

Supporting Experienced Hospital Nurses to Move into Community Matron Roles

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The Primary Care Nursing Research Unit

Report of a study to examine the key knowledge and support required by nurses, experienced in the management of patients with long term conditions, to work in primary care contexts in undertaking community matron roles.
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Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

Contents

Executive summary.....	4
Appendix to the executive summary.....	6
Main report.....	9
1. Introduction.....	10
2. Background.....	11
3. The method of enquiry.....	13
4. Evidence from the literature.....	14
5. Group and individual interview methods.....	22
6. Evidence from the perceptions of those participating in interviews.....	25
7. Discussion and conclusion.....	33
References.....	34
Appendix 1 Systematic review of the literature.....	39
Appendix 2 Expert researchers and educationalist group.....	43
Appendix 3 A brief history of district nurse education.....	44
Appendix 4 A brief history of health visitor education.....	46

Executive summary

1. Many NHS hospital Trusts and primary care organisations are employing or looking to employ hospital nurses, who are experienced in the care of people with long term conditions, for case management and community matron roles. These nurses are making a transition from working in a single institution with known boundaries and visible walls to the complexity of working in the community, which includes both primary care and domiciliary settings. While pre-registration nursing curricula aim to prepare nurses to work in both environments, this is still a developing aspect of nurse education in the UK.
2. This study aimed to identify the key knowledge and support that hospital based nurses, who are experienced in caring for patients with long term conditions, require to work in primary care contexts as community matrons. The primary purpose is to inform those with responsibilities for employing community matrons and nurses in case manager roles, as well as those with responsibilities for commissioning of education and training.
3. The study drew on a systematic review of literature, together with group and individual interviews that involved participants from across England. The participants included nurses who were new to primary care both as chronic disease management specialists and staff nurses, community practice teachers, managers, commissioners, researchers and education experts. Data collection took place in Spring 2005.
4. The findings revealed some important issues (detailed in 5 and 6) for employing organisations to consider in order to ensure the successful transition and retention of these nurses as well as the delivery of safe and effective services for their patients. For those who have worked for a long time in primary care and been involved in the support of nurses making the transition to primary care, the content of the report may appear self-evident. However, the study identifies a specific knowledge base that has not been well documented and is often invisible to those professionals and managers who have never worked in primary care. Consequently, it is a knowledge base that needs to be made explicit to all concerned in order to ensure successful and safe transitions.

5. A key message from the study is that nurses who move from the hospital environment to the community, irrespective of level of clinical expertise, become novice practitioners again. There are four main reasons:
 - a) **The patient is in control of all decisions** affecting their health and well being, including their home environment. Assessments, treatment, care and advice giving are continually negotiated acts between the nurse, the patient and their family carers/informal network of support. Achieving positive patient outcomes are therefore reliant on the nurse's ability to establish and maintain a relationship with the patient. This is unlike a hospital where the decision-making is led by professionals, including everything from the ward environment to the timing of treatments.
 - b) **The patients and their carers undertake most of their own health maintenance, treatment and care activities.** The nursing contribution is a small part of the overall patient's daily experience. This is in contrast to the hospital environment.
 - c) **The multiple systems and infrastructures** that support the delivery of health and social care vary between local areas. This is unlike a hospital with a single system and infrastructure.
 - d) **The nurse has to make clinical and professional decisions, sometimes rapidly in less than ideal circumstances, at a physical distance from professional colleagues.**

6. The study findings suggest employing authorities have to consider two elements in order to ensure successful transition for the nurses and safe and effective services for their patients/clients:
 - a) Ensure there is a range of **mechanisms for supported learning** for nurses to progress from novice to an expert practitioner working in primary care without compromising the patient, the care network or the nurse.
 - b) Ensure that there is **overt support and recognition from stakeholders** within the organisation and across the local network of health and social care for both the new role and the new to primary care nurse.

A more detailed checklist is appended to expand these points.

7. There is no empirical evidence on the length of time that it takes experienced nurses to make the transition from novice to expert in community settings. There is some evidence to suggest that some nurses make the transition faster than others. However, it is not clear whether individual attributes, individual prior experience or the model of support, mentoring or learning opportunities predicated this.

