use their collective voice
- take responsibility and be more proactive
- stimulate debate locally about the issues to be addressed
- be more politically aware, astute and active
- raise their profile and improve the image of district nursing
- clarify their role, values and educational preparation
- market and promote their knowledge and skills
- audit their practice to demonstrate their achievements
- stop being sponges and impose a caseload ceiling
- seize opportunities rather than wait to be told what to do
- be confident enough to 'rock the boat'.

The heart of the matter

Reflecting on what we heard during our meetings and drawing on the written submissions we received, we have identified four themes that we think encapsulate the issues of greatest concern to district and community nurses. The four themes are:

- professional and role identity
- vision and leadership
- engagement and influence
- image and profile.

The issue of identity was one of the most persistent themes to arise during our discussions. Skill mix changes, adoption of generic titles, a blurring of role boundaries and the introduction of new, expanded, specialist and advanced roles have all impinged on the traditional role undertaken by district nurses. Successive structural changes to primary care organisations have removed nursing leadership posts and diluted the professional vision that has in the past provided a sense of purpose and direction. Many district and community nurses feel that they have been let down by their professional associations and trades unions, who they believe have failed to provide the vision and professional leadership required. They regard the recent changes to the professional register as a clear indication of a lack of understanding within the regulatory body about the nature and importance of their role, and many believe their knowledge and skills are not recognised, appreciated or reflected in national policy making. One nurse summed it up by saying:

"...we need a clear national vision and strategy from the Chief Nursing Officer downwards."

Another nurse highlighted the essential core of a future strategy for community nursing:

"...it's all about vision and values."

The groups we consulted told us about the failure of local primary care organisations to properly engage district and community nurses in service planning and local decision making, leaving them feeling marginalised and undervalued. Many no longer have a clear sense of the scope of their professional responsibilities or where they fit in the larger family of nursing. Debates about who are generalists and who are specialists, or whose knowledge and skills justify application of the title advanced practitioner, have served only to mystify rather than to elucidate the

contemporary district nursing role. As a consequence of all these changes some nurses have lost confidence in their capabilities and professional authority. It is not too dramatic to say that many district nurses feel that they are experiencing a crisis of professional identity.

This is not just a matter of self-perception or simply about professional self-esteem. Nurses told us that the lack of clarity about their role and function is shared by service commissioners, general practitioners, social care colleagues and fellow nurses, but most importantly also increasingly by patients and the public. This has resulted in unrealistic expectations about what district nurses can or should do, inappropriate referrals and work, and a failure to get best value by deploying skilled and knowledgeable professionals in the most efficient and effective way. The absence of common agreement about role and purpose has undermined meaningful educational preparation and compromised some continuing professional development. We heard about the dramatic decline in student commissions for places on district nursing courses, not least because, as one nurse put it:

"...nobody knows what the DN qualification means anymore"

A lack of identity matters. It matters to nurses because professional self-esteem underpins high standards of professional practice and work satisfaction. It should matter to service commissioners and providers because clarity of role and function is associated with efficiency, effectiveness and productivity. It matters to educators because professional preparation intended to be fit for purpose presupposes an agreed role. And it matters to patients and to the public because they need to understand the professional standing, experience, qualifications and accountability of those in whom they entrust their care.

Many of the nurses we spoke to thought the district nurse title was still highly regarded by the public, even if the image held was outdated. Some thought it was well worth clarifying the role and reasserting the title because, as one said:

"...patients recognise the title, have faith in it and respect it"

The need to update the image of district nursing, to raise its profile and to market it to service commissioners was raised by most of the groups we consulted. Much was said about the need to try to ensure that professional colleagues fully appreciate the scope and limitations of the role, and to better express the concept and professional standing of the highly skilled generalist. It was acknowledged that, once again, this presupposed clarity about what is was that district nurses could and should do.

Next steps

It is not for us to prescribe precisely what action should be taken, especially where responsibility falls outside our remit and authority. Nevertheless, we feel this exercise has given us a mandate to speak up for district and community nurses and to make recommendations about what we believe is needed to tackle the main issues that have arisen from our consultation.

If district nursing is not to wither as a distinctive profession, we strongly believe there is a need for concerted national action to:

- establish and publish a consensus about the values, purpose, boundaries and functions of the district nurse role;
- clarify its relationship to other community nursing roles and establish its place in the wider primary care team;
- locate it in the wider family of nursing, and to
- agree the most appropriate form and level of educational preparation.

We believe it is time to develop a:

- national vision for district and community nursing and a strategy to deliver that vision to ensure that district nursing is fit for the future – a strategy comprising, at the very least, a programme of leadership development tailored to the needs of district and community nurses and plans to ensure that district and community nursing expertise is an integral part of decision-making about policy, strategic commissioning and service delivery.

