Community Nurses

A snapshot of Community Nursing in Norfolk
About this report

Healthwatch Norfolk came into being on 1st April 2013 as the consumer champion and local watchdog for people using health and social care services in Norfolk. As part of our watchdog role we chose to take a closer look at our local community nursing services and this report describes what we found out.

Community nursing deserves our attention and support in these challenging times. There is much debate locally about the joining-up - or integration - of health and social care services as a more cost-effective means to deliver better care for people closer to home. Alongside the GP, community nurses can sit at the very heart of the healthcare provided to people living with long term health conditions, a disability, or caring for others who are elderly and frail. Our community nurses have a key role in organising, coordinating and delivering person-centred care.

From our listening exercise over the summer, we know that local people do not always understand the health and social care system and who does what within it. People hold nurses in high regard but tell us they don’t always understand the different roles that nurses have and that getting the right information and support can be difficult. This report may go some way in helping people to understand what community nurses do and why we think they are important in delivering high quality, safe and personalised care.

We enjoyed discovering community nursing services in Norfolk and hope you enjoy reading about them.

Who this report is for

- The public - people who live in Norfolk and people who use health and social care services in Norfolk
- The people and organisations who choose and buy (commission) community nursing services on behalf of the local population
- Providers of community nursing services
- The Healthwatch Norfolk Board and the community and voluntary sector organisations who provide care and support to local people and who work closely with people in the community and in their own homes

Acknowledgements

We would like to thank the nurses that we spoke to when undertaking this project who were very supportive and willing to give their time to explain what community nurses do and the kinds of specialist skills they can offer. We are also grateful to staff working in our local NHS commissioning and provider organisations for their time in explaining how community nursing services work in Norfolk.

Front page photograph courtesy of The Queen’s Nursing Institute (2013)
**Why we looked at community nurses**

Healthwatch Norfolk came into being on 1st April 2013 as the consumer champion and local watchdog for people using health and social care services in Norfolk.

In April of this year, the Royal College of Nursing set out its view of current day district nursing and some of the challenges facing district nursing services. This review highlighted the essential contribution of district nurses in three areas of health care; acute care at home, complex care at home and end of life care at home.

In late April, a letter written by Karen Webb, the director of the Royal College of Nursing for the Eastern region, was published in the Eastern Daily Press (one of our local newspapers). The letter was a response to much debate in the local press about reports of queuing ambulances outside of our local Accident & Emergency departments and a limited number of available hospital beds. In her letter, Ms Webb said that local health service managers should also be turning their attention to the numbers of nurses working in the community when trying to resolve these problems. This was most important, she said, because the increasing numbers of people living with long term health conditions placed increasing demands upon the health care system to provide enough care to meet people’s needs at home and in the community.

In early May the Queen’s Nursing Institute launched their report on the changing face of district nursing in England, Wales and Northern Ireland. The Queen’s Nursing Institute reviewed the number of educational courses running in England and the number of nurses undergoing training to become qualified district nurses. This review voiced concerns about the steady fall in the numbers of nurses undergoing district nurse training and the falling numbers of qualified district nurses in the workforce.

![Fig. 1 Joined-up care](source: 'Joined-up Care: Sam’s Story' by The Kings Fund (2013))

Local people have been telling Healthwatch Norfolk about their experiences of health and social care services. People are talking about older people in Norfolk, people with complex needs and the large numbers of carers in Norfolk who are looking after their loved ones often on a daily or full-time basis. As well as this, the people and organisations who choose and buy (the ‘commissioners’¹) and provide (the ‘providers’²) our local services are concentrating on the joining-up, or ‘integration’, of services between health and social care. The Kings Fund, a charity who are a well-regarded think-tank on health care issues, put district and community nurses at the heart of integrated services (see Fig.1). All of these things put together prompted us to decide to take a closer look at district nursing in Norfolk.

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¹ In Norfolk, there are five local NHS Clinical Commissioning Groups. These are organisations which choose and buy services on behalf of their local population.