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

Appendix to the Executive Summary

Checklist for employers to consider for nurses who are new to primary care and working as case managers or community matrons.

1. Ensure that there is overt support from stakeholders in the organisation and across the local network of health and social care for both the new role and the new to primary care nurse. At a minimum this includes:

- a) A project management structure that includes stakeholder representatives
- b) Specify the outcomes, scope of functions and activities expected of the role
- c) Clarify operational details, particularly interface issues with key stakeholders, including general practices, relevant hospital consultants, social services, community nursing services
- d) Gain commitment and resources to support the learning trajectory of the nurse new to primary care
- e) Prepare the public/patients to receive a new health care professional in the local health and social care network
- f) Prepare the likely network of health and social care professionals to receive a new member
- g) Create a review mechanism so that individuals and the organisation can learn from critical incidents and successes arising from the new post

2. Ensure there is a range of mechanisms for supported learning for nurses to progress from novice in primary care without compromising the patient, the care network or the nurse. At a minimum that includes:

- a) Overt mechanism(s) for expert advice

For example:

- Working with role models and practice educators
- Mentors – access to expert mentors with different skills and knowledge, possibly an expert resource group
- Clinical supervision activities with mentors or through an action learning set

- b) Overt mechanism (s) for daily support and problem solving in client based activities

For example:

- A ‘buddy’ or peer to have daily de-briefing, reflect on activities of the day with and ask questions of and help place the role and the stress in context

- Case review and discussion with an experienced mentor with a high level of frequency in the first period of employment
- c) Orientation and induction processes

For example:

- Orientation should include tangibles such as: map, directory of local services, key team contact numbers and back up information
- Geographical and community orientation: guided as to how to get about and the socio-demographic nature of the area
- Shadowing others in the care network to observe and understand roles as well as facilitate networking with colleagues
- Detailed learning needs assessment at an individual level should guide the induction process

- d) Build confidence and competence through a process

For example:

- This includes a tailored induction but also a staggered introduction to the work role and caseload numbers.

3. Ensure the learning mechanisms address the following areas of knowledge for working in non-hospital environments:

- a) The centrality of both the patient/clients and the informal care/family networks**

For example:

- The patient/client is in control of decision-making and the nurse/case manager has to respect individual choice, knowledge about managing their condition, willingness and right to take risks
- The important role of informal carers and community network in delivering care
- Assessment, care and advice giving is a continually negotiated act built on establishing and maintaining a good interpersonal relationship
- The importance of providing accurate information on service provision to ensure patient expectations are realistic. The ability to negotiate realistic expectations about care provision and available services is based on a good understanding of local resources and range of provision

b) The service environment of working in the community and home

For example:

- Knowledge of how, when and which colleagues to contact and consult
- The local range of publicly funded, charitable and private funded health and social care services plus their referral pathways, eligibility criteria, budgetary /financial processes, and out of hours systems
- The importance of named and known key contacts in the statutory and non-statutory services
- The variety of different local health and social care records and the different levels of access to those for both the patient and the nurse/care manager
- How and who makes decisions about the expenditure and delivery of public services in the local health and social care economy as well as the detail of the new GMS contract and its influence on GP and practice activities

c) The physical environment of working in the community and home

For example:

- How to get about the area safely and efficiently as well as find and enter dwellings
- An understanding that the presence of the nurse/care manager in the home is by invitation only
- The important dimensions of assessing and reducing risk in environments not within the public sector control:
 - *Assessment and actions for personal safety*
 - *Assessment and actions for patient /client safety in their own home that respects the rights and choices of the individual*

4. Recognise that nurses who will thrive in case manager roles in the community are likely to be those who build confidence in or are comfortable with:

- a) Working with uncertainty and changing situations, priorities and services
- b) Responding quickly and flexibly to changing priorities
- c) Decision making in the home in the absence of other professionals
- d) Use negotiation as a main structural element of all work
- e) Partnership working with patients/ cares and other service providers
- f) Assertiveness to negotiate on behalf of patient/client

Main report

1. Introduction	10
2. Background	11
3. The method of enquiry	13
4. Evidence from the literature	14
5. Group and individual interview methods	22
6. Evidence from the perceptions of those participating in interviews	25
7. Discussion and conclusion	33
References	34
Appendix 1 Systematic review of the literature	39
Appendix 2 Expert researchers and educationalist group	43
Appendix 3 A brief history of district nurse education	44
Appendix 4 A brief history of health visitor education	46

1. Introduction

This study aimed to identify the key knowledge and support that hospital based nurses, experienced in caring for patients with long term conditions, will need to work in primary care contexts when undertaking community matron roles. The primary purpose of the study is to inform those with responsibilities for employing community matrons.

