



Royal College  
of Nursing

# The Community Nursing Workforce in England

Policy Briefing

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## **Introduction**

In England, in the last decade parallel goals for financial efficiency in the NHS and for care pathways which deliver the best outcomes for patients have aligned to ensure a consistent policy objective to move care out of acute (hospital) settings and into people's homes and communities.

Community nursing is at the heart of this model of care and in response community nursing services have developed into complex, multi-disciplinary teams. The work of nurses in the community encompasses the promotion of health, healing, growth and development, as well as the prevention and treatment of disease, illness, injury and disability<sup>1</sup>.

The RCN believes that whilst expectations on community nursing have never been higher, investment in community services has matched neither the increased levels of patient need, nor the expressed intent of government policy. Community nursing is a workforce stretched to breaking point; and in some places in England, particular services such as district nursing are in crisis. The problems of historical under-investment are now being compounded as community service providers (like the rest of the NHS) seek to make 'efficiency savings', resulting in chronic under staffing; and as cuts to other essential services, such as social care, add to the pressure on nursing services.

In this report, the RCN uses the latest official data and survey evidence to provide a picture of NHS services and staff under increasing pressure. Data from the NHS Information Centre is used to analyse community nursing workforce trends in the last decade, to expose the precarious current status of the community workforce. In addition, a survey of RCN nurses working in community services was conducted to explore the impact this understaffing has on patients and the delivery of health services. In April 2012, 2,219 nurses working in community settings in England told us about the changes to staffing in their teams in the last year; their perceptions of how well equipped community services are to enact the acute to community shift; and how current pressures on the social services' budgets are impacting on nursing services and patient care.

Finally, priorities are identified where action must be taken in order to build a community workforce with the capacity and skills needed to guarantee patients the quality of care they deserve – now, and in the future.

## **Executive Summary**

### **Current strength of the community nursing workforce**

- Service planning and investment in community nursing has not kept up with the policy ambitions. There is little evidence of a shift of nursing services to the community. In 2001, of the 256,218 (full time equivalent) qualified nursing workforce, 14.5% were designated as community services compared to 54.1% of nurses working in the acute, elderly and general sector<sup>ii</sup>. If nurses classified as working in community psychiatry and community learning disabilities are also included, the total proportion of nurses in community settings was 20.1%. Ten years later, despite the rhetoric around shifting care from hospitals into communities, the percentage of nurses working in community services is still only 15.1% (of a total of 306,346 qualified nurses). In contrast, the proportion working in the acute, elderly and general area has risen to 54.7%. Again, even when nurses working in community psychiatry and community learning disabilities roles are included, the total proportion is only 21%.
- The skill mix of community nursing teams has been diluted, with a substantial decline in highly clinically skilled roles such as district nurses and health visitors. District nurses, for example declined by 34% (3,589 FTE) between 2001 and 2011.
- Community nurses have a far higher age profile than the workforce in general. 38% of nurses in the community are aged 50 and over, compared to 23.6% of the acute, elderly and general nursing workforce. Nurses aged 45 and over could choose to retire in the next decade – which accounts for 59.2% of the workforce.
- The vulnerability of the current workforce is compounded by a dearth of workforce information. At a national level, as a result of both inadequate data collection and the transfer of many community services to non-NHS providers under the Transforming Community Services agenda, the workforce is not clearly mapped, meaning that planning future services is in jeopardy, and policies are being determined without clarity.

### **Impact of the ‘acute to community’ shift in patient care**

- Whilst there has been insufficient investment in workforce capacity, members responding to our survey confirmed that higher volumes of patient care are continuing to move into the community. 86% agreed that patients are being discharged from hospital more quickly than before; and 92% agreed that nurses are now caring for patients with more complex needs compared to a year ago.
- The inevitable result of increased patient need and an insufficient workforce is that nurses’ caseloads are rising. The vast majority of survey respondents (89%) reported that their caseload increased in the last year, with 62% saying

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that it had done so significantly. To meet the requirements of enlarged caseloads, nurses are forced to spend less time with their patient. Only 6% agreed that they always had the time to deliver the level of care patients needed, and 60% agreed that they were spending less time with patients than they did last year.

- Community nursing teams are also under increasing pressure from cuts made to other services, notably to social care. Three quarters (76%) agreed that social care cuts have resulted in increased work pressures in their teams, and only 15% agreed that the patients in their care receive adequate support from social care services. Nurses also painted a deeply worrying picture of the impact these cuts are having on the health of their patients – with unmet social care requirements resulting in increased health care need and unnecessary experiences of the ‘revolving door’ back into acute care.

