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Issues for Debate

Reinstating district nursing: A UK perspective

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ABSTRACT

As policy directives gather pace for service provision to be delivered in primary care, district nursing has not been recognised as a valuable asset to facilitate this agenda. Investment in district nursing and specialist district nursing education has fallen. This is concurrent with an ageing district nursing workforce, a lack of recruitment and growing caseloads, as district nursing adapts to meet the challenges of the complexities of contemporary healthcare in the community. The district nurse role is complex and multifaceted and includes working collaboratively and creatively to coordinate care. Redressing the shortages of specialist district nurse practitioners with increased numbers of health care support workers will not replace the skill, knowledge, experience required to meet the complex care needs of today's society. District nursing needs to be reinstated as the valuable asset it is, through renewed investment in the service, research development and in specialist practice education. To prevent extinction district nurses need to be able to demonstrate and articulate the complexities and dynamisms of the role to reinstate themselves to their commissioners as a valuable asset for contemporary practice that can meet current health and social care needs effectively.

1. Background and context

In the UK the NHS care system is under unprecedented pressure due to increased demand and limited resource allocation (Ham, 2014). Contemporary policy directives support services being delivered in the community setting with care closer to home, in the right place by the right person at the right time (DH, 2006, DH, 2013a, NHS England 2014, Primary Care Workforce Commission (PCWC) 2015). As the primary care agenda has gathered pace there has been repeated service redesign and reorganisation in order to meet the increasing demand with limited resources.

Despite this district nursing services have been neglected, undervalued, under sourced, and largely unrecognised (Longstaff, 2013; QNI, 2009). With ageing populations requiring assistance to manage long term conditions (Alderwick et al., 2015) it would seem that the future of district nursing would be not only safe but central to policy agendas (Durrant, 2013). Unfortunately this is not necessarily the case. Investment in district nursing is declining, staff numbers in the community have not increased despite growing caseloads and the number of trained district nurses has fallen (Royal College of Nursing (RCN), 2013). New community services are introduced in a reactionary response for a 'quick fix' and can fragment care; these services are often recruiting from district nursing workforces (RCN, 2013; Yeaman, 2014), leaving district nurses under resourced and demoralised (Longstaff, 2013).

2. District nursing

The context of district nursing can be confusing due to the variety of titles and names used nationally and internationally to describe the role (Health Education England (HEE), 2015). The term 'district nurse' is used to describe nursing within the community and in the home in the UK, New Zealand, Australia, The Netherlands and Sweden (Haybin et al., 2016; O'Connor, 2011; Dawson et al., 2015; Sprinks, 2014, Hollman et al., 2014). Other countries with comparable health care systems such a Canada and Japan utilise the term 'community health nurses' or 'community nurse' (Aston et al., 2009; Yamada et al., 2010) whereas the USA opt for 'home care nurse' (Truglio-Londrigan, 2013). What appears to be unique to the UK in the context of community nursing is the Specialist Practice Qualification, a post registration award at a minimum of degree level, measured against regulatory body competencies (NMC, 2001), which develops experienced registered nurses to a specialist level to effectively lead and manage teams in the delivery of quality care in the home (Haybin et al., 2016). The title of district nurse on qualifying is only applicable to those with the award, which is recordable with the regulatory body for nursing in the UK

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(NMC, 2001), nurses working in the community without this specialist knowledge are referred to a s community staff nurses, practitioners or in more senior roles, case managers sometimes interchangeably (Haybin et al., 2016; HEE, 2015).

District nurses have long been a robust part of UK primary health care service delivery with an established traditional role (Glasper, 2013; RCN, 2013). This is the delivery of nursing care to patients in community settings who by the nature of their ill health are unable to access services elsewhere (Queens Nursing Institute (QNI), 2015). The original underpinning ethos of the district nursing service set out by William Rathbone in 1887 is surprisingly concurrent with contemporary health care policy directives. It envisaged patient choice in people preferring to remain at home for care, better care closer to home in the unsuitability of hospitals for treating disease and long term conditions, and the expense of treating people in hospital (Cook, 2009).

District nursing services have remained the key providers of nursing care in the community since the 19th century (Glasper, 2013). The role of the district nurse has developed since its conception to meet the changing and increasing needs of the population, the foundations of specialist district nursing practice remain contemporaneous but the complexity of care needs has changed (Blackman, 2009; RCN, 2013).

District nurses have adapted and developed to meet the needs of the population, and are a valuable national asset; however this does not appear to be recognised or valued in the context of contemporary healthcare (RCN, 2013; Oldman, 2014). There is a need for district nursing expertise to meet the challenges of complexities of contemporary community healthcare (RCN, 2013) and therefore the district nursing service needs to be reinstated (QNI, 2009).

