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# The district nursing and community matron services workforce: A scoping review in South London for the South London Nursing Network

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**Academic, Health and Social Care**  
System



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## **Disclaimer**

The views and opinions expressed within the document are those of the author and not of the funding or commissioning organisations.

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## **Executive summary**

This report presents both an overview of the issues influencing district nursing and community matron workforces and also a scoping of key issues in respect of workforce development in district nursing and community matron services in South London to inform the work of the South London Nursing Network.

### *Over view of the issues influencing the district nursing and community nursing workforces*

The strategic policy direction relevant to the district nursing and community matron services attend is that for patient populations with long term conditions and their family carers. The policy expectations are for increased activity in support of public health and compassionate care and treatment outcomes that include health promotion (for example increased physical activity and smoking cessation), adult vaccination programmes, support for self-management, reducing premature mortality, increasing quality of life, improving rehabilitation following inpatient stays, greater integration with other health and social care services and improvement to end of life care. In line with other public services there is an expectation to reduce patient safety incidents, contribute to innovation and use technology to improve productivity and value for money.

All those working in the NHS community services form about 15% of the total numbers of nurses, health visitors and midwives in NHS England. District nursing and community matrons are a sub-set of the wider nursing labour market. Consequently the availability and calibre of staff in district nursing services is subject to the ebbs and flows of the supply of and demand for nurses of different levels of experience and skill in that larger pool.

Nurses who move from working in a hospital environment to the community, irrespective of level of clinical expertise, become novice practitioners again for four reasons that contrast to the situation in hospitals : 1) the patient is in control of all decisions and achieving positive patient outcomes relies on the nurse's ability to establish and maintain a relationship with the patient and their carers, 2) the patients and their carers undertake most of their own health maintenance, treatment and care activities with nurses proactively offering education , support, limited treatment and care activities and referral to other services, 3) the multiple systems of delivery of health and social care services and 4) the nurse has to make clinical and professional decisions, sometimes rapidly in less than ideal circumstances, at a physical distance from professional colleagues.

The last ten years have seen continued growth in nurses and health visitors employed in community services. District nursing teams are made up variously skilled and qualified nurses and support staff. It is the growth of employment of registered nurses in district nursing services that has contributed most to the growth in numbers of nurses employed in community health services. The London region demonstrates greater fluctuation in the full time equivalent posts in district nursing services than other regions with a downward trend since 2010.

The community nursing workforce has an older age profile than the acute hospital registered nurse profile, although this is not so marked when compared with only with nurses in more senior posts. It is only possible, from publically available data, to examine the gender and ethnic background of those with district nursing

qualifications (ten % male and ten per cent from minority ethnic backgrounds) and not the majority of nurses in community services. London region has reported some of the highest district nurse and other community nurses turnover rates in England.

In tandem with the growth of employment of registered nurses, the numbers with specific district nursing qualifications has been declining for over 20 years. The numbers of community matrons employed has also declined nationally and in London. There has also been a growth of other types of staff such as pharmacy assistants in the district nursing teams to assist with medication management in the home. There is however, no agreement as best model of skills in a district nursing team for efficient, effective and safe patient care or what is the optimum caseload size or case-mix for different levels and mixes of staffing. One recent economic modelling suggested that a more cost effective model of team included only qualified nurses rather than health care assistants.

The education and training needs for the district nursing and community matron services are defined by the service providers and variously commissioned from Higher Education Institutes, or provided in house, through NHS education and training commissioning mechanisms. These mechanisms are employer led within the Health Education England structures. The Centre for Workforce Intelligence horizon scanning report on the nursing workforce points to the key challenges in planning for the step change numbers in older people LTC by 2030:

It is evident from this brief overview above that the current and future staff in these types of services will have a range of ongoing education and training needs from the clinical, orientation to community and working in networks through to the management of people, time, resources and caseloads.

#### *The scoping review in South London*

Using web searches as well as interviews with a purposive sample of nurse leaders in commissioning and providing in south London, the following questions were investigated :

- Key issues facing district nursing and community matron services ,
- Perspectives on the development needs within these services both short and long term ,
- Perspectives on ways in which the South London Nursing Network could engage in addressing these in the context of Health Education South London (HESL).

The issues raised for the services included:

- Challenges in recruitment and retention of staff ,
- The changing case-mix of patients on district nurse caseloads,
- The overall capacity of the district nursing service,
- Tensions between generalism versus specialism in staff and services,
- Commissioning issues and interfaces with other services.

Key issues raised with regard to workforce development needs included:

- Clinical leadership,
- Clinical skills to meet changing patient case mix
- Creating career pathways that made it an attractive choice for the highest calibre staff.

Respondents valued the commissioning process through HESL and the responsiveness of the Universities to provide continuing professional development and bespoke development packages. It was suggested that there might be value in pan South London opportunities:

- For debate and learning about the benefits, challenges and consequences of different models of generalist and specialist services.
- For sharing learning about types of patient acuity tools and their use in caseload/resource management.
- To debate and consider the issue of preparation for leadership in district nursing teams.
- To share learning and ideas as to how to create sustainable career pathways in community nursing.
- To share learning and ideas as to how to develop, improve and sustain interprofessional working between district nursing and other services.<sup>4</sup>

When asked whether these were new issues or new requirements for development, most respondents replied they were not although some issues were thought to have heightened urgency in the face of the demographic, epidemiological and financial challenges now confronting the health service.

The potential activities for a Nursing Network in South London have been highlighted for creating opportunities for learning from evidence and experiences as well as debate for what are difficult and enduring issues.

## Contents

1.	Introduction .....	7
2.	The national influences and policy direction .....	7
2.1.	The national policy strategic direction for services in NHS England .....	7
2.2.	The service commissioning context: national and local.....	8
2.3.	Guidance for district nursing service commissioning .....	8
2.4.	CCG Service specifications and reviews of district nursing .....	10
3.	The provision and delivery of district nursing and community matron services .....	12
4.	District nursing and community matron services staffing levels .....	13
5.	Planning and provision of education and training of the workforce for these services .....	17
6.	Scoping Survey in South London .....	18
6.1.	The breadth of district nursing and community matron services .....	19
7.	Key issues facing district nursing and community matron services in South London .....	19
7.1.	Recruitment and retention of staff .....	19
7.2.	The changing patient case mix .....	20
7.3.	Changing shapes of services for patients in the community .....	21
7.4.	‘Busy-ness’, consequences and capacity .....	21
7.5.	Influence of the commissioning process .....	22
7.6.	Education, training and careers in community nursing .....	23
7.7.	Interface issues.....	23
8.	Conclusion.....	24

## 1. Introduction

This paper sets out key issues in respect of workforce development in district nursing and community matron services in the National Health Service (NHS) of England to inform the work of the South London Nursing Network. It provides, first of all, an overview of the national influences and policy direction, the national staffing profile and the planning of education and workforce development. It then turns to report on a scoping survey of nurse leaders in providing and commissioning organisations in South London.

## 2. The national influences and policy direction

The district nursing and community matron services work primarily with older adults with long term conditions (LTC), often multiple, in the home (including residential care homes without on-site nursing). Their services are specified and commissioned in relation to this patient population as part of England (NHS England). In order to highlight current and future issues relevant for these services and the workforce within them, this section considers

- The influences from the policy and commissioning levels of the health care system
- The evidence from the operational delivery of these services and trends in staffing and current staffing in these services.
- Planning and provision of education and training of the workforce for these services.