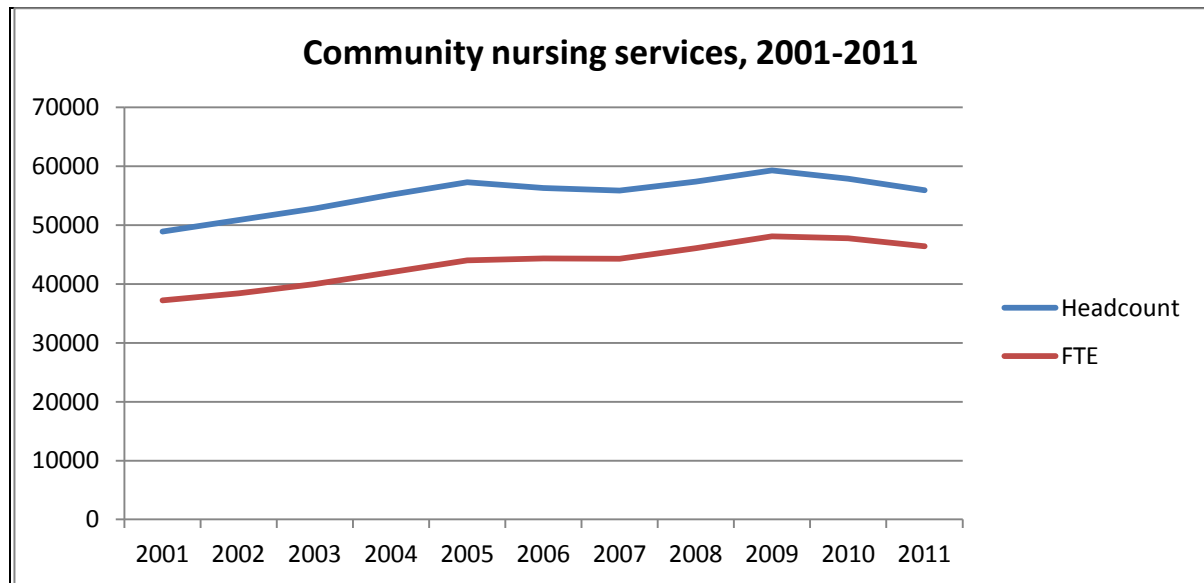
### ***Priorities for action***

- More investment in community services is needed as a matter of urgency if the acute to community shift is going to become a reality and if the community service is able to meet a future rise in demand. Short term approaches to meeting the ‘efficiency’ challenge should not take precedence over the delivery of a sustainable health service.
- Priority should be given to better aligning the planning of the community nursing workforce with service redesign, both in the immediate and long term. This should reflect national priorities to shift the delivery of patient care from the acute to community setting. The Department of Health (DH) and Health Education England should lead the way in encouraging service commissioners and providers to take a comprehensive, rather than piecemeal, approach to the planning of community services.
- The DH should take immediate action to rectify the lack of specific data relating to the community nursing workforce. More comprehensive categorisation of nursing roles and titles is needed, for example those currently categorised under ‘other 1<sup>st</sup> level’, and should include specialist nurse and nurse practitioner titles. The DH should also ensure that non-NHS providers of health services submit workforce data for collation centrally.
- Better understanding is needed of the role of community nurses in delivering high quality patient outcomes, in order to inform improved service commissioning at a local level. This includes the understanding of service commissioners and providers about the importance of investing in the leadership capacity of the community workforce.

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- There must be an urgent solution to social care funding – both long term under investment and the short term cuts currently taking place in social care budgets. The upcoming White Paper on social care reforms must address the crisis of long term and severe underfunding of social care.

## Community nursing numbers

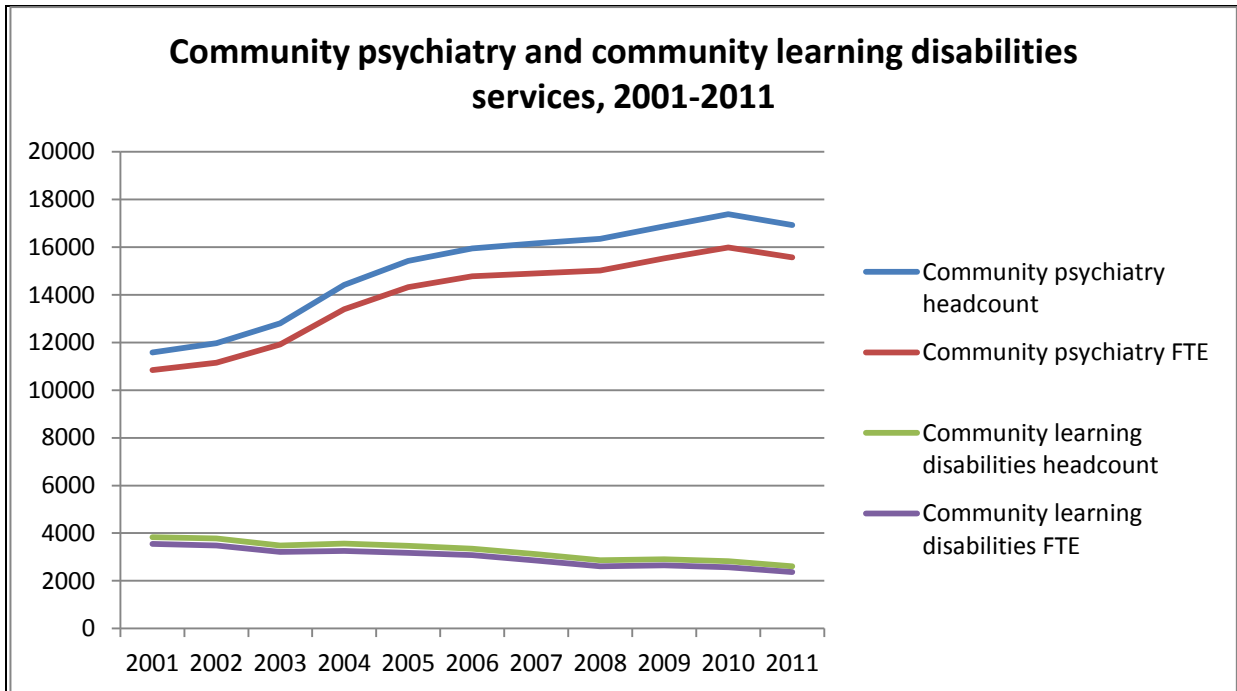
Statistics show an overall rise in nursing staffing levels in the community for most of the last decade, peaking in 2009 at 48,106 full time equivalent (FTE) qualified nursing posts designated as 'community services' by the NHS Information Centre<sup>1</sup> (please note that nurses working in community psychiatry and community learning disabilities settings are categorised separately by the NHS Information Centre). However from 2010 numbers begin to decline, to the current level in 2011 of 46,399 FTE qualified nursing posts – a loss of 1,707 or 3.5% from the 2009 peak.