As health care is increasingly delivered in primary care settings, including patient's homes, it is inevitable that more nurses and other groups of staff will follow. This transition to a new environment holds risk for the nurses, for their patients and clients and for the employing organisation. Therefore, the knowledge and issues revealed by the study has a wider application within local health and social care economies and partner education providers. The content of the report will appear self-evident and as though it is stating the obvious to those who have worked for a long time in primary care and have supported nurses make the transition to primary care. However, this collective knowledge of how to work in primary care is not well documented and it is often invisible to those professionals and managers who have never worked outside hospital settings.

This report provides the background to the study before describing the two main activities. These were:

- A systematic search for research evidence,
- Empirical activity through group and individual interviews.

The report concludes with a discussion and recommendations.

2. Background

2.1 The policy context

Current English government policy emphasises the need to improve the health and social care services responses to people with long term, chronic conditions (Department of Health England [DoH] 2004a, HM Treasury 2004a). A range of models from the Expert Patient Programme to the disease specific, specialist multi-disciplinary team have been endorsed in order to address more appropriately the needs of different groups within this population (DoH 2005a). The involvement of primary care nurses in chronic disease management has been encouraged in the NHS modernisation plans (DoH 1997, 2001, Colin-Thomé and Belfield 2004). The Department of Health has made a commitment that patients with complex long-term conditions will be supported by 3,000 community matrons, using case management techniques to care for around 250,000 patients with complex needs (DoH 2004a). Community matrons are expected to contribute to the national target on supporting people with long-term conditions (DoH 2004b) of both improving health outcomes for people with long-term conditions and reducing hospital emergency bed days (HM Treasury 2004b, DoH 2004b). The community matron is described as a new clinical role for nurses using case management techniques with patients who meet criteria denoting very high intensity use of health care (DoH 2004c). This role is clearly defined (see Box 1) by the Department of Health (DoH 2005b). Community matrons are expected to have a range of skills, knowledge and expertise (DoH 2005b) and the NHS Modernisation Agency has led on a consultation of outline competencies (Skills for Health 2005). These are due to be published later in 2005.

2.2 The nursing workforce context

Many groups of nurses already working in primary care will be candidates for community matron and case manager roles. In some areas, factors such as recruitment and retention problems within the existing primary care workforce (Drennan et al 2004a) will influence the types of nurses recruited to community matron posts. It is likely that some Primary Care Trusts (PCTs) will look more broadly and consider experienced nurses from within the acute care sector as potential recruits to these posts. This is a trend that is already visible in other condition/disease specific specialist posts in primary care such as for diabetes, multiple sclerosis, respiratory disease, coronary heart disease, dermatology, and epilepsy. It is unknown how many nurses in these posts have taken up these posts without prior community preparation or community specific qualifications. However, a brief review of advertisements in a national weekly nursing journal in 2004 found that it was the specialist knowledge of the

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

management of the disease that was the primary requirement, not a community nursing or health visiting qualification. The findings of this study are likely therefore to have a wider application than to just community matron posts.