3. Contemporary district nursing

Despite the changing landscape and demographics of 21st century health care, the district nurse role remains the foundation of a health care system that should be able to manage conditions to allow the sick and frail to remain at home (RCN, 2013). Modern day district nursing is a specialist role that utilises skills, knowledge and expertise in an unpredictable working environment (Kraszewski and Norris, 2014). Expert clinical assessment, therapeutic relationships and the navigation of complex health and social care systems concurrent with preventative and supportive approaches to care by district nurses facilitates the transformative way people receive care in their own homes in contemporary primary health care (Bliss, 2012; Edwards, 2014; Kraszewski and Norris, 2014).

The Royal College of Nursing (2013) identifies that district nursing services reduce the cost of patient care in long term conditions and provide appropriate care to assist people to live independently. Despite this in recent years district nurses have been a neglected profession, reportedly feeling undervalued, unrecognised and demoralised (Longstaff, 2013; QNI, 2009). The district nursing workforce in the UK has reduced by 44% since the Audit Commission (1999) first highlighted that numbers of qualified district nurses were falling due to an ageing workforce (While, 2013). The district nursing workforce has almost halved in the last decade (RCN, 2013). The need for district nursing services has always been high (Longstaff, 2013) and now with greater numbers of older sicker people requiring intensive nursing at home (RCN, 2013) the demand for district nursing services is increasing (QNI, 2013).

Dwindling numbers of district nurses and increased demand may result in an inadequate quality service (Gillen, 2013). Currently it is estimated that 38% of nurses in the community are aged 50 years or over (Kraszewski and Norris, 2014) and qualified district nurses make up only 12% of the community nursing workforce (While, 2013). District nursing has an ageing workforce with a large numbers of qualified district nurses approaching retirement (PCWC, 2015). Likewise there is a sustained lack of recruitment into the service (HEE, 2015; PCWC, 2015), where younger nurses are recruited there are limited experienced practitioners to supervise and develop them effectively (Kraszewski and Norris, 2014). This is of great importance in the community health care setting, where nurses work independently and autonomously often without direct supervision or immediate support, and thus care delivery and performance cannot instantly be reviewed (Dickson et al., 2011).

It is concerning that declining numbers of district nurses will not be sufficient to meet the prospective needs of primary health care populations (PCWC, 2015). Despite the focus of care being delivered in the community (Edwards, 2014) and the rhetoric of care closer to home (Monitor, 2015), the reality is that district nursing services may not be well equipped or prepared to meet the challenges of contemporary nursing in the community.

There has been a lack of investment in community nursing that is equal to the emphasis placed upon the primary care environment as the optimal context for the delivery of care (PCWC, 2015). Health care funding is paradoxical to health care policy in that it is weighted in favour of admission to hospital rather than care in the community (Oldman, 2014). This means a lack of funding provision for nursing care at home that is equal to the number of referrals into the district nursing service (Oldman, 2014). Since the coalition government was inaugurated in 2010 investment into district nursing services has reportedly been cut by 18% (Glasper, 2013).

For district nursing this has meant service redesign and organisation as services try to meet increasing demand with finite resource allocation. Thus district nursing services have become increasingly stretched, with nurses covering longer hours in diminishing numbers, resulting in frustration, burn out and change fatigue (RCN, 2013; Oldman, 2014a). Lack of understanding, recognition and value of the district nurse role has reduced it to a task focussed model (Bowers, 2013). This misunderstanding of the role has a potential to negatively impact on patient care (Kraszewski and Norris, 2014). Recent failings in care have demonstrated that task focussed approaches to care have the potential to produce ritualistic practice and cognitive blindness (Francis, 2013; Kirkup, 2015), where staff are unintentionally oblivious to omissions in care due to stress and burn out. District nursing service efficacy being measured in time units to complete tasks has compounded misconceptions, it needs to be understood that the service is more complex than administering insulin or dressing a leg ulcer, for the service to survive in contemporary contexts (Bowers, 2013; Oldman, 2014a). Risk of extinction of the district nursing service has been identified as a reality (RCN, 2013; Yeaman, 2014). Task allocation does not allow for the complexity of long term condition care, problem solving, the tacit skills of caring, and the building of therapeutic relationships by district nurses to be demonstrated or articulated in the provision of cost effective quality care (Bowers, 2013). Therefore the service may be over looked by commissioners. Complex health and social care needs and collaborative coordination of care which may be planned or unscheduled in a number of contexts cannot be facilitated effectively by an unskilled workforce (Rowse et al., 2013).

District nursing teams have heavy caseloads and poor referral systems (Wright et al., 2015). Similarly there is limited ability to define the capacity of workloads in ratio to staffing levels (Yeaman, 2014) and limited methods for nurses to raise workload concerns (Wright et al., 2015). Referrals into the district nursing service can appear limitless, with some nurses feeling unable to turn away inappropriate referrals regardless of their capacity to deal with them (Oldman, 2014). Conversely data from the QNI, (2013) identifies that a quarter of district nursing teams is refusing referrals,