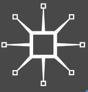

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Community Nursing Services in England

An Historical Policy Analysis

Donna Bramwell
Kath Checkland
Jolanta Shields
Pauline Allen

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Preface

This book is the result of a collaborative effort by members of the NHIR-funded Policy Research Unit in Health and Care Systems and Commissioning to analyse systematically the complex and abundant policy interventions that have shaped the community and district nursing service in the UK since the inception of the NHS in 1948. As the community and district nursing service continues to evolve to meet new challenges, we feel that contextualising the service in the wider historical and policy environment will enable practitioners, policy makers and other academic colleagues to gain chronological and thematic insights into the subject.

This book could not be more timely. According to the most recent Census (ONS, 2021), the population in England and Wales has seen the highest growth, adding 3.5 million to the total population count since 2011, with over one-sixth of the population now aged 65 and over. An ageing population will not only have an immediate impact on the district nursing service, with increased demand for care delivered at home, but also will affect the workforce itself, with many staff likely to retire in the next 5–10 years (QNI, 2021). Clearly clinical and service-based research is needed to explore the optimum approaches to delivering care outside hospitals, but we would also argue that future research also needs to consider the wider policy issues associated with planning, managing and organising services. Questions around workforce models, population coverage, payment systems and performance measurement and oversight require close attention, and this book is intended to provide a platform for such research.

The salient issues this book addresses will be of special interest to those who seek to develop and plan for future health policy by paying close attention to what worked in the past including the varied impacts of so-called policy innovations. This type of learning is pertinent particularly at a time when the wider context for decision making (Brexit, the Covid-19 health pandemic, the Ukraine war and an imminent cost of living crisis) has such unprecedented consequences on the health of the population as well as the wider health system.

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Queen's Nursing Institute (QNI), 2021, *Untapped potential: district nursing services and the avoidance of unplanned admission to hospital*, The Queen's Nursing Institute, International Community Nursing Observatory

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About the Authors

Donna Bramwell had a long and varied career in Human Resources and Marketing before changing track to academia and studying for a BA Hons in Psychology with Sociology at Manchester Metropolitan University, graduating in 2007. This led to a Medical Research Council funded PhD at the University of Manchester (UoM) exploring employers' and managers' experiences of supporting employees with long-term health conditions. In 2013, she was employed as a Research Associate with the Health Politics, Policy and Organisations research group at UoM and has worked on several projects with a focus on the interaction between health policy and health services, in particular primary care. Donna's principal research interests lie in the sociology of health and encompass taking a sociological perspective to understanding health policy, health organisations and the associated workforce.

Kath Checkland qualified as a GP in 1991, subsequently entering academia following a masters and a PhD. She has continued to practise as a GP, alongside developing a research career in the field of heath policy and systems at the University of Manchester. Kath's research addresses all aspects of system organisation and management, with a particular focus on commissioning and on primary care. Kath leads a research group at the University of Manchester, and she is co-director of the NIHR Policy Research Unit in Health and Care Systems and Commissioning. Her work involves ongoing engagement with policy makers, with a view to providing research evidence to inform policy and service delivery.

Jolanta Shields is a Lecturer in Politics at Leeds Beckett University and an Associate Fellow of the Higher Education Academy. She previously worked at the University of Manchester, where she completed her ESRC funded PhD on the role of Community Interest Companies in the English NHS. Prior to joining Leeds Beckett, Jolanta was a researcher at the University of Manchester's Centre for the History of Science, Technology and Medicine, where she worked on an oral history project exploring the social impact of Covid-19. She has been involved in a number of research projects covering a wide range of issues such as social determinants of health, health inequality, and new models of care. Before academia Jolanta had a successful career in local government working as a senior policy officer at Manchester City Council. Jolanta's research focuses on health policy and public service reform in the English NHS. Jolanta is interested in exploring how governance and specifically health system governance is affected by the earlier policy choices and shaped by wider socio-political forces.

Pauline Allen is a qualified solicitor and a Professor of Health Services Organisation at the London School of Hygiene and Tropical Medicine (LSHTM). Her PhD focused upon the organisation of Community Health Services, and since then Pauline has had a longstanding interest in this under-researched topic. Pauline leads a research group at LSHTM, and she is a co-director of the NIHR Policy Research Unit in Health and Care Systems and Commissioning. Pauline's research focuses upon the organisation of the health system, with a particular focus upon governance, accountability and contractual approaches to system management.

Abbreviations

AHA	Area Health Authority
CCGs	Clinical Commissioning Groups
CFTs	Community Foundation Trusts
CHS	Community Health Services
CN	Community Nurse
DHA	District Health Authority
DMT(s)	District Management Team(s)
DoH	Department of Health
DN	District Nurse
FHSA	Family Health Services Authority
FPCs	Family Practitioner Committees
FTs	Foundation Trusts
GP	General Practitioner
HA	Health Authorities
ICB	Integrated Care Board
ICS	Integrated Care System
LA	Local Authority
MDT(s)	Multi-disciplinary Team(s)
NHSE	NHS England
PC	Primary Care
PCGs	Primary Care Groups
PCTs	Primary Care Trusts
PHCTs	Primary Health Care Trusts
RHA	Regional Health Authority
TCS	Transforming Community Services

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CHAPTER 1

Introduction

Abstract In this chapter we introduce the background and rationale for our historical review of community nursing services through the lens of health policy. We provide the research questions the review is based on and detail the topic themes used to structure our answers to these questions. We have considered policy relating to community nursing services over seven eras from 1948 to the present day and each subsequent chapter details this. A definition of community/district nursing used for the purposes of the review is provided, as well as an outline of the structure of the chapters and the book. Each chapter will follow a consistent format:

- Historical context
- The role and function of community/district nursing services
- The management of community/district nursing services and the population covered
- Financing community/district nursing services
- Summary

Keywords Community nursing • District nursing • policy • historical • NHS

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Community nursing services are an under-researched area of the UK health system (Goodman et al., 2003). Often forgotten or appearing as an afterthought in policy documents, they nevertheless play an important role in service delivery. Indeed, the NHS Long Term Plan (NHS England, 2019) places a heavy emphasis on improving care outside hospitals, promising additional investment for both primary and community services, but also highlighting a need for 'increased efficiency'. In this book, we use an historical lens to consider how policy might need to change to achieve these aims. We confine ourselves in this book to community or district nursing services provided for adults; we do not examine maternity or child health services. Specifically we use the district nursing service as a lens by which to examine community nursing policy throughout history given that it is largely a specialist community and home nursing service. A definition of community/district nursing used in this report is provided at the end of this section.

In their 2003 assessment of the research and policy literature relating to community nursing, Goodman et al. (2003) highlight the multiple contradictions and tensions inherent in the role and argue that the professional status of what in the UK are called 'district nurses' has historically been limited by two parallel trends: the low status of the patient group for which they care and the higher status afforded to 'specialist' practitioners over 'generalists'(Martin et al., 2009). It should also be recognised that nursing in general has low status, which is partly attributable to its gendered nature (Davies, 1995). In the policy field, whilst successive governments have paid lip service to the importance of community services, investment has rarely followed, with payment systems, contractual models (Allen, 2002) and a dearth of high quality data (Audit Commission, 1999) all contributing to a relative disadvantage for community services when compared with specialist services provided in hospitals.

Since 2014, there has been a strong focus in policy on improving the integration of care in the NHS (NHS England, 2014, 2019). The Five Year Forward View argued that:

> The traditional divide between primary care, community services, and hospitals—largely unaltered since the birth of the NHS—is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Over the next five years and beyond the NHS will increasingly need to dis-

> solve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. (NHS England, 2014, p. 16)

Community Health Services (CHS)—and particularly those provided by community nurses—are a very important element in this ambition to create a more integrated health care system. Nursing services provided in the home, alongside more specialised community services provided in clinics and care provided by social care services, are important in: supporting patients to live independently; working alongside general practices to manage patients with long term conditions in the community; providing care which enables people to avoid hospital admission; and providing care which allows patients to be discharged from hospitals, thus reducing lengths of stay. Achieving these things requires community service providers to work across multiple boundaries, working with social care, primary care, mental health and acute hospital services. Ensuring that these different services join up with one another is a key task in supporting the development of care which is experienced by patients as efficient and integrated.

Building upon the Five Year Forward View, the NHS Long Term Plan (NHS England, 2019) identifies a number of ways in which community services will be strengthened and supported to ensure that they can deliver the care which is needed. These include:

- Increased investment, linked to investment in primary care services
- Closer working with primary care providers via Primary Care Networks
- Improved data collection about community service provision
- Greater use of digital and telemedicine systems to support service delivery
- Systems to support earlier discharge from hospital, including better planning in the early stages of acute hospital admissions
- Increased efficiency in community services, including more time spent face to face with patients
- Changing legislation to allow the creation of new NHS integrated care delivery organisations

In understanding how these things might be achieved and what policy changes may be required to support this, it is first necessary to understand the factors which have led to the presumed 'inefficiency' and lack of

integration in the current system. Community services as they exist today are not the result of a planned development of services over time. Rather, they are the result of multiple 'sedimented' (Cooper et al., 1996) policies which have incrementally accumulated to generate the system as it stands today. Importantly, few major policy changes in the history of the NHS have addressed community services directly; more often, the system design factors underpinning community service provision have emerged as a by-product of changes introduced to tackle problems elsewhere in the NHS. For example, in spite of policy objectives over many years that there should be increased investment in care outside hospitals, the 'payment by results' cost per case funding system for hospital care, which does not extend to community services (Department of Health, 2002), has made this difficult to achieve. In addition, when community services have been the direct target of policy, these have often not been followed through. For example, the '*Transforming Community Services*' programme in the late 2000s (Department of Health, 2009) was quickly overtaken by a wholesale reorganisation of the NHS under the Health and Social Care Act 2012 (HSCA, 2012).

As Berridge (2011) has pointed out, history has an important role to play in public policy, with a judicious appreciation of past policy an important tool for ongoing policy development. With that in mind, we offer an historical policy analysis of community nursing services in UK policy since the advent of the National Health Service. Our aim in doing this is to provide an analysis of the issues and opportunities facing community services which is rooted in what has gone before, using past policy as a tool with which to consider how future policy might most effectively deliver the aspirations of the NHS Long Term Plan (2019) to invest in and revitalise health care services provided outside hospital.

In this review we consider policy relating to community nursing services over a number of eras. Deriving in part from Ottewill and Wall's (1990) history of the development of Community Health Services, alongside our own past research (Lorne et al., 2019) and Klein's (2013) foundational account of the politics of the NHS (amongst others), we divide the history of the NHS into seven loosely defined eras which each form a separate chapter:

- 1948–1974—Community Health Services as a Local Government service
- 1974–1982—A unified geographically based health system

- 1983–1990—The era of General Management
- 1990s—The introduction of the internal market
- 2000s—Transforming community services
- 2010–2015—The Health and Social Care Act, NHS fragmentation
- 2015–date—Focus on integration

For each era we consider the major policy documents and reports relevant to community nursing services in order to answer the following research questions:

1. What are the key government policies in respect of the organisation and provision of community nursing services since 1948?
2. What are the overt drivers and aims of these policies?
3. How do the policies and/or drivers change or remain consistent over time?
4. What lessons can we learn for current policies concerning the organisation and delivery of community nursing services?

In order to address these questions, for each policy era we address the following topics:

- The presumed role and function of community nursing services
- The management of community nursing services
- Population coverage
- Finance and payment mechanisms

Our discussion then looks across the eras to answer our research questions and draws out lessons and themes of relevance to the current policy context.

1.1 Definitions: Community Nursing/District Nurse

Before setting out on the journey of documenting an historical account of community nursing it is first pertinent to provide the definitions upon which this report is based. According to NHS England (2015), community nursing encompasses a diverse range of nurses and support workers who work in the community including district nurses, intermediate care

nurses, community matrons and hospital at home nurses. This book is focused particularly on those nurses who provide services to patients in the home and community, and for this, we are concerned mainly with the role of the district nurse.

There is a lack of consensus around definitions of the district nurse and the term is used in different ways through time by different organisations and bodies, and often interchangeably with the term community nurse. However, there is consensus around specialist training, education and the type of patients requiring home care. The Queens Nursing Institute (2016) definition of a District Nurse is:

> A District Nurse is a qualified and registered nurse that has undertaken further training and education to become a specialist community practitioner. (Queen's Nursing Institute, 2016: Ch1)

The Department of Health document, Care in Local Communities (2013, p. 10) takes District Nurses to mean:

- 'Qualified nurses with a graduate level education and specialist practitioner qualification recordable with the Nursing and Midwifery Council.'
- 'Care provided in a variety of community settings by district nursing teams. This care includes a wide range of care, for example, supporting patients with long-term conditions in their own homes and providing complex and palliative care. Comprehensive high quality district nursing services have the potential to reduce use of hospital sector and residential social care.'

Further, The Royal College of Nursing (2013) suggests that the fundamental goal of district nursing is: 'The planning, provision and evaluation of appropriate programmes of nursing care, particularly for people discharged from hospital and patients with complex needs; long-term conditions, those who have a disability, are frail or at the end of their life' (p. 8).

As we will document, there has been a consistent trend within the UK for nursing teams delivering care in the community to include less well-qualified staff alongside qualified district nurses. Increasingly, care assessments are done by qualified district nurses, whilst care is provided by general nurses and by health care assistants working under supervision. In our account we therefore refer consistently to community

nursing services and community nurses in discussing policy more generally, but refer specifically to district nurses where relevant in terms of issues of training or qualifications. We recognise that Community Health Services also include services provided by specialist nurses, midwives and child health services including school nurses and health visitors. However, our policy history does not focus upon these services, as they have been subject to different policy drivers and pressures. Our focus is therefore upon community nursing services provided for adults in the community, with a particular focus upon the role and function of district nurses.

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QNI Queen's Nursing Institute. (2016). *Transition to district nursing service*. QNI.

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CHAPTER 2

1948–1974: Community Nursing Services as a Local Government Service

Abstract Taking the first era from the inception of the NHS through to 1974, this chapter documents the establishment of the service as a home nursing service. Known as the 'tripartite era' because of the way provision of health services were divided between three types of bodies—Local Authorities (LA), Executive Councils of the Ministry of Health and Hospital Boards—this era would see a split enshrined between LA-provided community nursing services and medical services provided by the others. This split has been a feature of the NHS ever since, despite successive unifying re-organisations of the health service, and has come to define the way community nursing is perceived by policy apparent in this review. In line with the format of the chapters, we start to look at the role and function of district nurses (DNs) and begin to see how the role was focused on home care for the sick, management of infectious diseases and supporting doctors. We also begin to examine how DNs were managed and paid for and identify the enduring tensions in how they are organised—either geographically or attached to GP practices. We conclude this chapter with a brief paragraph summing up that for this era the role of district nurse services, despite becoming a national requirement, is rarely fully set out in policy. In other words, the district nursing service was largely invisible in policy terms.

Keywords Local government • Tripartite • Invisible • Home Care

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2.1 Historical Context

At the inception of the NHS, a wide range of community nursing services were provided in most areas, generally co-ordinated or overseen by Medical Officers of Health employed by Local Authorities. However, these tended to focus upon services for pregnant women, mothers and their children, with district nursing generally provided by voluntary or charitable services (often known as 'District Nursing Associations'), driven in large part by the Queen's Nursing Institute (QNI, 2020). This charitable organisation led the establishment of training for nurses working in the home, and had a significant influence on the organisation and management of district nursing services until the 1970s (Ottewill & Wall, 1990). The 1946 Act establishing the National Health Service (UK Parliament, 1946) gave Local Authorities the responsibility for providing for 'the attendance of nurses on persons who require nursing in their own homes', specifying that this could be done either by making arrangements with voluntary organisations or by employing nurses themselves. In practice, 75 out of 146 Local Authorities at the time opted to employ nurses directly themselves (Ottewill & Wall, 1990). This was the first time that there had been a national requirement for the provision of home nursing services.

This era of NHS services is often known as the 'tripartite era', because responsibility for the provision of comprehensive health services were divided between three types of bodies: Local Authorities, responsible for maternity, child health, vaccination services, environmental health and home nursing; Executive Councils of the Ministry of Health, responsible for Family Practitioner (GP) services; and Hospital Boards responsible for the provision of secondary care services (Ottewill & Wall, 1990, p. 66). Thus, the foundation of the NHS enshrined a split between medical and nursing services provided to people in their homes, and this split has been a feature of the NHS ever since. This era lasted until 1974, when a wholesale reorganisation of Local Government and the NHS divested Local Authorities of many of their responsibilities for healthcare services (Ham, 1999).

2.1.1 The Role and Function of Community/District Nursing Services

In the early years of the NHS, little explicit advice was published which clearly delineated the role and function of community nursing services, with 'nursing in the home' assumed to be a self-evident category of activity. The best indication of what activity this was intended to encompass comes from considering the training which was provided. In 1948, most specialist district nurse training was provided by the Queen's Nursing Institute, although other smaller charitable bodies such as the Ranyard Mission also offered some specialised home nursing training (Denny, 1997). Such training was not standardised or compulsory. At this time general nurse training, as established in the 1949 Nurse Bill (Hansard, 1949), consisted of three years of training to become a State Registered Nurse. The QNI District Nurse Certificate consisted of a further 6 months training, with the content of the curriculum focused largely upon how traditional nursing tasks could be undertaken in the home. There was a strong focus on improvising equipment from items found in the home (Gibson, 1993).

