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Aim

This study aimed to investigate the factors influencing the development of district nursing workforces in a metropolitan area of England.

Background

Health policy in many countries aims to improve self-management and care for people with chronic conditions and increase delivery of care outside of hospitals including in the home. Despite these policy objectives in the United Kingdom, the workforce of the long established home visiting nursing service, known as district nursing, is reported to be in decline.

Methods

This was a qualitative study undertaken in a metropolitan area with over three million residents in diverse socio-economic communities. A purposive sample of senior nurses in in provider and commissioning organisations participated in semi-structured interviews. Thematic analysis was undertaken framed by theories of innovation and change.

Findings

All participants reported that the context for the district nursing service was one of major organisational changes in recent years in the face of wider National Health Service changes and financial pressures. Against this backdrop five themes were identified influencing the ways in which this workforce was developed. These were: the challenge of recruitment and retention, the changing case-mix of patients on district nurse caseloads, the growth of specialist home visiting nursing services and its impact on generalist nursing, the capacity of the district nursing service to meet growing demand and the influence of the short term service commissioning process on the need for long term workforce development. Workforce development was shaped by system level contexts. The influences identified here at the theoretical level require investigation and testing in different health economies where home health nursing is funded through different mechanisms.
Introduction

Many health care systems are looking to increase ambulatory and primary care services to address population changes and contain rising health care costs [1]. One element of this is the delivery of nursing within the home, known variously as home healthcare, home visiting, public health, community and district nursing (as used in the United Kingdom. UK). Home visiting nursing services feature in many, but not all, health care systems. Some countries such as the UK and United States of America (USA) developed these in the nineteenth century [2] while others have developed them more recently, for example Japan [3] and China [4]. In the UK district nursing services provide care to the housebound, mainly elderly, with long term conditions or who are dying. Current health policy in England aims to improve self-management of long term conditions and decrease unplanned hospital admissions, as well as increase palliative care at home [5]. These policy aims suggest that more and perhaps differently skilled district nursing services will be required and that this workforce will develop and change in response. However, recent investigations report the opposite with numbers of district nurses in decline and low morale within the staff [6, 7]. The national workforce figures show a decrease by 14% since 2009 (32,699 full time equivalents in September 2009 to 28,237 in July 2017, which includes those with the district nurse (DN) qualification as well as the registered nurses (RN) [8]. This paper reports on a study which investigated why there should be such an apparent contradiction between policy aims and the development of the district nursing service and workforce.

Background

Workforce development is a term that focuses both on how organisations provide learning opportunities to improve workforce performance but also how organizations respond to changes that affect workforce effectiveness [8]. Workforce development therefore implies change at individual, group and organisational level. Theories of development, change and innovation in health services are numerous. This study has drawn on that proposed by Greenhalgh et al. [9] with influencing factors such as the system context and readiness for change. A review identified that while there was some literature on the nurse numbers and required numbers (see for example from the UK [10], Australia [11], and the USA [12]) there was no exploration of the issues and influences on the broader aspects of workforce development for home visiting nursing services in the UK or other countries.

The English National Health Service (NHS) is tax funded and free at the point of care [13]. It has a strong suite of human resource practices guided by the NHS Constitution and nationally agreed employment terms and conditions. District nursing services are commissioned by local NHS Clinical Commissioning Groups (CCGs) mainly through block contracts i.e. payment for a broadly defined service in contrast to activity based payment system used in other countries such as the USA, France, Australia and the Netherlands [7]. The organisations that are awarded contracts are called ‘provider’ organisations. Senior NHS nurses in provider and commissioning organisations are required to
participate in regional workforce development planning, led by a national body called Health Education England (HEE). This study investigated the question as to factors influencing workforce development of the district nursing service in English metropolitan areas from the perspectives of senior nurses in provider and commissioner organisations.