² There several NHS organisations providing treatment and care in Norfolk. These include our Hospital Trusts and Community Care Trusts. Other organisations provide treatment and care funded by NHS monies.
What we wanted to know

This is what we set out to explore:

- Who are our district nurses and community nurses in Norfolk and what do they do?
- Which organisations are host to community nurses and what kind of nursing care is provided by them?
- What do services look like; the number and mix of staff within them and the range of expertise they are able to offer?
- Where do community nurses care for people - e.g. in people’s homes and community settings?
- Are there enough nurses in Norfolk to provide the right care for people in the right place at the right time?
- Who chooses and buys community nursing services on behalf of people living or using services in Norfolk?

How we did this

A series of questions were developed, guided by the issues raised locally and in reports of organisations representing the nursing profession.

Responses to these questions were gathered by holding telephone conversations and face to face meetings with people working in NHS commissioning and provider organisations in Norfolk. Approaches were made in the first instance to the senior managers in these organisations who either agreed to help or directed us to someone else that could.

We did not include district or community nurses employed by charities such as Marie Curie, Dementia UK or Macmillan or those in the employment of private nursing and care homes. We focused solely on nurses working in community services of two local community services providers covering the county of Norfolk. This exploration focused on services for adults and older people. We did not include mental health nursing or children’s nursing services in the scope of this work.

During our conversations, we also asked people to give us their top five take-home messages about community nursing in Norfolk.

Amongst the people and organisations we spoke to were:

- Local Clinical Commissioning Groups; the lead individual responsible for commissioning of community nursing services; Directors of Quality and Safety (senior nurses providing clinical nurse leadership, guidance and expertise)
- NHS providers of community services in Norfolk; Chief Executives, Directors of clinical leadership for nursing and quality, service managers, team leaders, case managers, district nurses, community nurses
- Local GPs
- Representatives of the Royal College of Nursing and The Queen’s Nursing Institute
- The Chair of the NHS Confederation Community Health Services Forum
- NHS England East Anglia Local Area Team, Fulbourn, Cambridge (clinical leadership for nursing and quality in Norfolk, Suffolk and Cambridge areas)

Conversations took place between July and September 2013 and all the information was gathered together by early October 2013.
What we found out

What is a community nurse?

The first thing we found was that people used different terms in general to describe nurses working in community settings and caring for people at home.

The Royal College of Nursing¹ says that the goal of district nursing is “the planning, provision and evaluation 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”. When we spoke to local commissioners and providers, the title ‘community nurse’ was used most frequently and ‘district nurse' used occasionally. Table 1 shows the some of the titles in common use with a short description.

Table 1 Nurses titles and their meaning

<table>
<thead>
<tr>
<th>Terms and titles</th>
<th>What this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse</td>
<td>A nurse who has undergone and completed a degree level programme and is registered to practice as a nurse with the Nursing and Midwifery Council (nurses working in the NHS must be registered with the NMC).</td>
</tr>
<tr>
<td>District nurse</td>
<td>A registered (trained &amp; qualified) nurse who has undertaken a graduate level education and specialist practitioner qualification recordable with the Nursing and Midwifery Council, who looks after people who are permanently or temporarily housebound.</td>
</tr>
<tr>
<td>Community nurse</td>
<td>A registered (trained &amp; qualified) nurse who cares for people in community settings such as community hospitals and clinics, hospices, private and state-funded care homes and in people’s own homes.</td>
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<tr>
<td>Case Manager</td>
<td>A district nurse who specialises in caring for people aged 65 years and over living in the community who have complex healthcare needs.</td>
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<tr>
<td>Specialist nurse</td>
<td>Some nurses chose to undertake further specialised or advanced training and qualifications, for example in specialist diabetes care, specialist cancer care, pain management, continence, wound care, tissue viability, palliative care at end of life, the prescribing of medicines and many, many more areas.</td>
</tr>
<tr>
<td>Community Matron</td>
<td>Community matrons are highly experienced and highly skilled senior nurses who provide leadership and work closely with patients in the community with a serious long term or complex range of conditions. Community matrons are usually deemed to be working as advanced nurse practitioners.</td>
</tr>
<tr>
<td>Unregistered staff e.g. healthcare assistant</td>
<td>A person working in community services, providing healthcare for people in community settings or in people’s own homes, who is not a registered nurse. This person may provide nursing care and will be either be trained, or highly trained, depending on their role.</td>
</tr>
<tr>
<td>Community nursing service</td>
<td>A service comprised of a mix of registered, specialised and unregistered healthcare staff providing planned care to people in community settings or to people who are temporarily or permanently house-bound; providing holistic health needs assessment for patients, families and carers; providing skilled clinical judgment, treatment and care to enable patients to improve, maintain or recover their health.</td>
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</table>