In 1953, a committee was established to examine the training of district nurses, under the leadership of Sir Fredrick Armer. The resulting report (Armer, 1955) recommended reducing training to between 3 and 4 months (longer for nurses not holding State Registration), with the argument made that 6 months training was no longer required because the general standard of housing in the country had improved (Gibson, 1993). Local Authorities could procure training for their nurses from existing courses such as that provided by QNI, or they could set up their own. In 1959, the Ingalls Report again addressed district nurse training (Ingall, 1959). The report argued for the creation of a national Panel of Assessors for District Nurse Training, with the remit to oversee and accredit district nurse training courses. They advised lengthening training, and established a central curriculum. It had two elements—health, welfare and social services, and 'nursing in the home' (Gibson, 1993, p. 832). The first part of this was not really about what would currently be considered prevention; rather it was about the structures in place, informing nurses about the role of medical officers of health, social workers and so on. A section of the curriculum considered liaison with other providers of domiciliary care, such as GPs. 'Treatment' was regarded as being about caring for people with infectious diseases (including how to do 'barrier nursing'),

pain relief, treating wounds, with care in the home also addressing such things as preventing accidents (Gibson, 1993). Thus, in the early years of the NHS, district nursing was conceptualised as the care of the sick in difficult circumstances—i.e. the home—with their role beyond caring for the sick seen in terms of teaching nutrition and preventing accidents. Importance was placed upon liaising with other providers of care in the home such as GPs and health visitors.

District nursing services were hence established at the inception of the NHS as the provision of nursing care—often to those sick with infectious diseases—in the home. By the early 1960s, there was a growing feeling that the separation of health care provision between Local Authorities and the NHS would need to change. District nursing, however, remained largely invisible in policy terms. Indeed a comprehensive appraisal of the NHS and its services by the Medical Services Review Committee under Sir Arthur Porritt (1962) failed to explicitly mention home nursing services at all, referring only to the fact that: 'in domiciliary care the family doctor needs the help of skilled ancillary workers and medical auxiliaries. The GP should be clinical leader of the domiciliary team'(Porritt, 1962, p. 1181). Nursing is thus conceptualised as a subsidiary 'helping' task, under the direction of a doctor. The context here is of a general practice workforce in crisis, demoralised and lacking in perceived status; the focus of policy was thus in 'supporting' general practice, rather than in developing community services in their own right (Peckham & Exworthy, 2003).

2.1.2 The Management of Community/District Nursing and Population Covered

After 1948, the direction and management of district nurse teams came under the remit of the Medical Officer of Health in the Local Authority (LA) (Ottewill & Wall, 1990). However, in 1969 the Mayston Report (Mayston, 1969) argued that nurses should not be seen as subsidiary to doctors, but should have their own three-tier management structure, and advocated having a Chief Nursing Officer in each LA. This translated to LAs appointing Directors of Nursing Services accountable and responsible for all community midwifery and nursing services. This mirrored similar moves in hospitals, in which a separate nursing management structure began to be established.

At this time, the location of district nursing services in Local Authorities meant that the population to be covered was that of the relevant Local

Authority boundary. Within this, district nursing teams were encouraged to work with local GPs, but they were, initially at least, a separate service. However, during the 1960s a movement began towards the better integration of community services, working together in a 'Local Health Centre'. The establishment of Health Centres had been prefigured in the Act establishing the NHS, which empowered Local Authorities to build Health Centres from which local community services would be provided (Ottewill & Wall, 1990). However, few were built until the 1960s, when a movement advocating their establishment began (Baker & Bevan, 1971). In their report on Health Centres Baker and Bevan (ibid, p. 3) argue:

> In the Ministry of Health Circular 7/6711, it is stated that "The Minister regards the main purpose of a health centre as facilitating integration of the family doctor and the hospital and local authority services". The Future Structure of the National Health Service (1970) states that the aim of health centres "is to co-ordinate local preventive and curative services so as to provide integrated health care to community". The Todd Report (1968) sees the health centres as "the most obvious and natural setting" for general practice in the future, particularly as only the health centre could link with the district hospital, unlike group practice premises. (Baker & Bevan, 1971, p. 3)

Thus it seems that by the late 1960s/early 1970s a more holistic view of community nursing was emerging, whereby district nurses would work alongside colleagues providing community based services in purpose-built premises and provide holistic and integrated care. Reports such as Baker and Bevan's (1971) take the view that a close relationship between the populations covered by community-based nurses and by GPs was desirable, with Health Centres seen as the mechanism by which this could be achieved. The report discusses whether or not nurses should be formally 'attached' to specific GP practices, but argues that, whilst desirable, this is not necessary as long as 'common rooms' are provided in which the different professional groups could meet informally to discuss their caseloads (Baker & Bevan, 1971). The work of community nurses in this scenario remains based around a vision of traditional nursing tasks such as dressings and tasks delegated by doctors. The Health Centres report does not explicitly discuss the management of nurses, but the picture painted is of team-based working, with teams led by doctors.

2.1.3 *Financing Community/District Nursing Services*

Between 1948 and 1974, the NHS budget was divided between the three branches of the tripartite system. District nursing services thus received a share of the Local Authority health budget. The amount directed into district nursing services was locally determined by local politicians. Plans were submitted to the Minister, and relevant local parties (e.g. voluntary providers) could suggest modifications. The Minister then approved the plans (with or without modifications) (Ottewill & Wall, 1990, p. 93). The service was thus relatively devolved, albeit with Ministerial sign off. Authorities were required to undertake 5–10 year reviews of their services, but these rarely looked forward to future plans, rather reviewing what had been provided. According to Ottewill and Wall (1990), in the 1950s 'there were few standards of performance by which local (health) authorities could be judged or could judge themselves' (Ottewill & Wall, 1990, p. 93). It was therefore difficult for the Ministry to judge whether or not services to be provided would be adequate. Ottewill and Wall (1990, p. 95) highlight the fact that, in the 1960s, Griffith (1966) commented that 'the attitude of the Ministry of Health towards health and welfare Authorities is 'laissez faire'. However, they go on to explain that: 'in this context he defines 'laissez faire' not as 'a negative attitude of indifference,' but as 'a positive philosophy of as little interference as possible within the necessary fulfilment of departmental duties' (Ottewill & Wall, 1990, p. 95).

Overall, therefore, during the tripartite era the finance and oversight of community services was relatively devolved.

2.1.4 *Summary*

The establishment of the NHS saw the formation of the first universal coverage of district nursing services, although pre-1948, most areas had some coverage by local voluntary or charitable District Nurse associations. The role of district nurses is rarely fully set out in policy, but examination of training programmes and materials suggests that district nursing was seen as the provision of nursing services to sick people at home, with a strong emphasis on improvisation and the management of infections. Nurses initially came under the management of the Medical Officer of Health, with a Chief Nurse function established in the late 1960s. District nurse training recognised the need for close liaison with GPs, but this was not officially reflected in policy. Towards the end of the 1960s a

movement was growing towards the establishment of Health Centres, from which both GPs and nurses would work together, with GPs seen as team leaders with nurses carrying out delegated tasks. The amount of funding that district nursing services received was locally determined.

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CHAPTER 3

1974–1982: A Unified Geographically Based Health System

Abstract In this chapter, we detail the first major re-organisation of the NHS since its inception and the consequences for community nursing. The 1974 wholesale re-organisation was born out of frustrations with the management and fragmentation of services resulting from the tripartite system. Services were bought together in a unitary model, centrally controlled but geographically organised. Local Authorities (LAs) were divested of many of their healthcare responsibilities including community nursing, which was transferred under the responsibility of newly created Area Health Authorities (AHAs). There was optimism that bringing community nursing under the NHS umbrella would foster a new era of co-ordinated working between all disciplines in the system, such as hospital nursing. Unfortunately, many of these intended aspirations were not realised despite the importance of the service to policy agendas emphasising integration, out-of-hospital care and prevention of ill health. In terms of managing and financing the district nursing service, this was not simplified by the re-organisation and population coverage continued as a mix of geographical and attachment to GP services. We conclude this chapter by emphasising the increasing demand for community and district nursing services. It became apparent in this era that the re-organisation did not bring any significant improvements and thus the attention shifted again towards organisational and management solutions to the NHS' problems.

Keywords 1974 • Re-organisation • Geographical

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3.1 Historical Context

As mentioned in Sect. 2.1.1, this era saw the first major re-organisation of the health service since its inception in 1948 and was focused almost entirely upon management of services.

Intended to address management, co-ordination and organisational issues with the NHS, including weaknesses with the tripartite system, changes began in April 1974 following the passing of the National Health Service Reorganisation Act in 1973 and it took over 2 years to implement (Office of Health Economics (OHE), 1977). The re-organisation aimed to bring a 'balance of services-hospital and community-throughout the country' and to put an end to the fragmentation of the national health system (DHSS, 1972, p. 1), importantly, each professional discipline was intended to manage itself. Thus, the replacement model brought together the three separate bodies into a unitary, hierarchical system administered by 14 Regional Health Authorities (RHA) and 90 Area Health Authorities (AHAs). These authorities were controlled by central government (DHSS) but geographically organised and coterminous with local government boundaries. Along with shifting the management and financing of community nursing services from local authorities to the NHS, one of the other main changes was that AHAs became responsible for the planning and providing of both hospital and community services.

The new, locally focused and less hierarchical organisational structure was an attempt to bring clarity to the system not only in terms of responsibilities and accountability but also to facilitate co-ordination and integration of services especially at the district level (OHE, 1974), described below. Indeed, there was initial optimism that bringing community nursing under the NHS umbrella would usher in a new era of co-ordinated working between community and hospital nursing, as well as 'other disciplines at all levels throughout the structure' (Ottewill & Wall, 1990, p. 220). Hence, from the 1st April 1974, the responsibility for community nursing was transferred to AHAs, who also assumed responsibility for running Health Centres. However, the new structure did not realise many of its intended aspirations for community nursing and by 1982 it all changed again.

3.1.1 The Role and Function of Community/District Nursing Services

The model of district nursing remained as one of 'nursing in the home' following the re-organisation and again, there is little mention in the literature of what the role entailed during this period. A DHSS (1977b) circular entitled Nursing in Primary Health Care (CNo.77, 8—appendix to Priorities documents) made much of the place of district nurses in the primary care team and the benefit to patients of effective, co-operative ways of working—in particular, between health visitors and district nurses. The importance of non-nursing care or help with social needs was also acknowledged. The circular went on to define that a district nurse:

> … is an SRN who has received post basic training in order to enable her to give skilled nursing care to all persons living in the community including in residential homes. She is the leader of the district nursing team within the primary health care services. Working with her may be SRNs, SENs and nursing auxiliaries. It is the district nurse who is professionally accountable for assessing and re-assessing the needs of the patient and family, and for monitoring the quality of care. It is her responsibility to ensure that help, including financial and social, is made available as appropriate. The district nurse delegates tasks as appropriate to SENs, who can thus have their own caseload, but who remain wholly accountable to the district nurse for the care that they give to patients. The district nurse is accountable for the work undertaken by nursing auxiliaries who carry out such tasks as bathing, dressing frail ambulant patients and helping other members of the team with patient care. (Baker & Bevan, 1983, p. 23)

However, the *function* of community nursing became increasingly important to policy agendas which emphasised out-of-hospital care and prevention of ill health. These being driven by rising costs of caring for a changing and increasingly elderly population. Indeed policy in this era was dominated by a 'rhetoric of financial crisis' according to Klein (2010, p. 79), especially towards the latter half of the 1970s, and steered the course of policy during this period. Thus, the focus on shifting care into the community to relieve financial pressure on the NHS was prominent in this era, and along with it, the corresponding reliance on community nursing to deliver these policy visions.

Several documents pivotal to the increasing focus on community nursing services were the 1976, *Priorities for Health and Personal Social Services in England: A Consultative Document*, the 1976a White Paper—*Prevention and Health: Everybody's Business* and the 1981, *Care in the Community: A Consultative Document on Moving Resources for Care in England* (all DHSS). The 'Priorities' document as it is known was the first attempt by the DHSS to look ahead and determine healthcare priorities for the coming years. It established how limited resources could be allocated (DHSS, 1976a) and proposed a switching of balance towards an expansion of primary health care and community support services with a lower level of growth and financing in the acute hospital sector. Although only consultative, it is acknowledged that the 'Priorities' document was influential in the planning of health care for this era, laying out the need to improve out-of-hospital services for the mentally ill, the young and on how to address the probable extra workload brought about by the ageing population (OHE, 1977). Correspondingly, the message of the Care in the Community document was that 'most people who need long-term care can and should be looked after in the community' and proposed looking to local authorities and voluntary organisations, as well as the NHS, as a way of spreading the financial responsibility of this (DHSS, 1981a, p. 1). Similar sentiments were echoed in the DHSS, 1978 discussion document, a *Happier Old Age*, which stressed the need to care and support the elderly in the community for as long as possible, suggesting the voluntary sector play a larger part in keeping people out of hospital.

Commensurately, it was the community nursing services that were tasked with providing this care and thus their workload increased exponentially. District nurses became increasingly under pressure from a number of sources not least from having to care for patients with increasingly complex needs but with schemes such as earlier discharge from hospital, the introduction of out-of-hours services and 'hospital at home' (Ottewill & Wall, 1990, p. 296). Indeed, a 24-hour-nursing service, or a version thereof, was eventually implemented into the district nursing service by the majority of district health authorities to provide continuous care to those who, 'might otherwise require hospital beds, to remain at home' (DHSS, 1977a, p. 16). Hence, it was proposed that the spending on district nurses should increase by 6% per year and an increase in district nurse numbers to increase by the same, to meet the extra workload (Baker & Bevan, 1983). Interestingly, the balance of patients treated in the home had shifted by 1980 and 'district nurses were treating five times as many

cases among those aged less than five years and twice as many cases among those aged 65 and over' (Baker & Bevan, 1983, p. 14).

Community nurses were also called upon to play their part in health promotion and preventing ill health as part of the government's cost-cutting measures. The associated discussion paper to 'Priorities', *Prevention and Health: Everybody's Business (*DHSS*,* 1976b*)* proposed to shift the responsibility for health onto an individual claiming that 'as a society [we] are becoming increasingly aware of how much depends on the attitude and actions of the individual about his health' (p. 7). However, this did not prove a fruitful strategy in terms of reducing expenditure, and much of the burden of this was pushed on to the district nurses' workload. According to the document, district nurses were well placed to offer preventative advice to the elderly about 'remaining active and about ways of safeguarding health' (Baker & Bevan, p. 26), as well as being able to observe the general condition of individuals in their home and identify potential healthcare problems which would if 'not corrected, prove difficult to manage later on' (Baker & Bevan, 1983, pp. 26–27).

The themes of health surveillance and prevention were among key recommendations included in the Report of the Royal Commission on the National Health Service (1979) led by Sir Alec Merrison. It would be remiss not to mention the Merrison Report here given the influence of the committee's findings on much of the policy discussed above and by implication on the district nursing service. Instigated in 1976 after some opposition to, and disillusionment with, the NHS restructure (predominately from the providers of health care), and to avoid a crisis within the service, Merrison and his committee were tasked with wholesale scrutiny of the NHS. This included investigating differing aspects of the healthcare system including community services. Whilst the recommendations of the report are many and wide ranging, it was relevant to district nurses in terms of examining the community nursing workforce skills, roles and acknowledging that there was little or no nurse manpower planning. The Royal Commission recommended expanding the role and responsibilities of district nurses, for example in 'health surveillance of vulnerable populations, in screening procedures and health education and preventative programmes' (Ottewill & Wall, 1990, p. 296). The committee also supported government plans to increase the workforce to meet the demand for its services and workloads as outlined above. To meet the needs of increased out-of-hospital care, some areas chose a route of community nurse specialisation—alongside more

generalist district nurses—for example in stoma care, stoke, diabetes and coronary care, etc. (Ottewill & Wall, 1990, p. 296).

Team Work

Joint care planning, which in the early 1960s developed as a co-ordinating mechanism to enable the transition of care for the elderly from hospital into community, expanded further in the 1980s following the 1974 re-organisation. Joint care planning teams (area level) and healthcare planning teams (district level) were set up to facilitate collaboration between health and local authorities and in doing so embedding the concept of joint working as a key policy objective (UK Parliament, 1973; DHSS, 1977a). The multidisciplinary membership of joint care planning teams was seen to offer added advantage by pooling on staff expertise and knowledge to achieve common goals.

The emphasis on integration and collaboration post re-organisation built on the concept of teamwork. For community nursing, this resulted in the expectation that, as part of their role, they would be active members of multi-disciplinary teams. The new structure was expected to provide new opportunities for working whereby all teams were 'to be multidisciplinary, so that nurses at all levels and in all situations [could make] an important professional input into any discussion or plan' (Smith, 1979, p. 448). Smith argued it was inevitable that the profession in future would develop along these lines and therefore it was crucial that they were prepared to take on 'extended responsibilities they will be well versed in the group dynamics of coping with multi-disciplinary group activities' (ibid.). However, Appleyard and Maden (1979, p. 1305) suggested that the term became a panacea and 'the establishment's answer to difficult clinical problems in the Health Service'. They argued that there was little evidence that the approach was effective except for diverting attention from the individual and statutory responsibility of each member. They concluded that the NHS could not 'afford an extensive multi-disciplinary framework' citing logistical and clinical reasons (ibid.).

In this vein, intentions towards multi-disciplinary collaboration within primary health care proved to be more of a theoretical than practical development following the restructure. Community nurses were disillusioned by managers who did not embrace their roles and activities and who did not understand the potential and benefits of team working (Ottewill & Wall, 1990). Initial optimism around the concept of primary healthcare teams also declined. Such was the concern about the problems

associated with primary healthcare team development, that a committee led by Wilfred Harding was formed to investigate and offer solutions (DHSS, 1981b). Amongst other aspects, such as professional relationships, The Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee looked to the structure and organisation of the district nursing service as a possible cause for impeding collaborative working. It was concluded that district nurses continued attachment to general practice, as opposed to geographical working, was beneficial to fostering team working but that this was contingent on conditions such as appropriate premises. However, it was also acknowledged that attachment in itself is not a pre-cursor to effective team working nor the creation of a primary care team.