Methods

The methodology drew on the interpretivist tradition and data was collected through semi structured telephone interviews in 2014[14]. A purposive sample was identified of Board level Directors of Nursing in eight organisations providing district nursing services and Board level nurses in in the twelve CCGs in the metropolitan area of South London (resident population of three million living in inner city and suburban areas). Invitations to participate were sent by publically available NHS email addresses. Participants provided written and verbal consent. A topic guide was developed with the study advisory group of NHS managers and academics. Question areas included views on: current strengths and weaknesses in the current district nursing workforce, factors supporting or inhibiting development and as well as perceived direction the development should take. A technique of participant verification within the interview was used to confirm the researcher’s understanding and interpretation [15]. Interviews were between 25 and 50 minutes. With permission, digital recordings (or notes) were made and transcribed with identifying features removed. The data were thematically analysed and through an iterative analytical process, tested in subsequent interviews. By the final interviews no different views were offered. The analysis and interpretation was then further tested for credibility and confirmed in a seminar with a different group of thirty senior community nurse managers and educators. The study received ethical approval from a University Research Ethics Committee.

Findings

Interviews were undertaken with six heads of district nursing services provider organisations and with the eight CCG Board nurses (total interviews =14). All had ten or more years’ experience in senior positions and all, but one, were female. All were or had been involved to some extent in the HEE processes for the allocation of funding for nursing workforce development.

In all areas the district nursing service (known as adult community nursing in some) only provided services to housebound adults. All district nursing services were reported to include different grades of registered nurses as well as health care assistants. Most participants reported that their district nursing services had been recently re-organised for one of the following reasons:

- The result of merger with, or separation from, other NHS funded organisations (a requirement with the enactment of the Health & Social Care Act 2012 [13]),
- Through the creation of new multidisciplinary or specialist teams,
- To align with other services (such as general practice) as required by commissioners.
The wider organisation and commissioning context was therefore already identified as a significant influence on district workforce development. The paper now turns to the five main but inter-linked themes identified from the participant’s perceptions, which were:

- Staffing the service - the challenge of recruitment and retention,
- The changing case-mix of patients on district nurse caseloads,
- Specialist versus generalist nursing,
- The capacity of the district nursing service,
- The influence of the service commissioning process.

**Staffing the service – the challenge of recruitment and retention of staff**

The participants from provider services described vacancy levels that were constant and problematic. They explained the challenges faced in recruiting the right calibre of registered nurses and retaining them. Some described a constant process of recruitment of junior registered nurses as these stayed for relatively short periods of time:

“*It’s just an endless struggle to keep these posts filled*,” provider nurse 6.

All participants described negative consequences of high staff turnover and high use of agency staff, including loss of continuity in care for patients:

“*It means you are always sending someone new to some patients*,” provider nurse 3.

It also resulted in loss of team and multi-disciplinary relationships which were noted as important to the quality and safety of care of patients living at home. A vicious circle of impact within teams was described:

“*It’s a downward spiral where vacancies lead to more stress for the rest of the team, so more sickness, so more vacancies needing cover by agency staff,*“ provider 10.

Issues related to salary and its consequences for recruitment and retention were frequently discussed. Those managing services in areas which attracted the lower rate of high cost area wage supplements (nationally agreed for NHS staff) described how nurses they recruited often quickly left to work in adjacent areas which paid the higher rate. Some participants pointed out that even though this was a city, patients were often widely dispersed and consequently the service required nurses who were car drivers, preferably car owners and willing to use them for work. The need to have car drivers was emphasised by one respondent who pointed to the consequence of employing staff who were “*walkers*” as “*they slow us down*” (provider nurse11). This was a specific issue in recruiting to any community nursing post (in comparison to a hospital post) but particularly for the lower paid grades:
“When they get down to the brass tacks of the changing the insurance and mileage [reimbursement], which is now less favourable, it can make them [job applicants] change their minds about working for us“ , provider nurse 3

All provider participants valued the HEE provided NHS funding for continuing professional development courses in Universities as it was seen to be not only to be attractive to potential employees but also aided service workforce development plans. However, it was reported that this funding was being reduced.