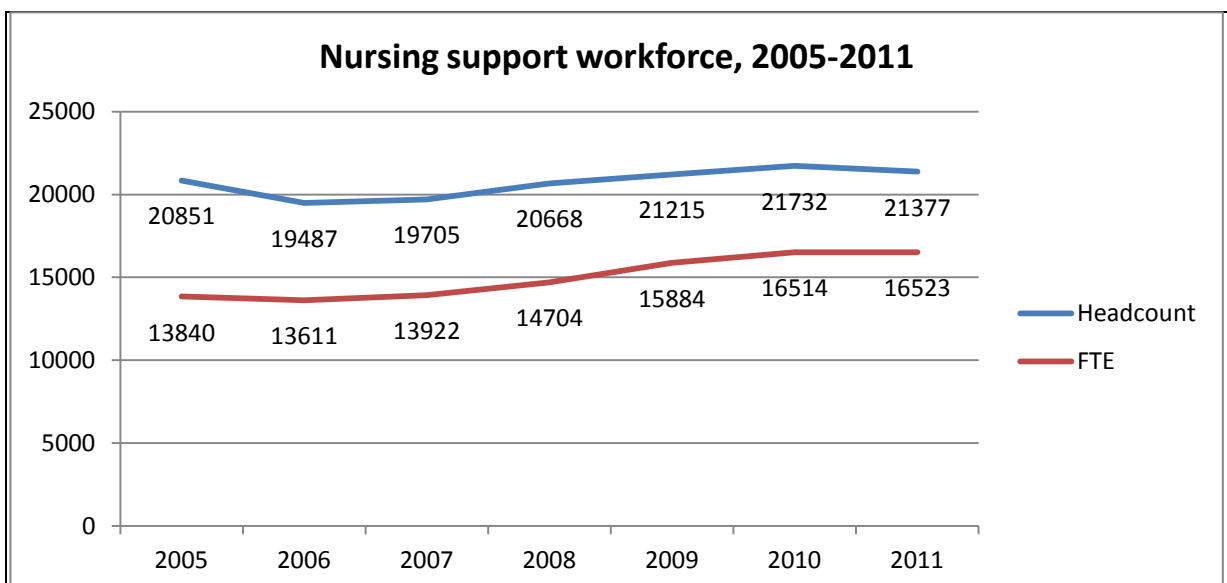
This decline in numbers makes no sense at a time when there is an ageing population, and increasing numbers of people living with long term and chronic conditions, who need to be cared for in their homes and communities. The resultant impact of this increased pressure on staff is highlighted in the RCN survey, discussed below. The reduction in community nursing numbers in the last two years also suggests that the nursing posts which are being cut in acute services, and which have been highlighted by the RCN's Frontline First campaign<sup>iii</sup>, are not being transferred in large scale to community services. Both sectors are losing staff.

If the total number of nurses in community services continues to decline, the percentage of the nursing workforce working in the community compared to the workforce as a whole, or indeed the acute sector, will barely have changed in a decade. In 2001, the total qualified nursing workforce was 256,218 (FTE), with 14.5% designated as community services. Including nurses working in community psychiatry and community learning disabilities settings brings the total to 20.1%. Ten years later, in 2011 only 15.1% of the total workforce (306,346, FTE) were working in community services. Again, even when nurses working in community psychiatry and community learning disabilities roles are included, the total proportion is only 21%. In contrast, the proportion of nurses working in the acute, elderly and general sector has risen over the same time from 54.1% to 54.7%.

Statistics for specific areas of nursing practice in community settings, including community psychiatry and community learning disabilities, also indicate a trend of under-investment. Community psychiatry numbers follow a similar pattern to the overall trend of community nursing numbers in the last decade, namely, a steady rise in numbers until 2010/2011. Community learning disabilities nursing numbers, however, have seen a long term and consistent decline over the last decade.

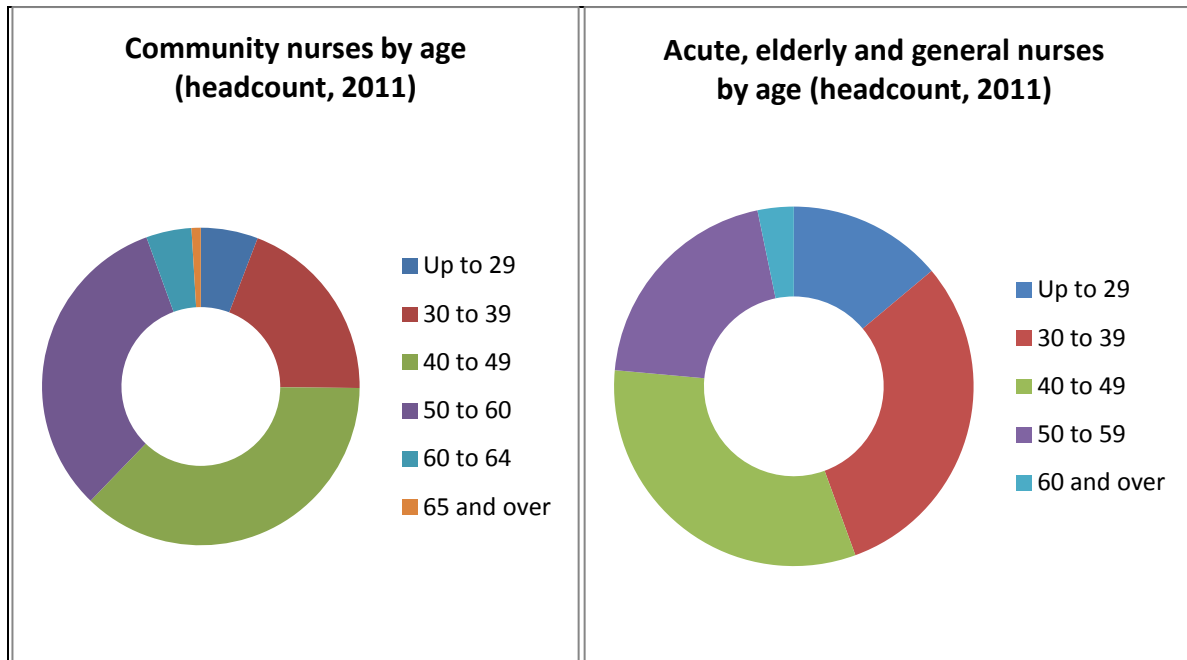


The registered nursing workforce working in community services is supported by a large number of support workers. An analysis of workforce data since 2005 shows that after a brief dip in numbers (corresponding to the NHS deficits 'crisis' in 2006), there has been a steady rise in numbers, with no reduction in 2010/2011.



## Age profile

The community nursing workforce has a higher age profile than the overall nursing workforce. In the community workforce, 38% of nurses are aged 50 and over, compared to 23.6% of the acute, elderly and general nursing workforce.