Box 1

The community matron will:

- Take responsibility for around 50 older people with high level needs
- Work collaboratively with all professionals, carers and relatives to understand all aspects of patients physical, social and environmental condition
- Work in partnership with the patient's GP, sharing information and planning together
- Work as members of the primary health care team to ensure a team approach to care
- Develop a personal care plan with the patient, carers, relatives and health professionals, based on a full assessment of medical, nursing and social care needs. The plan includes preventative measures and anticipates future requirements
- Keep in touch and monitor the condition of the patient regularly. This may be done by home visits or by telephone contact
- Initiate action if required such as ordering investigations
- Update patient's medical records, and inform other professionals about changes in condition
- Work in partnership with other local agencies such as social services, to mobilize resources as they are needed
- Show carers and relatives how to identify subtle changes in condition that may precipitate acute exacerbation of underlying condition, or of illness, and to call for help
- Generate additional support as needed, for example, from intermediate or palliative care teams, or geriatricians
- Maintain responsibility if patient is admitted to any in-patient facility and provide base line health data for the receiving team, to support integrated and consistent care and facilitate timely discharge
- Prepare patient and their family for changes in condition, and support choice about end of life care
- Evaluate outcomes in collaboration with GP and hospital colleagues.

3. The method of enquiry

A mixed method approach was used, which included a systematic literature review, group and key informant interviews.

A systematic literature search and review was undertaken of published and grey literature of empirical studies that had as their focus the experience, preparation, training or evaluation of nurses who were new to working in primary care. The detail of the review is given in Appendix 1. It included a search of electronic databases from 1990 as well as contacting key authors and experts in the field. In addition, key authors and literature on legislative and professional changes to the education of nurses in primary care from 1948 were searched and reviewed. The results are reported in section 4.

A series of group and individual interviews were held with a range of purposively sampled expert informants from across England. Participants were asked to identify the key knowledge and support that was required by experienced hospital based nurses moving to community matron posts. They were asked to rank the issues that they considered the most important. The results are reported in section 5.

Data collection was undertaken from January 2005 to April 2005. The proposal received approval from a multi site NHS research ethics committee and research governance approval was obtained for the relevant PCTs.

4. Evidence from the literature

This section reports on the systematic literature review and search for research evidence that demonstrates the knowledge and support required to make the transition to working in primary care and community settings. The systematic review of literature from 1990 is detailed in appendix 1. The search protocol was tested with a group of expert researchers and education providers in the UK (Appendix 2). However, it became evident that the systematic review did not capture all of the relevant evidence, for example, material on nurse education that was published as chapters within books. Consequently, a review of literature by key authors in the field of community nursing and health visiting education and research was undertaken. This section therefore provides:

1. A brief contextual overview of the development of educational programmes specific to working in primary care and community settings.
2. The empirical evidence of the differences nurses experience between working in hospital and community setting, and what it reveals about the required knowledge to work in non-hospital settings.
3. The empirical evidence for the optimum methods of knowledge acquisition and support for nurses working in the community.

4.1 A brief overview of the development of educational programmes specific to working in primary care and community settings

The UK has a hundred and thirty year history of specific education and training programmes for some, but not all, groups of nurses working in the community. In the case of midwifery, preparation for working in domiciliary settings has been integral to the training since the earliest point of regulation (1902 Midwives Act). However, there are other groups such as community mental health nursing for whom specific community preparation courses were only developed in the later part of the twentieth century, culminating in the national specification of an overarching BSc Specialist Community Practitioner with role specific pathways in 1998 (UKCC 1994)¹.

Community mental health nursing services were developed in the nineteen fifties in the UK but the first course intended to prepare registered mental nurses for working in the community did not emerge until the seventies. This was initially a three month integrated lecture and

¹ The new NMC has since altered this approach with the introduction of the specialist community public health register (NMC 2004)

practical course (White 1990). A post registration course for mental health nurses to work in the community has been available since the seventies. Two-thirds of mental health nurses working in the community do not have a community psychiatric nurse qualification (White and Brooker 2001). School nursing developed in the early nineteen hundreds and at one point, the national certificate of health visiting was a requirement for post holders in the state sector (Lamb 1977a). A specific three-month course for school nurses did not emerge until the late seventies, (HVA 1987). However, only a minority of school nurses employed in the NHS in England hold a specific specialist school nursing qualification (Drennan 2005). Specific courses for nurses employed in general practice, known as practice nurses, only emerged in the nineties with the marked increase in numbers of nurses employed in general practice (Damant 1990). Only a minority of practice nurses have undertaken a specific practice nurse course (Atkin and Lunt 1994 and 1995).