The term community nurses and community nursing services were most commonly used by staff in both commissioning and provider organisations so they are the terms used in this report.
**Providers of community nurses (and community nursing services)**

There are two organisations that provide community nursing services in Norfolk. One is the Norfolk Community Health and Care NHS Trust that provides community nursing services across Norfolk with the exception of the Great Yarmouth area. The second is East Coast Community Healthcare Community Interest Company which provides community nursing services in the Great Yarmouth area of Norfolk and in north Suffolk in the Waveney area.

Across Norfolk in total, services are arranged into five localities; North, Norwich, South, West and East. In total there are 21 teams of community nurses across the county; 5 core teams in the North locality; 4 in Norwich, 4 in the South locality, 3 in the West and 5 in the East.

Based on the figures we were given, there are an estimated 280 qualified and registered community nurses (see Fig 2 below) providing nursing care in Norfolk.

The current skills mix, or ratio of registered to unregistered staff, within the community nursing staff for the two provider Trusts is 55:45 and 75:25. Both Trusts cited the best case scenario as a skills mix of 75% registered nurses to 25% unregistered. Within the Adult Specialist Nursing Services of one provider Trust, 100% of nurses are registered.

The Chief Executive of the Norfolk Community Health and Care NHS Trust said that in Norfolk alone, community nursing teams make over 100,000 patient face-to-face contacts every month, which adds up to over 1,200,000 patient contacts every year. Each of the core teams is comprised of a team lead, a clinical lead, community matrons, case managers, link nurses, community nurses and healthcare assistants. There are also community physiotherapists and occupational therapists within each team.

In the East Coast Community Healthcare CIC the service is divided between a North locality and a South locality. The North locality covers Great Yarmouth, Gorleston and the coastal villages north of Great Yarmouth (and the South locality covers Waveney in Suffolk). There are five teams of community nurses within the North locality, 2 teams in Great Yarmouth, two teams in Gorleston and one team for the villages.

**Fig 2 Overview of community nurses in Norfolk**

- 2 trusts providing community nursing services
- 5 localities in the county
- 21 community nurse teams
- 280 registered community nurses

Both Trusts collect feedback from patients on a regular basis, using either patient feedback comment forms or the Friends and Family Test question, and through standing patient engagement groups and forums. Patient feedback, complaints, compliments and satisfaction with community nursing services are routinely reported at Board meetings in both Trusts.
What do community nurses do?

Community nurses support people in their own homes and help to keep them out of hospital. Community nurses are community team leaders, detecting problems before they become serious, supporting patients after they have been discharged from hospital and caring for them in their own homes at the end of their lives.

Community nurses carry out advanced physical assessments of people, may be non-medical prescribers and deliver nurse-led services. Qualified district nurses are specialist practitioners in community nursing and as such have an essential and central role in caring for people living with long term conditions, supporting them to manage their health needs and remain living independently at home.

In Norfolk, community nurses usually work between the hours of 7am and 10pm. Most have a team base for the administrative part of their role, such as coordinating care and making referrals to other professionals and services but they spend a significant amount of time with their patients or travelling to see their patients. Many have support in the form of the latest mobile ‘smart’ technologies but those working in the most rural areas can struggle, as many communities in Norfolk do, with time wasted due to intermittent telephone and internet connections.

When a patient is first referred to a community service, they are seen by a registered community nurse who undertakes an in-depth health needs assessment and creates a holistic care plan in discussion with the patient. Whilst not an emergency service, community nursing services have to be both reactive and spontaneous as there cannot be a waiting list for the kind of treatment and care community nursing services provide.