*A note on nomenclature. Throughout this paper the following is used:*

*'District nurse' is used for those registered nurses with a specialist practitioner qualification in district nursing.*

*District nurse –1<sup>st</sup> level is a registered nurse while district nurse –2<sup>nd</sup> level is an enrolled nurse with a district enrolled nurse qualification.*

*'District nursing service' or 'adult community nursing service' is used to refer to home nursing services for adults provided by teams of district nurses, registered nurses and support to nursing posts.*

*Community matron is used to refer to registered nurses who usually have a case management/co-ordination role for people with LTCs and at risk of unplanned hospital admission through exacerbations or multiple problems.*

### 2.1. The national policy strategic direction for services in NHS England

The central government policies influencing the commissioning of local district nursing and community matron services are specified in the NHS Constitution<sup>1</sup>, Health & Social Care Act 2012<sup>2</sup> and the Department of Health Mandate to the NHS England Commissioning Board<sup>3</sup>. These documents emphasise NHS values of: working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives and everyone counts. These are further emphasised in the Commissioning Board Chief Nursing Officer and DH Chief Nursing 's policy on **high quality, compassionate care** delivery by nurses, midwives and care workers<sup>4</sup>. The Department of Health also publishes a NHS Outcomes Framework<sup>5</sup> for monitoring performance and progress against its strategic directions. In summary the **strategic direction** relevant to the patient populations the district nursing and community matron services attend to includes:

- **Reduced premature mortality** of those under 75 years from long term conditions including cardiovascular disease, respiratory disease, cancer.

- **Increasing the quality of life of people with LTC** (including dementia) through:
  - Increased support for self-management of conditions , including telehealth and telecare
  - Reductions in unplanned hospital admissions,
  - Increased support for carers.
- **Improving re-enablement and rehabilitation** post –stroke and post-hospital admission for those aged over 65
- **Improving end of life care.**
- **Improving integration with health and social care services** to improve patient outcomes and reduce inequalities.
- **Reduce patient safety incidents** including newly acquired category 2, 3, 4 pressure ulcers and medication errors causing serious harm.
- **Contribute to innovation and unprecedented improvements in value for money** including through the Quality, Innovation, Productivity and Prevention (QIPP) programme.

These strategic directions include those for **public health**<sup>6</sup> and the Department of Health Public Health Outcomes Framework 2013-16<sup>7</sup>, with emphasis on health professionals using every encounter with patients and the public to help them adopt more healthy behaviours (**‘making every contact count’**) including : smoking cessation, increased physical activity, reduction in alcohol consumption, reducing obesity and improving nutrition and diet.

In support of these strategic directions, Health Education England, with Local Education and Training Boards (LETBs), was mandated to plan for a collective future health workforce that supports service transformation and quality improvement<sup>8</sup>.

## **2.2. The service commissioning context: national and local**

From April 2013 the 209 Clinical Commissioning Groups (CCGs) have had responsibility for clinician led commissioning of local health services within *the strategic policy direction* (set out above), in partnership with Local Authorities through Health and Well-Being Boards, supported and overseen by the NHS England Commissioning Board<sup>9</sup> . In relation to the patient population supported by district nurses and community matrons, the NHS Commissioning Board is expecting to support, and for CCGs to support, *approaches in 2013/14 that*<sup>8</sup>:

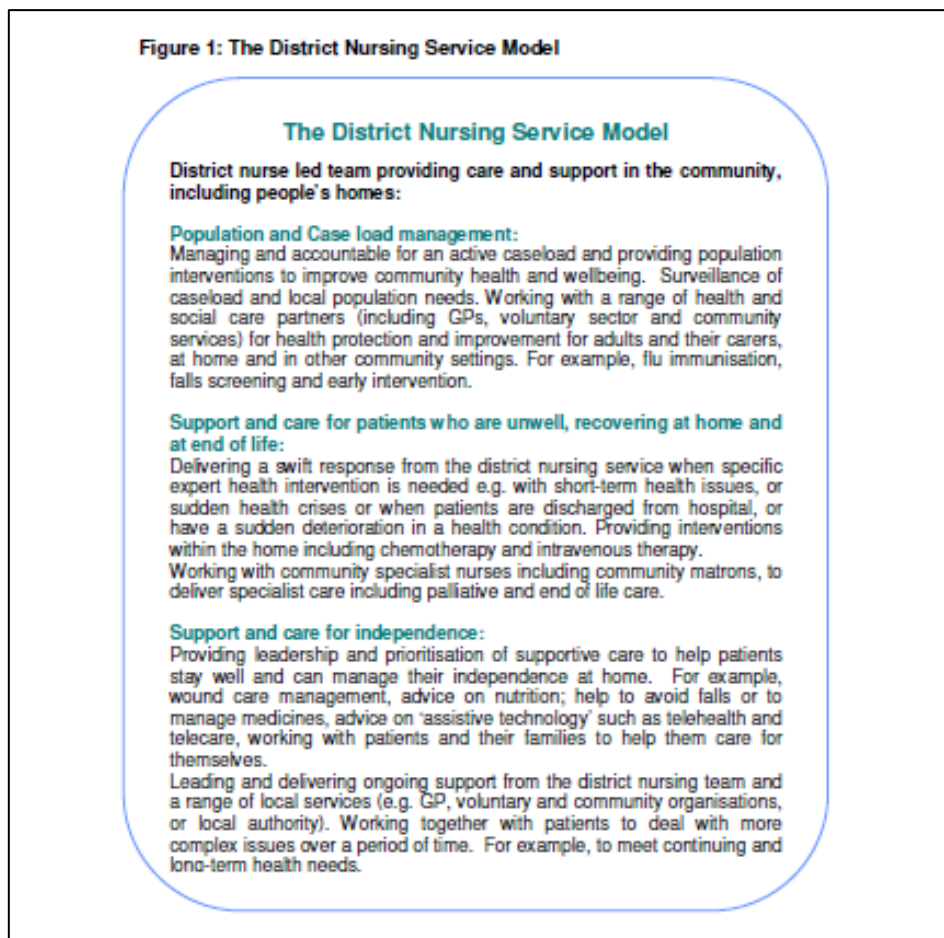
- Enhance the quality of life of people with LTCs by putting patients in charge and giving them ownership of their care such as through personalised care plans and budgets (section 2.8),
- Keep people out of hospital and co-ordinates care and support for people following discharge from hospital (section 2.10),
- Assess the experience of people who receive care and treatment from a range of providers in a co-ordinated package. (section 2.12),
- Secure local quality improvements over and above the norm by using national and local Commissioning for Quality and Innovation (CQUIN)<sup>10</sup> goals such as improvements in the NHS Safety Thermometer<sup>11</sup> which focuses on harm free care (defined by the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter).

## **2.3. Guidance for district nursing service commissioning**

In support of this commissioning agenda and the national policy on ‘Compassion in Practice’<sup>4</sup>, a best practice guidance for a model of district nursing has been published jointly by the Department of Health (Public Health) , the NHS Commissioning Board (Chief Nurse) and the Queen’s Nursing Institute<sup>12</sup> . See Figure 1 (reproduced



from page 11<sup>12</sup>). This guidance points to ways that the district nursing services can contribute to quality and innovation in care (for example through mobile working through technology), meeting outcomes not only in the public health and NHS outcome frameworks<sup>5,7</sup> but also the adults social care outcomes frameworks<sup>13</sup> such as adult safe guarding.



**Figure 1 The District Nursing Service Model , Department of Health England and NHS England**

The Chief Nursing Officer for NHS England announced in June 2013 a national two year *Community Nurse Development programme* for greater commissioning development and innovation in community nursing including primary care work to enable delivery of care closer to home<sup>14</sup>. It has 5 work programmes:

- “Commissioning Development – led by Hilary Garrett, , NHS England To ensure commissioners are engaged with the National Commissioning Development Programme for Community Nursing and actively involved in co-producing any products. To work co-productively to provide commissioners with robust and evidence based tools which informs commissioning intentions for staffing in 2013/14 contracting round and subsequent years.
- Integration –led by Jane Cummings, NHS England, to deliver person centred coordinated care. To work co-productively with key partners to synergise the nursing contribution with national and local integration priorities to identify and develop potential commissioning models
- Public health – led by Viv Bennett, DH. Maximise contribution of community nurses to improving and protecting the public’s health at individual family and community levels. Make every contact count for health and well-being, Improving the health and well-being of carers, Using community nurses to support wider population health, Supporting staff health and well-being.