Nurses aged 45 and over could choose to retire in the next decade – which accounts for 59.2% of the workforce. This compounds the urgent need to build the community workforce capacity in the future.

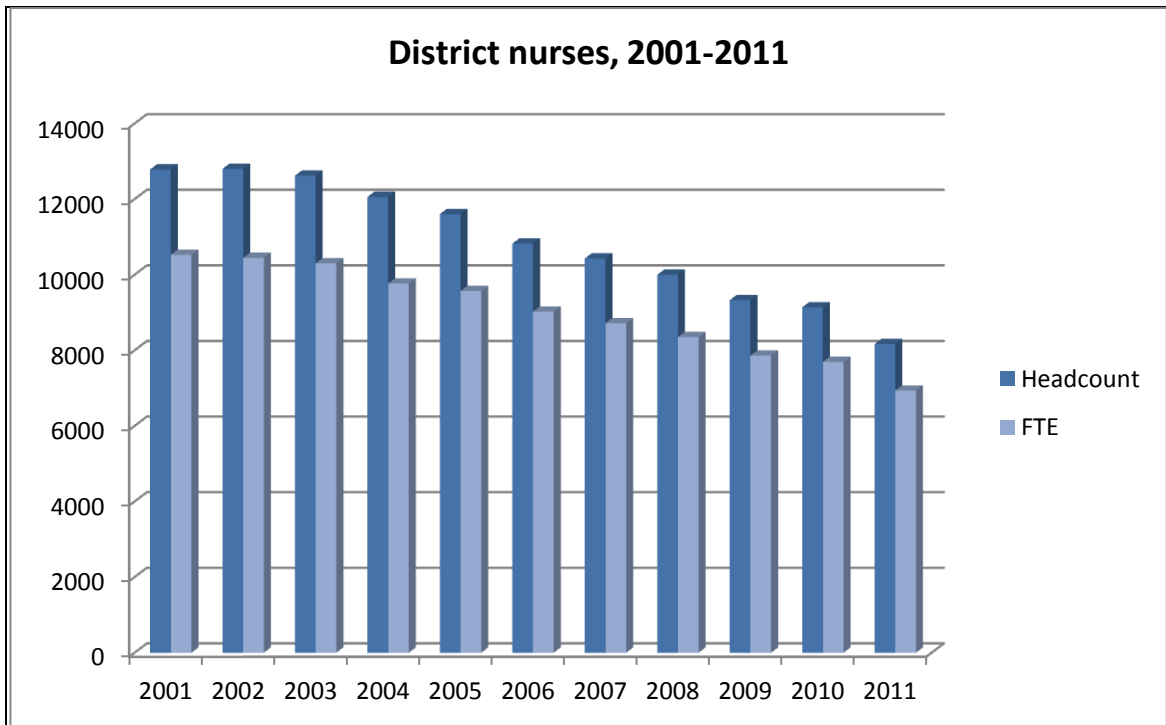
## Skill mix in community nursing teams

The RCN is concerned not only about the falling number of nurses in the community, but at the dilution of skill mix in the workforce. Within community teams there are critical roles which are highly autonomous, highly clinically skilled and provide vital leadership amongst the wider team, for example district nurses and health visitors. In contrast to the general rise in workforce figures (until 2010), data that shows that the number of qualified registered nurses in these highly skilled roles have dropped sharply over the same period. Without these skilled nursing roles, patients may receive poorer care or health outcomes, and the wider nursing team will suffer from a lack of experience.

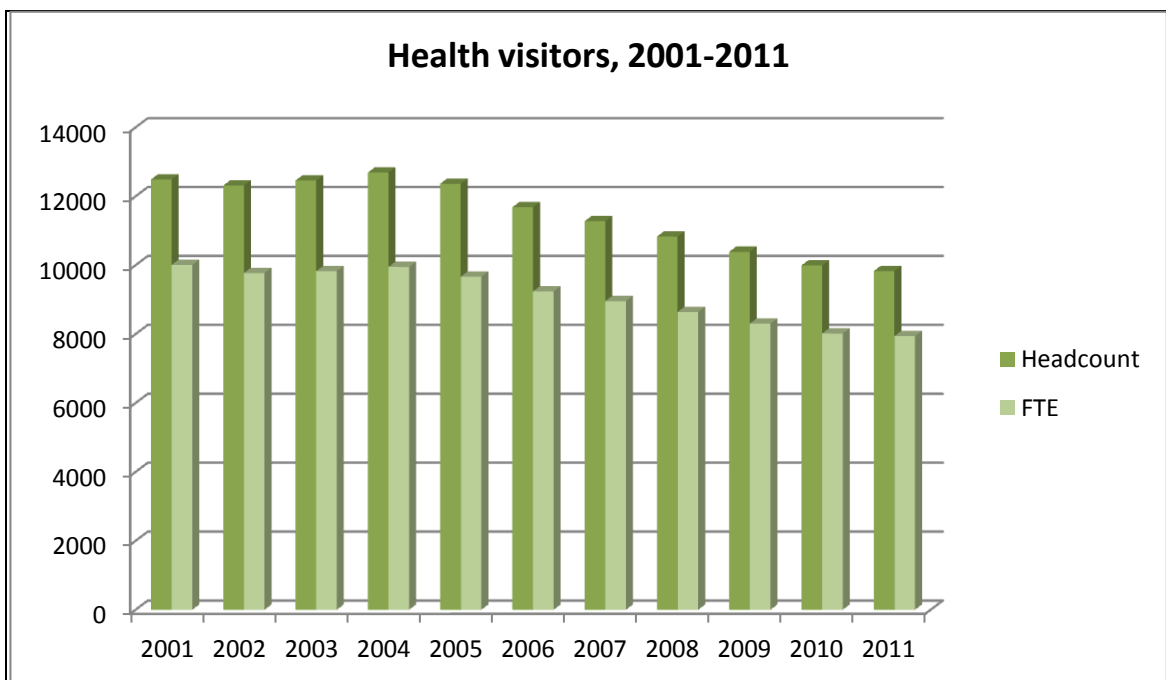
For example, district nurse numbers have dropped by 34% in the last decade, down from 10,526 FTE in 2001 to 6,937 FTE in 2011. The health visiting workforce followed a similar downward trend in numbers – being reduced by 20.7% between 2001 (when there were 10,012 FTE health visitors) and 2011 (7,941 FTE health visitors).