In contrast to the above groups, the first certificated course to prepare nurses for working ‘*on the district*’ was established in 1874 and the history is given in more detail in Appendix 3. To practice nursing in the home or community the qualification was never mandatory. Many organisations however required their nurses to undertake the course, which always included formal education sessions, practical apprenticeship and examinations. It is apparent with the increased numbers of teams of nurses providing home nursing, that those with the district nurse qualification are in the minority in many areas (Audit Commission 1999, Drennan et al 2004a).

Health visiting has likewise had a long history of a specific course of preparation (see Appendix 4 for details). This history differs from the other groups as it has included, at various times, legislation that linked: a) employment as a health visitor to holding the national certificate (Local Government Act 1929), b) health visiting duties to be carried out only by those holding the qualification (NHS Act 1948) and c) the title of health visitor to only be used by someone who held the qualification (Nurses, Midwives and Health Visitors Act 1979). As a consequence all health visitors employed in the NHS have undertaken one specific qualification. There is currently no legislation associating the title, employment or duties with a single qualification. There is an increasing trend for nursery nurses and registered nurses to work with health visitors (Drennan et al 2004a).

In all of the programmes identified above a defining feature has been the inclusion of both practical and classroom elements. Under the supervision of an experienced nurse or health

visitor, the nurse has had the opportunity to learn and practice the role in primary and community settings as well as attend group-learning events. The nature of the group learning has altered over time with greater application of adult learning principles in recent years.

4.2 Research evidence: identifying differences in the knowledge required to work in the home and community compared to hospital settings

Given the long history of programmes to prepare nurses to work in community settings, it would suggest that syllabi, curricula and also formal reviews of courses of preparation (e.g. UKCC 1991) would be sources of evidence. For the purposes of this study, an examination of curricula has limited yield because those elements concerned with working in non-institutional settings are rarely separated from other curriculum objectives. Textbooks, written by district nurse and health visitor tutors, have supported these courses and syllabus. Those written before the seventies rarely included research evidence to support their injunctions and observations (see for example Merry & Irvin 1955, McEwan 1959).

However, two aspects of the curricula review literature are noteworthy:

1. The reviews are usually undertaken as internal exercises, and mostly with those already expert in the preparation of nurses for these domiciliary and community roles. As a consequence many elements are taken for granted facts and not made explicit as the reviewers share an internalised knowledge base.
2. There is little empirical investigation that explores or tests the different content, forms of delivery, or merits of different academic levels beyond the review exercises.

4.2.1 Empirical evidence informing education programme content

The empirical evidence that makes explicit the difference between working in the home and community settings and a hospital environment first emerged in the seventies and eighties. It revealed:

1. The complexity of working with people, patients, and their informal carers over whom the nurse or health visitor had no authority (Clark 1973, Kratz 1978, Hockey 1979)
2. The uncertainty of working in the home environment, in which one was a guest, with no rights to enter or remain other than at the invitation of the person/client /patient (Clark 1973, McIntosh 1979, Hockey 1979).
3. The centrality of the development of an interpersonal relationship that permits the nurse or health visitor to undertake their work and overcome the lack of authority (Kratz 1978, Orr 1979, Robinson 1982).
4. The challenge of maintaining the boundaries of a paid professional, delivering a service in domiciliary settings, while at the same time keeping the interpersonal relationship at a

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

level that allowed the 'work' to be undertaken in those settings (McIntosh 1981, Montgomery -Robinson 1986).

5. The nurse or health visitor provides a small amount of care, health maintenance and health promotion activities in comparison to people/patients and carers in their own homes and in contrast to the hospital environment (Kratz 1978, Orr 1979, Mayall and Foster 1989).

Subsequent empirical studies have reiterated and refined these elements, suggesting in addition that:

6. District nurses and health visitors often undertake activities at the margins of their work role in order to maintain and continue a relationship with clients/patients (Luker and Chalmers 1990, Smith et al 1993, De la Cuesta 1993)
7. The assessment and care planning process undertaken by the nurse or health visitor in identifying health and social care needs was complex, using a) relationship building tactics with patient/client and carers, b) detailed knowledge of local health and social care systems, and c) internalised experiential knowledge (Luker and Kenrick 1992, Ong 1991, Appleton 1996, Bryans 2000, Goodman 2001).