- Technology & Innovation –led by Anne Cooper, H7SC Info Centre. To ensure commissioners support the adoption of technology in community nursing practice and seek innovation through commissioning practices. To develop an understanding of the best, evidence based tools for the management of caseload.
- Workforce – SRO Lisa Bayliss-Pratt, Health Education England. To ensure an adequate supply of highly skilled staff to meet service needs, improve patient care and support the move of care out of acute settings into primary and community settings” Caroline Alexander , Chief Nurse (London Region) Presentation to Directors of Nursing Meeting 1th October 2013.

It was announced that the programme also includes: a) an integration collaborative, b) the QNI was commissioned to scope a workforce tool for adult community nursing and c) a London network to support community nursing managers/leaders. In addition the Department of Health had announced a 100 million pound initiative to support nurses and midwives with mobile technology.

#### **2.4. CCG Service specifications and reviews of district nursing**

CCGs replaced the previous 49 Primary Care Trust clusters. They commission for populations ranging from 68,000 (NHS Corby) to 901,000(NHS North, East and West Devon CCG). Twenty eight CCGs cross Local Authority boundaries<sup>15</sup>. The publication of their commissioning intentions for 2013/14 builds on work already undertaken in the period of their establishment since 2011. An internet search undertaken for this briefing found 6 publicly available reviews of district nursing or adult community services by Commissioning Groups from 5 different regions in England since 2012 and 5 contract specifications for district nursing services in the same period. See Figure 2 as a summary example of the district nursing service commissioned.

Key observations from reviewing these documents include:

- A variety of titles for the services are used: district nursing, community nursing, adult community nursing –this has been noted before <sup>16</sup>.
- All refer to teams with a lead nurse but varied on whether this lead nurse had to have a specialist practitioner district nursing qualification or not – this has been noted in a previous Queen Nursing Institute survey <sup>16</sup>.
- All referred to the need or presence of appropriately skill mixed teams for efficient use of resources. The teams had registered nurses and others such as health care assistants but the reviews noted variation in team capacity, staffing and types of staff - this has been also reported in a national survey of support roles in community nursing services<sup>17</sup>
- All the services were available 365 days a year but with varying periods of time – some through the night, some ceasing in the evening – this variation in hours of service has been noted before <sup>16</sup>.All referred to the need for integration of health and social care services but emphasised the need for the district nursing services to work more closely with general practices and services preventing unplanned hospital admission and early discharge.
- Not all referred to community matrons as part of the provision (previously identified in other studies<sup>18</sup>) and where this group was referred to it was often in relation to preventing unplanned hospital admissions and their integration within the district nursing service.
- All referred to the patient population to be served by the district nursing service as being mainly those that were housebound or unable without great difficulty to attend their general practice. Some reviews noted the tension in boundary issues between district nurse and practice nurse provision in their surgery – this has been reported before <sup>19</sup>.
- High levels of patient satisfaction were reported, (noted before<sup>16</sup>), but also some issues about continuity in nurses, appointment times and limitations in accompanying health promotion in their activities – some of this has been noted before<sup>20</sup>.

- There were reports of a range of views from general practitioners from positive ,close working with identified district nursing team leaders and community matrons to negative views about poor communication, lack of response to urgent referrals and little input into that practice and their patients – this range of views has been noted before <sup>19,21</sup>
- The reviews used national benchmarking or benchmarking between practice populations to consider issues such as equity of resource distribution between practice patient populations, efficiency and effectiveness.

From NHS Derby City District Nursing Specification Executive Summary (undated)

*“The service provides appropriate planned specialist nursing care to adults who require nursing care within their own home due to long term chronic disease or as a result of an acute episode of ill health. Care is delivered in patients’ own homes and residential homes. Nursing care is also provided in community clinics for patients with complex wounds. The district nursing service operates seven days a week.*

*The key roles of the team are as follows:*

- Assessment and follow up of patients with complex needs such as:
  - o Contenance care including indwelling catheter care
  - o Tissue viability and wound care management
  - o Medicines management including administration of intravenous drugs such as appropriate antibiotics and chemotherapy
  - o End of Life care
  - o Managing the nursing needs of patients with long term conditions
- Incorporate multi factorial falls risk assessments into holistic assessment
- Key Worker/Case Manager for patients at the End of Life to ensure the delivery of Specialised End of Life care in the patient’s preferred place of death
- Identify and respond to issues regarding safeguarding vulnerable adults
- Review of patients’ nursing needs on continuing care in partnership with the continuing care team, including a minimum of three monthly review of patient by DN sister
- Provide nursing care support for people on Fast Track Continuing care
- Support for patients and carers along the relevant care pathway
- Education for patients and carers as appropriate to their health needs
- To be an integral part of the Primary Health Care Team
- Appropriate supplementary prescribing by trained practitioner to enhance effectiveness of patient care
- Skill mix community teams working in partnership with Primary Care Services meeting the nursing needs of the Derby City Population within the referral criteria of the service
- To support nursing homes with the care of patients where there may be lack of skills and knowledge in advanced nursing interventions e.g. the use of syringe drivers for patients at the end of their life
- To ensure handover is carried out in a timely manner, on agreed documentation, of any expected patients who may require interventions during the out of hours period”

**Figure 2 Excerpt from NHS Derby City District Nursing Specification Executive Summary (Accessed at on 02-11-2013 at NHS Derby City Primary Care Trust website).**

At the same time changes in commissioning have led to innovations for services for people with LTCs as in the following recent examples cited by the NHS Commissioning Board<sup>22</sup> :

- A new rapid response and re-ablement service and a community geriatrician post to advise GPs and community teams , Reading CCG,
- Community wards for patients vulnerable to admission identified by use of predictive models and given intensive care and support through multidisciplinary teams, Wandsworth CCG,
- Patients with lung conditions have a centralised contact line to request urgent support and treatment without visiting hospital and so are now looked after in the community, Warrington CCG
- The Hospital@Home service, through which patients get urgent treatment in their own homes for conditions like chronic obstructive pulmonary disease (chronic lung disease), severe urinary tract infections and cellulitis, rather than having to be admitted to hospital through A&E, NHS West Cheshire CCG

### **3. The provision and delivery of district nursing and community matron services**

Since the Transforming Community Services Programme<sup>23</sup> was implemented in 2011/12, community nursing services are provided from over 100 organisations in England. In 2012, 67 of these were acute or mental health service NHS Trusts, 15 were Community NHS Trusts, 3 were left temporarily with a PCT, 15 were social enterprises and 2 were for-profit private companies<sup>24</sup>.

Service models and delivery are influenced by the commissioning specifications, joint development activities with commissioners, historical investments and patterns of delivery as well as internal reviews and quality assurances activities. District nursing and community matron teams may be attached to a specific general practice or aligned to a number of practices or work with all patients in a specific geographical area. There may be specific teams who work in care homes or this provision may fall to the team covering the geographical location of the home<sup>25</sup>. The generalist teams may be supported by a range of clinical nurse specialists (who are the community matrons in some areas) – the numbers and types will vary but the most common are: palliative care nurses, continence nurses, diabetes nurses, respiratory nurses, tissue viability nurses, heart failure nurses and liaison district nurses in the acute hospital.

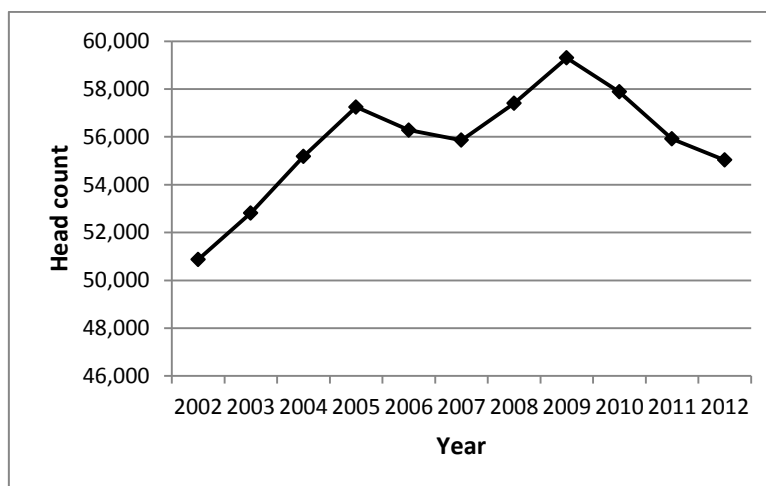
Since the sixties, district nurses have worked in teams with other qualified nurses and a nursing auxiliaries<sup>26</sup>. The trend for the past twenty years has been for district nursing service teams to become larger with multiple registered nurses led by a team leader – mainly the district nurse i.e. the registered nurse with additional specialist practice, district nurse, qualifications. The district nurse team leader may be paid at Agenda for Change band 6 or 7 dependant on responsibilities and local structures.

