

The Queen's Nursing Institute and Royal College of Nursing: Roundtable discussion on the future of District Nursing

Purpose

In 2014 both the Queen's Nursing Institute and the Royal College of Nursing published reports on the current state of District Nursing, which, taken together, provide important new data on team composition, workload, partnership working and perceptions of quality of care – in addition to a clear articulation of the rewards and challenges that District Nurses encounter on a daily basis. Separately, both organisations have made recommendations for policy makers, service planners and commissioners based on the data gathered.

In order to test out these themes, a round table event brought together leading clinical, academic and policy experts in District Nursing. The challenge to the group was not to go over old ground about what is already known about District Nursing but to look to the future and consider what a blueprint for a dynamic and modern District Nursing service might look like.

Participants were encouraged to consider this in the context of the recent NHS Five Year Forward View, as well as the opportunities available, with a general election forthcoming, to promote healthcare priorities in the political agenda; and specifically to determine whether there are service or workforce models for which the QNI and RCN should be advocating.

Challenges set out by QNI and RCN

To start the discussion, the QNI set out three major themes arising from their survey data:

- the District Nursing workforce is stretched – District Nurses love their job but are concerned about the skill mix and teams becoming more task oriented;
- mobile working – services need to be brought into the 21st century with appropriate hardware and software to free up more time to care; and
- partnership working, with discharge planning singled out as the most significant issue, impacting on the ability of the District Nursing service to deliver the highest quality of care.

The RCN set further parameters to the debate, asking 'how do we talk District Nursing up' without inadvertently 'talking it down' when using the negative figures about the District Nurse workforce to raise public awareness of this issue?

Participants were asked to consider that whilst the decline in District Nursing numbers cannot be reversed overnight, what should be done in the mean time? Is there a 'right number' of District Nurses we should be aiming for? Those present were offered a stark reminder that in RCN's survey, where District Nurses self-reported on their perceptions of the care given on last shift, there was a clear relationship between the size of caseload and the quality of care given, which fell in line with the increase in caseload sizes.

National Education and Workforce Context

It was noted that District Nursing is on the national agenda for Health Education England, which is working on a strategy for District Nurse education in the future. Participants noted that recruitment and retention for District Nurses must be seen in the context of local economies across the country: there is no single national picture. For example, geographical issues are highly significant, with turnover in District Nursing posts very low, in general, in regions such as the northeast, but the labour market as a whole is far more dynamic in cities like London, which has a higher turnover.

District Nurses and the integrated team

Some time was spent considering the parameters of the discussion and whether it should focus solely on qualified District Nurses or the wider community team. It was suggested that this issue is very relevant to how the workforce is described and accounted for when considering District and Community Nursing teams, because whilst District Nurse numbers have fallen in recent years, total community nursing numbers have held steady.

It was acknowledged that this is an issue which comes up frequently when discussing District and community nursing; there is always a challenge in finding the right balance in focusing on District Nurses (by which we mean a nurse who is the team leader holding the specialist qualification) whilst recognising the contribution of the broader spectrum of community nursing services.

It was considered helpful to refer to the District Nursing service, by which we mean the whole team managed by the team leader, including the staff nurses and nursing assistants. How far is it possible – or desirable – to separate decision making and planning about District Nurses from the wider teams in which they work?

Two points came out strongly. One, solutions honing sharply on the unique education/training requirements and subsequent supply of qualified District Nurses are critical because of the nature of their 'offer' to the healthcare economy. And yet, alongside this, there was recognition that part of the strength of that unique offer is in itself the integration of the District Nursing service with the other services a patient might require along the care pathway. It was agreed that planning the workforce for a locally appropriate District Nursing service must take into account the context of integrated service planning and delivery models.

There was a strong view that it was legitimate for the table to focus on the District Nurse who holds the NMC approved specialist practitioner qualification (SPQ), with one participant noting, "obviously, District Nursing doesn't exist in isolation...but we will dilute the focus if we look at all strands of nursing".