4.2.2. Studies prompted by changes in health care delivery in the nineteen nineties

UK

The nineteen nineties saw a significant and increasing number of registered nurses working in primary care without specific community health nurse preparation (Drennan et al 2004a). Factors influencing this were both shifts in the types of services being delivered in primary care settings as well as a specific endorsement from the Department of Health for skill mixed teams that included registered nurses (NHS Management Executive 1992). At the same time a new pre-registration nursing curriculum was introduced (UKCC 1986, 1999), which was designed to prepare nurses to work in both hospital and community settings. A recent scoping review in England identified a wide range of innovative local programmes aimed at supporting newly qualified and other nurses to enter and stay in primary care positions (Drennan et al 2004b). These included specific mentoring programmes, extended clinical induction programmes, training posts for staff nurses in primary care, rotational clinical posts for staff nurses new to primary care, opportunities for peer support meetings as well as more formal educational input from University lecturers (see for example McKoy 2003, Bishop 2004). However, there is currently little beyond general description from any of these programmes and no published evaluations of impact.

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

Two recent exploratory studies investigated the roles and development needs of staff nurses in community nursing services in England (Hallett and Patemen 2000, Forbes et al 2001). In both studies it was noted that a key difference between hospital and community settings was the physical distance of colleagues to consult with when working in someone's home. Both studies provided examples of hospital nurses as novice practitioners in the complexity of the community and home environment and illustrated the variety of local definitions of the staff nurse role in primary care. Informants in both studies indicated the benefits of experiential work based learning for development.

Mental health services have also increased the numbers of staff working in community settings during the nineteen nineties. Similar questions have been raised as to the skills and preparation required by hospital based staff to be able to practice in a community based working environment. Bugge et al (1999) surveyed 695 mental health nurses and professions allied to medicine. The nineteen nurses working as community psychiatric nurses in the study prioritised communication skills as the most important skill. Unlike other groups within the study they rated the ability to work alone in making decisions without the immediate help of others as one of their top essential skills.

There are recurrent themes about the knowledge and skills nurses require to work in primary care, regardless of their speciality or client group. An educational needs analysis for a community gerontological nurse programme interviewed fourteen specialist community nurse practitioner participants (Oberski et al 1999). These nurses emphasised that in the community the locus of control was with the patient in contrast to the hospital setting. Proctor et al (1998) undertook a training needs analysis for community children's nurses based on an analysis of the needs of families caring for sick children at home. This unusually took the perspective of the user as well as the professional. It included a focus group discussion with representatives (unspecified number) from children's charities with an interest in sick children cared for in the home. They emphasised that the community children's nurse had to have the skills, amongst others, *“to draw on a network of professionals when necessary”* and *“make us feel comfortable when s/he comes into our home”*(p3)

North America

Despite the different health care systems and methods of nurse education, the North American literature revealed the same themes in the knowledge and skills required to work in primary care. During the eighties and nineties North America experienced similar shifts of care delivery to non-acute and community settings (Rathwell 1996,Gold 1999). As in the UK, increasing numbers of nurses are employed in delivering services in community and home settings (Sprately et al 2000). Like the UK, a specific qualification is not required in North America to practice nursing in community settings. Baccalaureate degree nursing programmes have traditionally included preparation for community health settings and been viewed as a pre-requisite by community health service employers (Bramadat 1996, Murray 1998). However, by the eighties baccalaureate degree preparation was not a pre-requisite qualification for employment in home and community health agencies (Kalnins 1989, Community Health Nurses Initiative Group 2000) or public health agencies (Quad Council of Public Health Nursing Organisations 2001). These changes resulted in a small number of studies examining the issue of the needs of registered nurses in the transition from hospital to community settings. A survey of 150 Californian new to home health care nurses identified educational needs in a range of clinical skills and communication skills (Dela Cruz 1986). Two large surveys were undertaken in the United States in the late eighties and early nineties investigating the views of leaders in service and education (n=588 and 200) as to priorities in curricula content for masters level programmes in community health and home nursing (Selby et al 1990, Bryant and Cloonan 1992). These studies noted the likely expansion of demand for community health nurses. In both studies there were differences in the views of educationalists and service managers as to priorities for content. Both groups ranked the practical experience component as the most important. After the emphasis on the practical experience, knowledge areas such as epidemiology, public health administration, research methods and management theory were highly ranked. The managers ranked management knowledge and skills more highly (Selby et al 1990), while the educationalists ranked areas such as community health concepts more highly, (Bryant and Cloonan 1992). Bramadat et al (1996) surveyed 76 staff nurses, 37 administrators and five educators in the province of Manitoba as to their perceptions of the skills and knowledge required to work as community health nurses in order to shape a new education programmes. Particular emphasis was reported to be placed on:

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

- a) Understanding the community networks of resources,
- b) Skills in negotiating skills in networking,
- c) Confidence in working independently, particularly in rural communities where the nurse could be professionally isolated.

Murray (1998) interviewed twenty five baccalaureate qualified, experienced hospital nurses, new to home health agencies in Missouri in the previous six months. They emphasised their sense of inexperience in the new setting and role irrespective of the length of their prior nursing experience. Key differences to hospital work were reported as

- a) Making decisions without other health team members,
- b) Relinquishing responsibilities to families and other caretakers,
- c) *'Performing nursing care on the client's turf'* (p59).

4.3. The empirical evidence for the optimum methods of knowledge acquisition and support for nurses working in the community

The North American experience led to a number of agencies making explicit their orientation programmes for hospital nurses moving to home health care (Carr 1991, Harris and Yuan 1991, Humphrey and Milane –Nunzo 1992). Descriptions also appeared of other models of transition programmes that incorporated group learning (Belanus and Hunt 1992), mentoring over six months (O'Shea 1994), and formal college based learning programmes (O' Neill and Pennington 1996). None of these provide evaluative or outcome analysis. Smithbattle et al (2004a, 2004b) undertook a longitudinal study over eighteen months of thirteen inexperienced public health nurses in Missouri in which experiential learning and experienced colleagues and supervisors were identified as significant in making the transition from novice to expert, able to see and work with the wider factors that impacted on their patients health.

In the UK, research literature informing the educational preparation of nurses and health visitors who work in the community is very limited (Crow and Steadman 1995). While the mid-nineties saw attempts for greater consistency in preparation of nurses working in the community (UKCC 1994), the standards laid down by the regulatory body were broad based, specifying that “ *specialist nurses must be able to adapt to working in peoples' homes and also small institutions, health centres, surgeries, schools and places of work* (UKCC 2004 section 13.2). Consequently, the interpretation of the standards by different higher education institutions has led to markedly different curriculum and debates as to effectiveness (Oldham 1999, Ewens et al 2001) and value of these standards across all nursing groups working in the

community (Trenchard et al 2002, Cowley et al 2000) in different arenas and with different populations.

There is **no** empirical educational research evidence pointing to the optimum methods for acquiring both understanding and competence in this complex environment. There is some evidence as to the role educational preparation courses have played in the socialisation to new roles in community settings (Dingwall 1976, Howkins and Ewens 1999). MacKenzie (1992) undertaking an observational study of the learning experiences of district nurse students in practical placements remarked that it was “*characterized by as much uncertainty as the community itself portrays*”(p685). She noted that a practical skills based model of teaching seemed to prevail, as did, Twinn investigating health visitor training in the same period (Twinn 1989). Mackenzie (1992) identified three elements in the clinical learning processes for student district nurses. The first was learning how to fit in to the social environment i.e. the network of colleagues, recognising the overlap in roles in the team, and gaining acceptance by colleagues, patients and families. The second was learning how to manage and balance the caseload with the clinical role. The third was learning how to address clinical problems in the uncertainty of the community where there were ongoing patient needs and no easy answers. Mackenzie noted that “*there was no obvious stock of practical district nursing for them [the district nursing students] to apply*” (p 689) and therefore expert and confident supervision and support was viewed as critical.

This study undertook a small empirical element, against this backdrop of limited empirical evidence and a literature that often assumes shared implicit knowledge of the differences between working in hospital and community,

5. Group and individual interview methods

The purpose of this element of the study was to identify the current key knowledge and support required by hospital based nurses in their transition to a community setting, informed by the experience of those currently involved in making that transition or supporting others through that transition. To this end, information was gathered from 120 participants in 13 group and 10 individual interviews from across all the government regions of England.