It is evident that services are shifting and innovating in response to the policy agenda with service models to bring care closer to home<sup>27</sup>, reducing unplanned hospital admissions<sup>28</sup> and improve patient experience and safety<sup>29</sup>. Different services use different methods for monitoring the patient case mix, patient requirements from the service and accordingly planning and deploying the workforce<sup>30</sup>. Alongside direct and indirect (e.g. liaison with other professionals) patient care and support for carers, the service may be required to be involved in formal assessment processes for specific groups of patients e.g. community care assessments and NHS continuing care health care and NHS funded nursing care assessments<sup>31</sup>. Individual services will have variations for example some may provide clinics for patients with leg ulcers or leg clubs<sup>32</sup>. The service also contributes to the education and training of nursing<sup>33</sup>, medical and specialist practitioner district nurse students. The Royal College of Nursing argues from their surveys that district nursing services are under increasing stresses to meet both the demand and the policy aspirations<sup>34</sup>.

#### 4. District nursing and community matron services staffing levels

This section considers the staffing and associated issues of these services. It should be remembered that this staff group is just one sub section of the wider nursing labour market. The supply and demand for nurses working in the community is affected by all factors affecting the supply and demand of nurses<sup>35</sup>.

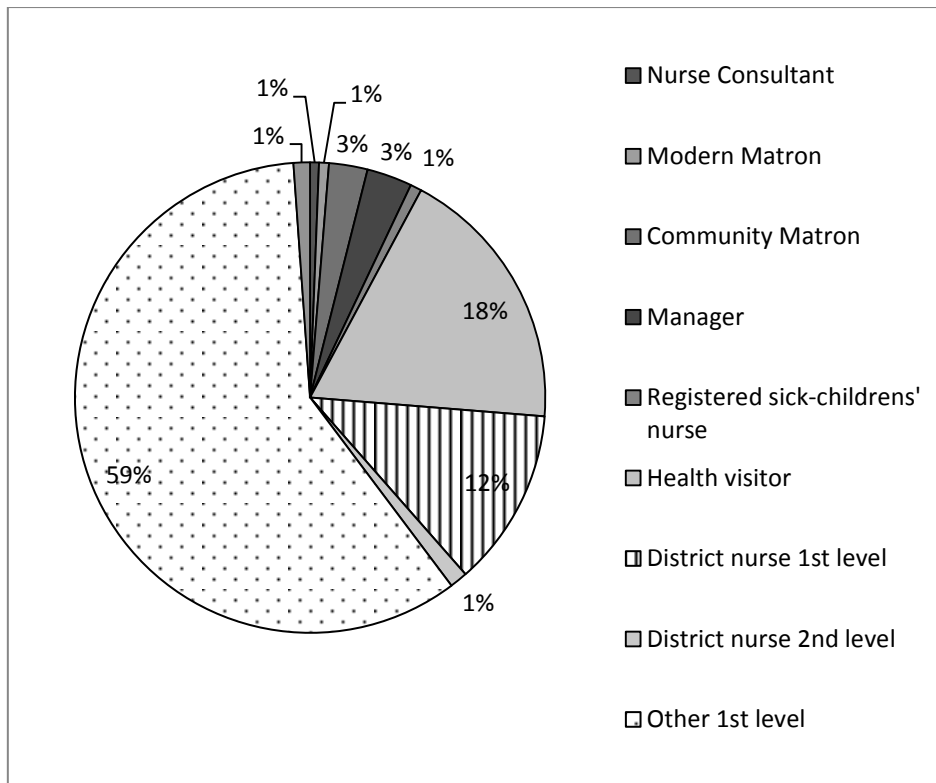
The last ten years has seen growth in the numbers of qualified nurses employed in all types of community services (Figure 3).



**Figure 3 Trends over 10 years of qualified nurses and health visitors in community services in England.** (Source Health & Social Care Information Centre. 2013) NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Non-medical staff – 2002-2012, as at 30 September (published March 2013 ) Table 3b. NHS HCHS: Qualified Nursing, Midwifery & Health Visiting staff by area of work 2002-2012)

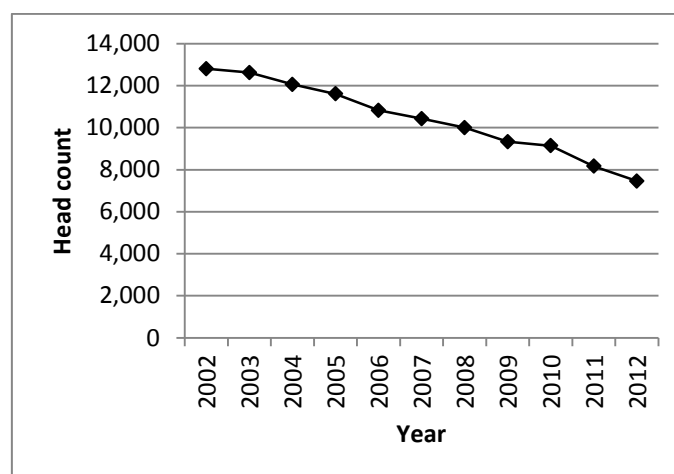
In 2012 there were 55,035 (head count equating to 46,035 full time equivalent posts) qualified nurses and health visitors working in community services (excludes school nursing) in England. These represent 15% of the total qualified nurses, health visitors and midwives employed in NHS commissioned hospital and community services<sup>36</sup>. In addition, 19,753 support staff (assistant nurse practitioners, nursery nurses and nursing auxiliaries) were employed in community services in England accounting for 15,247 full time equivalent posts and 25% of the total community services nursing workforce.

First level registered nurses formed the largest staff group in community services (59% of headcount) with those with district nursing qualifications accounting for 12% of headcount and community matrons 3% of headcount (See figure 4).

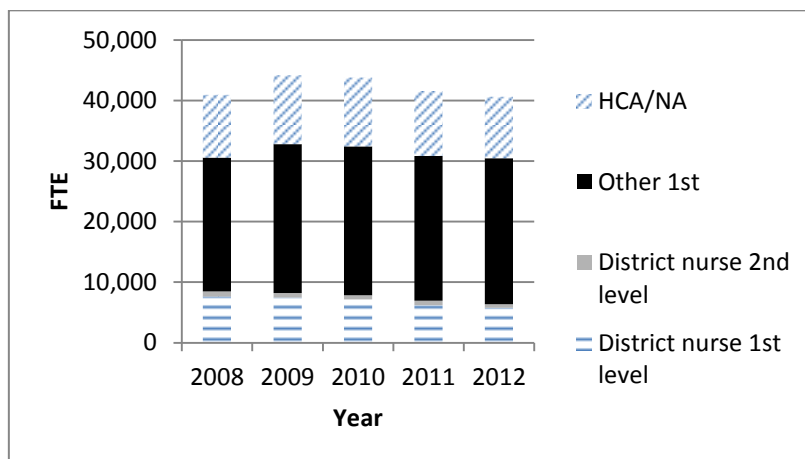


**Figure 4 Distribution of Qualified nurses and health visitors, by headcount as a percentage of employed in community services in September 2012 in England.** (Source NHS Information Centre. (2013) NHS Hospital and Community Health Service (HCHS) Workforce Census 2012 Detailed results). Table 2.2..)

A previous study demonstrated that about 90% of first level nurses in community services were employed in district nursing services<sup>37</sup>. Using this assumption the figures provided in the NHS workforce census have been examined and estimates made. While the numbers of nurses with the district nursing qualification i.e. district nurses have dropped over the past 10 years (see figure 5), it is estimated that the full time equivalent numbers of qualified nurses and support staff to nurses grew and then returned to about the 2008 level (see figure 6), with the ratio of qualified to support remaining similar.