Concluding this section of discussion, there was a suggestion that with regard to the number of District Nurses as opposed to the wider community workforce, we may not have all the information we need to make a credible argument for the numbers required. For example, an acceptable overall number of District Nurses might look very different if there was a more sophisticated inclusion of the additional uncontracted hours worked by District Nurses in order to meet the needs of their patients. Employers must reflect workload and population need more accurately before we can consider formulating a 'right' number.

Commissioning of District Nursing services

NHS England chief executive Simon Stevens' recent call for nurses to demonstrate their innovation and leadership in the challenging climate facing the NHS was referenced as a rallying call for articulating a clear and compelling case for the commissioning of District Nursing services.

There was a view that in commissioning, the importance lies in ensuring that the right patient services are secured, rather than focusing on the nature of the service provider. If the service is commissioned correctly, patient outcomes are more likely to be good. Influencing commissioning is critical and a clear message to

commissioners about the potential of the District Nursing service to improve patient safety, outcomes and choice is required.

With regard to influencing commissioners, a national competency framework across the health economy will help. We are more likely to get commissioners on board with a well evidenced business case than if we provide a case based on a professional agenda. It was recognised that NHS England and the Department of Health produced in January 2013 'Care in Local Communities: a vision and model for District Nursing' with QNI input, which provides a guide for commissioners on the role of the District Nursing service.

The point was also made that District Nurses play an important role in supporting carers and families as well as patients. The service needs to be able to articulate what is provided for everyone in order to keep people cared for at home, where they want to be. More work is still needed to build the District Nurse value in the context of cost effectiveness as well as patient experience.

There was a discussion around the benefits and drawbacks of a 'professionalising agenda'. It was felt by many present that this kind of agenda was a challenge for GP commissioners and that a better approach was to articulate the services that District Nurses provide for patients – for example administration of medicines, caring for people with multiple co morbidities who may have needs that are not covered by community care packages, people requiring palliative care, and people with long term conditions which fluctuate and exacerbate.

This can be difficult, as much work has been done to represent the broad spectrum and generalist nature of the District Nurse role, to challenge the reductionist view focusing on overly simplistic 'tasks' or work with particular demographic groups. For example, whilst many participants talked about the role of District Nurses in caring for the frail, the elderly, and those with long term conditions– many felt this was a reductionist approach which did not recognise the broad scope of the District Nurse role.

In any commissioning environment, there is a need to focus on patient needs and outcomes, which will resonate more than the professionalising agenda. However it was also recognised that District Nurses need a professional identity as well. The block contracting of the service across the country does not always allow for the detail and value of the service to be well-articulated. Detailing what is required from the service, where the costs lie and the value of leadership of the service needs to be understood.

Evidence of impact is key for commissioners, but it was posed that it can be hard to make the case for specific outcomes delivered by the District Nursing service because they are 'highly dynamic', often dependent on the interplay of many aspects of the health and social care economy. This means that there is a need to improve the way in which outcomes are measured and articulated.

What is the District Nursing contribution?

The discussion about focus led participants to consider what the District Nursing service has to offer and the importance of recognising the skills and competencies that the District Nurses leading the teams can provide.

It was suggested that the way to 'sell' the importance of District Nursing is to set it in the context of the integrated care agenda. One participant suggested that 'District Nurses are interdependent with wider team members as they are part of a whole system approach to patient care in the home.'

There can be a consequent issue with identity. One District Nurse present noted, 'some of my patients think I'm from social services'. There was a desire among those present for District Nurses to retain a distinct professional identity: the SPQ was considered vital to District Nurses' offer to a wider integrated team and this should be embraced and articulated.

It was suggested that the title of District Nurse resonates well with and is understood by the older population in particular. The challenge is to ensure that District Nursing has a contemporary feel and that it is seen as a modern, forward looking service.

What is a District Nurse?

This led into discussion about what precisely a District Nurse is. Many in the room voiced the feeling that it is hard to define the complexity of District Nursing work because of its holistic and fundamentally flexible nature. Some are case managers, some may specialise and others may be generalists for their entire career.

Whilst complex case management was acknowledged as a 'given', one participant also noted the volume of work District Nurses carry out for people who are not part of a defined caseload, e.g. partners and carers, noting, 'it can be quite invisible work...not easy to find in data or literature'.

