

A Nursing Perspective

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Community nurses will be pleased to see that they have a central role in Professor Lord Darzi's vision for primary care in London. Working at the interface between health and social care, community nurses, and particularly district nurses, know all too well about *'the bits in between where there are little holes that patients fall into'*. In their daily work, they also bump up against those boundaries described by Lord Darzi as more *'virtual than real'* when trying to arrange packages of care for just that group of patients, the elderly and those with long term conditions, who are seen to pose the greatest challenge for health services in London.

With a long established tradition of delivering care in the home district nurses should be ideally placed to contribute to the Professor Lord Darzi's vision, yet in spite of this, the service has struggled to retain its importance in the eyes of local commissioners. This response attempts to offer an explanation for the perverse disregard of generalist district nursing at a time when its services are most needed and to highlight the very real problems of delivering care where important components of patient need remain means tested. It also considers how a suitably evolved service could be pivotal to Professor Lord Darzi's agenda for healthcare in the capital.

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How a service, nationally regaled in a Punch cartoon of 1938¹ with the caption *'you will be well looked after now old man, here comes the district nurse'*, came to lose its importance with policy makers and commissioners can largely be understood in the light of one piece of legislation; the NHS and Community Care Act 1990.² The Act effectively undermined the case management role of district nurses by explicitly separating health and social care (though without any robust definitions). The net result was a break down in the relationships between district nurses and home helps. These relationships had ensured that the small details of care were covered; those details that matter so much to patients and their carers but that are not easily classified as health or social care.

The issue of payment for social care remains a real rather than a virtual issue for patients and district nurses. In an unpublished study of older patients (n= 177) admitted to an established hospital at home scheme³ just over 50% (24/44) of those referred on to the local authority social services department at the end of their stay declined home care services. Whilst with the scheme, the same patients had accepted help with social care, this being provided free of charge as part of a service level agreement. Whilst innovative and ring fenced schemes may make use of Health Act⁴ flexibilities, ordinary ongoing care constantly stumbles against the thorny problem of means tested social care delivered by a number of disparate agencies.

Arguably, the development of the community matron/ case manager role was recognition of the value of the district nurse, as most matrons have this professional formation. Yet the role offers but another layer of complexity for patients and their statutory and informal carers. The promises of Evercare and similar have not been realised in the United Kingdom⁵ and, anecdotally, community matrons report varying levels of difficulty in engaging with general practice. The community matrons largely operate outside of the general district nursing teams and so the potential for further fragmentation occurs.

The development of the community matron role reflects a curious process within community nursing and within policy directed towards delivering care in the home. Instead of investment in the development and modernisation of existing district nursing services, new modalities are constantly created and these draw from, and persistently weaken the home nursing infrastructure. The service splinters rather than evolves. The creation of intermediate care services was another such 're-badging' development where in the words of the Department of Health a 'thousand flowers bloomed'.⁶ The 1990s witnessed the rapid commissioning and decommissioning of many of these schemes.⁷

Over the last couple of years, notwithstanding the demographic challenges, a number of inner and outer London PCTs have opted not to commission places on specialist practitioner district nursing courses though they have continued to send nurses for health visitor training. With community matrons in place, a less well professionally prepared district nursing workforce was deemed sufficient to look after the majority of older patients requiring domiciliary care. The thinking driving the commissioning of education for district nurses would be analogous to that leading to general practitioner training being downgraded because a relatively small number of patients required highly specialised care. In medicine the value of the generalist to primary care has been established.⁸ Generalist district nursing needs Barbara Starfield!

Community matrons see a relatively small proportion of the population, those purported to be at risk of admission and readmission to hospital, though even the authors of the original

case finding algorithms admit there are limitations in trying to make predictions for those who have yet to have a hospital admission.⁹ There is debate as to whether interventions would be better directed towards patients in the lower levels of the Kaiser Permanente triangle.⁹ The jury is out on the effectiveness of community matrons but in the meantime generic district nursing services seem to be losing ground and the effects are yet to be fully felt. Though education for continuing professional development is in place it is not of the sort that seeks to extend the role and skills of the generalist. Unlike their practice nursing colleagues the majority of district nurses still only prescribe from the limited community practitioner formulary though their patients are likely to be sicker and have more complex needs.

So, to meet the challenges ahead, should practice based commissioning look to continuing to promote the proliferation of specialists who only see a small proportion of patients (and indeed only see a small proportion of the patient) and who are connected only tangentially to GP services? In Professor Lord Darzi's vision the notion of the polyclinic extends to federations of GP practices. It is suggested here that the concept can be stretched further so that through proper professional education and development it is embodied in all of those who play the greater part in caring for those patients at home who are unable to get to any sort of building. Investing in and developing generalists who have historically been closely connected with general practice and whose acceptability and value to patients has been documented¹⁰ may be more successful in avoiding fragmentation of care and improving the patient experience. Sorting out means tested social care will prove a tougher nut to crack!

References

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