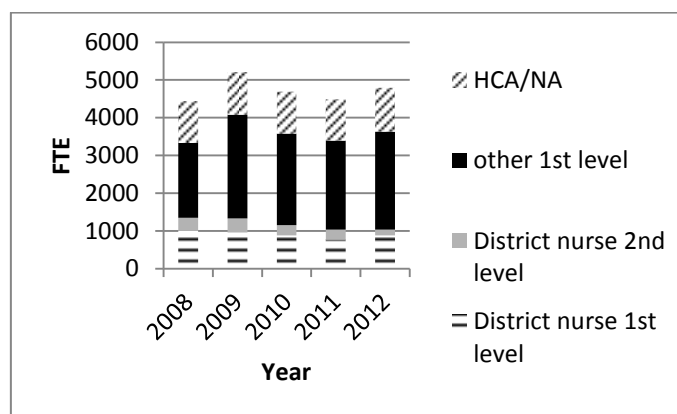
**Figure 5 Trends in numbers of nurses with district nurse qualifications employed in England.** Source: Health & Social Care Information Centre. (2013) NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Non-medical staff – 2002-2012, as at 30 September (published March 2013) Table 2a. NHS HCHS: Nursing, Midwifery & Health Visiting staff and support staff by type 2002-2012



**Figure 6 Trends over 5 years of nurses and support to nursing staff in adult community nursing in England using estimates of percentages of registered nurses** (Source Health & Social Care Information Centre. NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Non-medical staff detailed tables for 2008,2009,2010,2011,2012).

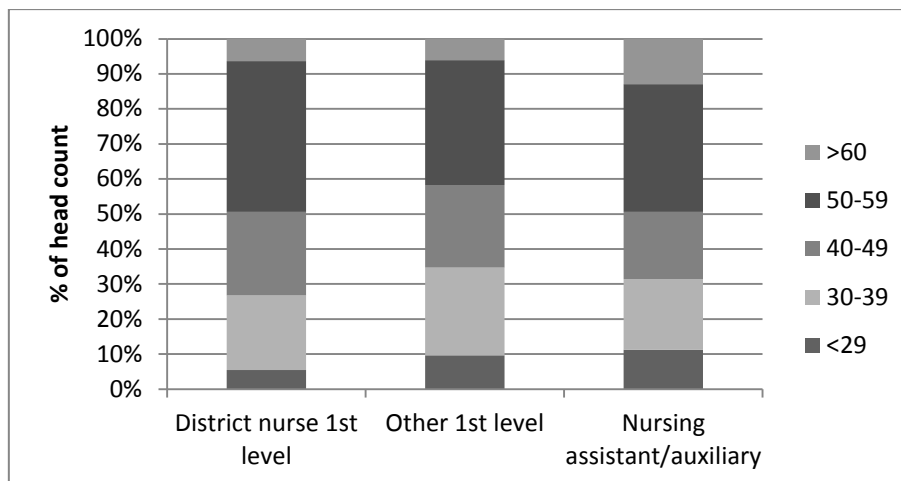
The London region shows a greater fluctuation in full time equivalent numbers over the period (see Figure 7) but similarly the largest group of staff are registered nurses without district nursing qualifications and 24 % staff are grades in support of nursing such as nursing auxiliaries /health care assistants (HAC/NA). Very small numbers of assistant practitioners were noted in the NHS Workforce Census data for community services (appearing from 2011 onwards).

This is a continuation of staffing patterns previously noted<sup>35</sup> It is evident that there are other types of staff being employed in district nursing teams for example pharmacy technicians<sup>38</sup> and in support of increased provision for certain groups of patients<sup>39</sup>. There is however, no agreement as best model of skills in a district nursing team for efficient, effective and safe patient care or what is the optimum caseload size or case-mix for different levels and mixes of staffing<sup>29 40</sup>. One recent economic modelling suggested that a more cost effective model of team included only qualified nurses rather than health care assistants<sup>41</sup>



**Figure 7 Trends over 5 years of nurses and support to nursing staff in adult community nursing in London using estimates in percentages of registered nurses** (Source Health & Social Care Information Centre. NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Non-medical staff detailed tables for 2008,2009,2010,2011,2012)

As always the community nursing workforce has an older profile than the acute hospital nurse profile with 50% of those with district nursing qualifications and 40% of registered nurses without district nursing qualifications are aged over 50 years (see Figure 8) compared to 25% of all qualified nurses in the NHS acute sector. However the difference is not so marked when compared to the senior nurses in the acute sector (nurse consultants and modern matrons) where 38% of these nurses are aged over 50.



**Figure 8 The age profile of selected staff groups in community health services in England in 2012** (Source Health & Social Care Information Centre. NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Non-medical staff as at September 2012)

Ten per cent of those with district nurse qualifications are of minority ethnic backgrounds and five per cent are men<sup>24</sup> but it is not possible to disaggregate this data for other nurses and support to nursing staff in community services.

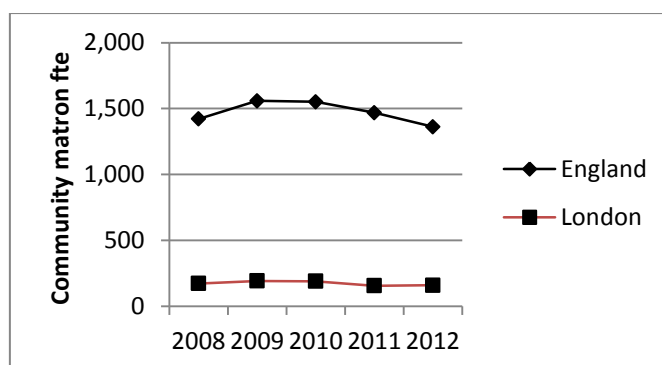
Staff turnover statistics are no longer publically available for nurses in adult community nursing services but NHS Vacancy Surveys up until 2010 show that London region has had some of the highest rates in England for district nurses and other qualified nurses in community services.

District nurses and other registered nurses with appropriate qualifications are able to prescribe medicines within their scope of practice or to a nurse's formulary<sup>42</sup>. While there were 49,428 nurses with prescribing qualifications with the Nursing and Midwifery Council (NMC) in 2008<sup>43</sup> it is not possible to identify how many of these are employed in community nursing services. A recent analysis of national e-pact prescribing data in primary care suggests that not all those with the qualifications and authorisation to prescribe actually do so<sup>44</sup>

While there will be nurses within these services with advanced practice clinical skills and/or nurse practitioner qualifications there is no way of knowing how many or where they work as these qualifications are not registered or recorded either by the NMC or the NHS workforce census.

**Community matrons** Over the last five years there has been an overall decline in full time equivalent community matron posts in both England and London (see figure 9).





**Figure 9 Trends over 5 years of community matron full time equivalent posts** (Source Health & Social Care Information Centre. NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Non-medical staff detailed tables for 2008,2009,2010,2011,2012)

It should be noted that the district nursing and community matron workforce is one subset of the nursing labour workforce and therefore influenced by the issues that effect that wider labour market.

### 5. Planning and provision of education and training of the workforce for these services

The education and training needs for the district nursing and community matron service are defined by the service providers and variously commissioned from Higher Education Institutes, or provided in house, through NHS education and training commissioning mechanisms. These mechanisms are now employer led within the LETBs. The Centre for Workforce Intelligence horizon scanning report on the nursing workforce points to the following key challenges in planning for the step change numbers in older people LTC by 2030:

- *“Planning the education and training system to train nurses to practice in a community settings*
- *Attracting new recruits into the field of nursing when more care will be community and not hospital based*
- *Training nurses to care for older people with complex needs*
- *Managing the changing working patterns of potentially providing 24/7 care in the community*
- *Managing the changing work environments for nurses providing more care in the community”*<sup>45</sup> page 3

It is evident from the overview above that the current and future staff in these types of services will have a range of ongoing education and training needs from the clinical, orientation to community and working in networks through to the management of people, time, resources and caseloads.