Community nurses work as part of a large, multidisciplinary team and work alongside other allied healthcare professionals such as physiotherapists, occupational therapists and phlebotomists. Community health services have a holistic and person-centred approach to meeting needs and endeavour to work closely with social care services and other professionals.

Community nurses themselves have a very wide range of skills and expertise. It would not be possible to list them all because there are so many. Examples of the skills and specialisms mentioned to us in the course of our conversations are shown in Fig 2, as described by the people we spoke to.
Fig. 2 Some of the things that community nurses do

- receive referrals from a wide range of health and social care professionals
- carry out holistic health needs assessment and comprehensive risk assessment
- regularly liaise with GP practices and talk to GPs, acting as a named nurse link in community services
- make referrals to housing officers, benefits advisors, fire service and environmental health services
- make referrals to social care services to support patients with functional needs such as washing, dressing, meals and going to bed at night
- provide specialist nursing care for people at home who are dying
- make referrals to the voluntary and community sector for such services as befriending and community transport
- make referrals to mental health services for professional assessment and services
- write, update and maintain patient records
- provide care packages to people and their families following a stroke
- provide pressure area care and advice on avoiding pressure sores
- administer vaccines to many people e.g. in response to H1N1 flu pandemic
- support people to lose weight or stop smoking
- carry out an electrocardiogram (ECG)
- take blood for blood tests
- check eyesight, glasses, hearing and hearing aids
- deliver a Leg Ulcer Clinic on rotation with other staff, treating venous ulcers
- carry out screening, such bladder screening in continence care, using portable scanners
- prescribe medicines, administer intra-venous medicines, escalate drug errors
- care for wounds and sutures following surgery at hospital, apply and check dressings
- provide specialist nursing support to people with respiratory and cardiovascular diseases, diabetes, cancer, neurological diseases (Motor Neurone disease, Parkinson’s disease, Multiple Sclerosis)
- oversee rehabilitation following a stroke, at home or in the community hospital
- care for patients on a community hospital ward
- raise awareness, look out for and assess for dementia; be dementia-friendly
- discuss and involve family members and carers in care plans and emergency plans
- assess risk of falling in the home and take actions to avoid a fall
- ask patients to complete a patient experience questionnaire or give feedback
- oversee specialist medicines and equipment such as syringe drivers
- support the health needs of care home residents, with intensive in-reach into some care homes in some areas of the county
- provide support to staff in the county’s care homes such as delivering training events e.g. on preventing pressure ulcers and continence
- make referrals and requests for home-loan equipment
- provide specialist nursing care for people with spinal injuries and paralysis (e.g. following a road traffic accident)
A Day in the Life of a District Nurse

A Case Manager was asked to describe a working day they had experienced in the last week or so, and this is what they said:

My day usually starts when I head to my team base at the Community Hospital in Norwich. I pick up several telephone messages from the GP practice that I am linked to. Checking my email I find the usual mix of corporate messages from the Trust (my employer) along with policy changes and new guidance I must keep up to date with. I also catch up with other members of the team. Our team is led by a Community Matron who is a clinical specialist in long term health conditions and a nurse prescriber. Then there are District Nurses who provide nursing care to people who are permanently or temporarily housebound.

As a Case Manager, I specialise in supporting people aged 65 years or older who have complex healthcare needs. I take care of people in the community, usually because a GP has made a referral. Most of the people I care for have several long term health conditions and regularly take lots of medicines. Living with long term health conditions means people can also be worried, frightened and depressed. I look at the whole person and their health and wellbeing needs and often the needs of their family members as well. The feedback we get tells us people want to see the same person rather than several different people. As a Case Manager I’m able to offer that kind of service and build a rapport with them.

