**What’s in a name?**

**District Nursing: in danger of extinction?**

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Abstract.

District Nurses have been delivering care at home for over 150 years. Their role is appreciated by colleagues, patients and carers alike and can often make the difference between remaining in a preferred location of care or a preferred place of death.

The role has changed considerably over this time: patients are living longer with increasingly more complex conditions; earlier discharges from secondary care are common with more acute patients returning to be cared for at home and comorbid mental health conditions are often the norm for people.

However, against this backdrop, District Nurse numbers are falling, and are expected to continue to fall, due, in part, to an ageing workforce but also a reduction in training, both places and funding, which is potentially putting the future of the District Nurse in jeopardy.

Urgent action is required to avoid losing this cornerstone of ‘care closer to home’.

Key words: district nurse; community; advanced practice; team working.

Background.

According to the Queen’s Nursing Institute (QNI) (2013), the title ‘District Nurse’ (DN) refers to a Registered Nurse with a Specialist Practitioner Qualification, recorded with the Nursing and Midwifery Council. District Nursing has a rich history, a profession since 1859, long before the establishment of the National Health Service (NHS) in 1948. The first ‘training school’ was established in Liverpool in 1863 triggered by the death of the wife of William Rathbone, a wealthy merchant. Rathbone had employed a nurse to care for his wife at home and on her death, he decided that such a service should be established but found that there was a lack of appropriately trained nurses. In 1860, Florence Nightingale advised Rathbone to start a nurse training school for nurses, which was completed by May 1863. The QNI was established to co-ordinate DN training nationally in 1887.

Over the ensuing 150 years, many things have changed for DNs. Patients are living longer; male life expectancy has increased from 65 to 79 years and female, from 70 to 83 years over the last 60 years (ONS, 2014). Alongside such dramatically improved longevity has come the ‘burden’ of increasing complexity and dependency (DH, 2014). Similarly, the care delivered by DNs and their teams has undergone substantial change. Some of this ‘change’, has been as a direct result of service delivery demands, including a call for a move of care delivery from secondary to primary care, endless cost savings, reorganisations and restructuring. Added to this, the overall picture of healthcare delivery has dramatically changed; in-patient stays are now of considerably shorter duration and patients are discharged whilst still very dependent, to be cared for at home or within the community. The prevalence of patients with multimorbidity – where two or more diseases occur at one time – is increasing at an alarming rate due in part to changing demographics but also due to improvements in healthcare delivery (American Expert Panel, 2012; Barnett et al, 2012). Such complex patients often have frequent contact with a range of health care professionals (HCPs); a complex system which is most often coordinated and supported by their DN. Widespread reports from patients reflect experiences of fragmented care; frequent consultations with an array of specialists, multiple appointments and a ‘chaotic experience’ of healthcare (Coulter et al, 2013) – often a complex jigsaw held together by the DN service.

The role of the District Nurse

Alongside and in response to these changing demographics and healthcare provision, the delivery of nursing care within the community has also undergone quite dramatic ‘modernisation’. This has expanded the remit of DN teams to include responsibility for patients with greater acuity; this has resulted in busier schedules and mounting, competing demands on the service provision (QNI, 2009; DH, 2013, RCN, 2013). In addition, each DN team continues to have day-to-day responsibility for the care of the many patients who suffer from complex and debilitating long term and palliative conditions. Balancing these competing demands, often accompanied by diminishing staff numbers, presents every DN team with daily challenges (QNI, 2013). These increasing demands, according to the QNI (QNI, 2009; 2013), potentially result in delayed visits, hurried consultations and the possibility of compromised care. Such pressures intensify the challenge of allocating and managing the daily workload for the DN and can impact on the ability of the team to consistently deliver high quality care.

The Specialist Practice Qualification.