When published, The Harding Report explored a set of standards to facilitate team working most notably: the importance of working collaboratively, the need for role clarification and setting common objectives in the primary care (DHSS, 1981b). There was, however, little evidence that these recommendations were implemented despite government's continued emphasis on the role of primary healthcare teams (DHSS, 1986). To this end, Elliott (1978) suggested that preparing district nurses for how to work in a multi-disciplinary team should be part of the curriculum of the mandatory district nurse training to be introduced in 1981 (see below).

Education and Training

Although published in 1972, the Report of the Committee on Nursing, or the Briggs Report, was not actioned until 1979 when it was integral to the implementation of new models of nursing and nurse preparation (Bradshaw, 2010). The remit of the committee was

> To review the role of the nurse and midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower and to meet present needs and the needs of an integrated health service. Briggs, 1972, p. 1)

There were several issues which provided background to the Briggs Report, which at the time were rooted in the rejection by nurses both of the 'handmaiden' ideal—and recognition that this was gendered in nature—and of the idea that it was a selfless vocation in which they were happy to labour for minimal rewards. The report aimed to bridge the gap between education and practice and took the education and training of all

nurses as its focus with some proposals regarding regulations. Briggs concentrated on the need for continual adaptation. The report discussed the need for flexibility between hospital and community—with the implication that nursing in the community is the same as nursing in hospital, apart from the difference in the site at which care is delivered.

Responsibility for professional standards, education and discipline was vested in the new Central Nursing and Midwifery Council, created after a reorganisation of nursing bodies which developed a structure that would explore the training needs of the three professions (Nurses, Midwives and Health Visitors Act 1979, UKCC 1986). Mandatory training for district nurses was introduced in 1981, overseen by the Committee for District Nurse Training, in order for them to practice. During the period of 1976–1980 and despite much emphasis on community-based care, the number of district nurses that enrolled and entered training fell (DHSS, 1981b).

3.1.2 The Management of Community/District Nursing and Population Covered

One of the defining characteristics of the re-organisation was the introduction of the concept of the team or 'consensus management' approach defined as 'decisions … need the agreement of each of the team members' (DHSS, 1972, p. 15), hence services were organised to facilitate this approach.

However, following their transition to the NHS, management arrangements for community nursing services was complex compared to that of other community health services. Hospital and community nurses became part of one single nursing service located in districts with a District Nursing Officer in charge of co-ordinating activities. This was quite a departure from Local Authority Management, affording less local autonomy due to the removal of the democratic role of LAs but again was intended to facilitate greater collaboration and integration between the hitherto disparate services.

Districts were seen as a way to manage the large populations (between 500,000 and 1,000,000 people) covered by AHAs. Their role was administrative rather than as statutory authorities (Lorne et al., 2019), and they were managed by multi-disciplinary District Management Teams (DMTs) as per Fig. 3.1. DMTs worked by consensus and were responsible for the day-to-day operational management of planning, organising and

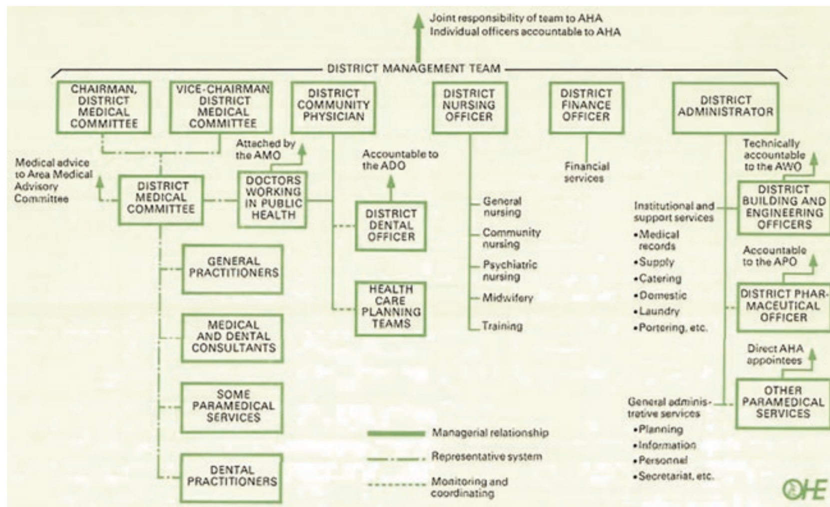

Fig. 3.1 Framework of the District Organisation. (*Reproduced with permission from The Reorganised NHS, 1977, OHE, p. 7*)

providing healthcare services for local populations between 250,000 and 300,000 (OHE, 1977, p. 9).

Based on this structure, the management of community nursing services should have been straight forward. However, the eventual reality was rather more complex. This was driven by a number of factors. First, services were further divided at sub-district level into a variety of models based on *sectors*, which were locally determined sub-divisions of the district. Two different models emerged: functional sectors, in which, for example, there was a sector responsible for community services and a sector responsible for hospitals; and geographical sectors, in which the sector covered hospital and community services in a defined area, or a mix of both. A third model (less common) involved care sectors in which, for example, a sector was responsible for the care needs of a group such as the elderly. It was at the sector level that policies for the type of service to be delivered were set.

It was the aspiration that by further organising districts into single sectors that integration and collaboration would occur between teams with shared interests and responsibilities. Instead, in some cases, the sectors

only exacerbated separatist working (OHE, 1977, p. 209) and introduced complex managerial relationships.

Second, the nursing management structures were complex, driven by a desire here to increase the professional standing of nurses. The underlying motivation was that nurses should not be overseen by doctors. Again there were many layers of nursing roles across the regional, area and district levels that informed and were accountable to the other (Ottewill & Wall, 1990, p. 222).

- Regional Nursing officer—planning and offering nursing input to plans as well as training
- Area Nursing Officer—nursing input to plans and providing advice to LA
- District Nursing Officer—planning for district, AND managed nursing services, both hospital and community.
- Structures below this level were variable, but in general followed those proposed by the Management Arrangements for the Reorganised NHS or the Grey Book (DHSS, 1972), and these were taken up by the majority of AHAs in some form. Thus, district nurses were managed by Divisional Nursing Officers, who either covered functional divisions—i.e. midwifery, general, community OR covered hospitals or community services. They managed staff beneath them and *held a budget*.

However, these arrangements would prove to be short lived and the framework of the NHS structure was again under scrutiny, having been proved to be less successful and less popular than anticipated. The new structure was deemed to be too bureaucratic and unwieldy and further streamlining was suggested by the Royal Commission on the NHS (Merrison, 1979), essentially advocating a paring back of hierarchical layers. This led to the publication of the 1979 Consultative Paper—*Patients First* (DHSS, 1979) which proposed amongst other things, strengthening of management arrangements at local level and a focus on localism—which was welcomed by CHS. Specifically, it suggested that: '(1) for each major hospital or group of hospitals and associated community services, there should be an administrator and a nurse of appropriate seniority to discharge an individual responsibility in conjunction with medical staff, (2) the administrator and nurse should wherever possible be directly responsible to the district administrator and district nursing officer, respectively'

(Williams et al., 1980, p. 91/6). Wholesale re-organisation of the NHS was enacted in 1982 (Levitt et al., 1999), but it is noted that GP services came under the auspices of the Family Practitioner Committees (FPCs)—so separate from CHS.

In terms of population covered post re-organisation, this was left vague and continued to be a mix of both attachment to GP Surgeries and geographical. This was because the organisation of services below district level was a local decision and therefore 'attachment' vs 'geography' fell under this remit. The district boundaries were built around the idea of the 'natural' districts for health that were based on the existing use of community and hospital services rather than boundaries of the new health areas. The notion of 'natural' is problematic but what it meant in the context of the proposed changes was that health care was supposed to be planned and coordinated to meet the specific needs of local populations (OHE, 1974). According to McClure's (1984) survey of district nurses, health visitors and community nurses in one AHA, nurses had been attached to general practice schemes for up to 10 years. By 1975, about 80% of AHA nurses were working in some form of attachment arrangement, a dramatic change from the mid-1960s, when less than 5% were attached to general practices (Reedy BLEC, 1980 unpublished data). *The Way Forward—Priorities for Health and Social Services* (DHSS, 1977a, Appendix)—reiterated the need for an increase in community nursing staff suggesting that the time they 'spend on professional duties can be increased where general practitioners practice within defined geographical areas'. That model combined both attachment and geography and much the same is echoed in the 1980, Black Report, *Inequalities in Health* (DHSS)—a working party reporting on inequalities and health—which recommended that 'where the number or scope of work of general practitioners is inadequate in such areas we recommend Health Authorities to deploy or redeploy an above-average number of community nurses attached where possible to family practice' (Baker and Bevan, p. 16, para. 8.66).

3.1.3 Financing Community/District Nursing Services

Community health services were financed by AHAs, their employing organisation (Greengross et al., 1999). Funds came centrally from the DHSS to RHAs who distributed funds to the AHAs. However, the way funding was allocated was a continued source of dissatisfaction, especially following the unification of community and hospital services. Funding driven by supply and based on 'historical precedent' (Gorsky & Preston, 2013) had resulted in geographical health inequalities and inequitable

access to health care. Here, deprived areas had historically received relatively less funding than their wealthier counterparts. Thus, in 1974, the DHSS commissioned the Resource Allocation Working Party (RAWP) (Gorsky & Preston, 2013) to review how, what and why, NHS capital and revenue was distributed so as to address better equitable and fair share of funding to regions. In the event, the RAWP allocated resources to regions based on formulae which tried to take account of their population levels and need based on weighting of usage of various activities weighted against national levels and standardised national mortality ratios. This, however, did not take account of disability which was problematic for CHS both because morbidity and disability rates varied across the country, but also because this directly affected their workload. Regions then allocated money to areas, using similar formulae. Money was not specifically earmarked for community services at area level—it was up to areas to decide how to allocate between districts, and up to districts how to allocate between hospitals and community. This raised concerns that CHS would not receive the necessary budgetary allocations. It should be noted, however, that actual budgets were held at sector (defined as sub-divisions of a district) level, and the nursing budget was separate from others at this level (Ottewill & Wall, 1990, p. 210).

Despite this, CHS actually benefited slightly from the RAWP formulae possibly due to the requirement for CHSs to grow faster than the acute sector resultant from the 'Priorities' documents. In real terms, on average, CHS received just 6% of capital allocations from 1974 to 1982 and approximately 6% of revenue, of this district nursing took the largest share (Ottewill & Wall, 1990). Some monies were also ring fenced to stimulate joint collaboration between HAs and LAs. The joint finance introduced in 1976 (0.5%–1.5% of total allocation to area) was supposed to mitigate institutional and administrative discrepancies allowing teams to secure a better outcome in terms of overall care (DHSS, 1976). Aimed at encouraging transfer of monies between health authorities and local authorities, it also extended the scope of community-based care for priority groups to include educational initiatives as well as housing. However, in practice, joint planning had mixed results although CHS did benefit slightly from the availability of joint monies (Ottewill & Wall, 1990, p. 214).

3.1.4 Summary

This era saw community nursing and especially district nurses, under increasing pressure from demand for their services—resulting from a combination of cost-cutting measures which focused on increasing care in the home, as well as an ageing population and lack of nurses. The reorganisation was intended to foster integration which was not realised. It became apparent that the structural changes did not produce any significant improvements in integrating health and social care and the attention shifted towards organisational and management solutions to the NHS' problems.

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CHAPTER 4

1983–1990: The Era of General Management

Abstract This was another period of churn for the NHS. First, the service endured another restructuring exercise, reducing hierarchical layers to a less rigid bureaucratic structure. Area Health Authorities (AHAs) were abolished in 1982 and replaced by 192 District Health Authorities (DHAs). Second, there was a move away from 'consensus' style management towards 'general management' following the publication of the influential Griffiths Report in 1983. This marked an important phase in the NHS in which a clearly defined management function was implemented to improve efficiency, planning and accountability but bought shifting sands to the way community nursing services were managed. A review of community nursing services in a similar vein, The Cumberlege Report (1986), also proved significant. We focus on the recommendations of this report for improving the role and function of district nursing services and their geographical deployment to strengthen the concept of a localised, neighbourhood nursing structure. Whilst this was a period of change in terms of the organisation and management of Community Health Services and indeed the NHS as a whole, the core role of community or district nurses remained as one of care in the community but with an emphasis on greater multi-disciplinary team working.

Keywords General management • Griffiths • Cumberlege • MDT

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4.1 Historical Context

This was another period of churn for the NHS following two significant developments which came to characterise the era. First, the structure in place since the 1974 re-organisation was again under scrutiny and the NHS endured another restructuring exercise. This saw a pruning of the hierarchical layers to one of a less rigid bureaucratic structure. Area Health Authorities (AHAs) were abolished in 1982 and replaced by 192 District Health Authorities (DHAs). Second, there was a move away from 'consensus' style management towards 'general management' following the publication of the Griffiths Report in 1983. The Griffiths Report (DHSS, 1983) marked an important phase in the NHS in which 'general management' defined as 'the responsibility, drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance' (p. 11) was implemented. In short, the review concluded that management by consensus slowed up the NHS' decision making and change processes, making it inefficient and that it lacked a 'clearly defined management function' (p. 9) resulting in little accountability for action (Ottewill & Wall, 1990). In order to reverse this, people in charge were needed to make things happen, whether recruited internally, or external to, the NHS—managers were required from the top to the bottom of the organisation (Klein, 2010, p. 118).

Implications for community nursing were to be seen therefore in the way they were managed resulting from both another re-organisation and through Griffiths' recommendations. Whilst CHS was not a direct focus of the review, Griffiths recognised the importance of their role in the delivery of health care and suggested that the tenets of the review were equally applicable to all aspects of health service delivery. In his recommendations to the Secretary of State for Health in 1983 (NHS Management Inquiry), Griffiths admitted that the report lacked detail on CHS due to on-going discussions with the DHSS. However, several key white papers and a review (The Cumberlege Report, DHSS, 1986) were published in the latter half of the decade, which were influential in shaping the CHS and community nursing landscapes. Not least of these was another review by Griffiths in 1988, *Community Care: Agenda for Action*, which when taken in combination with the White Paper—*Promoting Better Health*—1987, amounted to further reform for community nursing going forward.

4.1.1 The Role and Function of Community/District Nursing Services

One of the conclusions from the Cumberlege Report; *'Neighbourhood nursing, a focus for care'* (DHSS, 1986) was that community nursing services 'are in a rut' (p. 2)—which the authors felt was a succinct summation of the state of affairs for community/district nursing at the time. Commissioned by the government in 1985 to examine—'nursing services provided outside hospital by HAs and to report back to the Secretary of State on how resources could be used more effectively so as to improve the services available to client groups' (DHSS, 1986, p. 2)—the Community Nursing Review Team, led by Julia Cumberlege, produced recommendations which would prove contentious but significant to the service.

The report focused on community nursing within, and attached to, primary care. District nurses were treated as holistic practitioners but it was suggested that they had become set in their roles, resulting in professional skills being under and/or unused (Ottewill & Wall, 1990). Thus, the role and function of district nurses continued to be aligned with the policy priorities of the era with little change save for a greater demand on their skills. Here, the review did not focus on the specifics of district nurses' tasks nor what they did, except to say that the focus should be on (DHSS, 1986, p. 8):

- Caring for old/disabled/frail to enable them to stay in own home
- Professional nursing help for sick people/people discharged early
- Health education, illness prevention

Instead, the report outlined recommendations intended to *improve* the role and function of the district nurse service by offering proposals for improving the organisation of services, training and making better use of nursing skills. The proposals were rooted in focusing on local need, 'knowing communities and individuals' (ibid., p. 11), better linkage with community resources and better primary healthcare team working. The authors argued for mitigating overlap, duplication and lack of co-ordination of skills, workloads and caseloads, especially with other services such as health visitors by proposing a Neighbourhood Nursing (NNT) service based on geographical zones (outlined in next section). The review team also recommended enhanced training—a 1-year, diploma, with opportunities to add on specialist models or a masters. It suggested invention of

nurse practitioners as more highly skilled nurses within the team and that nurses should be able to prescribe from a limited list whilst also emphasising nurse's ability to diagnose and manage minor ailments (ibid., p. 31/33). The authors also suggested that GP practices should no longer be subsidised to employ practice nurses. The roles being taken by practice nurses could be done by district nurses working in clinics, under the agreement between a NNT and each practice. A skill mix model was advocated, with enrolled nurses and auxiliaries to do tasks under the direction of district nurses (ibid., p. 21).

The recommendations of The Cumberlege Report were incorporated into the 1987 *White Paper—Promoting Better Health* which was the product of the first ever review of Primary Care Services in the UK. As such, it would prove pivotal in shaping community nursing services going forward since, on the whole, the recommendations of Cumberlege were accepted, in particular the emphasis on effective primary healthcare team working. The review of primary care had been conducted with a view to improving services, raising standards of care, promoting health and prevention of illness, giving patients wider choice and improving value for money. Cumberlege espoused the view that the basis of many improvements was a strong, multi-disciplinary primary health care team, for which roles and objectives were documented and agreed. This was not a new concept as can be seen from previous sections of this report. In conclusion, to the 1987 White Paper, HAs were invited to review:

> the organisation of their community nursing services in the light of the proposals in the Report, and make suggestions about possible developments in the range of activities carried out by nurses working in the community. The strengthening of primary health care teamwork is essential if nurses are to be able to maximise their contribution to the provision of better primary health care services. (ibid., p. 58)

At the same time, a working party was also initiated—The Whitley Council—tasked with reviewing nurse's pay in an attempt to identify a fairer framework for rewarding nurses based on level of clinical expertise and tasks performed, rather than qualifications or level of management responsibility (Gavin, 1995). The outcome was radical and controversial. In April 1988, a clinical grading system was introduced for nurses with grades starting from A up to I. District nurses would start at a minimum of Grade G rising to H and I based on the number of staff managed at

Grade G (DHSS, 1988). This would prove an unpopular policy which provoked industrial action and thousands of nurses appealing the grades they believed they were wrongly assigned to (O'Dowd, 2008). However, this was not to be the only time nurses took industrial action. Proposals contained in the *White Paper—Working for Patients* (1989a)—introducing the idea of marketisation for the NHS (see Chap. 5), also prompted action.