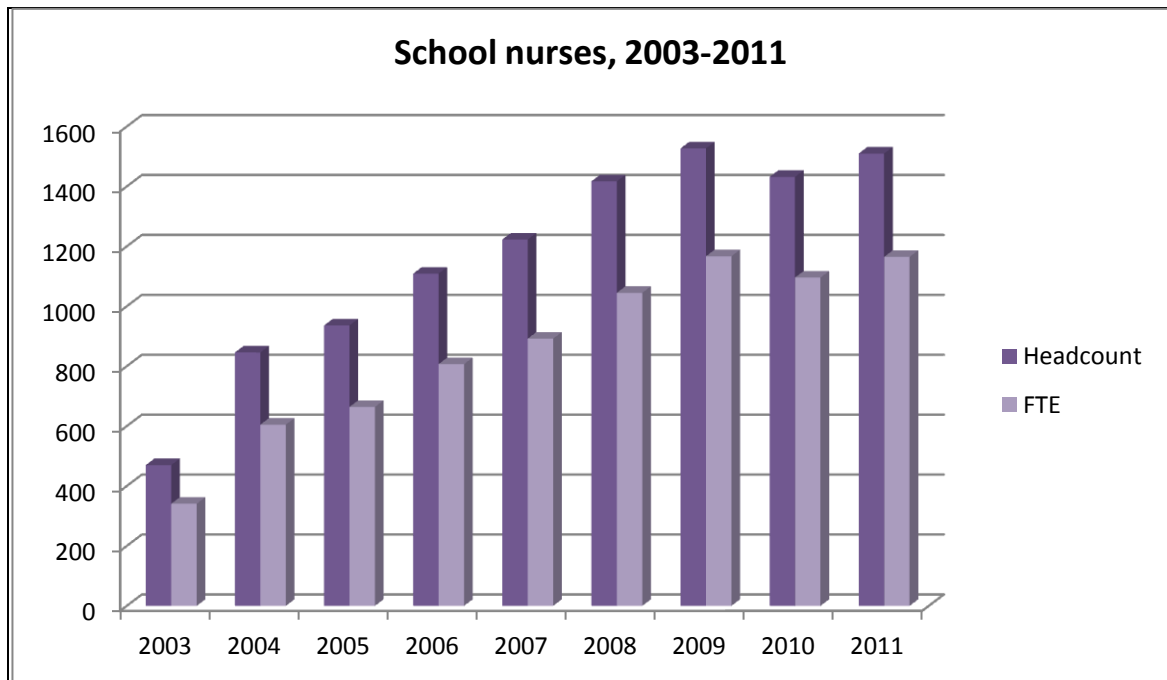
The graph below demonstrates the decline in district nurse numbers:



A similar trend can also be seen in the health visitor workforce. RCN acknowledges that it is expected that this trend will soon be reversed, as a result of the Department of Health's current programme to increase the health visitor workforce by 4,200 posts:

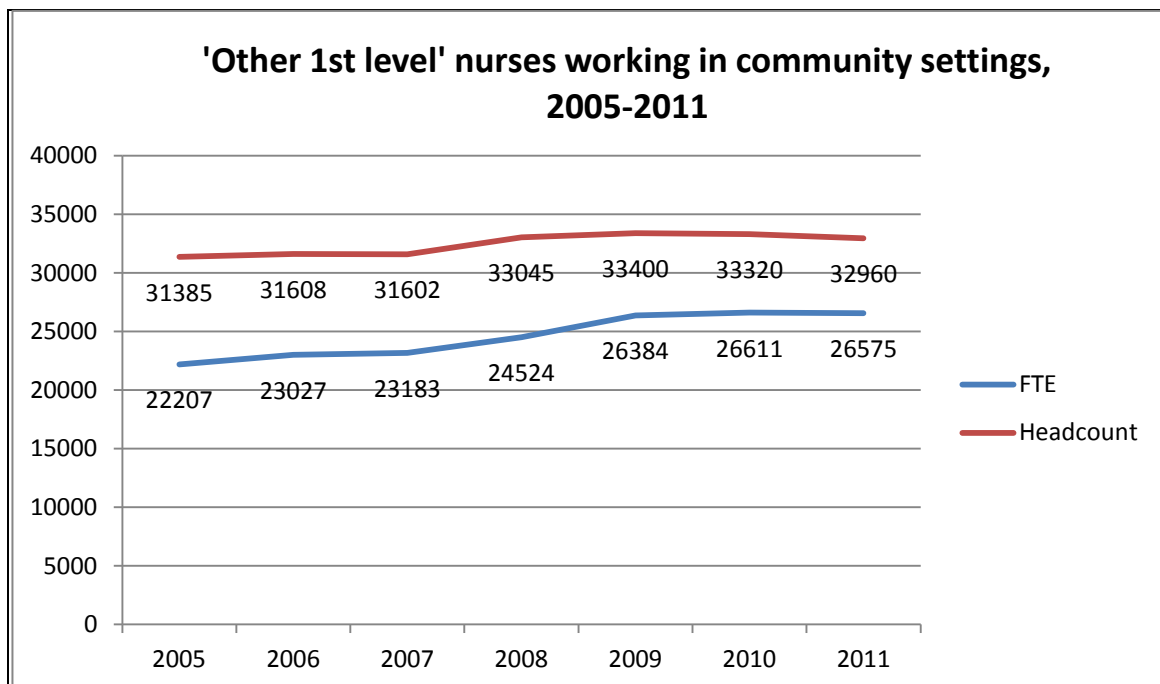


In contrast, qualified school nurse numbers showed a steady rise until 2008-9 then, a slight dip in 2010, and have plateaued in the last three years.