The variety and immediacy of demands placed on DN teams has increased considerably (QNI, 2014). In order to effectively manage and prioritise these competing demands, whilst ensuring maintenance of best quality care, it is essential that the leader of each team – the DN – has had additional, specific training; the Specialist Practice Qualification (SPQ DN). The SPQ DN, to date, available at both degree or postgraduate level, is a course that, when successfully completed is recorded by the Nursing and Midwifery Council (NMC) recordable qualification and gives the nurse the title District Nurse. The NMC (2001) define specialist practice as:

‘…….the exercising of higher levels of judgement, discretion and decision making in clinical care. Such practice will demonstrate higher levels of clinical decision making and so enable the monitoring and improving of standards of care through: supervision of practice; clinical audit; development of practice through research; teaching and the support of professional colleagues and the provision of skilled leadership.’ (NMC, 2001; p1).

Until 2017, the course has been commissioned at a number of Higher Education Institutions (HEIs) across the United Kingdom (UK) and is ‘transformational’ for practitioners, enabling future DNs to lead and support complex care in a variety of community settings working alongside a range of professionals and agencies (DH, 2013).

The DH, QNI and NHS commissioning board released a document in 2013 which made it clear that the DN SPQ is highly valued and should remain for those leading District Nursing (DN) teams, in order to provide the expertise of care required by patients, the team and the wider community. Indeed, reports cited the DN SPQ as being the core of community nursing leadership with complex, frail and end of life patients. This was reiterated in the Health Education England Career Framework where the minimal educational requirement for a level 6 District Nurse role was: NMC recordable DN SPQ. Although courses were required at a minimum of degree level (level 6), by 2020 there is an expectation that significant progress would have been made towards all courses being at postgraduate level (level7).

Recently the QNI (2015) explored the value of the SPQ DN qualification in response to a reported fall in national numbers of commissioned places on SPQ DN courses. The report (QNI, 2015) demonstrated a distinct image of the effectiveness of the SPQ DN course to ‘lead and manage a responsive DN service’ (p.4). Overall work, however, highlighted concerns that commissioners and employers fail to acknowledge the true value of the course (Longstaff, 2013) and there is evidence that in 2017 the uptake and number of places available have fallen (QNI, 2017). A further challenge for future SPQ DN programmes from 2018 onwards are the changes to continuing professional development and postgraduate funding and a shift to an apprenticeship model. This may be the death knell for District Nursing.

Earlier in 2017, the King’s Fund published a report, ‘Understanding NHS financial pressures: How are they affecting patient care?’ (Robertson et al, 2017). The report reviewed the impact of financial pressures on 4 services: Genitourinary (GUM), District Nursing (DN), Total Hip Replacements and Neonatal care; and concluded that GUM and DN are areas where financial pressures are having the greatest impact.

The report acknowledged that metrics were particularly difficult to gather from community services, however the data sourced evidenced the impact of financial pressures on patient care, including increased episodic DN care, task orientation during visits, limiting opportunities to fully assess patient’s needs (Robertson et al, 2017). All challenges evidenced in the earlier QNI report of 2013. In many cases, staff were acting as ‘shock absorbers’ working longer hours and missing breaks, to maintain a quality service; however, the report acknowledged that this was not a sustainable situation. Indeed, the King’s Fund report (Robertson et al, 2017) reinforced intelligence in relation to the impact of escalating financial pressures on the provision and quality of DN services. The report effectively evidenced the need to ensure that the ‘resource:demand’ gap in DN services is urgently addressed, to ensure that staff have sufficient time to holistically assess and support their complex patients.

In addition, the report (Robertson et al, 2017) highlighted workforce issues; it evidenced a falling number of qualified DNs who hold the Nursing and Midwifery Council (NMC) recordable SPQ, further evidenced by the QNI report (2017) on numbers of SPQ students recruited to courses 2016-2017. In addition to the fall in DNs, there was also an identified fall in the overall numbers of community nurses. These falling numbers, the report identified, were being further exacerbated by a lack of appropriately qualified applicants for vacancies and an ageing workforce; both issues that are destined to deteriorate.