Those in team leader roles or aspiring to team leadership need (and will) need education for management both of people and caseloads but also of clinical skills. The provision for and numbers of registered nurses undertaking the one year (full time or 2 year part-time) specialist practitioner , district nurse, qualification has declined since 1999<sup>46</sup>. Not all services require their team leaders to have this qualification. There is little research into the best forms of preparation and education for such roles<sup>47</sup>.

The introduction of community matrons was accompanied by the expansion of modular education linked to their and other roles in care of people with long term conditions e.g. case management, advanced clinical skills , independent prescribing<sup>48</sup> and Skills for Health now produce a suite of national occupational competencies for long term conditions<sup>49</sup> It also offered the opportunity to become explicit about “that nurses who move from

hospital environments to the community , irrespective of level of clinical expertise, become novice practitioners again ., for four reasons:

a) **The patient is in control of all decisions** affecting their health and well being, including their home environment. Assessments, treatment, care and advice giving are continually negotiated acts between the nurse, the patient and their family carers/informal network of support. Achieving positive patient outcomes are therefore reliant on the nurse’s ability to establish and maintain a relationship with the patient. This is unlike a hospital where the decision-making is led by professionals, including everything from the ward environment to the timing of treatments.

b) **The patients and their carers undertake most of their own health maintenance, treatment and care activities.** The nursing contribution is a small part of the overall patient’s daily experience. This is in contrast to the hospital environment.

c) **The multiple systems and infrastructures** that support the delivery of health and social care vary between local areas. This is unlike a hospital with a single system and infrastructure.

d) The nurse has to make clinical and professional decisions, sometimes rapidly in less than ideal circumstances, at a physical distance from professional colleagues. “

<sup>47</sup> p5

More recently there have been other resources looking at how to help nurses make the transition to community services<sup>50</sup>.

Much currently in the press focuses on education of ‘the district nurse’ but this is the smallest group of staff in the service and that is unlikely to change given the financial pressures. Perhaps a more important question is how to appropriately prepare, train and update the bulk of the staff who are the registered nurses and support staff in ways that support the achievement of the desired service outcomes, attract new staff into the community and offer career progression.

## 6. Scoping Survey in South London

This paper now turns to South London, in the context of that national picture, to investigate:

- Key issues facing district nursing and community matron services,
- Perspectives on the development needs within these services both short and long term,
- Perspectives on ways in which the South London Nursing Network could engage in addressing these in the context of Health Education South London (HESL).

A scoping survey<sup>51</sup> was undertaken through a) review of open access web pages of commissioning and provider organisations across South London and b) telephone interviews of lead nurses in providing and commissioning organisation in November 2013. The analysis was intended to reveal the breadth and frequency of issues and perspectives rather than specific details of individuals or individual organisations. It should be noted that most of those who volunteered to participate in the scoping telephone interviews were very experienced managers and commissioners of district nursing services. Most had previous experience of working as senior nurse managers with some responsibility for district nursing in two or more organisations in the past.

### **6.1. The breadth of district nursing and community matron services**

Adult patients and their carers in the 12 boroughs across South London have access to a wide range of community health services including community nursing delivered in the home. These services are commissioned by 12 Clinical Commissioning Groups (CCGs) and provided by eight provider organisations. The provider organisations are of different types including social enterprise, NHS Community Trust and community divisions of previously acute hospital, specialist hospital and mental health services NHS Trusts. It is perhaps worth noting here that the CCGs have differently configured nurse membership of their Boards and lead nurses within their individual organisations. Lead nurses in provider organisations and CCGs are involved in mechanisms for the education and training commissioning by Health Education South London.

There is great variety in the types and names of community health services for adults provided in each Borough. Appendix A provides information from the public websites of the provider organisations as available by borough. A caution should be noted in reading this appendix in that in some Boroughs the service may be named as a community health service while in the next Borough it may not be named but exist as an outreach from a hospital and not thus feature.

While all areas have adult community nursing services who provide care in the home not all had these named as district nursing services. Respondents noted that this variation had arisen in response to previous Department of Health guidance and at points of re-designing the services. It was also evident that there were many different multi-disciplinary teams which included community nurses, often with therapists, for intermediate care/rapid response/ emergency response to different groups of patients. Some provider services have ‘*virtual wards*’ or variations of them i.e. a multidisciplinary team including community matrons or advanced practice nurses who provide care to those with multiple long term conditions who are at high risk of unplanned hospital admission. Some provider services had their teams co-located with social service and mental health teams. It was reported that many had had service re-designs of their district nursing services in the previous couple of years. Other respondents commented on working with their CCG to look at re-designing services.

## **7. Key issues facing district nursing and community matron services in South London**

The issues raised included: The issues raised for the services included: staffing the service (recruitment and retention of staff ), changing case-mix of patients on district nurse caseloads, the capacity of the district nursing service, generalism versus specialism , commissioning issues and interfaces with other services. The ordering of these issues in this report reflect the frequency with which the issues were raised and depth in which they were discussed. Suggestions for pan-south London activity by SLNN are underlined.

### **7.1. Recruitment and retention of staff**

#### *Vacancy rates and consequences*

The respondents from provider services highlighted the challenges they faced in recruiting the right calibre of registered nurses to different grades and retaining them. It was notable that many described vacancy levels that were constant and problematic. For some areas this meant over reliance on agency staff, who were a constantly

shifting group, Some areas described the constant recruitment of registered nurses in Band 5 graded posts as these stayed in post for relatively short periods of time: *“it’s just an endless struggle to keep these posts filled”* . All could describe the negative consequences of high staff turnover and high use of agency or locum staff : This included loss of continuity in care for patients *“ it means you are always sending someone new to some patients”* and also loss of team, and multi-disciplinary, relationships. It should be noted these types of network relationships are important to the quality and safety of care of patients living at home. Other team consequences were noted such as a *‘downward spiral where vacancies lead to more stress for the rest of the team , so more sickness , so more vacancies needing cover by agency staff.* *“ higher sickness rates as higher sick rates in teams with on-going vacancies , which the reduced capacity*

#### *Recruitment issues for community posts*

Some areas described the factors beyond their control in this such as the lure of inner London weighting to pay packets for staff working in outer London provider services which were adjacent to inner London provider services. Respondents point out that even though this was London, patients were often widely dispersed and public transport systems not appropriate to make the most efficient use of time. Some pointed out the services need for staff who were car drivers, preferably with cars and willing to use them for work. The need to have car drivers was emphasised by one respondent who pointed to the patient and business consequence of employing staff who were *‘walkers’* as *“they slow us down”*. This was a specific issue in recruiting to any community nursing post (in comparison to a hospital post) but particularly the lower paid grades. *“When they get down to the brass tacks of the changing the insurance and mileage [reimbursement], which is now less favourable, it can make them [job applicants] change their minds about working for us “.*

All reflected on the large percentages of their most staff experienced in the community (both those with district nurse qualifications and those in health care assistant posts) coming up to retirement age. They described their district nursing workforce” as *“ageing”* or *“shall we say [the staff are] on the mature side “.* They were acutely aware that they needed appropriate workforce planning and training to replace the exit of this workforce: *“it’s a demographic time bomb”:*

Respondents in provider services commented on the importance of having *‘good leaders in district nursing teams’* (picked up in 4.6). They also noted the importance for staff and overall service morale for the senior managers of the organisation to recognise and acknowledge the contribution and work of this staff group.

#### **7.2. The changing patient case mix**

All the respondents from providers organisations stated that the patient case mix was changing. Higher volumes of patients who needed complex, technical procedures to be done at home were described than seen by district nurses *“ say five or six years ago “* . In addition it was reported there were higher numbers of people who were choosing and being supported by district nursing services to die at home. These types of patients required more time from staff than those with needing simple procedures and *“ often needed two staff rather than one”* . All commented this was a reflection of policies to ensure patients were in acute hospitals for as short a period as

possible. Commissioner respondents commented that there CCGs were looking to increase the volume of care and treatment undertaken outside of hospitals.