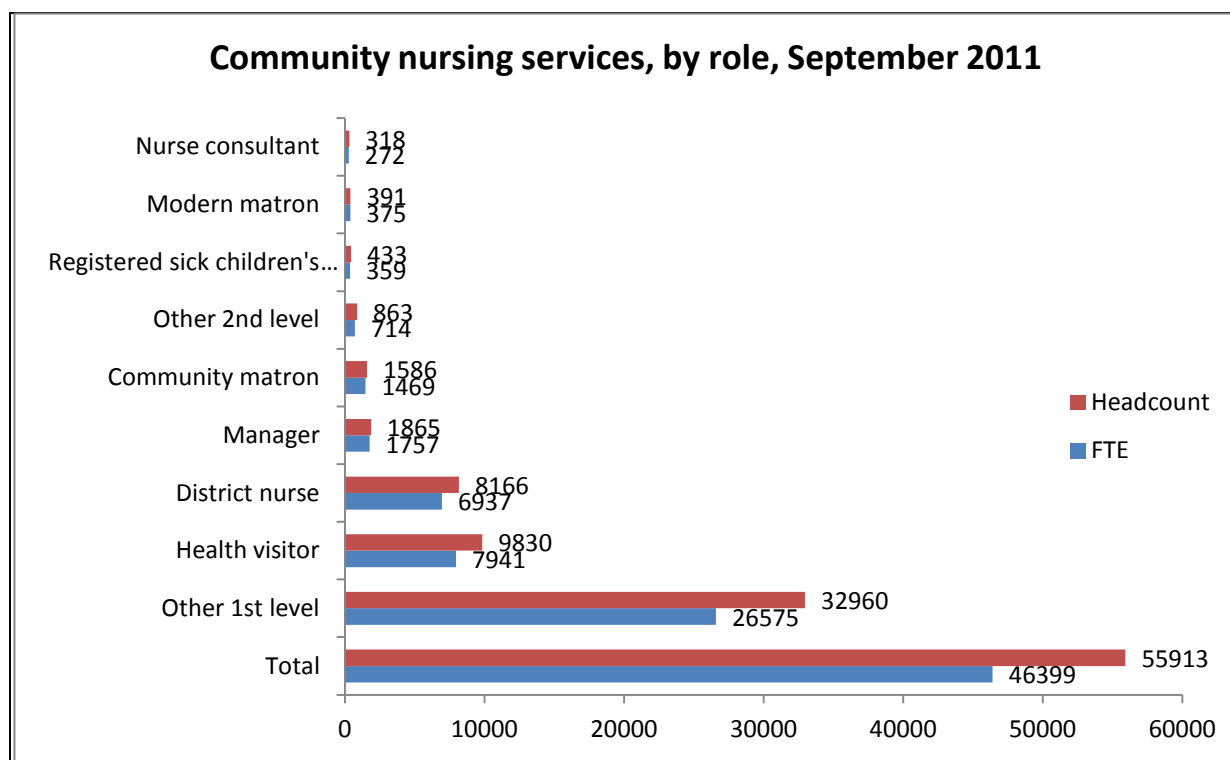


The largest single group of registered nursing staff in the community is designated under a non-specific category, as 'other 1<sup>st</sup> level' (first level registered nurse- the category assigned by the NHS Information Centre when collating workforce data). There is no comprehensive picture of precisely what these roles are.

Unlike the specialist workforce, data from 2005-2011 shows a modest overall increase in the number of nurses performing first level registered nurse roles in the community:



In 2011, at national level, community services are split by role type in the following way:



## ***Workforce intelligence gaps***

The national workforce statistics in this report are based on those provided by the NHS Information Centre, and are derived through the NHS Electronic Staff Record. They do not include GP practice staff or staff who no longer work for an NHS organisation (but who do provide NHS services) following service divestment under the Transforming Community Services programme. The Information Centre is currently undertaking a programme of work to resolve the implications for determining accurate workforce data with this shift towards third party providers in the community.

Put simply, it is not known how many nurses now work in community services which are delivered by non-NHS organisations. Many are working for social enterprises. In 2011, the Nursing Times carried out an investigation into the number of nurses working for social enterprises, obtaining information on 21 of 25 known organisations<sup>iv</sup>. They found that 9,134 nurses and nursing support staff had transferred to social enterprise and predicted the number would go beyond 10,000 including unverified data. However, a number of social enterprises refused to provide Nursing Times with workforce details.

There are further problems with the statistics which are collected by the NHS Information Centre, relating to a lack of detailed coding for individual roles/job titles. For example, whilst there is information about nurses performing roles such as Health Visitor or School Nurse, many nurses working in the community are recorded under a general category. This makes it difficult to develop an accurate or comprehensive national picture of the variety and mix of nursing roles in community teams.

There are also problems relying on statistics which show (or equate) the number of nurses with a given qualification. For example, a nurse with a district nurse qualification may not be employed as a 'district nurse'. Equally, some nurses may be employed under that title but not hold the particular qualification. For a similar reason, caution must be applied when considering other source of nursing workforce data, such as the Nursing and Midwifery Council register. Not only can we not assume that a nurse who is registered as having a District Nurse qualification is performing a district nurse role, we also cannot assume that they are currently practising.

The NHS Information Centre statistics designate a large number of staff working in community services as simply 'other 1<sup>st</sup> level' and 'other 2<sup>nd</sup> level'. The Information Centre states that these groups can include staff with specific community qualifications such as community psychiatric nurse or community learning disabilities nurse, but we have no comprehensive picture of the variety of roles the category encompasses.

## **Workforce oversight**

Community nursing services should be planned and delivered on the basis of local patient need and to a large degree, local areas have been left to develop appropriate services (and staffing).

However, in recent years there have been examples of national intervention on behalf of particular areas of nursing practice. For example – the health visiting action programme, designed to create 4,200 more health visitor posts by 2015.

The RCN is concerned that paradoxically, the intense current political interest in health visitors could have negative implications for other areas of the community workforce if nurses in other community roles, such as school nurses, are ‘poached’ in order to meet the only nationally set target.