The question was asked, “Should we be advocating what the expertise of District Nurses is, for example, with reference to the client groups they care for, which would mesh well with care pathways, for example?”

There was reluctance to voice approval for any one service model, as it was suggested that models themselves may differ but the principle of the District Nurse role within that model will be same, for example in relation to quality clinical care and leadership, regardless of what the local health economy looks like. Ultimately, the skills and experience of District Nurses were felt to enhance care, regardless of differences in the way local areas may choose to design or deliver their services.

There was a recognition that District Nurses work with a range of populations, not only frail older people. A number of functions and demographic parameters could be identified, for example frailty, end of life care, self care, rapid response – District Nurses bring unique skills to their work in each area.

The group then considered the question – how would they explain District Nursing if they had 30 seconds in an elevator with the prime minister? What would they say to sell the concept?

One suggested, ‘a District Nurse is a person who glues the services together, whatever those services need to be...District Nurses know what’s out there and can bring the services required in plus they offer flexibility and don’t close caseloads.

Another offered, District Nurses ‘support patients to be cared for where they want to be cared for in their own homes and prevent avoidable admissions and readmissions to hospital’.

This second example is a wider, more generic descriptor of what a District Nurse does, without going into the specifics of particular roles or care offered to different population groups.

Ultimately, it was pointed out that we already have clarity about the skills and competencies of District Nurses. The ‘Care in local communities: a new vision and model for District Nursing’¹ document from January 2013 gives a clear description and clear principles about the functions and the types of services they might work in. We need to be better at utilising what is already out there rather than reinventing the wheel.

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213363/vision-District-Nursing-04012013.pdf

What should the immediate priorities be?

The group agreed that there are determinants other than team numbers which could increase service capacity, for example appropriate administrative support and intelligent technology, but also improved referral management systems.

It was also noted that the right tools to support workforce planning appear to be lacking, certainly none that can be promoted nationally at the time being, because they are not yet flexible enough.

There was brief discussion about the ageing nature of the District Nursing workforce and how to retain those experienced Nurses in the service. It was suggested by one participant that this concern can be over egged – District Nurses are inevitably an older workforce because they have reached a more senior level in their career and are an extremely experienced group of Nurses. The problem is not so much the current 'ageing' workforce but being clear about sufficient numbers of Nurses coming through the system to replace them.

It was suggested that we need to find urgent workable solutions rather than keep re-articulating the problem, looking for the short term actions we can push through whilst more sophisticated long term workforce plans are made.

For example, we know we need to introduce undergraduate nurses to the community and to the career possibilities there: how can we get them through to the community more quickly? Perhaps we could be more radical in how we use the workplace for learning, finding and training more facilitators in community settings to support this. This depends on supporting the staff we have there now, so that they have the time to work with students and nurses moving into community settings. This is where it was felt that administrative support and the best hardware and software was so crucial, to ensure that District Nurses' time is spent efficiently. District Nurses need agile working solutions so that they can spend their time both with patients and supporting the learning of other nurses.

Conclusion

Rumination on the subject of District Nursing can often fall into the same traps – namely, a circular debate about the importance of District Nursing versus or alongside the wider integrated community workforce; and sermonising on the unique ‘offer’ of and importance of the District Nurse.

It is important to remember that this is well trodden ground and there is existing recent work we can refer to and promote which clearly sets out what a District Nurse is, and their contribution to the patient care pathway, in answer to these questions.

A clear message from around the table was that we all need to be better at harnessing that existing and current impact to make well-articulated and evidenced based representations to commissioning authorities.

The discussion highlighted that there are multiple facets both to promoting the value of and planning for the future of District Nursing. There are opportunities at this exciting time to influence the shape of health services, with multiple audiences to target, from politicians in the run up to the general election, to commissioning groups, the public and the media, influencing the portrayal of nurses working in the community. The messages to all these audiences may contain subtle differences but for all, it is about building a convincing case which articulates how District Nursing can help provide an economically viable and high quality experience for patients in financially challenging times, allowing people to be cared for at home, where they want to be.

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