In workforce terms, providers and some commissioner respondents commented on the need to have nurses with technical and advance clinical skills to respond to this growing demand. A few pointed to the challenge as to how to maintain confidence and competence in specific technical skills if the patients who required them were relatively infrequent on any individual district nurse team caseload, “*the last time that team had one [patient with a recent tracheostomy] was 7 years ago*”, examples were given such as care of tracheostomies, vacuum assisted dressings for wound healing, drainage systems for pleural effusions and supra-pubic catheters. However other respondents noted that this could be planned for and addressed through ‘*just- in- time updating such as going to the ward to do the procedure before discharge*’. Some suggested that there was a perception that these types of situations were used to draw boundaries around types of work and patients some staff/teams would accept or decline. This observation links to the issues raised in the sections on service capacity, interfaces and innovation.

### **7.3. Changing shapes of services for patients in the community**

As pointed out in section 3 there were increasing numbers of specialist teams or nurses for either specific types of patients (e.g. respiratory, stroke) or at specific points in the patient pathway (e.g. discharge or rehabilitation). Respondents had mixed views about this and the consequences in particular for the district nursing service. In summary it was the ‘*specialist versus generalist debate*’. Respondents expressed concern for continuity and integration of care for patients where the teams only looked after a specific time period or single condition. Others could see the value in specific expertise for some conditions or critical periods. However there were real concerns for the consequences for the district nursing service if they were considered to be the service for “*all the patients or work no one else wants*”. Respondents outlined negative consequences for maintaining skill levels, attractiveness of the service for high calibre staff and in particular career pathways – a point picked up in section 4.5.

It was suggested that there might be value in pan South London opportunities to promote debate and learning about the benefits , challenges and consequences of different models of generalist and specialist services .

It was interesting to note that few respondents mentioned the use of telehealth as an issue with consequences in community workforce development. Those that did mentioned the mixed evidence to date as to its utility for the types of patients this group of nurses worked with and viewed it as unlikely to create major changes for them.

### **7.4. ‘Busy-ness’, consequences and capacity**

After noting the changing profile of the patients and their requirements, nearly all respondents from provider services commented on the increased levels of patient contacts, higher levels of staff activity and ‘*busy-ness*’ of the district nurse teams.

Nearly all respondents commented that this ‘*busyness*’ led to the nurses becoming ‘*task focused*’. The consequences of this was noted by all “*the sisters are so busy they can’t see the wood from the trees, they don’t or can’t stop to look at whether this is the best way of doing things and manage their teams efforts to best effect*”. However, some, particularly from the commissioning side, perceived the focus on doing ‘*tasks*’ (i.e. going to a patients home to do only a dressing or only give an injection) was the orientation of the majority of the nurses rather than being proactive and alert to all aspects of the person’s situation and wellbeing i.e. practitioners who made “*every contact count in terms of promoting self-management, health promotion and anticipating and addressing problems immediately*”. This was viewed as a problem by commissioning respondents who were looking for home nursing services to actively engage and contribute to the broader agenda of increased anticipatory care for people with long term conditions in order to prevent unplanned admissions.

Many respondents commented that they considered the nursing teams could improve their organisation to use their resources (particularly staff) more efficiently. Some pointed to the lack or very limited use of patient acuity or dependency tools to understand the resource demand and manage the case load and the staff allocation. It was suggested that there might be value in pan South London opportunities to share learning about these types of patient acuity tools and their use in caseload/resource management.

At the same time provider services pointed to administrative or infrastructure issues, both internal to their organisation and externally imposed, which increased demands on particularly the lead nurses and reduced efficiency. Examples were given of the increased paperwork to be completed such as in NHS Continuing Care Assessments, serious incident investigations required for certain grades of pressure ulcers. Some respondents flagged the inefficiencies resulting from under-investment in information technology support to community services and home nursing in particular – particularly when community services were a small part of a very large organisation. These types of issues led some to question whether the nursing service workforce had to include more ‘*business workforce support*’ in the future to become more efficient.

#### **7.5. Influence of the commissioning process**

All the district nursing and community matron services were being commissioned by ‘block’ contracts i.e. without specification for different types of patients or patient pathways. The divide between those respondents from commissioning and from provider services were most evident here. On the one hand some from commissioning indicated there was not ‘*enough granularity*’ to understand the activity and outcomes of these services. Some commented that the CCGs were paying for ‘*overperformance*’ that was not addressing the key issue of improved care of people with long term conditions and hospital avoidance. On the other hand some provider service respondents considered the CCGs preferred block contracts because it masked the level of their activity and ensured the contract price did not increase: ‘*keeps their costs down but not ours*’. Respondents reflected both adversarial and also collaborative relationships between these two types of organisations.

Many of the respondents commented on their awareness of the possibility of contracts going to ‘*any willing provider*’ and as a result provider service leads were having to help their staff understand this new landscape

and the risks and consequences of how they delivered services. Some also noted that there was a sense of ‘short-term-ism’ in contracts which makes it very difficult to plan long term for a workforce” This linked to the next point regarding career development in the community (4.6).

#### **7.6. Education, training and careers in community nursing**

Different organisations did or did not require specialist practice (district nursing) qualifications for their team leader posts. There were very divided views as to whether the team leaders of home nursing teams needed the specialist practitioner qualification. There were those who firmly believed that the job could not be done without that preparation “it makes such a difference as to how they approach the job, the patients, the staff”. There were others that suggested the leaders needed specific elements that did not need a yearlong course. The elements included : caseload and people management education/training plus education /training to be an expert clinical case manager of patients. Some thought the actual specialist practice qualification programme content was out of date and needed to be replaced/include advanced clinical skills and clinical decision making.

It was suggested that there might be value in pan South London opportunities to debate and consider the issue of preparation for leadership in district nursing teams.

There was , however, a consensus that there needed to be career pathways , and many could outline ‘an escalator of experience and training taking them from one type of post to another’ . Most however pointed to many experiences and problems in creating that, for example creating new posts as support to nursing but a lack of wider support resulted in them dwindling then disappearing. It was suggested that there might be value in pan South London opportunities to share learning and ideas as to how to create sustainable career pathways in community nursing.

All respondents discussed the importance of innovation in clinical practice, service delivery and technology and the accompanying need for on-going training and education. Provider service respondents were very positive about the capacity to commission CPD and bespoke timely education for specific innovation in their services.

#### **7.7. Interface issues**

All respondents discussed, both positively and negatively , about interface issues between district nursing and other services. Multiple types of issues about multiple interfaces with acute services, general practice and social care were described. On the one hand they described close working, communication strategies , membership of primary care or integrated teams and on the other they described situations in which they clear demarcations and separations were made . This was particularly in relation to when patient care was the work of this service or another’s. Examples included wound dressings: the district nursing team provided this for those who are ‘housebound’ and the practice nursing team in the GP surgery otherwise.

Many described re-configurations of services and staff and initiatives such as co-location and could point to positives such as increased knowledge of other disciplines or services. However from provider services described these types of initiatives as not sustained or changed again when a new manager or commissioner was

appointed. Other examples of lack of sustainment of an improvement to a team interface were when it involved Local Authority funding which was then withdrawn.

Most respondents described the importance of communication with the patients GP and that different areas had found ways to achieve that for example shared electronic records . Other respondents noted this could be much improved. It was suggested that there might be value in pan South London opportunities to share learning and ideas as to how to develop, improve and sustain interprofessional working between district nursing and other services.

## **8. Conclusion**

This report has outlined key issues facing district nursing and community matron services, from a purposive sample of nurse leaders in commissioning and provider services. The development needs have been identified and it should be noted that the respondents saw the education commissioning process through Health Education South London (HESL) and relationships with Universities as important in this. When asked whether these were new issues, most respondents replied they were not although some may have heightened urgency in the face of the demographic, epidemiological and financial challenges facing the health service. The potential activities for a Nursing Network in South London have been highlighted in creating opportunities for learning from evidence and experiences as well as debate for what are difficult and enduring issues.



## ***Appendix 1***

### **Scoping of provision of district nursing and community matrons in South London by Borough**

These tables provide data by south London Borough taken in November 2013. Data taken from public websites of providers (named and website given). Services specifically for children, families or sexual health services have been omitted as have those referring to therapist only services. Some services listed may not have community nurse involvement but have been included where the information was not clear to ensure comprehensiveness.