At a local level, action is needed to:

- help community nurses engage with local commissioning and planning groups
- provide the strong local leadership that makes such a noticeable difference
- address the technology issues: phones that work and access to computers
- consult staff genuinely about the best forms of team working
- work with community nurses to explain to the public and other staff how different roles fit together in the local model of community nursing.

Our purpose in undertaking this exercise was to update our understanding of the experience of district and community nurses to help inform our work. In doing so we listened carefully to what frontline nurses told us. We have tried to summarise as accurately as possible what we heard but we have, of course, edited and amalgamated records of our discussions and the written submissions we received to produce what we hope is a readable synopsis. Nevertheless, we believe we have been able to provide a fair account of how district and community nurses view their work now and in the future.

We need to check with the wider profession that our understanding is correct. You can help by telling us:

- whether our account of what we were told reflects your experience as a district or community nurse
- if our analysis of the main themes is reasonable
- whether we have identified the right issues for action, and
- what you or your organisation can do to help take the agenda forward.

Email your comments to us at: mail@qni.org.uk

We are keen to work with district and community nurses as individuals, in groups and in organisations, and we plan to engage with the Chief Nursing Officers, the Nursing and Midwifery Council, professional associations, trades unions and other professional leaders to promote action on the issues we have identified. We believe it would be helpful if a collaborative of lead organisations were to establish a national forum to consider this report and to plan joint action. Tell us whether you agree.

Most importantly, we want this document to be the start of a dialogue, not an end in itself. It presents a snapshot in time of the views of district and community nurses, together with what we believe are realistic proposals for action. Our hope is that this report will be the start of a process of transformation and growth.

End notes

¹ *District Nursing - The Invisible Workforce*, (2002), London, English National Board for Nursing, Midwifery and Health Visiting and the Queen's Nursing Institute.

² We invited nurses from community nursing teams (although the great majority were qualified district nurses) and discussion covered community nursing services in the widest sense.

³ Nurses travelled from large geographical areas, often from several organisations, to meetings we held in Birmingham, Cardiff, Devon, Hampshire, London, Liverpool and Newcastle. The views of district nurse educators were obtained at the annual general meeting of the Association of District Nurse Educators in Leeds. The views of community nurses from Northern Ireland, taken from a similar consultation recently undertaken there, were shared with us. Our sister organisation in Scotland (the Queen's Nursing Institute for Scotland) convened and hosted a meeting there.

⁴ Written submissions were received from meetings with student groups in universities in Aberdeen, Gloucestershire, Hertfordshire, London, Oxford, Reading, Sheffield, Southampton, Staffordshire and Swansea. These meetings were facilitated on our behalf by members of the Association of District Nurse Educators.

⁵ For example the last available figures for England indicate that initial contacts with district nurses were 2% higher in 2003-04 than the previous year, that in the same period first contacts rose by around 3% on the previous year and were highest for patients aged 85 and over, and that the duration of a district nursing episode rose from two months in 1988-89 to over three months by 1999-2000 (*Patient Care in the Community - NHS District Nursing - Summary Information for 2003-04 - England*, London, Department of Health).

⁶ *Patient Care in the Community - NHS District Nursing - Summary Information for 2003-04 - England*, London, Department of Health.

⁷ In discussions reference was often made to the 'Gold Standards Framework'. See for example: *The Gold Standards Framework - A programme for community palliative care*, (undated) London, Macmillan Cancer Relief; and *Cancer in Primary Care - A guide to good practice*, (2004), London, Modernisation Agency Cancer Services Collaborative, Macmillan Cancer Relief and National Cancer Action Team.

⁸ New pay arrangements are being introduced under the *Agenda for Change* reforms. All posts are subject to job evaluation and grading into a new banding structure. We heard that some qualified district nursing posts were being placed in the same band as community staff nurses, against the expectations of the trades unions that negotiated the new agreement.

⁹ In Scotland a review is already underway to identify the core components of a modern community nursing service to meet the needs of patients and communities in Scotland. The review is being led by the Chief Nursing Officer. In addition, a new nursing and midwifery action plan is embedded in *Delivering for Health* (2005), Edinburgh, Scottish Executive Health Department.

In 2005 the Welsh Assembly Government published its 10 year strategy *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century*. The Chief Nursing Officer has decided that this is the appropriate time to undertake an all Wales review of *Realising the Potential* (1999) in order to build on and produce an updated strategy and enable the wider nursing family to make the best possible contribution to meet health and social care needs across Wales for the next 10 years. Nurses in Wales are engaged in the process of determining the nature of the future workforce.

In Northern Ireland a project managed by DHSSPS Nursing and Midwifery Advisory Group focusing on the redesign of community nursing is underway with anticipated completion April 2006. This project involves the piloting and evaluation of the effectiveness of eight new models of service delivery to test the strategic thinking and examine new ways of working for all community nursing staff.

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Ros Lowe, Chair QNI, for facilitating regional focus groups

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