4.1.2 The Management of Community/District Nursing and Population Covered

What of community nursing and the organisational changes? From a restructuring perspective following the 1982 changes, the responsibility for district nursing often came under Community Units where implemented in DHAs. These were discreet 'Units of Management' with their own District Management Teams (DMT) with responsibility for the community services of the district. According to Lorne et al. (2019), existing DMTs District were reshaped and covered what was described as 'the smallest possible geographical area within which it is possible to carry out the integrated planning, provision and development of health services' (ibid., p. 35). Nurses held important, senior leadership roles within the unit. Nursing officers reported to Directors of Nursing Services responsible for the overall management and planning of community nursing within available resources.

However, DMTs were subsequently reformed following the 1983 Griffiths inquiry, and the status for senior nurses was lost (Rivett, 1998, p. 355). There was a reduction in the number of District Nursing Officers at the District Health Authority (DHA) level, with the role transformed into a general advisory position and the introduction of general management at the unit level (DHSS, 1983, p. 5). Under the Griffiths proposals, the system of a professional hierarchy for nurses established by the Salmon Report (1966) was effectively superseded by a general management structure with few nurses appointed to these roles.

The Cumberlege Report bought attention to the importance of locally based planning and delivery and the role of community nursing services (DHSS, 1986). The report proposed that nursing services should be organised around specific geographical, neighbourhood patches rather than managed on a district-wide basis claiming that the latter was too large for meaningful interactions to take place (ibid., p. 17). At the same time, the report warned against organising nursing services solely around

general practices, as these were not related to a specific geographical area unlike community nursing services that had a responsibility for all residents of a defined area. The argument for geographical coverage was made on grounds of:

- Nurses would get to know their local patch, including needs and available voluntary/community services and be able to work with them to promote health
- Same geography as social workers where the report recommended linking to social workers to Neighbourhood Nursing Teams
- GPs do not cover everyone—there are unregistered patients
- GPs do not link with local community groups and are not linked to LA
- Time is wasted in travel

To prevent 'a wasteful criss-crossing of community health workers', the report recommended that each District Health Authority would identify within its boundaries an area (or locality) to be used for planning, organising and provision of nursing and primary care services (DHSS, 1986, p. 14). In specifying what this meant, the Cumberlege Report defined an area comprising at the minimum of 10,000, and the maximum 25,000 people. This was to be organised via newly established Neighbourhood Nursing teams (NNTs), covering a defined geographical patch (or Zone) and managed by a nurse manager who was herself district nurse trained (DHSS, 1986, p. 16). The nurse manager would coordinate a wide range of teams most notably specialist care teams, district nurses, health visitors, social services, as well as local voluntary groups, school nurses and other specialist nurses to be attached in some way. Cumberledge was strongly against attachment to general practice and suggested that NNTs have formal written agreements with GP surgeries agreeing the composition and goals of teams and the number of hours nurses are available to provide services in practices. The authors suggested GPs who did not enter into such an agreement would only receive nursing services at the discretion of the NNT manager, and then without any guarantees. As per page 41, 'We have great sympathy with the view expressed to us by the RCN that as a matter of professional principle, nurses should not be subject to control and direction by doctors over their professional work'. Needless to say, the recommendations of the report proved unpopular with GPs who were vehement in their opposition to it.

The report received mixed reviews prompting some to question to what extent community nursing could be equated with primary care and whether the potential of community nurse manager was overstated (Allsop, 1986). Holmes et al. (1986) proposed that the changes ignored difficulties arising from a need to provide continuity of care to patients who might not easily map onto the neighbourhood boundaries. For Williams and Wilson (1987), on the other hand, the recommendations were unnecessarily introducing another layer of management albeit at the community level. They also pointed out that the neighbourhood units were not coterminous with general practice and likely to overlap with other services, suggesting that contracts rather than a common agreement would need to be in place to manage these interactions. The lack of clear definition of what constitutes neighbourhood and a community is also problematic but tends to be considered as a priori positive thing. Kivell et al. (1990, p. 710) for instance, drew attention to political expediency of the terms with policy makers at the time pursuing decentralisation and 'localisation of many services with "neighbourhood" as the key unit for service management and delivery'. From a British *Journal of General Practice* commentary on Cumberledge (Williams & Wilson, 1987), 'management problems also emerge when considering the proposed agreement or contract between neighbourhood units and practices. The number of agreements necessary with overlapping units and practices would be a bureaucratic nightmare' (ibid., p. 507).

Despite all of these issues, the concept of a localised, neighbourhood nursing structure appears to have been embraced by those providing services at the ground level and many District Health Authorities had, by 1988, plans to, or had, implemented them (Ottewill & Wall, 1990, p. 433).

4.1.3 Financing Community/District Nursing Services

As a result of the proposals of the 1983 Griffiths Report, there was a change to the way CHS were funded. Instead of receiving budgets apportioned per function (such as for catering, supplies, nursing), they received budgets for the entirety of their operations (Greengross et al., 1999). These 'fixed-sum' payments were paid through their DHAs and were increasingly finessed with the introduction of computer-based financial information systems. The increasing cost of financing CHS was, however, a concern for the government, and Griffiths was tasked with a second

review as mentioned earlier: *Community Care: Agenda for Action*—1988 (Griffiths, 1988). This aimed to examine and provide options on both how public funds were being used to support and increase the effectiveness of the policy of increased care in the community (Ottewill & Wall, 1990). Griffiths' key recommendations predominately focused on the role of Local Authorities in funding, providing and organising personal packages of care in the community using community services. These recommendations did not include medical care, which was to be the responsibility of health authorities. However, as Wing (1988) commented, the two are not divisible. Interestingly, the recommendations of the review were not taken forward into the *Working for patients—1989 White Paper* which focused on the organisation of hospital and general practice, yet variants were included in the *Caring for People*—1989b *White Paper* (DHSS, 1989a—see next chapter).

As for Cumberledge (DHSS, 1986), this report did not make concrete recommendations about levels of resources as 'it is a matter for individual health authorities to decide what should or should not be the correct balance of resources between community and hospital services and between nursing and other community services' (p2). Cumberledge was more concerned with the development, management and organisation of the service rather than how it was to be funded, however, the report does go on to suggest that money could be 'vired' from hospital budgets and that the additional resources would be found by: (ibid., p56).

- Saving money by keeping people out of hospital—the money saved by no longer keeping people in hospital unnecessarily could be vired to community budgets such that it is community nurses supporting earlier discharges.
- Stopping paying GPs to employ practice nurses and shifting resources into community nursing.
- Better organisation of the service—reduced duplication within NNTs, reduced paperwork and reduced travelling time.

4.1.4 Summary

A period of change in terms of the organisation and management of CHS and indeed the NHS as a whole, but not necessarily for the role of community or district nurses. The emphasis is still very much on care in the community and the role of district nurses in providing this. Greater

multi-disciplinary team working between social services and community services was advocated in this era and as a means to reduce costs, and although Griffiths (1988) advocated greater separation between social and health care because of the cost implications—the latter being free at the point of use whilst the former being subject to means testing—this was not taken forward into the subsequent policies of the 1990s.

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CHAPTER 5

1990s: The Introduction of the Internal Market

Abstract The National Health Service and Community Care Act 1990, set in motion by the publication of the 1989 White Papers—*Working for Patients* and *Caring for People*, saw an intense time of policy change which would profoundly impact community and district nursing services. These papers ushered in the introduction of the internal market with purchaser/provider split between commissioners and providers of services, aiming for better services, better patient choice and to reduce costs. This chapter focuses on how the NHS was re-structured to facilitate this quasi-market organisation with Health Authorities (HAs), once pivotal, replaced by Primary Care Groups (PCGs) at the end of the decade. We document here the impact of these changes on the district nursing service as well as bringing to the fore that it was a service in crisis and in need of attention. Heavy caseloads coupled with a diminishing workforce led to a review of the grading system and an increasing use of 'skill-mix'. We also highlight that aligned with internal marketisation ideals, funding of community services was based on a crude count of average number of contacts rather than based on the complexities of the role. As ever, there was a need for district nurses to 'deliver more for less' (Audit Commission, 1999, p. 94) at the end of the era.

Keywords Internal market • Purchaser • Provider • Crisis • Workforce

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5.1 Historical Context

According to Webster (2002, p. 197), this era was to constitute 'the biggest shake up the health-service had ever seen'. This was a time of intense policy change which would have a profound impact on the way that the community and district nursing services were managed, organised and practiced. Commencing at the start of the decade with the National Health Service and Community Care Act 1990, this was the era of Klein's (2010) 'big bang' for the NHS, set in motion by the publication of the 1989 White Papers—*Working for Patients* and *Caring for People*. These papers put forth proposals towards reforming the NHS along quasi-market, competitive, business orientated lines (Lorne et al., 2019), although not in so many linguistic terms. As ever, some of the drivers for the policy were to reduce spending, better service for patients, overcoming regional variability in care and an emphasis on the 'local'. The NHS and Community Care Act1990 was the statutory implementation of the recommendations of the White Papers, effected in 1991. This ushered in the introduction of the internal market with purchaser/provider split between commissioners and providers of services, aiming for better services, better patient choice and to reduce costs. It is important to note however that the community care elements of the Act were delayed until April 1993 (Thornicroft, 1994).

Health Authorities (HAs) became purchasers of care separated from its providers. HAs were responsible for assessing the health needs of their populations and then purchasing the services needed to meet these identified needs from a mixed range of providers, which theoretically could include the private sector (Greengross et al., 1999). Budgets based on population capitation were given to HAs to purchase care, rather than budgets given directly to providers, and hence money was to follow the patients for which providers had to compete. NHS providers conversely were to be established as 'self-governing', semi-autonomous (still accountable to the Secretary of State for Health) organisations or trusts, the benefits being they could focus on the quality and efficient delivery of services (Greengross et al., 1999). Thus, standalone trusts were established to manage the provision of hospital and community services, which were bought by HAs. A trust combining both services was discouraged by the Secretary of State in the spirit of internal market competition (Levitt et al., 1999). In this regard, 'community services providers were encouraged to

establish themselves as separate Trusts from acute providers, thereby promoting a shift of care towards community and primary services and preventing the more powerful acute hospitals taking money away from them' (Greengross et al., 1999, p. 14).

In this regard, and to overcome GPs reliance on referring to secondary care, they were also empowered to purchase some types of care for their patients, one of which was community health services. The introduction of voluntary GP fundholding into Primary Care was one of the most significant but short-lived changes of the time. Those GPs opting to become fundholders were given budgets to operate as alternative purchasers of health care in addition to HAs, intended to introduce a further level of competition into the market. This all motioned towards a purposeful shift towards the NHS becoming Primary Care rather than hospital led, which became more apparent when the White Paper—*The New NHS. Modern. Dependable* was published in 1997 by the incoming Labour government (DoH, 1997).

This policy saw the introduction and rapid development of Primary Care Groups (PCGs) in 1999 and the abolition of GP fundholding. The New Labour government sought to exercise financial restraint given tight spending limits and therefore followed the tenets of the philosophy of what they termed the 'Third Way', which included not throwing money away by discarding things that worked effectively. Thus, the internal market was retained but GP fundholding was replaced by giving GP's a bigger role in commissioning—or as Klein (2010) states, 'in effect fundholding was universalised' (p. 193). 481 Primary Care Groups (PCGs) were established which had responsibility for direct commissioning of services for populations of around 100,000 (Greengross et al., 1999). This was a devolved responsibility from Health Authorities (Lorne et al., 2019), although they continued to have strategic input from HAs. The vision of *The New NHS Modern, Dependable* (1997) was that teams of local GPs and community nurses should work together in the PCGs to shape services for patients (p. 24). PCGs were to eventually evolve into Primary Care Trusts (PCTs) replacing HAs entirely. What does remain consistent through this era is the policy emphasis on integrated care and more care in the community.

5.1.1 The Role and Function of Community/District Nursing Services

Again, there was little change in the practical, day-to-day activities that district nurses provided for patients, such as dressing wounds, end-of-life care or providing injections. Indeed an audit of the service in 1999 (Audit Commission, 1999) defined district nurses as 'the main providers of professional nursing services in the home' (p. 6), a definition similar to that used at the inception of the NHS in 1948. What was different following the 1990 NHS reforms was a change to the 'practice' of district nursing and their responsibilities brought about by the *Working for Patients* (DHSS, 1989a) and the *Caring for People* (DHSS, 1989b) White Papers, on which the reforms were based. Both of the papers emphasised the importance of district and community nurses in delivering local and home-based care aimed at keeping people out of hospital. The vital role of district nurses, their contribution, the value of confidence and trust people place in district nurses, and their closeness to the local community, were all elements highlighted as being integral to realising the ambitions of providing more care in the community (DHSS, 1989b). District nurses were seen as having a wealth of skills and 'expert' knowledge (ibid., p. 35), able to assist people with 'social, psychological and healthcare needs' and able to mobilise resources at local level to respond to people's needs' (ibid., p. 35).

However, whilst the *Working for Patients* Paper advocated examining the effective use of the nursing workforce at local, community level (managers were expected to examine all areas of nursing work to identify the most cost effective use of professional skills), the *Caring for People* Paper took an ideological shift towards separation from what is 'health' and 'social' care (Levitt et al., 1999, p. 19) and to the responsibility of LAs in providing social care packages. The importance of making best use of district nurses time and skills and collaboration with cross agency (Local Authorities (LA)/Family Practitioner Committees (FPCs)/HAs), cross professional and multi-disciplinary team working was advised—particularly between NHS and social care—in order to bring the services closer together. It was the responsibility of District Health Authorities to ensure district nurses could provide care outlined in care packages.

Bearing this in mind, what was new 'practice' for district nurses espoused in the White Paper was that they should have active involvement in LA social services assessments as part of a multi-disciplinary team, it

being suggested in the paper that they may need to be 'clients' keyworkers' if appropriate (DHSS, 1989b, p. 36).

This, however, presented district nurses with a possibly unwelcome expansion to their roles away from traditional nursing care (Higgs & Read, 1992). With the requirement to work as part of multi-disciplinary teams to assess patients holistic care needs, their role and workloads grew to encompass more paperwork and to acting as negotiators between social care, funding and patient needs and personal circumstances. Moreover, according to Higgs and Read (1992), district nurses were bearing the brunt of policies which focused on early discharge of patients from hospital, without the corresponding resources to meet the demand of nursing sicker people in their homes. Similarly, concerns over coping with the demands of changing population demographics, different patterns of disease and changes to the district nurse workforce were also issues for the service in this era.

Increasing concerns over how best to identify and address all of these issues were the subject of multiple reports and included in two White Papers –*The New NHS: Modern, Dependable* (DoH, 1997), which was the New Labour government's statement of proposed changes to the NHS (including retaining the internal market) on their accession to power. And *Saving Lives: Our Healthier Nation* (DoH, 1999a), which put both public health and community nursing at the centre of the government's agenda. The government outlined a strategy to enhance the public health elements of community nurses roles (DoH, 1999a, p. 79) whilst also identifying an opportunity for district and practice nurse roles to become integrated to offer greater flexibility, although how easily community and public health functions would be negotiated under this arrangement was questionable. Community nurses and GPs were expected to work together in newly created Primary Care Groups (PCGs) (replaced in the NHS Plan by Primary Care Trusts, PCTs) taking responsibility for developing and commissioning services for local populations (DoH, 1997). The government was keen to build on the earlier work where community nurses were increasingly in charge of management of care, development of nurse-led clinics and district-wide services (ibid., p. 40). Further, a strategy for strengthening the nursing workforce was also outlined in the government's 1999 document; *Making a Difference* (1999)—detailed below.

A brief review of these documents reveals a service in crisis and in need of attention. At the beginning of the decade, a report of a national study into the district nursing service—*The Nursing Skill Mix in The District*

Nursing Service (Britain et al., 1992)—concluded that there is a wide gap between theoretical management of care and organisation of the service, and operational reality. The authors specified that the task of district nursing services is essentially two functions: management of care and caseload and delivery of care and support to patients and carers in their homes (ibid., p. 9). Findings from the study (using three sample sites) showed heavy case load pressures impacted on senior grades ability to conduct their role but that their visiting caseload was largely inappropriate.

Thus, the study focused on the impact of clinical grading on the organisation, management and delivery of district nursing services, and also whether the existing grade and skill mix reflected the workload of district nurses. Suggestions included that the existing organisation of the service and utilisation of district nurse skills was 'grossly' wasteful. 50% of district nurses were at Grades G and H at the time of study, and that the higher graded district nurses were not doing the 'role' they were supposed to be doing, i.e. more assessment and management activities, instead attending to individual activities/tasks that are also being conducted by lower grades (see Fig. 5.1). Essentially, the authors argued that the skills of the workforce should relate to the demands of the workload and went on to recommend an alternative grading system to that in place since 1988 (see Sect. 4.1.1), which redefined the roles and delivery of care/tasks along the lines of Care Managers and Care Practitioners. These suggestions were not implemented however, and it is not until the *Agenda for Change* policy is introduced in 2004 (DoH, 2004) (see Sect. 6.1.1) that the grading system changed and equated to skill level.