All participants were very aware of the demographic profile of the district nursing workforce as an ageing one, “Shall we say [the staff are] on the mature side“, (provider nurse 4), which needed appropriate workforce planning and training to replace, “it’s a demographic time bomb”, (provider nurse 6). They commented on the importance of having “good leaders in district nursing teams”(provider nurse 11). Not all organisations required their team leaders to have a district nursing qualification. Opinions were divided on the value of this qualification known as specialist practice (district nursing) qualification. There were those who firmly believed that the job could not be done without it:

“It [the district nurse qualification] makes such a difference as to how they approach the job, the patients, the staff”, provider nurse 8.

There were others who suggested the team leaders needed to learn about caseload and people management in the out of hospital setting but that did not require a twelve month University course.

There was, however, a consensus that there needed to be a clearly described career pathway into and through district nursing which was currently absent.

The changing patient case-mix and the requirement for clinical skills

All the participants from provider organisations stated that the patient case-mix was changing, creating increased demand on the district nursing service. Higher volumes of patients who needed complex, technical procedures to be carried out in their homes were described than “say five or six years ago “, (provider nurse 3). In addition, it was reported there were higher numbers of people choosing to die at home. These types of patients were reported as requiring more time from staff than those needing simple procedures and “ often needed two staff rather than one” (provider nurse 8). In workforce terms, providers and some commissioner participants commented on the need to have nurses with advanced technical and clinical skills to respond to this growing demand. A few provider organisation participants pointed to the challenge for the nurses of maintaining confidence and competence in specific technical skills when the patients who required them were relatively infrequent on any individual district nurse team caseload:
“The last time that team had one [patient with a recent tracheostomy] was seven years ago”, provider nurse 3.

Some participants pointed to previous initiatives such as staffing rotations between community nursing teams and hospital teams as one way of both addressing clinical skills and also giving a wider cadre of nurses an opportunity for clinical experience in home settings. When asked why these schemes no longer existed, participants suggested changes in financing, managers and hospital shift patterns had all contributed.

Two participants suggested that lack of current clinical competency in rarely seen conditions and technical procedures were used by some district nurses to draw boundaries around their caseload. It was reported as one of the few ways the district nurses had to control patient numbers on their caseloads. For other participants it reflected a wider change in district nurse patient case mix being brought about the growth in specialist services which is now discussed.

**Specialist versus generalist nursing services**

Participants reported that there were increasing numbers of specialist teams and/or specialist nurses being commissioned to provide services to people in their own homes. The participants contrasted these with the generalist district nursing service. Some participants expressed concern for continuity of care for patients where the specialist teams only looked after a specific time period (e.g. post hospital discharge) or for a single condition (e.g. diabetes when patients had multiple co-morbidities). Others could see the value in specific teams/nurses with specialist expertise for some conditions or at critical periods. However most expressed concerns for the consequences for the district nursing service and workforce development if they were considered to be the service for:

“All the patients or work no one else wants”, commissioner nurse 9.

At the extreme, participants perceived this as likely to make the district nursing work very unattractive and therefore increase the problems with recruitment and retention of staff. They also considered it made it harder to maintain advanced clinical skills and therefore map out attractive career pathways in the community.

**Capacity of the district nursing service**

After noting the changing profile of the patients and their requirements, nearly all participants from provider services commented on the increased levels of patient contacts, higher levels of staff activity and ‘busy-ness’ of the district nurse teams. Nearly all participants commented that this ‘busy-ness’ led to the nurses becoming ‘task focused’ (commissioner nurse 12). This was viewed as a problem by commissioning participants who were looking for district nursing services to actively engage in the
broader agenda of increased anticipatory care for people with long term conditions in order to prevent unplanned hospital admissions.

“They do the dressing and go [leave the patient’s home], rather than make every contact count in terms of promoting self-management, health promotion and anticipating and addressing problems immediately”, commissioner nurse 12.