At the request of his GP, I drive to see a gentleman with diabetes. I telephoned him last week to ask if I could see him at home and to make an appointment. He also has dementia and has been forgetting appointments and his insulin. The GP is concerned this man may be isolated following the death of wife. When I arrive at his house he doesn’t answer the door. I don’t know if he’s forgotten his appointment and I’m concerned about him. I telephone his GP to ask if he has seen him and also call the hospital to make sure he’s not there. After a while I realise the gentleman was in the house after all. Later he tells me he’s had a letter about his kitchen from the council and workers came the day before to take his kitchen out. When he got up that morning he’d forgotten what had happened the day before, saw his kitchen in disarray and got frightened. He’d been hiding in the bedroom, too scared to answer the door. Together we talked about what he needs and I ask him for consent to record the key points of our conversation. I take some time to explain why consent is important and that he can choose which information he wants to keep confidential. Without consent, other healthcare workers won’t know the kinds of problems he’s facing and any actions taken. He will very likely forget that I came to see him. This may result in him having to answer the same questions all over again, which is irritating for him.

At my next visit I drive to the patient’s house - again to find nobody home. I try to make some telephone calls and check my laptop for messages but the signal is weak so a bit of time is wasted in logging in to the system and out again. Eventually I find out that the person has gone out for the day! Sometimes it can be a bit frustrating to visit a person at home when they are actually well enough to see a nurse at their GP surgery.

The next person I see is an elderly lady with heart and breathing problems. Her son is at home with her because he wants to talk to me. This lady has been showing signs of memory loss and is in the very early stages of dementia. I was pleased when she telephoned me, saying she didn’t feel well. She said she had no energy, wasn’t eating or moving around much. The night before she had been phoning her son constantly and talking about how she wanted to be buried. He had been very distressed by this. I found she had a low grade chest infection and a urinary tract infection. It can be difficult for people with dementia to be aware of when things aren’t right,
plus a urinary tract infection can make older people very muddled. If untreated, she could be at risk of further complications. She’s more likely to fall at home or get admitted to hospital because of the infection. My role is to ensure this doesn’t happen. A general hospital ward is not the best place for an elderly, confused person. They are easily distressed and it takes them a long time to readjust once they go home again. To avoid an admission to hospital I call in the Care at Home Support Team. For three days they will provide personal care support which should help her to remain at home and get better. They help with things like washing, dressing and having meals. At the end of this time, if I feel she could do with more support I will contact the reablement team called Norfolk First Support. They provide free support for up to six weeks to help people to get back to their previous level of independence. Her son, like most people, didn’t know this sort of help and support was available.

Trying to keep people out of the hospital is an important part of my role. Lots of people present with a medical or health problem which is the result of other problems in their life. Late in the morning I go to a multi-disciplinary team meeting called the Integrated Care Management Team at the doctor’s surgery. This is where people from different services spend time discussing how best to support people facing multiple problems. Today there’s myself, an Occupational Therapist, a District Nurse, several GPs, a housing officer, a physiotherapist, a mental health nurse and a social worker. Together we find can help solve the problems as a team. For example, today we talk about supporting someone with diabetes, heart disease and short term memory loss. Mastery of their health condition is diminishing and they can no longer drive. I see many of my patient’s needs in this way - it’s a gentle blend of keeping independence and dignity but giving the support that’s needed. For this person their future needs may be better met through a personal budget and the services of a personal assistant to take them out and about.

I organise most of my complex work to take place in the morning which gives the remainder of the day to get things actioned. On my way back to the Community Hospital I manage to find time to eat a late lunch in the car and swing by the GP surgery so I can discuss the situation of the elderly lady face to face with her GP. Once back at base I take part in our team handover. The next lot of nurses are coming on duty and we exchange information to ensure continuity. I make several telephone calls to the Oxygen Nurses and Diabetes Nurses at the local hospital. I’ve received several updates on patients that have been seen at the hospital, the results of routine blood tests and have copies of letters sent by the hospital consultants to read and so on.

Case Managers don’t regularly discharge their patients so this particular afternoon I’m back out on the road to make several monitoring visits. I check that breathing conditions are maintained for a man with respiratory disease who is using oxygen and the continence of a lady who has dementia. Whilst I visit people fill me in on their recent outpatient appointments or ask me for the results of hospital tests. I talk to carers and family members and I have a very important conversation about end of life care. Each time I see someone I record the visit, what was discussed and any actions that myself and the patient agreed. I do a final check to make sure the records are complete and accurate for today’s visits; only then do I finish for the day.