Another review, which informed the *Making a Difference* (DoH, 1999a) document, concurred with these findings. Conducted by the Audit Commission and titled the *First Assessment: A Review of District Nursing Services in England and Wales* (1999), the reviewers set out to assess district nursing services against a backdrop of 'rising demand' due to demographic changes and an ageing population. It also examined district nursing services to assess how 'existing services are performing against the expectations set out' in *Modern and Dependable (1997)* and two Welsh Government White Papers (pp. 17 and 18).

The review situates district nurses as being the 'main providers of professional nursing care in the home', complementing the informal care provided by family, friends and others (DoH, 1999b, p. 6). The main reason district nurses visit patients according to the review is to 'care for chronic illness; terminal care; wound management and diabetes' (p. 6), which

Purpose	H	G	E	D
Observation	11.32%	10.08%	6.69%	7.70%
Intermediate Leg Ulcers	10.04%	6.42%	12.74%	7.93%
Insulin injection	8.87%	8.60%	12.42%	10.45%
Other Intermediate Dressings	8.28%	9.61%	8.60%	6.62%
Hygiene and Physical Help	7.35%	8.80%	9.24%	19.07%
Other Major Dressings	5.37%	4.40%	6.05%	4.20%
Terminal Care	5.13%	5.02%		3.89%
Intra Muscular Injection	4.43%			
Minor Dressings	3.85%	4.48%	7.01%	5.42%
Major Leg Ulcers	3.38%	3.74%	5.41%	4.58%
Incontinence		3.31%		
Eye Drops				4.12%
Minor Leg Ulcers			5.41%	
Care of Pressure Areas			4.14%	

Fig. 5.1 Top ten purposes of visit by grade (excluding Assessment and Re-assessment). (*Adapted From:* Britain et al. *(*1992*) The Nursing Skill Mix in the District Nursing Service. MHS Management Executive, London; HMSO (p. 20)*)

aligns with the *Nursing Skill Mix Report* (Britain et al., 1992). At the time, 60% of people they visited had multiple nursing needs and the majority were over the age of 65 with a growing caseload of very elderly patients aged over 85. The increasingly elderly caseload along with the policy emphasis on more care in the community, for example following early post-surgical discharge, pointed to the need for more qualified staff capable of more 'technical' nursing care, such as dressings and management of catheters for example (ibid., p. 8).

The review confirmed that the role of district nurses of grade G and H (those with an additional district nurse qualification) is to assess patients' and carers' needs in their homes, plan appropriate services for patients, implement and evaluate programmes of planned nursing care, manage a team and supervise performance of all team members (ibid., p. 9). What the review did identify is that this 'need' for the district nurse services was hard to ascertain when it was not being clearly identified by trusts, thus making it hard to further ascertain if the 'need' was being met in the community and therefore to manage demand. The review goes on to examine the role of district nurses in the referral system into the service, discovering that district nurses had little control over the admissions to their service and therefore juggled their workloads and visit durations and

frequencies. With elements such as these in mind, the Audit Commission (like the preceding *Nursing Skill Mix Report,* 1992 above) also examined the skill mix in the profession and similarly concluded that some of district nurses clinical work could be entrusted to others of a lower grade (Audit Commission, 1999, p. 78). This was in order to free up time for the changes to their 'practice' in being caseload holders and patient managers but also, given the high cost of employing district nurses, to ensure their skills are appropriately used.

When this was represented in the *Making a Difference* document (DoH, 1999a), what was important for district nurses was the recognition that they—and all nurses—faced new challenges in this era. A stronger workforce would be needed to meet changing patterns of health care such as demographic changes, patterns of disease, morbidity and mortality, reliance on use of technology and public expectations of their service. In this regard, the document outlined multiple areas in which nurses working lives could be improved starting with implementing a new career structure, strengthening leadership, education and training and recruitment and workforce planning. A major expansion of the workforce was planned to address the rate in which it was shrinking. The words promised much towards the modernisation of the service;

> We want to improve their education, their working conditions and their prospects for satisfying and rewarding careers. We want to expand and develop their roles. We want them to be able to continue to take pride in working in the NHS. We want above all to enable them to continue to provide the exceptional care they do to people when they are at their most vulnerable. (Making a Difference, 1999a, p. 5)

Whilst the document covers the full gamut of nurses—community, school, primary and secondary care—it offered a development agenda drawn up to drive implementation of change. It uses example of district nurses expanding their skills 'to support earlier discharge and to prevent admission and re-admission' (ibid., p. 12). The document also goes on to suggest that 'in addition to long-term care, working with specialist nurses and others, district nurses are providing rapid response teams, enabling individuals with acute health crises to avoid hospital admission by providing intensive support for a limited period' (ibid., p. 64). There was also an emphasis on ensuring that nurse's roles are clearly defined within Multi-Disciplinary Teams and a focus on collaborative working and integration to allay district nurses fears that their roles would be

eroded by GP fundholding and/or marketisation. Other suggestions included the development of nurse consultant posts which would extend nurses career ladder for those who 'otherwise have entered management or left the profession to advance their careers and improve their pay' (ibid., p. 32).

5.1.2 The Management of Community/District Nursing and Population Covered

The reforms introduced in the *1990 Community Care Act* (House of Commons, 1990) received criticisms from The Royal College of Nurses (RCN, 1998) who claimed that these contributed to the profound divisions between health and social care further emphasising the professional differences. District nurses were employed and managed by provider organisations that were self-managed and self-governed community trusts or NHS trusts. As such, the distinct organisational structures that rested on specific lines of accountability 'militate[d] against joint working and inter-agency collaboration', (HC, 1998, p. 24) rather than facilitating them. This situation was further exacerbated by a lack of co-terminosity between health and social services with some patients unable to access care because of living in the 'wrong' postcode (RCN, 1998, para. 24). An Audit Commission report (1992) also found that the '[s]eparate lines of control, different payment systems [...], diverse objectives, all play a part in limiting the potential of multi-professional, multi-agency team-work' (in West, 1999, p. 3). For the RCN, this signalled a need for structural reforms if community care services were to become integrated and truly client focused (RCN, 1998).

One report in particular was a significant contributor to policy debates around community nursing in the early 1990s. The *Nursing in the Community* (Roy, 1990), or the Roy Report, offered a number of organisational options for community nursing although did not advocate for a particular approach (Wood et al., 1994). Again the report emphasised the need for 'joint working, shared visions and joint needs assessments between District Health Authorities (DHAs), Family Health Services Authorities (FHSAs) and Social Services' (Exworthy, 1993, p. 5). Five discreet models—or new models of care—were proposed in the report involving different forms of integration; a 'stand-alone' community trust or District Management Unit responsible for community health services; the neighbourhood nursing service proposed by the Cumberlege Report (DHS, 1986); the expanded FHSA acting as commissioning agent for DHA;

hospital/community outreach team providing a 'complete package of care' (vertical integration) and finally GP managed primary healthcare teams (in Wood et al., 1994, p 244).

There were also concerns over the supply of the district nurse workforce due to an ageing workforce, retirement and a drop in recruitment (Audit Commission, 1999) to meet demands on it. The commission suggested that these factors make a 'review of the way that trusts organise, manage and deliver' district nursing services important in the context of ensuring that the NHS makes best use of its resources. The review discusses the state of the district nursing workforce noting that the proportion of qualified staff was reducing at this time. Given these parameters, the review focuses on how to manage demand on the service effectively and efficiently, to 'deliver more for less' (ibid., p. 94) but a large focus of the review was on the organisational structures necessary to do this. The variability in the management of district nurses (ibid., p. 103) was also noted, as was the variation in visibility of district nurses in trust management and highlights the role of community nursing in PCGs, defined in *Making a Difference* (1999) (see below). Again new models of care were proposed, moving away from hierarchical structures that meant district nurses were several layers away from trust boards or 'being out of sight out of mind' in flatter structured organisations (ibid., p. 101). It was documented that managers need to have clinical oversight, supervise and performance manage the clinical practice of district nurses in order to be responsible for an efficient service, and in this sense, the review advocated integrated nursing teams. These would also break down professional barriers between specialist roles such as practice nurses.

Integrated working was also one of the main themes of the *Making a Difference* (1999) document commensurate with the direction of policy set down in the *New NHS Modern. Dependable* (DoH, 1997). The objective was to integrate primary and community health services and work more closely with local authorities. Here it should be noted that the structure of the NHS was once again changed with the incoming New Labour government as mentioned in the introduction to Chap. 5. Most community health services were merged into PCTs when they were introduced. *Making a Difference* (1999) proposed that community nurses, midwives and health visitors were also to have new roles as planners and commissioners of care on the boards of PCGs and eventually on PCT boards too. The document also outlined that nurses are working in integrated Primary Health Care Trusts (PHCTs) to meet the needs of their local population.

These allow team members to pool their skills, knowledge and abilities going on to say that; 'Self-managing integrated teams also have authority for their objective setting and financial control. Working in these teams, with defined common objectives, enables members to gain a greater understanding of each other's roles and expertise, reduce duplication, and make more appropriate use of specialist skills' (ibid., p. 65).

Finally, the Audit Commission (1999) also pointed out possible side effects of the purchaser–provider split. Namely that GP Fundholding introduced some confusion (ibid., p. 11), with fundholders wanting more say over the management and co-ordination of nurses, introducing tensions between trust management. District nurses also felt divided loyalties between general practice and trust management in terms of who they were accountable to. The review also demonstrates the effect of community services being provided by self-managed trusts (ibid., p. 14)—it documents great variation in the organisation and delivery of services, for example in the type of services provided (out of hours or not, clinics, etc.) and in the number of contacts per patient.

Again there was a mix of populations covered during this time. *The Nursing Skill Mix in The District Nursing Service* report (Britain et al., 1992) suggests a mix of working based on geographical patch and attachment to GP practices. This was echoed in a study conducted at the time into a needs assessment for purchasing district nursing services in an inner city location covering 1m residents (Conway et al., 1995). Although all of the district nurses interviewed were employed by community trusts, organisational arrangements with general practice varied widely between geographical and patient list coverage. The *Audit Commission, Review of DN services (*1999) makes the point (p. 10) that although Cumberledge (DHSS, 1986) recommended geographical coverage, most trusts had attached district nurses to general practices. The review points out that GP Fundholding had made this more rigid. In essence, the review rehearses the tensions identified by Cumberledge between attachment (ibid., p. 8) (good working relationships, more joined up care BUT leads to tensions over who manages the service as mentioned above—the Trust or GPs—higher travel costs and difficulties in managing demand) versus geography (equity, more efficient BUT less easy to promote teamwork).

A series of White Papers which were published around that time, *Primary Care: The Future Choice and Opportunity* (DoH, 1996), *NHS: a service with ambitions* (DoH, 1996a) and *Primary care: delivering the future* (DoH, 1996b), all emphasised a determination 'for a high-quality,

integrated health service which [was] organised and run around the health needs of individual patients, rather than the convenience of the system or institution' (DoH, 1996a, p. 7). However, the extent to which these documents embedded the role of district nurses in the national policy varied and it could be argued that during the period of GP fundholding, the focus shifted towards practice-based nursing contracted to deliver services within the practice-specific area.

5.1.3 Financing Community/District Nursing Services

The responsibility for Community Health Services and thus by implication district nursing was to change again in the early 1990s following the proposals of another review of the NHS by Griffiths—*Community Care: Agenda for Action* (Griffiths, 1988). Suffice to say that this review was pivotal in raising the importance of CHS and also in bringing into sharper focus who should organise and pay for what, i. e. NHS-led medical (free) care versus LA (means tested) social care. Griffiths saw a greater role for LAs' social services in providing community care, for example in planning care packages for elderly patients, which district nurses took as a perceived threat to their profession (Ottewill & Wall, 1990). The *Caring for People*—White Paper (1989b) was focused mainly on the re-organisation of social care but outlined the role DHAs were to play in providing health care for their population including community nursing. DHAs were responsible for setting out their community care policies and proposed arrangements for securing community services and community care. Plans could be standalone or produced jointly with LAs but needed to be shared and agreed with social services authority.

Working for Patients (DHSS, 1989a) set out the key objectives for delegating care to the local level with money following the patients rather than the administrative boundaries. As outlined previously, the paper was also crucial in introducing the concept of the internal market to the NHS with language that suggested a purchaser/provider split although without defining it as such. DHAs were reimagined as 'budget holders' who buy relevant services from self-managed units. Hospitals could retain existing obligations for running a range of community-based services of which district nursing is considered a core service and core services provided by DHA managed hospitals were to be funded by a management budget (ibid). Core services provided by a hospital trust or neighbouring hospital can be bought by a DHA under an annually negotiated contract for

provision of an agreed range of services. NHS trusts were to settle pay and conditions of their staff including nurses or follow national pay agreements. GPs were invited to become fund holders responsible for directly procuring services for their population including community nursing and district nursing (DoH, 1992). GPs budgets for this were allocated by Regional Health Authorities. Some hoped this would act as 'a catalyst to the development of integrated nursing', with integrated nursing teams playing a central role in advising on how public, community and primary health could be brought together under one roof (Bull, 1998, p. 124).

In line with the commercial ideals of the purchaser/provider split, the thinking was basically one of nursing services as a package to be 'bought' by relevant health authorities—so DHAs were configured as 'buying' district nursing and other services from providers although these were not necessarily the cheapest. The development of hospitals as self-managed trusts removed the oversight by which the health authority could plan shifts from hospital to community care—at this stage, essentially hospitals and community services began to compete with one another for funds. Providers were responsible for managing their own financial and human resources and generating income sufficient to meet these costs by selling their services at competitive prices. This was reiterated in the *Caring for People* White Paper (DHSS, 1989b), which stated that DHAs need to 'place' contracts for community care and that these can be with a range of providers including NHS trusts, private sector and other agencies. The paper also specified that contracts need to take account of the requirement for CHS and district nurses involvement in social services assessments.

With the introduction of the quasi-internal market, payment of 'providers' and contracting of their services was made by DHAs and fundholders (Allen, 2002). DHAs were responsible for purchasing both community and hospital services for their residents. The *NHS and the Community Care Act* (House of Commons, 1990) also instructed LAs to 'prepare and publish a plan for the provision of community care services in their area'. DHAs remained until 1996 when they merged with FHSAs to become Health Authorities. HAs were responsible for purchasing care based on population health needs assessment (Lorne et al., 2019). According to the *Audit Commission Review* (1999), payment for district nurses services were based on the number of patient contacts made and were purchased by HAs on a block contract (a one-off annual sum which did not vary according to the number of contacts made during the year). There was an inherent problem with this, documented in the review, in that there were

significant inadequacies in a payment model based on counting the volume of contacts. The review highlights the difficulties in contracting for district nursing services given that counting fails to account for workloads, case mix, 'length, appropriateness and purpose of visit' (ibid., p. 16), and the grade of staff involved. The contracting of district nurses through GPs fundholders was no better, for the same reasons, it failed to account for complexities within the role out with the cost of paying for a nurse's salary. Thus, the review recommended the use of sophisticated data collection and measurement tools to capture these elements. These details would in turn also provide a window onto how much the district nursing service was being depended upon (ibid., p. 35).

Examining nurses pay was a focus of the *Making a Difference* (1999) proposals to provide a new framework for the service in recognition of the valued role of nurses in implementing policy. An overhaul of remuneration was suggested which resulted, in 1999, with the biggest pay rise for nurses, midwives and health visitors for 10 years. Newly qualified staff received a 12% rise—a starting salary of over £14,000 per year and over £17,000 in London. Pay bands for the differing nursing roles was to be related to responsibilities, competencies and performance.

5.1.4 Summary

This era saw change to the 'practice' of district nursing, expanding the profession towards that of a managerial role in becoming caseload managers and assessors and co-ordinators of care. Driven by policy, there was also more of an emphasis on working with LAs' social service departments in identifying patients' care needs and MDT working. This combined with the continued policy direction of increasing out of hospital care, integration and changing population demographics amounted to increasing pressure on their services. This was set against a backdrop of a diminishing work force and a seismic shift in policy focus towards an internal marketisation of the NHS. Tensions ran high for district nurses in this era in terms of workload, new organisational structures—for example torn loyalties between general practice and trusts—redundancies and perceived concerns over maintaining their professional identities in the *New NHS*. As ever, at the end of the era, there was a need for district nurses to 'deliver more for less' (Audit Commission, 1999, p. 94).

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CHAPTER 6

2000s: Transforming Community Services

Abstract The new millennium saw the publication of *The NHS Plan* in 2000, which bought a welcome focus to community health services (CHS) and the role of community nursing. We outline the proposals contained in the plan which furthered the quasi-marketisation of the NHS and increased commissioning of health care at the local level of Primary Care Trusts (PCTs)—replacing Health Authorities (HAs) and Primary Care Groups (PCGs). A further review by Lord Darzi and subsequent policy, *Transforming Community Services: Enabling new patterns of provision* (DoH, 2009) instigated the separation of commissioning/provision and laid out timetables for how PCTs were to do this. The long held roles of the district nursing service continues in this era, although not always clearly defined, understood or acknowledged and policy attempts to expand their remit feature heavily. This included more clinical tasks as well as focusing on such things as public health/health protection and promotion programmes that improve health and reduce inequalities. This chapter also describes the uncertainty for frontline nurses that the Transforming Community Services (TCS) brought in terms of who their employer would be or what management arrangements they would work under given the establishment of some standalone Trusts, some third sector and some combined acute/community Trusts. The aims of the TCS programme were bold but in reality achieved little by the end of the era.