The risks of these pressures on the DN services include a potential for unmet need due to changes in access to the service and the need to maintain the quality of care provision. The report identified that staff were ‘on their knees’ trying to maintain quality but were straining under this pressure, which was damaging staff morale and their ability to function effectively (Robertson et al, 2017). As a result of working under such pressure, it was also noted that innovations aimed to increase productivity, in this environment, were more difficult to achieve within a workforce whose focus is simply to survive.

The report identified priorities for District Nursing including improved relationships with commissioners, more responsive finding to support the intended shift of care closer to home, ensuring training DNs to Specialist Practice level to lead teams, enhanced education for Community Staff Nurses and Health Care Support Workers; all areas often overlooked for investment in the light of financial pressures; aimed at preventing DN services becoming a Cinderella service (Robertson et al, 2017).

The 'specialism' of District Nursing is truly a unique profession. DNs and their teams care for complex patient's own home, an environment that differs dramatically from the nursing roles performed in a safe and supported clinical environment. DNs undertake advanced health assessment during every visit; these ‘advanced’ skills are active from the time they arrive at the home and knock on the door. DNs take in a multitude of information from the local environment, the state of the garden, the condition of the house – even before their patient has answered the door! Often, they do not have the luxury of a coherent patient history or reported symptoms to act on as many patients are poor historians; the diagnosis and treatment by the DN is based on their multi-faceted knowledge and skills that include the environment, living conditions, social support, physical symptoms, etc. In addition to the application of these advanced clinical skills, the DN also manages a busy and demanding caseload; DNs triage and allocate work taking in the acuity of patients and skills of their team. Their team management issues all go far beyond other advanced clinical roles.

The Royal College of Nursing (RCN) DN Forum recently surveyed the members of the Forum about the value of DN SPQ. Responses included that 86% of Trusts valued and continued to support staff to complete the SPQ qualification. Sadly, where a Trust no longer supported staff to undertake their SPQ, often the replacement was a single module; a situation that may be repeated across many Trusts if this recordable qualification is lost. Of the survey respondents, 80% felt that the SPQ qualification was an essential qualification for the DN to effectively manage a caseload; stating it prepared nurses for caring for complexity, effective multidisciplinary team (MDT) management, leading large teams of nurses with a range of skills and competencies, understanding the underpinning theory, analysis of community needs, advanced practice & leadership skills, applying tools to lead and manage a team, caseload management, planning for future needs, professional development, critical thinking, understanding of healthcare challenges, political understanding and holistic assessment. Indeed, one respondent stated that DN care is most complex care delivery that there is.

Much like the role of a General Practitioner (GP), the role of the DN is multi-faceted; keeping people at home and out of hospital requires advanced health assessment, clinical decision making and prescribing, along with team management skills and exceptional clinical leadership for a multi-disciplinary team. The autonomous role of the DN requires an assertive advocate for patients, along with clinical decision making and risk assessment skills for effective caseload management and anticipatory care, to promote independence.  DNs often manage caseloads of more than 200 active patients; they actively profile the community they serve, developing an awareness of the needs of the local population that they serve.

As a complex, multi–faceted role, the skills, knowledge and competencies of the DN are not directly transferrable from any other area of nursing.  The clinical autonomy and professional accountability of the DN role therefore, requires assurance from commissioners, employers and the NMC, that is will be maintained and supported; this is essential, not least for the patients, carers, families and the public that we serve. This assurance requires Specialist Practitioner training, time to bridge theory to practice and competency sign off. Just as a Consultant in General Medicine cannot simply transfer and function effectively as a General Practitioner, an A&E Nurse is not able to transfer to District Nursing without additional training and qualifications.

The care delivered by DNs, and their teams, is complex, 24-hour and requires great skill and judgement. Specialist training for the leaders of our community teams is essential to ensure that quality care is maintained and patient safety preserved. We need a commitment that future funding and investment will be maintained to ensure that the role of the District Nurse does not become extinct.

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