Another example of the distorting effect of selective, narrow and sometimes short term top down policy “fix” rather than sustained and consistent approach to workforce planning is that of the community matron role established in 2006. It is highly probable that of the current 1,469 community matrons, a significant number may have crossed over into the role from that of being district nurses, therefore contributing to the decline of the district nursing discipline.

A short term or piecemeal approach which only focuses on a particular sub category of nursing e.g. school nurses or health visitors can be counter-productive. It undermines efforts to deliver a workforce fit for purpose across the board, and can result in the skills deficit shifting from one branch of nursing to another.

## **Investing in the next generation**

*Views from the frontline*, RCN’s employment survey for 2011 showed that many district nurses in particular believe their NHS pay banding does not fully reflect their skills or responsibilities (both managerial and clinical), including when compared to colleagues in other settings<sup>v</sup>. This has implications for the next generation of community nursing, if key leadership and clinically skilled roles in the community are seen as less attractive than roles in other settings which nurses may consider to be less stressful and/or better financially rewarded. Nurses told the RCN:

*“Have overall management responsibility for 11 other members of staff, a full caseload of patients and manage 3 GP practices. I am also a community practice teacher. I feel my current band and pay do not reflect this at all.”*

*“Community Care is diverse and in parts specialised. I am responsible for care 24/7 365 days year. I work alone, no backup ie no GP with me, I make clinical judgements independently. Specialist Nurses are band 7 even staff nurses in community hospitals are band 6 and they do not work alone.”*

## ***Moving care into the community: policy context***

The decline in parts of the qualified nursing workforce in the last decade belies both the consistent policy drivers demanding an increase in community capacity and an 'acute to community' shift; and the rising need for services as a result of an ageing population and the increasing burden of long term conditions.

In 2008, *High quality care for all – the NHS Next Stage Review final report*<sup>vi</sup> (the 'Darzi report') set out a blueprint for an NHS fit to meet the challenges of the 21<sup>st</sup> century. New ways of delivering services were proposed, emphasising frontline clinical empowerment and health care that is more responsive to patients' personal needs. Moving services into communities and closer to people's homes, rather than in hospitals and surgeries, was key to the vision.

Individual strategies such as the End of Life Care strategy launched in 2008<sup>vii</sup>, also emphasise the importance of access to care in community settings. It called for Primary Care Trusts and Local Authorities to make sure there was 'rapid access to care', by ensuring that medical, nursing and personal care services were available in the community 24/7, without delay.

A major upheaval in community services followed, under the Transforming Community Services (TCS) programme which was designed to help meet the aspirations of the Next Stage Review. TCS was intended to support the delivery of new models of high quality care, helping to provide integrated working between services and seamless patient care, and was considered to be key to the Quality Innovation, Productivity and Prevention (QIPP) agenda. Under TCS the split between commissioning and provision of community services was enacted, leaving Primary Care Trusts as the commissioners of care and provider functions with the option of integrating with acute or mental health trusts, forming community trusts or establishing social enterprises.

## **Results of the RCN survey of community nurses**

In April 2012 the RCN surveyed nurses working in community teams across the UK. The results paint a picture of a workforce under pressure. A majority of respondents reported that registered staffing levels had decreased (61%), and when asked to give further details of the kind of changes which had taken place in their team in the last year, familiar patterns emerged. Nearly half (47%) reported recruitment freezes and vacancies being left unfilled; over a third (37%) identified changes to the skill mix within teams; a similar number (34%) identified that roles were being expanded so that staff were covering wider areas.

### **Community services under pressure**

Our survey results clearly demonstrate that this contraction of the community workforce, alongside what appears to be an uplift in both volume and complexity of patient care needs, has had a dramatic impact on the capacity of community nurses on the front line. A startling 89% of nurses reported that their caseloads had increased in the last year (with 62% reporting a significant increase). Inevitably, the rise in caseloads has resulted in a reduction in the time that nurses can spend with their patients – 60% of respondents were spending less time with patients than they did a year ago, with over a quarter (26%) claiming their patient-facing time had significantly decreased.

Nurses told us that they are working overtime and unpaid in order to keep up with patient need:

*“Our patients receive good care most of the time because the team works extra, unpaid, 90% of the time.”*

*“Staff are working over to meet needs of service without being paid but feel they need to do this to provide the appropriate care.”*

Less time with patients means that there is an increased risk that the quality of patient care will suffer. Only a small minority of nurses (6%) felt that they always had the time to deliver the level of care patients needed. Sometimes this lack of time resulted in the inability to properly discuss patients concerns:

*“It takes time for people to open up or discuss concerns, we don’t have the time to give them.”*

*“Very limited time for patient appointments, not enough time to discuss patient concerns or deal with complex needs.”*

Nurses also expressed that ‘something would be missed’ due to lack of time, as they are being forced to strip nursing care down to individual tasks rather than assess a patients wider needs:

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*“My team have become very task oriented due to the increased amount of daily patient visits. This has meant that the staff are not sometimes noticing vulnerable adults at risk.”*

*“Nurses are rushing around on their daily visits so much that they are very task orientated and are not looking at the care of the patient holistically, this is leading to more problems building up and needs not being met.”*

*“Our visits are necessarily so brief and task focused due to the number of patients we must visit per day, that we do not have time to look at psycho-social or environmental issues (that) may be putting patients at risk. We need more time with patients to discuss and observe the other problems they are encountering...you cannot do this if you are rushing to between 15 and 20 different houses in 7 hours.”*

### **Acute to community shift**

Alongside the reduced capacity and increased caseloads placing pressure on community teams, the experience of nurses on the ground suggests that the health system is actively moving more patients more quickly into community settings. For example, most nurses (86%) agreed that patients were being discharged from hospital more quickly than a year ago. They also overwhelmingly agreed (91.5%) that community services are dealing with patients with more complex needs than previously.

There has been broad consensus that shifting care out of hospitals and into homes and communities is a good thing for patients and successive governments have sought to incentivise the health system to bring this about. However, alongside the shift in activity there must be corresponding investment in the community services in order to ensure they have the capacity not only to ‘cope’ but to deliver quality care for all patients. The analysis of the short term and long term trends in community nursing numbers above demonstrates that sustained and necessary investment has not been made.