Keywords Transforming Community Services • Darzi • PCTs • commissioning

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6.1 Historical Context

Lack of attention and years of underinvestment led to a focus on community health services and the whole NHS and social care system in this era. This was initially acknowledged at the start of the new millennium with the publication of *The NHS Plan* in 2000 (DoH, 2000). The plan outlined ambitions to again modernise the NHS with 'a plan for investment, a plan for reform' (DoH, 2000, p. 1). Again, there was an emphasis on joining up services and breaking down barriers between multi-disciplinary staff in order to better serve the needs of patients and the public. It was noted in the document that where traditional boundaries and hierarchies were replaced by new and flexible ways of working, for example in community clinics (p. 82) where different professionals such as district nurses came together to deliver care, the resultant reduced lengths of hospital stay and enabling more people to stay at home was measurable.

The Plan also suggested the possibility of a radical redesign of the whole care system (in areas which wished to experiment), including bringing provision of local health and social care services together into one organisation as Care Trusts. Giving 'nurses and other health professionals even bigger roles' (ibid., p. 15) commensurate with skills and qualifications was also espoused, as was introducing greater accountability, performance management and incentivisation into the system. Another radical proposal was encouraging private health care sector entry into the NHS quasi-market in order to increase the volume of care provided and to give patients more choice. *The Plan* also outlined that there would be less central governmental control of the NHS and that more responsibility for commissioning health care was to be devolved to the local level of Primary Care Trusts (PCTs). As mentioned in the preceding chapter, Primary Care Groups (PCGs) were to be developed into PCTs by 2004. In the event, this was bought forward to 2002 following the publication of the *Shifting the balance of power within the NHS* (DoH, 2001) White Paper. According to *The NHS Plan* (DoH, 2000), PCTs were given substantial financial resources which would allow new services to evolve bringing primary and community services under one clinic/surgery roof.

This however, as Imison (2009) pointed out, was problematic given that PCTs were both providers and commissioners of services such as community care, creating conflicts of interest. Thus *The Next Stage Review* (DoH, 2008) conducted by Lord Darzi, instigated the separation of provision and commissioning of community services from PCTs with an

emphasis on 'world class' commissioning/quality in patient-centred care. As documented in the *Transforming Community Services* documentation, this was seen to afford an opportunity for better alignment between services while 'delivering improved quality and productivity, as well as building on preventive approaches to reduce costs associated with lifestyle related disease and preventable complications' (DoH, 2009b, c:4). Darzi's review (DoH, 2008) put a renewed focus onto the organisation and modernisation of CHS (community health services) for realising the aims of the 2000 *Plan* (DoH, 2000) with a commitment to developing them as successful provider services and giving them greater autonomy, which they had so far lacked.

Darzi's recommendations led to the Department of Health requiring PCTs to formulate strategies for community services, including district nursing, by October 2009. Therefore in 2009, the government launched the programme *Transforming Community Services: Enabling new patterns of provision (*DoH, 2009a*)*, in which it laid out its new 'vision' for primary and community services that involved structural changes to how services were organised and delivered (DoH, 2009b). The TCS *Enabling New Patterns of Provision* (DoH, 2009a*)* set out the timetable for separating commissioning and provider functions of PCTs, and outlined different organisational forms that PCTs could consider for delivering primary and community services. These included leaving the NHS and becoming independent social enterprises as well as for profit firms (ibid.). It was anticipated that by April 2011, all PCTs would separate their commissioning and provider functions and move towards an 'any willing provider' model, bringing more competition and choice into the health care market. However, the frequent structural and organisational changes in primary and community care, particularly the transfer of Community Health Services from PCTs to other providers—such as larger mental health and community trusts that covered much larger areas or social enterprises (QNI, 2006)—led to further impact on district nurses.

6.1.1 The Role and Function of Community/District Nursing Services

Again, it appears the traditional tasks, function and practice of the district nursing service continue although attempts to expand them feature in this era. The companion Paper to the *NHS Plan (*DoH*,* 2000), *Liberating the Talents: Helping Primary Care Trusts and nurses to deliver The NHS Plan(*DoH, 2002*)*offers proposals in this direction, providing a

framework for the planning and delivery of nursing services in primary care to meet the objectives that had been set out in *The NHS Plan*. The Paper referred to nurses in the broader sense to be inclusive of all nurses providing care outside of 'the hospital setting' (p. 4). Outlined in the Paper are a number of areas in which nurses' role would be extended, for example by taking some work currently done by GPs, by providing more secondary care in community settings and having a greater voice in decision making. In addition, nurses in primary care were expected to focus on prevention and tackling health inequalities with more opportunities for skill mix and leadership. The changes proposed by *Liberating the Talents* suggested that there was also an expectation that nurses' role would further expand to take on more clinical roles involving prescribing and specialist approaches to community care.

Three core functions were at the heart of the new framework for nursing care regardless of setting, employer or title, pointing to the integral role of nurses in a one-service approach (ibid., p. 8):

- First contact / acute assessment, diagnosis, care, treatment and referral
- Continuing care, rehabilitation, chronic disease management and delivering NSFs
- Public health / health protection and promotion programmes that improve health and reduce inequalities

However, there was some criticism of the Paper as exemplified by Howkins and Thornton's (2003) discussion of it in the Journal of Nursing Management. As Howkins and Thornton proffer, the proposals try to address the 'handmaidens to doctors' (p. 219) stereotyping of nursing but they go on to point out that this would require significant overcoming and blurring of professional boundaries between practitioners that might even perpetuate the ideal. In 2002, The QNI published a report, *District Nursing—An Invisible Workforce* (Low & Hesketh, 2002) in which it offered the sector's perspective. It claimed that the service was under considerable pressure from an overload of demand and complex patient needs, with much financial and professional uncertainty surrounding district nurses' roles. Many of the district nurses questioned for the report lamented the loss of the hands-on aspects of their role, lost with the blurring of the boundaries between what is health and social care (Pollard, 2002). Many had taken on the assessment and management

responsibilities espoused by policy, although by grade promotion not necessarily by choice (Low & Hesketh, 2002). The report concluded that the workforce needed to be more visible and take an active approach to shaping and influencing the national policy agenda. It was a controversial report as not all district nurses agreed they were an invisible force. However, what the document did was to highlight the important policy context in which the workforce was increasingly operating and the corresponding concerns. Namely; 'workforce issues, integration into community teams; development of skill mix within those teams; greater management responsibility; challenges to caseload and workload management; earlier discharge from hospital to community services and a corresponding 'loss of a clear identity' for district nurses' (QNI, 2014, p. 5).

This was further challenged by the introduction of Community Matrons (CM) in 2004 to manage the increasing caseload of patients with complex long-term conditions in the community. Building on the aspirations of the *NHS Plan* for more patient centred, at home care, the *NHS Improvement Plan* (DoH, 2004a) introduced the new role of the CM as 'clinical specialists' posts. These were supposed to provide a local and co-ordinated care service delivered with other professionals (mainly in primary care), who would 'help, anticipate and deal with problems before they lead to worsening health or hospitalisation' (DoH, 2004b, p. 37). Many of the roles were taken by district nurses because of their extensive experience of working in the community. Whilst this enabled district nurses to enhance their careers, it introduced concerns over role clarity, confusion and tensions with regard to overlap in responsibilities (Dossa, 2010). The approach was part of a growing trend in primary care whereby case management was increasingly an integral feature in health policy in England (Boaden et al., 2006). While these policy initiatives constituted important developments in primary care, the role of district nurses was not always clearly defined or understood.

The publication of the White Paper—*Our health, our care, our say: a new direction for community services* (DoH, 2006), signalled a renewed focus on prevention and early intervention, particularly in the context of changing demographics with growing new needs. *Our health, our care, our say*, in particular, set out a new strategic direction for primary and community care centred around prevention and early intervention, extending choice for patients, addressing inequalities through better access to community services and supporting people with complex and long-term needs to live independently. The suggestions were built around the idea that care

planning and co-ordination must be contingent on integrated health and social care information systems to avoid duplication across different agencies. A 'skilled individual' was supposed to act as a case manager organising and coordinating services from a wide range of providers (ibid.). The White Paper sought to create multi-disciplinary networks and teams operating on a sufficiently large geographic footprint and involving social services, NHS primary, community and secondary care services and housing (ibid., p. 116). Again, there was limited evidence that initiatives from the White Paper were successfully implemented or continued beyond implementation (Salisbury et al., 2011) possibly because the Paper was too vague.

Later on in the decade, whilst the Darzi Report (DoH, 2008) did not directly refer to district nurses, it acknowledged that nurses and other allied health professionals played an important role in providing personalised care. Darzi suggested that staff should be allowed to use their skills to transform community services so that these are flexible and responsive to local community needs. The report reaffirmed the greater role for community services including nurses and encouraged practice-based commissioning involving a wide range of health care professionals. *Transforming Community Services* (DoH, 2009a) was a rare attempt to give national policy focus to CHS in a co-ordinated way. It focused on empowerment of 'front-line' staff, clinician collaboration and integration of service pathways. Practitioners closest to patients were expected to lead change. Six transformational 'best practice' guides were published for front-line staff based around 'ambition, action and achievement'. Each guide is themed on a key area of nursing care such as end-of-life or rehabilitation and provides a section on how to take actions forward. District nurses were included in the role of taking on these actions and implementing policy. TCS also introduced a programme of professional development introduced to 'strengthen clinical skills and clinical leadership', developing a 'productive community services' programme. 'These programmes will review the evidence base for care pathways (initially focusing on wound care, continence services and stroke services), help free up more time for direct patient care, and improve quality and patient outcomes' (DoH, 2008, p. 43). It addressed concerns about flux and fragmentation of services and the need to find new ways of working with other health and social care providers to deliver patient care, support and management within the community.

The government also published another White Paper—*Healthy Lives, Healthy People: Our strategy for public health in England* (DoH, 2010b)—in which it outlined the role of local government in preventing ill health and 'promote[ing] active ageing' (p. 47) so that people could live independently at home for as long as possible. District nurses and allied health professionals were seen central to this agenda delivering advice and support around falls prevention and nutrition to enable people stay safe and well. At the same time local government was 'closely linked with the NHS through its role in supporting re-ablement through social care' provision (DoH, 2010b, p. 49). However, despite much emphasis on strengthening and promoting local and joined up provision, the government did not explicitly acknowledge the role of nurses.

It could be argued that the *Transforming Community Services* agenda was curtailed by the 2010 election (see next chapter). As noted above, the document set out an ambitious plan for quality improvement, based around 'best practice' guides, alongside the separation between the provision and commissioning of community services. However, in practice its publication in 2009 meant that PCTs were beginning the work required to develop this agenda in late 2009/early 2010. Divesting PCTs of their so-called community-based provider arms required considerable work around employment rights (TUC, 2009), which had to be dealt with before the quality improvement agenda could be addressed. However, in July 2010 the newly elected coalition government published their new reform agenda for the NHS, *'Equity and Excellence: liberating the NHS'* (DoH, 2010a) (see next section). This proposed the abolition of PCTs and their replacement by GP-led Clinical Commissioning Groups (Checkland et al., 2012).This meant that the transfer of community health services to new forms of organisation had to be completed quickly, as PCTs' focus shifted to winding up their own activities and transferring their responsibilities to the new organisations. The intended quality improvement agenda therefore received little attention and the TCS agenda would eventually fade away achieving little (Edwards, 2014).

6.1.2 The Management of Community/District Nursing and Population Covered

As set out first of all in the 1997 White Paper—*The New NHS; Modern, Dependable* (DoH, 1997)—and again in the NHS Plan of 2000 (DoH, 2000), the management of CHS came under the auspices of Primary Care

Trusts (PCTs). These bodies had statutory responsibility for the purchasing and provision of care for a geographical population including commissioning primary and secondary care services; providing CHS; and being responsible for population health via a public health function. The size of PCTs varied over the years, with a tendency towards increasing in size with a wave of mergers in the mid-2000s, when the number of PCTs in the country reduced to around 150 (Walshe et al., 2004). PCTs were managed by an Executive team, which usually included a nursing lead. At the same time, each PCT had a Professional Executive Committee (PEC), which had an advisory role and was made up of representatives of all of the local health care professions, including GPs, nurses, pharmacists, optometrists and dentists. The PEC had little power but considerable influence (Checkland et al., 2011). In general, within PCTs, there was a separate Directorate with responsibility for providing CHS. An allocated budget was managed by the Directorate, with oversight coming from Strategic Health Authorities, which managed the performance of PCTs (Lorne et al., 2019). This management structure ensured that, as had been argued for over decades, nurses were managed by nurses rather than by doctors.

Transforming Community Services (DoH, 2009a) disrupted this structure, requiring a separation between commissioning and provision of CHS, as mentioned earlier. The options for transfer included: the creation of a standalone Community Foundation Trust; the transfer of services to a Social Enterprise; the integration of CHS into another NHS organisation; or the commissioning of different types of Community Services from a variety of different providers including for profit firms (Spilsbury & Pender, 2015). A mapping of the resulting change in organisational structures found that 67% of Community Service providers were integrated with another type of NHS provider, either an Acute Hospital Trust or a Mental Health Trust, with only 15 standalone Trusts and 15 Social Enterprises created (Spilsbury & Pender, 2015). Importantly, two thirds of those services which integrated with another NHS organisation were essentially taken over by Acute Trusts. This had the advantage for the parent Acute Trust in that should the promised shift of care from hospitals into the community occur, Trusts would not lose income.

It is also possible that this outcome—which was to some extent counter to the intentions set out in TCS, which emphasised the possible advantages associated with social enterprise and other ownership models—arose in part out of the speed with which the changes needed to be introduced once the abolition of PCTs was announced. The transfer of services to an

existing Trust was easier and quicker to achieve than the setting up of a separate new Trust or Social Enterprise or running a procurement exercise and contracting with an existing for profit firm, such as Virgin. There has been little research exploring how CHS managed under the umbrella of an Acute Trust perform compared with those which standalone either as Community Foundation Trusts or as Social Enterprises, or as for profits. Notwithstanding this, a study published in 2021 confirmed that there were no differences in use of emergency hospital services by frail elderly patients associated with the different models of ownership of community service providers (Wyatt et al., 2021).

Spilsbury and Pender (2015) highlight the disruption associated with these changes, with considerable uncertainty for frontline nurses about who their employer would be or under what management arrangements they would work. The new framework for commissioning community services in a more competitive market as set out both in TCS and following the 2010 White Paper (see chapter below) (DoH, 2010b) was also said to risk increasing fragmentation and rivalry amongst different health and social care providers (RCN, 2010a). The RCN (2010a, p. 3) highlighted the initial absence of the Chief Nursing Officer (CNO) in the plans for the establishment of GP-led commissioning bodies, suggesting that nurses were frequently an afterthought in the policy process. They also called for 'designated nursing posts on commissioning consortia boards, Public Health England, and local health and wellbeing boards' to be established in order to strengthen the nursing component in the public health policy (RCN, 2010b, p. 3).

In terms of community nursing practise, community nursing services continued with a mix of geographical teams and attachment to GP practices. The tensions that we have highlighted between these different models remained, with commissioners negotiating locally specific ways of working, emphasising skill mix diversity, with senior nurses managing teams of less-qualified nurses, and local mechanisms for liaising between district nurse teams and GP practices which were not always particularly functional (Speed & Luker, 2006).

6.1.3 Financing Community/District Nursing Services

Under PCTs, CHS received a budget that the Provider Directorate had to manage. These budgets were largely based upon historical activity. In the more competitive market introduced by TCS (2009), commissioners used

a block contract mechanism to commission services, with providers paid a set amount, again usually based upon previous activity. This gave them little incentive or opportunity to increase service provision or to innovate (Allen & Petsoulas, 2016) and made them subject to considerable financial pressures (Robertson et al., 2017). This was in contrast to the 'payment by results' activity-based contract used to commission acute services(Rogers et al., 2005). In discussing these different payment mechanisms, a report by the Nuffield Trust (Marshall et al., 2014) highlights the impact on ambitions to shift care from hospitals to the community:

> The predominance of activity-based payment in the acute sector, introduced at a time of long waiting lists, encourages activity in hospitals; at the same time, block budgets in community services and capitated budgets in primary care offer little incentive to increase activity or efficiency in these settings. (Marshall et al., 2014, p. 3)

There was a persistent policy intention to move CHS towards a more activity-sensitive form of contract (Sussex, 2010), but this has proved difficult due to the lack of consistent and accurate data about community services activity and the difficulty in assigning meaningful activity codes to the work of community staff (Monitor, 2015).

6.1.4 Summary

Transforming Community Services had two main aims: to move CHS towards a more competitive model, with innovation and improvements in efficiency driven by competition; and to use quality improvement methods to improve the care provided, including increasing integration between CHS and other community-based services such as social care and local multidisciplinary teams. In practice, the intended 'transformation' of services heralded by the TCS agenda was arguably undermined by the need to rapidly transfer services to other providers once the abolition of PCTs was announced in 2010. The complex negotiations required to transfer staff to new organisations and the uncertainty and concern that this engendered left little energy for more 'transformative' quality improvement work. In spite of a policy push towards more competitive markets and a multiplicity of providers, there is no evidence that one particular ownership model of community service provider offers benefits over others (Bramwell et al., 2014). The continued lack of good data about

community service activity and consequent use of block contracts limited the potential for services to innovate or expand.