Community nurses and GPs

Each GP surgery in Norfolk has a named nurse lead for their practice. A GP described the particular strengths of community nurses as dealing with very elderly, socially isolated people who may have up to six long term health conditions and therefore very complex needs. Another GP said that people shouldn’t assume that that complex, high quality medical and nursing input can only be provided by staff in a hospital - this kind of care can also be provided by community nurses in a person’s own home or at the GP surgery. The quality of holistic assessment carried out by the
community nurses is very important, particularly if a person has made a call to NHS 111; the outcome of such an assessment could mean the difference between someone receiving care from a community nurse at home or having to go the Accident and Emergency Department of the local hospital. GPs said that demand for community nursing support for patients is increasing as the numbers of people living with complex needs and the numbers of frail elderly people increases locally.

Community nurses and hospitals

When people are discharged from an acute hospital - such as the Queen Elizabeth, James Paget or Norfolk and Norwich - they may need a period of rehabilitation in a community hospital. Community hospitals in Norfolk include, for example, the Norwich Community Hospital in Bowthorpe, Ogden Court Community Hospital in Wymondham and Northgate Community Hospital in Great Yarmouth. A proportion of our community nurses are working in the community hospitals. For example, the Norfolk Community Health and Care NHS Trust delivers a community nurse-led early supported discharge service at the Norwich Community Hospital. This service is for people who have had a stroke and ensures people get the right level of support after their stroke. In these services, community nurses will go onto the wards in the acute hospitals and actively identify patients who have had a stroke for an early, supported discharge. Some people can go home with support from community nurses at home, whilst others will stay at the community hospital and undergo a period of rehabilitation before going home. The community nursing team have strong links with GP practices, therapists and social care services and work closely with the person who has had a stroke, and their families and carers, to develop a package of support which is tailored to people’s individual needs.

One senior nurse spoke of the length of time people now spend in hospital is becoming much shorter than it was a decade ago. Hospitals are being asked to trim down their services and to help save the NHS money, in line with the budget cuts of the previous few years. It’s not uncommon these days for people to be in hospital for a very short period of time and more people recover at home rather than in hospital. Community nurses have a central role in helping people to come out of hospital more quickly. This means that if decisions are taken to reduce the time people spend in hospitals to save money, and they need to recover at home, these decisions will have an impact upon community nursing services.

Community nursing services have an important role in supporting people who have complex health needs, especially the very elderly and frail people residents in care homes around the county.
Community nurses in some areas are able to deliver to more intensive ‘in-reach’ services in some care homes. This means residents are better supported to remain in their care home when acutely ill, rather than going into hospital which can be very disorientating and upsetting, particularly for people with dementia. Being able to do more in-reach into the county’s growing number of care home resident would require additional investment in services, leading to more community nurses.

**Education and training**

As highlighted by the Queen’s Nursing Institute report, people agreed that the numbers of places on specialised education and training courses for nurses who work in the community or who want to work in the community, are decreasing. This is partly because the funding of such places has been reduced (we were given the figure of a 50% reduction in two years) and that employers aren’t offering the same level of studying and training opportunities as they used to. Also, commissioners aren’t specifying training within their contracts with providers or funding it. All these factors were cited as being the result of cuts in NHS funding. Health Education England are currently carrying out a piece of work to determine what the district nurse training needs of the Norfolk (and Suffolk) workforce are and there is currently a pilot project underway in Norfolk which is developing the skills mix of community nursing teams. This pilot is intended to help improve the joined-up care available to frail, older people and people with dementia through improved education and training of community nursing teams.