The results of our survey further suggests that nurses are no more confident that it will be made in the future. We asked if, in the last year, they had seen evidence in their local area of new community health services being developed to meet the needs of the community. Just over a quarter (29%) agreed that this was the case, but far more (40%) disagreed. Unsurprisingly given the evidence on reduction in staff in many areas, very few respondents (7%) agreed that in their area more community health staff were being employed to meet community needs.

### **Capacity to meet future patient need**

The survey also explored whether community nurses are confident their services could cope if, in line with government policy, even more care was to shift out of hospitals and into the community. The RCN asked whether, within a normal working day, nurses had the capacity to do additional unplanned visits in response to patient need. Many (40%) responded that they could do this ‘sometimes’, but the largest proportion (42%) said that rarely or even never, did they have capacity for this. This



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is a stark warning that there is simply no slack in the system.

Indeed when asked directly how confident they were that community nursing services in their area could cope if more services move from the acute sector into the community, a large majority of nurses said they were not confident (80%).

The views of this nurse sum up the pressure nurses are feeling in trying to keep up with current, let alone future, needs:

*“We no longer have a designated rapid response service to keep acutely ill patients at home. This was disbanded and the D/N team have had to absorb this service without any extra staff. They are trying to extend the service they provide with reduced staffing levels. I feel the wallpaper is coming off the walls and I am trying to keep it up with my hands.”*

### **Impact of cuts in social care**

Community nursing teams work as part of a wider system. Patients’ needs should be seen holistically – and frequently patients requiring nursing care in the community will also require care and support from social services. Community nursing teams need to be able to work with professionals from other services, therefore, in order to ensure patients have the best experience possible. However, the results of our survey show that social care services are also under extreme pressure with 62% of respondents agreeing that social care services in their area have been cut.

The RCN asked nurses for examples of how these cuts are impacting the NHS service and patients and the results are deeply concerning. Three quarters (76%) agreed that social care cuts have resulted in increased work pressures in their teams. Only 15% agreed that the patients in their care receive adequate support from social care services.

Nurses identified a number of common themes which demonstrate the realities of social care cuts:

- Social services frequently taking too long to assess patients, and then to put a package of care in place.
- When care packages are agreed, eligibility criteria has increased to include only those with the most pressing and severe needs.
- Inadequate training for some social care staff.

Nurses told the RCN:

*“The threshold at which a patient gets a service has increased so that only the seriously unwell get help now.”*

*“Care packages being cut. Patients now not showered...patients being put to bed at 5pm as low staffing levels then not seen again till 9am for breakfast calls.”*

The impact of the lack of capacity and raised eligibility criteria is felt by community nursing teams and their patients in a number of ways.

The right community services need to be in place before patients leave acute care. This means having the right assessments and referrals in advance of discharge from hospital, to ensure that correct package of care is available to support people to stay out of hospital. Responses to our survey showed that this is not always happening. There appear to be particular pressure points around out of hours requirements, and again, community nursing teams are forced to step in when lack of planning or capacity in other services fail.

A number of nurses highlighted this:

*“One particular patient who was at risk was left over a weekend and into the middle of the following week before he was able to get any help. This was an urgent referral yet because it was put in on a Friday nothing was done. This is happening more and more with hospitals wanting to discharge patients as soon as possible and having no package of care in place.”*

*“The hospitals appear to be lapsing into bad habits whereby they are discharging unwell patients without the necessary equipment/referrals etc being established.”*

*“There seems to be a real drive to discharge patients home before they are ready. Home support is not always adequately assessed. Care manager are not always listening to nurses during meetings and some patients are back in hospital within days of discharge.”*

The most damaging impact of lack of social care provision is that on patients, and results in increased health need, for example:

*“Social care becomes health care due to lack of continuity of carers, catheter problems, pressure damage.”*

*“Pressure sores are on the increase because social care staff are short staffed and inadequately trained.”*

Ultimately this can also result in increased or unnecessary ‘revolving door’ admissions to hospital, which is the very antithesis of the principles underlying the acute to community shift policy:

*“I work for the out of hours service and a lot of the calls I go out to now are elderly people who can’t cope at home and don’t want to go into hospital as they have had a bad experience there. There isn’t the social support there to help prevent this, so a lot of the time they end up going in (and I suspect, bounced back out again soon after).”*

*“Extremely difficult to obtain adequate packages of care...but services at best not increasing to cope with demand. More patients are ‘bouncing’ back into hospital within short period after discharge.”*

*“Patients are admitted due to lack of community support to enable them to remain at home.”*

Nurses also gave examples of nursing services called on to ‘fill the gap’, and a number of comments exposed the inappropriate use of district nursing teams to make sure basic care needs were being met:

*“District nurses appear to be expected to fill in gaps and solve ALL problems which arise.”*

*“Patients have stayed on the DN caseload even when there is no nursing need because there is no social care to take over.”*

All of these tasks take nurses away from providing nursing care and contribute to the fact that both social services and nursing services alike are so stretched for time that they are ‘fire fighting’ once patients are at crisis point, because they are unable to prioritise and spend time taking preventative action.

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<sup>i</sup> RCN (2010) *Pillars of the community: the RCN’s UK position on the development of the registered nursing workforce in the community*, London, RCN. See:

[http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0007/335473/003843.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0007/335473/003843.pdf)

<sup>ii</sup> Note. All national NHS workforce data in this report is sourced from the NHS Information Centre for health and social care, using workforce census data published between 2006-2012. Data for September 2011 was taken from *NHS Hospital and Community Health Services: Non-medical staff, in England – 2001-2011, as at 30 September* (March 2012). See:

<http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers>

<sup>iii</sup> RCN (2012) *Frontline First Congress 2012 update*, London, RCN

<sup>iv</sup> <http://www.nursingtimes.net/whats-new-in-nursing/news-topics/health-workforce/10000-plus-nurses-have-joined-social-enterprises/5037234.article>

<sup>v</sup> [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0019/407242/004184.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0019/407242/004184.pdf)

<sup>vi</sup>

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_085828.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf)

<sup>vii</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086277](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277)