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CHAPTER 7

2010–2015: The Health and Social Care Act, NHS Fragmentation

Abstract A change of government in 2010 brought fresh NHS reforms and a new *Health and Social Care Act* (HSCA, 2012). Both, along with the 2014, *Five Year Forward View* (NHSE) set the tone for this Chapter. We discuss how the continued emphasis on competition between providers, and the introduction of Clinical Commissioning Groups (CCGs) which replaced Primary Care Trusts (PCTs) as commissioners of community services, impacted on community nursing service management and delivery. Policy shifted in favour of a more co-operative approach to service provision and familiar agendas were set out for keeping people out of hospital with reform based around integration between health care sectors and between health and social care services. There was little change on the ground for district nurses in this era despite increasing emphasis on integrated care, collaborative, cross-sector working (i.e. with LA social care) and multi-disciplinary team management of complex patients. The HSCA 2012 began to unravel almost as soon as it was enacted, with the emphasis on competition undermined by the *Five Year Forward View* shift towards integration between sectors as a dominant organising principle. Community Health Services (CHS) were, to some extent, protected from the fragmentation associated with the Act, and in terms of district nursing practice, this era generated little change with patterns of service provision remaining very much as they were following the upheaval generated by the Transforming Community Services agenda.

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7.1 Historical Context

A new Government saw more changes for the NHS during this time and the White Paper—*Equity and Excellence: Liberating the NHS,* was published soon after the 2010 general election (DoH, 2010). Much has been written about the genesis and enactment of this wide-ranging NHS reorganisation, which was subsequently written into law as the Health and Social Care Act 2012 (HSCA, 2012) (Exworthy et al., 2016; Timmins, 2012). From the perspective of Community Health Services (CHS), and in keeping with our focus upon the impact of policy on community nursing service management and delivery, the important aspects of the reforms were a continued emphasis on competition between providers and the abolition of geographically based Primary Care Trust (PCT). As well as commissioning organisations in favour of GP-led commissioners whose populations were determined by the population covered by their GP 'members' (Checkland et al., 2012). At the same time, the regionally-based intermediate tier of NHS management, Strategic Health Authorities, were abolished, with most of their functions moving to a new national commissioning organisation, the NHS Commissioning Board (later known as NHS England) (Lorne et al., 2019). In 2012 responsibility for Public Health passed to Local Authorities.

The result of these changes was a significant increase in the fragmentation of the commissioning landscape, with responsibility for commissioning services for populations no longer vested in a single geographically based commissioner. This fragmentation had significant consequences for some complex types of service, for which responsibility was now split between as many as three different commissioning organisations (Checkland et al., 2018). Community service commissioning became the responsibility of GP-led Clinical Commissioning Groups, and as such community services escaped some of the most negative impacts of the 2012 Health and Social Care Act, as responsibility for their commissioning was vested in a single body. Whilst competition was more firmly embedded in the statutory framework underpinning the NHS, in practice, competitive tendering of community service contracts was rare, particularly after the high-profile collapse of a number of large-scale procurement exercises (National Audit Office, 2016).

Not long after the enactment of the HSCA (2012) policy shifted sharply in favour of a more co-operative approach to service provision. In 2014, the *Five Year Forward View* (NHS England, 2014) set out an ambitious agenda for further reform based around integration between health care sectors and between health and social care services. Underpinned by a familiar policy drive to keep people out of hospital, the *Five Year Forward View* envisaged new forms of integrated care providers which would bring together primary, community and acute care services to deliver services to geographical populations. Funding was provided to pilots known as 'Vanguards', and it was intended that these would test out new models of service delivery. In particular, it was envisaged that new types of provider organisations or alliances (known as Integrated Care Providers) would develop, underpinned by new forms of contract which would provide capitation-based funding. However, in practice, whilst the pilot funding did catalyse a number of local service integration initiatives, large-scale integrated service models were not developed (Checkland et al., 2019). Notwithstanding this failure, towards the end of this era the policy landscape clearly shifted towards the more integrated approach to service delivery, with CHS at their core.

7.1.1 The Role and Function of Community/District Nursing Services

Against this background of a renewed focus upon shifting care into the community, the Department of Health (2013) along with the Queens Nursing Institute produced a framework, *Care in local communities: A new vision and model for district nursing*. In this was described the specific roles of district nurses in population and caseload management, delivering care for patients with long term conditions, preventive support as well as end of life care. In looking to the future, the document set out the requirements needed from the service to meet local population health care demands, whilst at the same time recognising that this depended on raising the profile of the service in order to attract nurses into it. Together with *Compassion in Practice* (DoH, 2012) these frameworks were intended to build competencies that would enable district nurses to meet the needs and expectations imposed by different healthcare settings and in particular by new models of service provision structured around integrating care (ibid.). District nursing services were meant to deliver services that promoted health and well-being and encouraged self-care in the person's own

home, independence, local surgery and community. However, to be effective these services needed to be locally led and appropriately integrated with social care.

Likewise, for the new care models to become a reality, staff needed to have a right skill mix and values that would support new ways of working (ibid.). In *Transforming Primary Care* (DoH, 2014), the government acknowledged that new ways of working required changes to be made to the traditional professional boundaries with an expectation that staff would be able to take on new roles that benefit patients. Joint working was encouraged particularly through the increased use of new technology to enable sharing of information about patients and make timely and effective decisions. District nurses were seen as central to the policy directed towards improving health outcomes by delivering community care, reducing admissions and supporting early discharge from hospitals. However, such policy documents and frameworks generated little change on the ground, with a continued focus upon teams of nurses overseen by qualified district nurses, alongside case managers or Community Matrons taking on a case load of the most complex patients.

7.1.2 The Management of Community/District Nursing and Population Covered

During this era, there was little change in the formal management arrangements for district nursing services. The CHS provider organisations—whether standalone or integrated with Acute Trusts—continued to operate services based around the commissioning of services under a block contract. However, at local level, in keeping with the ethos of the *Five Year Forward View* (NHS England, 2014) and the renewed emphasis on integration between services, some providers began to work more closely with other services such as social care, setting up integrated teams and broadening the use of multi-disciplinary teams to manage the health of the frail elderly. For example, in Greater Manchester, so-called Local Care Organisations were established (Walshe et al., 2018). These brought together community health and social care services into integrated teams, which were usually co-located. However, whilst teams potentially functioned in a more joined-up way, professionals retained their existing line management arrangements, and joint management boards had no statutory or formal decision-making powers, and funds were not formally shared. Thus, decisions continued to be made by the Boards of the

individual organisations, albeit with a strong ethos towards working in partnership. Such on-the-ground integration arrangements may support the delivery of more joined up care for patients, but professional tensions remained, with differences in terms and conditions between the different professions potentially problematic, alongside ongoing difficulties around data sharing (Mitchell et al., 2019).

More generally, whilst CHS engaged positively with a variety of integration initiatives, many of which included attendance at multi-disciplinary team meetings to support the co-ordinated delivery of care to frail elderly patients, day-to-day district nursing services continued to be delivered by teams of district nurses with a mix of skills and qualifications, generally covering geographical populations albeit with ongoing relationships with local GP practices.

7.1.3 Financing Community/District Nursing Services

During this short era, CHS continued to be delivered according to block contracts, with all of the complexities that such contracts bring in terms of managing increases in activity (Sussex, 2010). As discussed above, the *Five Year Forward View* (NHSE, 2014) proposed the development of new contractual models by which groups of providers would work together under a capitation-based contract (Sanderson et al., 2018), but such contractual models did not, in fact, develop. In 2015, a guide to commissioning Community Health Services was published by Monitor, which was at that time the organisation charged with regulating NHS Foundation Trusts. The report summarised the difficulties that commissioners reported that they experienced in commissioning community services:

> Commissioners said their greatest challenge in improving community services is a lack of robust activity, cost and quality data. Recording of data for community services has been poor historically. Because a wide range of community services is paid for with a fixed-sum payment, providers have had little incentive to understand the costs of individual services. Commissioners sometimes find it difficult to know whether providers are delivering value for money. In some cases, commissioners said, a lack of robust activity and cost data has hampered their efforts to determine costs for new pathways of care or for particular populations. (Monitor, 2015, p. 9)

Monitor reported that in 2013/2014 CHS accounted for £9.7 billion of NHS spending, with the vast majority of this allocated according to block contracts. 87% of services were provided by NHS providers, with this breaking down as 42% standalone Community Trusts, 18% integrated with Acute Trusts and 27% integrated with Mental Health Trusts. 7% of expenditure was with independent providers, and 4% third sector. More than 90% of CCGs contracted with a single large community provider for the vast majority of their services. Thus it would seem that the HSCA 2012 push for a more competitive approach had not generated any substantive change in the sector. The report goes on to summarise commissioners obligations under competition regulations, and to encourage 'competitive dialogue' in actively commissioning services, rather than continuing to roll over existing contracts, concluding with an exhortation to use the opportunities associated with the Vanguard programme to develop new contractual models or payment systems.

7.1.4 Summary

The HSCA, 2012 began to unravel almost as soon as it was enacted, with the emphasis on competition undermined by the *Five Year Forward View* shift towards integration between sectors as a dominant organising principle. The Foundation Trust regulator, Monitor, appears to have taken the view that the way in which the circle could be squared between greater competition and better integration was via the competitive awarding of large-scale contracts to alliances of different types of providers, as well as to single independent providers. The extent to which this has actually occurred is unclear, with competitive tendering more common in some regions than others. A National Audit Office report suggests a combination of reluctance on the part of NHS commissioners in many areas, and some failures in commissioning practice may have influenced this (National Audit Office, 2016). CHS were, to some extent, protected from the fragmentation associated with the Act, and in terms of district nursing practice, this era generated little change with patterns of service provision remaining very much as they were following the upheaval generated by the Transforming Community Services agenda. At local level, various integration pilots and initiatives supported the development of multidisciplinary teams, with ongoing emphasis on the need to develop services to keep people out of hospital. District nursing practice remained largely unchanged, other than something of a shift towards case management of

complex patients by senior nurses. Day-to-day services continued to be delivered by teams of nurses and health care assistants, led by qualified district nurses. The continued use of block contracts and limited availability of high-quality data about service activity or outcomes rendered investment or innovation difficult to achieve on any scale (Monitor, 2015).

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CHAPTER 8

2015–Date: Focus on Integration

Abstract This chapter centres on the publishing of the *NHS Long Term Plan* in 2019 and subsequent revised *Health and Social Care Act (2022)*, both of which focus on integrated, out-of-hospital approaches to health service delivery. The creation of a layered system across geographical levels is advocated, with nested levels of 'place' and 'neighbourhood' intended to be the building blocks of Integrated Care Systems (ICS), which replaced CCGs in July 2022. We introduce the concept of newly created, 'neighbourhood level', Primary Care Networks (PCNs) of general practices and how district nurses fit into them, especially with regard to their organisation around geographical versus GP registered lists. Whilst not explicitly mentioned in the H&SC Act, it is clear that the Act situates community-based services as essential in the context of the desire to reduce the amount of hospital care, which has implications for district nursing services in particular. This mode of care delivery will require multi-disciplinary team working across all levels of the new system whereby community nurses will be required to liaise and co-ordinate with primary and social care to deliver services. Continuance of case management approaches for patients with complex needs and lack of funding in the social care system, means that we discuss in this chapter, the further strain on already pressured community nursing teams.

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Keywords Integration • ICS • PCN • Case management

8.1 Historical Context

Building upon the *Five Year Forward View* (NHSE, 2014) (described in previous chapter), the *NHS Long Term Plan* published in 2019 (NHSE, 2019) suggested that policy would deliver a 'new service model' focused on 'patients get more options, better support, and properly joined-up care at the right time in the optimal care setting' (p. 6). 'We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services' (ibid., p. 13).

Overall, the Plan proposes the creation of a layered system that formalises more integrated approaches to service delivery across geographical levels as set out in Fig. 8.1.

Such a system is somewhat at odds with the legislative framework established by the HSCA 2012 (HSCA, 2012), and so the *NHS Long Term Plan* (2019) proposed a number of legislative changes which would support these developments. Further guidance from NHS England was issued in November 2020 (NHS England, 2020) with a White Paper setting out concrete proposals for legislative change in February 2021 (DHSC, 2021). At the core of the proposals was the creation of statutory organisations at so-called system level, with the responsibility for overseeing the more integrated provision of services for a geographical population. Currently 42 such 'Integrated Care Systems' have been established, initially in shadow form, and established in statute in July 2022. At the same time, the requirement to follow European Competition Law has been removed, reducing the need for competitive procurement processes (although in summer 2022 it remains unclear what the replacement procurement regime will require).

The Health and Care Act (H&CA, 2022) does not address the organisation of Community Health Services directly at all and by default assumes that these services will continue to be delivered by the broad range of providers currently doing so, whilst assuming that the wider changes being enacted will make care more 'integrated'. It is, nevertheless, possible to discern a number of potential implications for CHS in general and district nursing services in particular, which we will address in subsequent sections. Overall, it is clear that the Act situates community-based services as

Level	Functions	Priority areas from the NHS Long Term Plan
Neighbourhood (approx. 30-50,000 population)	• Integrated multidisciplinary teams • Strengthened primary care via Primary Care Networks (PCNs) • Proactive role in population health and prevention • Services linking with community, voluntary and independent sector providers	• Integrate primary and community services • Implement integrated models of care • Use population health management approaches • Roll out PCNs via new contract • Appoint a named accountable Clinical Director for each PCN
Place (approx. 250-500,000 population)	• Usually council/borough level • Integration of hospital, council and primary care teams/services • Develop new approaches to 'anticipatory' care • Models for out-of-hospital care for specialist care and for hospital discharge and admissions avoidance	• Closer working with local Government and voluntary sector partners, focus on prevention and health inequalities • PCN network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes model
System (approx. 1-3 million population)	• System Strategy and planning • Develop governance and accountability arrangements across the system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system	• Streamline commissioning arrangements, with typically one CCG for each system • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity

Fig. 8.1 Components of the new system. (Adapted from: https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf(p. 3))

essential in the context of an overall desire to reduce the amount of care which takes place in hospitals, with a continuing focus on: case-management approaches which seek to streamline care for individuals; early discharge and 'hospital at home' approaches to minimise length of stay in hospital and reduce admissions; and co-ordination with primary and social care services. A particular approach highlighted in the *NHS Long Term Plan* (NHSE, 2019) is the creation of community-based 'rapid response teams' able to respond quickly to need and put in place more intensive services to support patients who might otherwise need admission.

Needless to say, the success of this approach is dependent upon the capacity and capabilities of a skilled and fully resourced workforce to

deliver them. Historically, however, the district nursing workforce has been in decline and according to figures published in a report by the RCN and QNI in 2019, has declined by 46% since 2010, leaving just '4,000 District Nurses to provide care to a population of approximately 55.8 million in England alone' (RCN &QNI, 2019, p. 4). The decline in district nursing staff presents a paradox between health policies which seek to deliver more care closer or at home (Drennan, 2019) and as such will need to be addressed in order to meet the challenges of delivering the *Long Term Plan*.

8.1.1 The Role and Function of Community/District Nursing Services

Within the *NHS Long Term Pl*an, CHS in general and district nursing services in particular are situated as a key component of an NHS which aims to keep people out of hospital as much as possible. Within the system as envisaged, community services providers are required to liaise and co-ordinate with primary and social care to deliver an increasing proportion of care outside hospitals. The mechanisms by which it is envisaged that this will occur are: the increasing use of multidisciplinary teams, across neighbourhoods and sectors; and the continued development of case management approaches by which community-based staff take responsibility for the overall care required by patients with complex needs. A report published in 2018 by NHS Providers about the commissioning of community health services emphasises these points:

> In fact, there is a real opportunity for community services to not only contribute to but take a leading role in the transformation and sustainability of future models of care given their ability to:
>
> - act as system integrators as they offer a valuable interface with other parts of the health and care system, particularly with primary and social care, and work across organisational boundaries
> - understand local populations, hard to reach groups and place-based working, meaning they are well placed to tackle health inequalities
> - address population health as they work collaboratively with and within multiple other parts of the public sector, such as schools and care homes, so can help tackle the wider determinants of health (social, economic and environmental)

- promote public health through universal interventions and local relationships with other public sector organisations, given their spread across a geographic area, as well as encourage self-care and patient activation
- spread the learning from their work in vanguards testing new models of care, particularly from multispecialty community providers where community services have been working together with general practitioners, nurses, hospital specialists, mental health and social care services to deliver integrated care in the community
- identify, strengthen and bring together community assets to promote health and wellbeing (e.g. voluntary organisations, informal networks). (NHS Providers, 2018)

Whilst these approaches may be justifiable and of value in supporting the aspiration to improve population health and increase care outside hospitals, in the absence of a change in the funding model they risk putting increasing strain on community nursing teams already under pressure, particularly as social care provision is squeezed by the impact of austerity on Local Authority funding (Lowndes & Pratchett, 2012). They also bring with them issues related to skill mix, with such roles requiring high levels of skill. This means that there is a risk that qualified district nurses are pulled away from front line care teams in order to take on these more co-ordinating roles.

8.1.2 The Management of Community/District Nursing and Population Covered

In the vision set out under the *NHS Long Term Plan* (2019) and subsequent White Paper(DHSC, 2021), district nurses will be important members of multidisciplinary teams planning and managing care for complex patients, as well as taking leading roles in engaging across sector boundaries. The complexities of population coverage associated with this cross boundary working bring to the fore the longstanding tensions around geographical coverage vs attachment of district nurses to GP surgeries. The *NHS Long Term Plan*(2019) and the associated White Paper (2021) put in place an additional contract for general practices whereby groups of practices would work together across geographical 'neighbourhoods' as Primary Care Networks (PCNs) to provide additional services. Additional funding has been provided to support this. Several of these new services

require GPs to work closely with community nursing teams, including additional support for patients living in care homes (Coleman et al., 2020) and so-called anticipatory care planning, which involves multidisciplinary teams engaging together to plan care for frail and complex patients. In pursuit of these aims it is suggested that Community Services providers will rearrange their community nursing teams to cover the same geographical footprints as PCNs. This is far from straightforward, as PCN footprints are based around GP practice registered populations, which are not necessarily neat or geographically contiguous (Hammond et al., 2020).