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<p><b>Bexley</b></p> <p><a href="http://www.oxleas.nhs.uk/gps-referrers/gp-community-health-services/gp-chs-bexley/">http://www.oxleas.nhs.uk/gps-referrers/gp-community-health-services/gp-chs-bexley/</a>  Oxleas NHS Trust  Bexley Adult Community Services</p> <ul style="list-style-type: none"> <li><b>Care Navigation Team</b></li> <li><b>District Nursing Team</b></li> <li>Step Up Step Down</li> <li>Specialist Nursing - Diabetes</li> <li>Specialist Nursing - Respiratory</li> <li>Specialist Nursing - Multiple Sclerosis (MS)</li> <li>Specialist Nursing - Parkinson's Disease</li> <li>Specialist Nursing - Tissue Viability</li> </ul>	<p><b>Bromley</b></p> <p><a href="http://www.bromleyhealthcare.org.uk/find-a-service">http://www.bromleyhealthcare.org.uk/find-a-service</a>  Bromley Healthcare.</p> <ul style="list-style-type: none"> <li>Bladder and Bowel Management (continence)</li> <li>Care Home Liaison Team</li> <li><b>District Nursing</b></li> <li>Integrated Community Team</li> <li>Intermediate Care</li> <li>Leg Ulcer Assessment and Management Service &amp;The Leg Club</li> <li>Long Term Conditions Nursing</li> <li>Post Acute Care Enablement (PACE)</li> <li>Rapid Response+ (RR+)</li> <li>Tissue Viability Nursing</li> </ul>
<p><b>Croydon</b></p> <p>From <a href="http://www.croydonhealthservices.nhs.uk/about-us/Community-Health-Services.htm">http://www.croydonhealthservices.nhs.uk/about-us/Community-Health-Services.htm</a>  Croydon Community Health Services.  Services for Adults:</p> <ul style="list-style-type: none"> <li>A&amp;E liaison team</li> <li><b>District nursing</b></li> <li><b>Community matrons and virtual wards</b></li> <li>Croydon intermediate care services</li> <li>Diabetes services</li> <li>Homeless health</li> <li>Health visiting for older people</li> <li>Heart failure service</li> <li>Nurse specialists for diabetes, continence, cardiac care</li> <li>Pulmonary rehabilitation</li> <li>Virtual Ward</li> </ul>	<p><b>Greenwich</b></p> <p><a href="http://www.oxleas.nhs.uk/gps-referrers/gp-community-health-services/gp-chs-greenwich/">http://www.oxleas.nhs.uk/gps-referrers/gp-community-health-services/gp-chs-greenwich/</a>  Greenwich Community Health Services</p> <ul style="list-style-type: none"> <li>Single Point of Access Team (SPA)</li> <li>Intermediate Diabetes Team</li> <li>Falls Prevention Team</li> <li>Heart Failure Service</li> <li>Chronic Obstructive Pulmonary Disease (COPD) Team</li> <li>Continence Advisory Service</li> <li><b>District Nursing Service</b></li> <li>Integrated Wound Care Service</li> <li>Intermediate Care</li> <li>Joint Emergency Team</li> </ul>

<p><b>Lambeth</b></p> <p>Guys and St. Thomas' NHS Foundation Trust  <a href="http://www.guysandstthomas.nhs.uk/our-services/adult-community-nursing/overview.aspx">http://www.guysandstthomas.nhs.uk/our-services/adult-community-nursing/overview.aspx</a></p> <p><b>Adult community nursing services led by district nurses</b> and charge nurses</p> <p>Bladder and bowel specialist nursing service  Heart failure clinics with specialist nurses  Leg ulcer clinics  Multiple sclerosis specialist nurses  Rapid response and supported discharge teams  Specialist clinics for long-term conditions eg: chronic obstructive pulmonary disease (COPD), chronic heart disease, asthma and diabetes</p>	<p><b>Southwark</b></p> <p>Guys and St. Thomas' NHS Foundation Trust  <a href="http://www.guysandstthomas.nhs.uk/our-services/adult-community-nursing/overview.aspx">http://www.guysandstthomas.nhs.uk/our-services/adult-community-nursing/overview.aspx</a></p> <p><b>Adult community nursing services led by district nurses and charge nurses</b></p> <p>Bladder and bowel specialist nursing service  Care home support team  Continuing care nursing team  Diabetes team and Diabetes education group (DESMOND)  Heart failure clinics with specialist nurses  tissue viability specialist nurses and Leg ulcer clinic  Multiple sclerosis specialist nurses  rapid response and supported discharge teams  specialist clinics for long-term conditions eg: chronic obstructive pulmonary disease (COPD), chronic heart disease, asthma and diabetes</p>
<p><b>Lewisham</b></p> <p>Lewisham and Greenwich NHS Trust  <a href="http://www.lewishamandgreenwich.nhs.uk/community-services">http://www.lewishamandgreenwich.nhs.uk/community-services</a></p> <p>Community matrons  District nursing  Intermediate Care (for admissions avoidance and supported discharge)  Leg ulcer clinics</p>	<p><b>Kingston</b></p> <p>Your Health Care  <a href="http://www.yourhealthcare.org/Services/">http://www.yourhealthcare.org/Services/</a></p> <p><b>Community Matrons</b></p> <p>Continence care  Diabetes care</p> <p><b>District Nursing</b></p> <p>Intermediate Care  Rapid Response  Specialist Nursing Services : Tissue Viability and Leg Ulcer Clinics, Diabetes care, Cardiac rehabilitation, Continence care, Infection Control</p>

<p><b>Merton</b></p> <p>Sutton and Merton Community Services NHS</p> <p><a href="http://www.smcs.nhs.uk/community-nursing.asp">http://www.smcs.nhs.uk/community-nursing.asp</a></p> <p>Adult Nursing Services</p> <p><b>Community Nursing</b></p> <ul style="list-style-type: none"> <li>Community Prevention of Admission Team</li> <li>Community Respiratory Team</li> <li>Continence Service</li> <li>Diabetes Service</li> <li>End-of-Life Care Service</li> <li>Heart Failure Service</li> <li>Tissue Viability Service</li> </ul>	<p><b>Richmond</b></p> <p>Hounslow and Richmond Community Health Care NHS Trust</p> <p><a href="http://www.hrch.nhs.uk/our-services/services-directory/">http://www.hrch.nhs.uk/our-services/services-directory/</a></p> <p><b>Community matrons</b></p> <ul style="list-style-type: none"> <li>Continence/bladder and bowel dysfunction</li> <li>Diabetes specialist nurse</li> </ul> <p><b>District nurses</b></p> <ul style="list-style-type: none"> <li>Intermediate Care team</li> <li>Multiple sclerosis nurse specialist</li> <li>Respiratory care team</li> <li>Tissue viability</li> </ul>
<p><b>Sutton</b></p> <p>Sutton and Merton Community Services NHS</p> <p><a href="http://www.smcs.nhs.uk/community-nursing.asp">http://www.smcs.nhs.uk/community-nursing.asp</a></p> <p>Adult Nursing Services</p> <p><b>Community Nursing</b></p> <ul style="list-style-type: none"> <li>Community Prevention of Admission Team</li> <li>Community Respiratory Team</li> <li>Continence Service</li> <li>Diabetes Service</li> <li>End-of-Life Care Service</li> <li>Heart Failure Service</li> <li>Tissue Viability Service</li> </ul>	<p><b>Wandsworth</b></p> <p>St. Georges Health care NHS Trust</p> <p><a href="https://www.stgeorges.nhs.uk/service/community-services/">https://www.stgeorges.nhs.uk/service/community-services/</a></p> <p><b>Community nursing</b></p> <p><b>Community matrons</b></p> <ul style="list-style-type: none"> <li>Community wards</li> <li>Diabetes specialist nursing</li> <li>Heart failure specialist nursing</li> <li>Intermediate care services</li> <li>Telehealth</li> <li>Tissue viability services</li> </ul>

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