Many of the commissioning nurses considered the nursing teams could improve their organisation to use their staff resources more efficiently. Some pointed to the lack or very limited use of patient acuity or dependency tools to understand the resource demand and manage the caseload and the staff allocation:

“They [the district nursing services] don’t seem to have any way of categorising the patients in terms of the illness or dependency on the service – I don’t see how they can understand the demand and allocate staff accordingly”, commissioner nurse 1.

In contrast the participants from the provider services reported on burdensome administrative or infrastructure issues, both internal to their organisation and externally imposed, which increased time demands on registered nurses and reduced overall efficiency. Examples were given of the increased paperwork to be completed such as in NHS Continuing Care Assessments which are required for the NHS to accept payment of care responsibilities. Some participants flagged the inefficiencies resulting from under-investment in information technology support to district nursing – particularly when community services were a small part of a very large acute hospital organisation:

“So we’ve now got more computers that the nurses can use – but still not mobile and if there is a problem the IT support from [name] Trust puts us [the district nursing service] at the bottom of the priority list after all the acute services” provider nurse 4.

These types of issues led some participants to question whether the district nursing service workforce had to include more “business workforce support” (commissioner nurse 5), in the future to become more efficient. It also raised questions as to what extent the team leaders and senior nurses in district nursing were involved in the planned development of their staff when their focus was on patient delivery.

The influence of the commissioning process

The divide between those participants from commissioning and from provider services were most evident when discussing the commissioning process. All the district nursing services were commissioned by ‘block’ contracts. Some commissioner participants commented there was not “enough granularity” (commissioner nurse 13) to understand the activity and outcomes of district nursing services. They considered that the CCGs were “paying for over-performance” (commissioner
nurse 14) that was not addressing the pressing issue of improved care of people with long term conditions and hospital avoidance. In contrast some provider participants considered the CCGs preferred block contracts because it masked the level of their activity and ensured the contract price did not increase:

“It [block contracts] keeps their costs down but not ours”, provider nurse 8.

It was evident that in some areas there were quite adversarial relationships between commissioners and provider organisations as to the problems and costs of the district nursing service, while others appeared to describe more collaborative relationships to address workforce development. Many of the participants discussed the possibility of contracts for district nursing services being awarded to different provider organisations. This had consequences for workforce development:

“So there is a sense of ‘short-term-ism’ in contracts which makes it very difficult to plan long term for a workforce”, provider nurse 10.

Examples were given of integration initiatives with Local Authority funded social care teams and/or general practice which had not been sustained in subsequent commissioning rounds due to changes in commissioners or reduction in funding available. All of these were cited as examples as making long term planning workforce development problematic.

Finally, when asked whether these were new issues in developing the district nursing workforce that they were reporting, most participants replied they were not and that they were long standing and enduring problems.

**Discussion and conclusion**

This qualitative study explored factors influencing district nurse workforce development from the perspective of English NHS nurse managers and leaders in a metropolitan area and as such it offers new insights not described before or elsewhere. The evidence from these nurse managers supported the theoretical framing of change. [10]. The service context influencing factors identified include: the availability of nursing staff to develop the workforce from, the perceived increasing demand for the service and increased patient acuity, the encroachment of other specialist types of services and the adversarial mechanisms of the contracting process.

District nursing or home visiting nursing is just one small sub-group in the overall nursing labour market in any country. Increased demand for nurses from all sectors and shortage in supply, as reported currently in the UK and other countries [16,17], means that employers are competing for nurses from the same diminishing labour pool. Factors identified here such as lower financial incentives than other
nursing work are reported as ‘push’ factors from the district nursing labour market to other parts of the wider nursing labour market. While there is very little literature on factors influencing employment decisions of home visiting nurses, the studies that do exist suggest that intention to remain is linked to factors such as perceived reasonable workload, supportive work relationships, autonomy over work and adequate pay and benefits (see for example from a recent survey from the Netherlands [18]). It has been reported in reference to wider health and social care workforce planning in the UK, that in situations where the dominant preoccupation of managers is recruitment then wider strategies of workforce development become lost [19]. The views from the provider nurse managers in this study adds further evidence of contextual influences of the rising demand, funding availability and commissioning environment.