At the time of writing, the complexities arising from the negotiation of these new working relationships and cross-sector working are still in the process of being worked out. The Health and Social Care Act 2022 created Integrated care Systems (see Fig. 8.1) on a statutory basis. New Integrated Care Boards (ICBs) have been set up, overseeing Integrated Care Systems (ICSs). Each Board must have a representative of a local NHS Trust or Foundation Trust, as well as a Primary Care representative. At the same time it is intended that significant responsibilities and funding will be devolved from System to 'Place' level, although what structures might be established at this level remains unclear despite the enactment of the Bill into law. Many community providers cover large geographical populations(NHS Providers, 2018), and so it seems likely that each provider may need to engage with a number of different Places and PCNs. How management and oversight of teams established to support this new geographical arrangement of cross-sector services will work remains to be seen. In summer 2022 further guidance on these issues is awaited.

8.1.3 Financing Community/District Nursing Services

The report by NHS Providers (2018) highlights the financial pressures facing CHS providers, and identifies block contracts and lack of high quality data as factors holding back service development. In the new system based around statutory Integrated Care Systems it is envisaged that Systems will receive a population budget, which they will be responsible for allocating to the different types of service and to sub-system level geographical 'places', subject to certain national-level allocations such as those directed towards PCNs and GP practices. It is envisaged that funding mechanisms will move away from activity-based payments for acute services, using a system of block contracts which incorporate some

mechanisms to recognise activity, with overall financial balance achieved at the System level. Even after the creation of Integrated Care Systems, the new approach to funding has still not been fully specified. It seems at least theoretically possible that an ICS might decide to redirect funding from acute services into community services or primary care; this suggests a funding system with some similarities to that seen in previous eras, when redistribution between sectors was the responsibility of District or Area Health Authorities. However, the significant difference between previous finance systems and that currently proposed is that in the past the distributing Authority was independent of service providers. Under the current Act, decisions about the distribution of funding between different sectors will be made by a board (the ICB) which includes representatives of those providers, raising questions as to how it will be ensured that decisions represent the best interests of the population rather than the relevant providers (Checkland et al., 2021).

How will this arrangement affect the district nursing service? The RCN and QNI (2019) argue that investment and commitment in the service is needed to maintain a sustainable district nursing service. They suggest that a 'national standardised data collection system and data set within England, collecting meaningful data that recognises 'value for money' and is not just seen as a 'notional saving', thus promoting a strong economic case for investment in the district nursing service and providing systems at an operational level nationally, regionally and locally to prepare and support the district nursing service' (p. 5).

8.1.4 Summary

Under the new Act, service provision is moving away from a competitive model to one based on co-operation and collaboration between sectors across geographical populations, with funding moving away from an activity-based model to one where finances are balanced at System level and planned reallocation of funding between sectors is possible. However, many aspects of how the newly created system will function remain unclear, and decision making bodies (ICBs) will potentially be dominated by large scale providers with significant conflicts of interest. The role of district nurses is increasingly being reimagined as that of case management and care co-ordination, with more senior nurses acting in these roles as well as managing teams of less well-qualified staff who deliver hands-on care. The

tension between organising community services to cover geography as opposed to being centred around GP registered populations remains, albeit expanded to the larger PCN population rather than that of individual practice populations. Nevertheless, this change looks likely to require reconfiguration of many district nursing teams, with ongoing concerns about the availability of the workforce required.

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CHAPTER 9

Discussion

Abstract In this final chapter of the book, we return to our original research questions and draw together our findings, looking across the eras to illustrate how the policy changes of the past have defined the services of today and the future. We show how, over time, there has been a consistent pattern in policy by which community nursing services are rarely the focus of policy. Rather, changes have occurred in policy which have had a knock-on effect on Community Health Services (CHS), and these effects have often been to their detriment. In the conclusion, we offer observations on the incoming policy changes in 2022 (H&CA, 2022) and suggestions for future research. Proposals for the development of Integrated Care Systems (ICS) offer both opportunities and threats to the provision of community nursing/health services—the former from more investment or the latter from being dominated by larger acute services. Our main concern is there is a danger that the voice and needs of CHS will yet again remain unheard and un-regarded.

Keywords ICS • Future • Voice

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9.1 Research Questions

1. **What are the key government policies in respect of the organisation and provision of community/district nursing services since 1948?**

We have analysed and presented summaries of the key aspects of formal policy affecting district nursing services since 1948. We have done this under four thematic headings: the historical context; the role and function of district nurses; management and population covered; and financing services.

2. **How do the policies change or remain consistent over time?**

The integration of services has remained a continuous ambition, albeit one which has not yet been realised. Indeed, it remains a strong focus in current reform proposals. At the same time, the call to nurse more people in the community to reduce the burden of costly hospital care has also been constant through successive policies, especially following the 1974 re-organisation, and this currently forms part of the strategy of the *NHS Long Term Plan* 2019. Building upon this, current policy suggests a need to 'dissolve the historic divide between CHS and Primary Care' (NHSE, 2019, p. 13) but with no details as to how this is to be achieved. There has thus been a perceived need to shift care into the community over decades, and the fact that this has not yet been achieved suggests that new policy approaches may be needed. In particular, issues related to funding and system-level incentives arising out of the use of different types of contractual payment mechanisms for different sectors may be important.

More generally, there have been shifts in attitudes to the skills required by community nurses, with a gradual shift from emphasis on the provision of skilled nursing care in the home to a more case-management approach, with senior nurses planning care and engaging with other services, managing a team of less skilled staff. At times there has been the suggestion that community nurses should also provide health promotion and other

preventative care, but this has never been consistently sustained and has gradually become diluted to a role in preventing hospital admission, rather than promoting health.

The tension between whether district nursing services should cover geographical populations or be attached to GP surgeries and provide care to their registered populations has been constant through policy since the 1970s. Most recently, there is tension around the delivery of services to Primary Care Networks, with a policy push for CHS to reorganise their teams around the geography of their constituent practices.

An early focus of policy was around the *management of CHS*, with a particular focus upon the tension between whether they should be managed by nurses or doctors. This tension has clearly been resolved in favour of nurse-led management via separate providers of community nursing services, with each iteration of NHS management structures since the 1990s having a role for senior nurses. Recent guidance on the constitution of Integrated Care Systems suggests that each must have a Director of Nursing.

3. **What are the overt drivers of these policies?**

Overall, health service policy across the decades has been, in part, driven by a longstanding desire to shift care from (presumed expensive) hospitals into the (assumed to be cheaper) community. Beyond putative savings, discharging patients more rapidly and preventing admissions to hospital offer potential benefits in terms of increasing hospital capacity to tackle waiting lists and in reducing iatrogenic harm such as hospital acquired infections. Moreover, policy documents imply the potential for increased patient satisfaction, embodied in the repeated use of the phrase ‘care closer to home’. Evidence to support these assumptions is limited, particularly in relation to cost savings (Checkland et al., 2013) but this has not prevented successive policies from being formulated to address this objective, with CHS clearly important if the objective is to be achieved. However, CHS have rarely been the prime focus of policy; in the historical eras we have covered, CHS have usually been reorganised or reconfigured around the needs of the rest of the service. In this context it is notable that CHS are barely mentioned in the 2021 White Paper (DHSC, 2021), with CHS mentioned in passing in a document which largely focuses upon acute providers. This suggests an underlying dominance in policy of the needs of large acute providers, with community services of all kinds

lacking in political influence, despite the continued rhetorical statements emphasising is the importance of care near to home.

Beyond this, one of the most significant drivers since 1989 has been the ideological pursuit of competition between providers. This culminated in *Transforming Community Services (*DoH*,* 2009*)*, with the result that community services became distinct provider units, either standalone or under the umbrella of a larger NHS Trust. At the same time, the drive for competition led to the payment regime known as Payment by Results for acute services, driven by the need for commodification of care bundles if competition is to be achieved (Harrison, 2009) alongside the need for incentives to increase activity in order to tackle unacceptable waiting times for treatment. CHS, by contrast, have continued to be paid according to block contracts, in part due to the difficulties associated with commodifying community-based care. Such contracts do not reward additional activity, ensuring that the desired shift of care into the community has not been incentivised. This has led to a consistent pattern by which community services are cash-squeezed in comparison with services which are paid according to activity, further limiting opportunities to increase care in the community. Addressing this will require the design of a payment system which does not incentivise expensive activity and which allows the active movement of resources from one sector to another. Such movement will require attention to the political influence enjoyed by different sectors.

These trends in turn are driven, in part at least, by the lack of good data about CHS activity and outcomes. Without clear ways of accounting for CHS activity it is difficult to argue for increased funding, and this in turn has further driven the funding limitations which have affected CHS over time. New community datasets are in development, but recent analysis of their potential usefulness found that the data are: not highly user nor access-friendly; difficult to link with any other publicly available data due to its aggregation and geography levels; difficult to link internally within the dataset itself; and relatively poor data coverage and reliability, with no information available as to what proportion of community service provider organisations are contributing data regularly (Malisauskaite et al., 2021).

Workforce issues have remained a constant problem over time, with both financial pressures and lack of senior qualified nurses driving an approach towards skill mix and care delivery by less qualified staff. This in turn limits the options for meaningful health promotion or a wider role for community nurses, as services become task-based.

4. **What lessons can we learn for current policies concerning the organisation and delivery of community/district nursing services?**

Disappointingly, CHS in general, and community nursing services in particular again figure in current policy by omission rather than there being any coherent vision for their role in the new system. The creation of ICSs has been discussed above. It has been argued by commentators that these proposals formalise many of the changes which have been happening locally, with organisations currently working together informally in order to try to provide more integrated care to patients. It is intended that the new architecture will facilitate cross-sector and cross-organisation working, with more emphasis on collaboration and less on competition between providers. ICSs cover large populations of between one and three million people, and have taken on the commissioning functions previously undertaken by Clinical Commissioning Groups. CHS will thus be commissioned by ICSs. However, ICSs cover large populations and it is suggested in the White Paper (DHSC, 2021) and associated guidance (NHS England, 2021) that much of the day to day work of commissioning will be delegated to what are called 'place-based partnerships'. These will generally be established on geographical footprints similar to those previously covered by CCGs, covering, for example, Boroughs or towns. However, in summer 2022 after the establishment of ICSs in statute, guidance as to how service commissioning will be accomplished in practice is still awaited. Much of the White Paper setting out the new system was devoted to the role of acute hospitals, with CHS services only intermittently mentioned and with no clear policy proposals directed towards them. It is anticipated that community and other providers will work collaboratively together at place level and below this in 'neighbourhoods' to provide more integrated care which will support people outside hospitals, but the mechanisms by which this is achieved are not currently specified. Table 9.1 sets out the changes which may be of relevance to CHS providers.

From this summary it can be seen that many of the issues that we have identified through history remain salient. In particular, the new Act clearly situates CHS as predominantly concerned with supporting people to remain at home and to avoid hospital admission. This has been a policy focus over many years but, as we have highlighted, realising this policy ambition requires effective mechanisms for funding to flow from acute services to those in the community, something which is difficult under

Table 9.1 Summary of proposed policy changes

Element of current proposals	Specific relevance to CHS	Comments
ICSs are led by a Board, at least one member of which is from an NHS or Foundation Trust	This member could be from a Community Trust, but it seems more likely that they will be from a large Acute Trust	If CHS are not routinely represented on ICS Boards they could be disadvantaged
Each ICS also has a 'partnership board', bringing together representatives from all local providers and from Local Authorities	CHS providers will be represented here	The role of the partnership board is unclear
'Place-based partnerships' will be established to which ICS commissioning functions and budgets may be delegated	CHS services may be commissioned and overseen by place-based partnerships, but this remains unclear	Guidance about the role and function of place-based partnerships lacks specificity, leaving most things to be decided by ICSs
'Provider Collaboratives' will be established, responsible for co-ordination of services across large areas. Budgets may be delegated to them	Guidance suggests that Acute Trusts MUST be part of one or more collaboratives, whilst CHS providers MAY join a collaborative	How provider collaboratives will work with or across place-based partnerships is unclear. There is a risk that standalone CHS providers will be disadvantaged if provider collaboratives in which they are not involved become significant decision makers
New payment models will be developed which provide fixed payments for an agreed level of planned activity, with variable payments for activity above or below these plans.	CHS are currently disadvantaged by the disparity in payment models, with acute services paid for activity whilst CHS receive fixed budgets	Alignment of payment models between different types of services will potentially allow planned investment in CHS and redistribution of resources between sectors
Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee	This will allow for central direction of investment in CHS if that is deemed necessary	
Legislation will allow the formation of joint decision-making committees	Joint committees may be formed, with commissioners and providers coming together to jointly make decisions about about integrated care in a particular area	Such committee may make it easier for CHS providers to co-ordinate their work with other providers and sectors
The Act has removed the 'section 75' requirement for competitive procurement, and has also removes the NHS from the remit of the Competition and Markets Authority. The Act allows for the removal of NHS contracts from the Public Contracts Regulations 2015, although this will require secondary legislation to complete. A 'new procurement regime' will be developed by NHSE	Competitive procurement processes will not be required as frequently. However, until NHS contracts are actually removed from the Public Contracts regulations, individual providers who are not commissioned may still make a legal challenge on procedural grounds	It remains somewhat unclear at present what the new procurement regime will look like. And, in the case of CHS currently contracted out to non NHS providers, these new procurement rules may require the use formal competitive procurement processes when contracts expire
Aspects of the Care Act which require assessments to be provided prior to hospital discharge have been amended	This will allow patients to be discharged into the community sooner, with CHS providing support and rehabilitation	There remains a policy push to increase care in the community
PCNs will develop integrated multi-disciplinary teams that include staff from community services and other providers	CHS providers will need to work effectively with all PCNs in their area	The geographical footprints of PCNs are complex and do not necessarily straightforwardly map to CHS providers. Flexibility of teams will be required to establish effective MDTs

current pricing mechanisms. It has been promised that this will change, but the exact details of this are not yet available. Secondly, the new system requires CHS Services to collaborate at neighbourhood level with GP practices, but the question of geographical coverage is not addressed. Our historical analysis has demonstrated a constant tension over time between the organisation of community services over a geographical footprint as opposed to their organisation around the population covered by GP practices. Current guidance resolves this in favour of community services orientating themselves around the footprints of GP practices, albeit across groups of practices rather than individual ones. How easy this is to achieve remains to be seen.

Thirdly, although the current guidance associated with the Act signals a move away from competitive tendering for services, it is by no means clear how the new procurement regime will operate in respect of CHS which have been subject to competitive tendering in the past. Over the past decade or so there have been instances of community service provision shifting between providers as a result of such competitions. It is possible that the new regime will cement current provision, with existing providers (whether NHS owned or otherwise) being offered longer term contracts. On the other hand, it is also possible that the new regime may have the effect of condemning those CHS currently contracted out to be subject to further competitive tendering on the expiry of those contracts. Finally, the Act does not address the very pressing nursing workforce issues.

More generally, the new system offers a prominent place for large providers of acute services, and it is unclear how much influence community service providers will have at ICS level. Clearly arrangements as to representation on ICS Boards and Partnerships will be important, as will whatever is set in place to provide operational support for providers at Place level. Unless the NHS as a whole has a significant funding uplift (which seems unlikely), providing adequate funding for CHS providers to manage more patients in the community will require shifting resources between sectors. This may be difficult if acute providers have the strongest voice in ICSs, and it is further likely to be undermined by the needs for acute providers to tackle current treatment backlogs. These issues are complex and difficult to resolve; there is nothing in these current legislation which will necessarily support a stronger voice for CHS providers.

9.1.1 Conclusion

We have shown how, over time, there has been a consistent pattern by which community and district nursing services are rarely the focus of policy. Rather, changes have occurred in policy which have had a knock-on effect on CHS and the community nursing service, and these effects have often been to their detriment. Prominent amongst these has been the pricing regime that has tended to reward acute care to the detriment of care in the community. The current guidance surrounding the development of ICSs offers the possibility of more planned investment in CHS to support the policy objective of providing more care outside hospitals, but this will depend crucially upon the new pricing regime, which is yet to be established. It is worrying that the role of CHS leaders in ICSs and in Place-based partnerships remains unclear, and there is a significant danger that these entities will be dominated by large providers of acute services. Mechanisms for managing conflicts of interest among ICB members who are commissioners of care, many of whom will also be employees of provider organisations, are not yet clear, and there is a danger that the voice and needs of CHS will yet again remain unheard and un-regarded. The role of provider collaboratives is particularly concerning, as current guidance suggests that these ill-defined groupings may be responsible for significant budgets. The extent to which the needs of CHS are taken into account will depend crucially on ICS leaders having a broad vision that encompasses all types of providers.

More generally, it would seem that the organisational form of CHS providers has slipped from policy focus. We do not know what form of provision is best suited to providing integrated care in the community, and research could usefully consider the extent to which CHS ownership and organisational form affects service delivery in the current NHS structural context. Similarly, policy has defaulted to a model of skill mix provision, in which care is provided by less qualified nurses undertaking tasks under the supervision of a more senior nurse. The impact of different models has not been studied in detail and is not addressed in current policy. The provision of accurate information about community service activity and outcomes will be important but achieving this seems to still be some way off. Current policy envisages community teams working closely with groups of GP practices and further research is required to explore how this can be made to work in practice, given the complex geographies embodied in both

CHS providers and Primary Care Networks. In summary, it seems that, as Griffiths pointed out, CHS remain:

> Everybody's distant cousin but nobody's baby.
>
> —Griffith's (1988)

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