**Recruiting staff**

From a recruitment perspective, it can be challenging to fill vacancies particularly in the more rural and coastal areas in the county. Both provider Trusts told us it can be challenging to recruit nurses who hold a community nursing specialist practitioner - or ‘district nursing’ - qualification and the numbers of such nurses did indeed appear to be decreasing. We were told it can sometimes be easier to recruit to more specialised roles which carry a higher banding\(^3\) or grade and that caution is needed when recruiting to entry-level (graduate) roles. One provider Trust said that they were very pro-active with regards to engaging with students who were about to complete undergraduate programmes at the University of East Anglia and attended careers fairs to recruit newly qualified nurses. Clinical staff tend to use the NHS website for job hunting so this site is used for advertising clinical roles in Norfolk. Websites which enabled job-seekers to identify local health and community based jobs worked better for non-clinical and support roles.

**Messages for Healthwatch Norfolk**

When we listened to what people had to say about community nursing, we also asked them to give us their top take-home messages. These messages are listed below:

- District nurses are specialists in community nursing and provide holistic care and support for people with complex health needs who may also be elderly and socially isolated
- People are much more likely to use a community service than any other kind of service (e.g. a hospital)
- District nurses can provide rapid, intensive and short term support
- Communication between GPs and community nurses is important and should ideally happen several times a week
- Community services are best placed to deliver good care closer to home but require more funding in order to meet rising demand
- Commissioners should plan now for future workforce demand for community nurses

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\(^3\) NHS Band 5 is the banding or ‘grading’ given to roles for newly qualified nurses, NHS Band 6 is given to specialist roles whilst NHS Band 7 is given to roles requiring advanced, specialist practitioner skills.
There is a lack of public awareness and understanding of the balance between the funding of acute services and community services; acute services get more funding.

We need to invest more in our community nursing services, especially to meet older people's needs.

Community nurses do give a level of support to care homes in Norfolk for frail, elderly people. There are over 6,000 care home beds across Norfolk.

Community nurses also have a public health role, for example in the event of a pandemic such as the H1N1 flu pandemic, in administering large scale vaccination programmes in workplaces and the community.

It is important for the public to understand what community nurses do and what they don’t do. Unfortunately there are some people using community nurses inappropriately; these individuals are able to be mobile and to get out of the house, so should see the nurse at their GP surgery.

Recruitment to community nursing roles in Norfolk’s rural and coastal communities is a significant challenge.

There has been a 50% reduction in two years in the number of funded training places on offer for specialist community nursing.

The local, regional and national workforce surveys are revealing there are fewer registered and specialist nurses working in community services; doing more work over a longer working day.

Tariffs are set nationally and stimulate activity in the acute services (i.e. hospitals) but this doesn’t usually leave enough funding left over for community services.

It is harder for community services to trim down services in the same way as a hospital can because community services are light on buildings and overheads but heavy on staff; trimming staff is the only way community services can significantly reduce their expenditure and thus save money.

Commissioners

In Norfolk there are five local bodies who commission services for the local population. They are:

- Great Yarmouth and Waveney Clinical Commissioning Group
- North Norfolk Clinical Commissioning Group
- Norwich Clinical Commissioning Group
- South Norfolk Clinical Commissioning Group
- West Norfolk Clinical Commissioning Group

Within each Clinical Commissioning Group there is an individual who has a lead responsibility for commissioning community nursing services. Four of the five Clinical Commissioning Groups in Norfolk currently work on a collaborative basis and commission services from the Norfolk Community Health and Care NHS Trust. At the time of undertaking this project, the South Norfolk Clinical Commissioning Group was currently the lead organisation for commissioning community nursing services on behalf of the North, Norwich, South and West Norfolk groups. Great Yarmouth and Waveney Clinical Commissioning Group commission community nursing services from the East Coast Community Healthcare Community Interest Company. In summer 2013, the Great Yarmouth and Waveney Clinical Commissioning Group’s lead commissioner for community nursing services had started a review and redesign of the service and patient pathways in Great Yarmouth and

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4 Tariffs are the payments made for healthcare activities undertaken by providers of NHS services. The payments are set by government on the advice of the Department of Health.
Waveney. Around the same time, the South Norfolk Clinical Commissioning Group commenced a review of community nursing services in the rest of the county.

Commissioning support to the Clinical Commissioning Groups, in relation to supporting activities such as contracting and performance monitoring, is undertaken by the NHS Anglia Commissioning Support Unit in Norwich.