The provider nurse managers reported a contextual influencing factor was increasing demand for the service and more complex patients referred. There is evidence of increasing referrals to district nursing service in England [20] but no published data reporting on changes in patient complexity. Similar growth has been reported from South Australia [21]. The reported growth in complexity of patients in this study was matched by the reported growth in specialist teams and nurses. This however created a paradox: on the one hand the senior nurses were concerned with a workforce development strategy to address changing types of patients but on the other hand they had to balance that against the potential that some of those patients were being routed away from the generalist district nursing service. Concerns from community nurses and general practitioners about increased specialisation at the cost of generalist community nursing services have been noted before [22] but this study reports for the first time ambiguities it poses for nurse managers in addressing workforce development.

While the participants were unanimous in creating attractive career pathways for nurses, they were divided in their views on the nature of the educational preparation required for both the patient population of the future and also the leadership roles in district nursing services. In this they were one group of knowledge purveyors [10] with differing views. The consequences of these divided views are evident in the decline in numbers of attending the district nursing specialist practitioner courses [7]. The differing views are not surprising as the evidence base is minimal as to the most effective and efficient ways of educating nurses for home visiting. This is an issue which merits further investigation.

Finally this study identified the contextual influence of commissioning and contracting for district nursing workforce development. It was evident that there were both adversarial and collaborative experiences, a feature that has been identified since a contractual process was introduced to the NHS in the early 1990’s [23, 24]. This study adds examples of the ways in which that impacts both on immediate workforce development and long term workforce development. Sustaining and developing any health care workforce is a long term endeavour which internationally governments are engaged with to varying degrees [25]. This study demonstrated that the policy actors [26] within different parts of the health
care system had divergent views of the routes and endpoints to the development of the district nursing workforce: differences magnified by the process of a contractual system in a setting of public financial austerity. The mechanisms for funding, provision and use of home visiting nursing vary between countries. Whether these findings hold true for home visiting nursing in other countries requires further investigation.

In England it is evident that many of the underlying issues identified here are long standing. There has long been a narrative explanation that this is a nursing workforce that is generally invisible and politically marginalised [27] - a view born out to a degree by Allen et al.’s [24] work on commissioning processes for district nursing. However, this study also offers another contextual insight in that this is workforce, in England at least, that is subject to perpetual re-organisation and leadership change. Re-reorganisations of health services have been demonstrated to take at least three years for the services to return to their earlier level of functioning [28]. It can be argued that addressing long standing underlying issues in workforce development in home visiting nursing requires some stability both in context and also in the knowledge purveyors in the form of the nurse leaders. The question as to whether stability in senior nurse managers (and the organisation they work within) leads to the development and stability of the home visiting workforce requires further investigation.

This is a qualitative study in one setting that can be generalised only at the theoretical level. The evidence presented here is set within theories of change in health services and offers new insights which requiring testing in other contexts and settings. The purposive sample was only senior nurses and further studies are required of others’ perspectives. The involvement of one researcher may be seen as a limitation however methods were used to ensure trustworthiness and credibility.

**Conclusion**

There is an apparent paradox between health policies which promote more care within and close to home and the reported decline in district nursing services. Explanatory frameworks have been suggested here including the influences of contextual factors, knowledge brokers and the commissioning environment process. While issues in increased patient demand have been noted before, the impact of staff recruitment, retention, repeated re-organisations and the commissioning process have not. These have consequences not just for the workforce but the quality of patient care and are worthy of attention by practitioners, managers and commissioners. The extent to which these influences are significant in other health economies requires investigation.
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