In January of this year, the Department of Health, the NHS Commissioning Board (now called NHS England) and the Queen’s Nursing Institute produced a guidance document on what makes a good model of district nursing services. This guidance, called Care in Local Communities, can be used by commissioners when developing a model of community nursing services which meets the needs of their local population. Fig 3 describes some of the most important aspects of community services that can be delivered by a district nurse led team. The Care in Local Communities guidance sets out a call to action to commissioners who are developing service specifications. This call to action asks commissioners that they:

- fully consider all three elements of the district nursing service model
- ensure ‘patients are offered a full range of services which are tailored to their needs’
- ‘utilise the national model contract for community services, complemented by local schedules where appropriate’

Fig 3 The District Nursing Service Model

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**The District Nursing Service Model**

**District nurse led team providing care and support in the community, including people’s homes:**

**Population and Case load management:**
Managing and accountable for an active caseload and providing population interventions to improve community health and wellbeing. Surveillance of caseload and local population needs. Working with a range of health and social care partners (including GPs, voluntary sector and community services) for health protection and improvement for adults and their carers, at home and in other community settings. For example, flu immunisation, falls screening and early intervention.

**Support and care for patients who are unwell, recovering at home and at end of life:**
Delivering a swift response from the district nursing service when specific expert health intervention is needed e.g. with short-term health issues, or sudden health crises or when patients are discharged from hospital, or have a sudden deterioration in a health condition. Providing interventions within the home including chemotherapy and intravenous therapy. Working with community specialist nurses including community matrons, to deliver specialist care including palliative and end of life care.

**Support and care for independence:**
Providing leadership and prioritisation of supportive care to help patients stay well and can manage their independence at home. For example, wound care management, advice on nutrition; help to avoid falls or to manage medicines, advice on ‘assistive technology’ such as telehealth and telecare, working with patients and their families to help them care for themselves.

Leading and delivering ongoing support from the district nursing team and a range of local services (e.g. GP, voluntary and community organisations, or local authority). Working together with patients to deal with more complex issues over a period of time. For example, to meet continuing and long-term health needs.
What this means

Community nurses are trained to carry out advanced, holistic assessment of people’s needs and deliver, or arrange, complex care and treatment which meets those needs, in community settings and people’s own homes. Currently there is a strong local focus on shifting of care from acute to community settings and on the joined-up care between health and social care services.

We estimate that there are 280 registered community nurses currently working in Norfolk who have a central role to play in delivering and coordinating the care of people who are discharged from hospital, the very elderly, frail and socially isolated, people who are living with multiple long term health conditions and those who wish to be cared for at home at the end of life. From what we have been told, the demands on community nursing services will increase as a result of an ageing population, living longer with more complex health needs and the shift of care from acute to community settings. The Royal College of Nursing report of 2013 concludes that “the need for services to invest in high-quality, home-nursing services is far greater than it has been in the past”.

What Healthwatch Norfolk will do

- Scrutinise local commissioning intentions for the coming year 2014-2015, to see what our Clinical Commissioning Groups intend to commission from providers of community nursing services in Norfolk: a) i.e. at least the same level of service, ideally more, but certainly not less and b) to see if commissioners have utilised the national model contract for community services with a complementary local schedule which is based on the current and future predicted community nursing needs of the local and ageing population
- Ask patients, families, carers and the public about their expectations of community services and of community nurses
- Use our place on the Health and Wellbeing Board and the current focus on integration of social care to champion the contribution of community nurses in meeting the healthcare needs of some of the eldest and most vulnerable residents of Norfolk
- Listen and gather together people’s experiences of ‘integrated care’ and work out if this better, the same or worse than the care already they receive

Recommendations

We recommend that

- Commissioners of community nursing services allocate appropriate funding to provide specialist community nurse (district nursing) training places for the Norfolk workforce in 2014-2015

References

Royal College of Nursing (April 2013) District nursing - harnessing the potential. www.rcn.org.uk


Department of Health, NHS Commissioning Board & The Queen’s Nursing Institute (Jan 2013) Care in local communities: A new vision and model for district nursing www.gov.uk/government