5.1 Group interviews:

Individuals were identified through their primary care organisation and through the University that they were linked to as practitioner teacher/mentors. They were purposively sampled and invited by letter to participate in a group discussion with other practitioners from their geographical area who shared a common background of experience, in total; four group “types” were recruited:

- Community practitioner teacher/mentors responsible for student nurses and student district nurses (5 groups in the North East, the Midlands, London, the South West and the South East)
- PCT Managers and practice development nurses who had an organisational view of knowledge and skills required to work in primary care (2 groups in the West of England and London,)
- Nurses new to working in primary care who had been in post for less than a year (3 groups in the South East and London,)
- Advanced practice nurses and chronic disease management nurses new to primary care (2 groups in the West of England and London,)

In addition, a group was convened of expert researchers from across the UK, who had investigated aspects of learning to work in primary care. They were identified from publications and known research programmes. This group also had the task of commenting on findings from the systematic review and identifying relevant research.

Each group was asked to:

- a) Identify the core competencies needed to work in community and primary care settings as a community matron
- b) Agree how this learning could be acquired through local practice.

The group interview process was informed by a nominal group technique (Van der Ven and Delbecq 1972). This is a structured process facilitated by two people. It allows time for individual reflection, the gathering of views of all group members recorded contemporaneously on flip chart. The individuals then rank the charted issues and discuss the outcome. All group interviews except two were able to rank their ideas within the time constraints of the meeting. Field notes were completed after each session.

5.2 Individual interviews

In addition, ten individual interviews were held with nurses and managers who had direct experience of introducing new nursing roles, including advanced primary nurses, into primary care. They were asked to identify key areas of learning from their experience. In particular, their perceptions were sought on the key organisational responsibilities and individual competencies required to enable these roles to embed within the organisation. Where possible interviews were taped and transcribed. When this was not feasible, extensive notes were taken and fully written up after the interview. Within the time constraints of the study it was not possible to reach all types of informants as originally identified, for example it was difficult to identify and interview medical mentors of nurses new to primary care and in case management roles.

Content analysis of the data from the group and individual interviews was undertaken to identify recurrent themes, common links and patterns of experience. Internal differences were mapped and tested to identify the key knowledge and support practitioners perceived were necessary for hospital nurses new to primary care to be able to fulfil community matron roles.

5.3 General observations from the process of group interviews in different parts of the country

It was evident that in many areas the PCTs were in the early stages of developing community matron and case management roles. Consequently, this study generated considerable interest and debate from participants eager to learn from the early adopters and pathfinders. At front line staff level, it was noticeable that there was generally confusion about who and what community matrons might be. Many staff were looking for more information and detail. It was observed that staff in the Universities were also confused as to the best way to engage with this initiative. They were also looking for direction and clarity.

There was a great deal of ambivalence expressed to the title “community matron” and in some areas to the concept of “community matrons” as another form of nursing service. In some cases this was expressed as outright hostility. Some participants joined the interview group expressly to register their dislike of the concept. Other district nurses were keen to express their desire to undertake additional clinical skills training in order to take up community matron positions.

It was apparent from participants that there were three types of diversity that influenced local understanding of the concept of community matron. These were:

1. The title of community matron was being used for a variety of job roles –from professional leader/manager to clinical nurse specialists for one disease group to case manager for targeted people with long term conditions
2. Nurses in case manager roles for targeted people with long term conditions were being called a variety of titles including the advanced primary nurses, community matron, and specialist community nurse
3. There were regional differences in the organisation and delivery of primary care nursing. Rural areas with dispersed populations reported lone district nurses working only with a part-time health care assistant and attached to the only general practice. In contrast high density urban areas reported district nurses leading large teams of registered nurses and health care assistants and attached to a number of general practices.

6. Evidence from the perceptions of those participating in interviews

6.1 General comments

Participants were asked to identify the key knowledge, support & skills for experienced hospital based nurses moving to community matron posts. Some participants found it difficult to separate those elements concerned with working in primary care settings from the case manager responsibilities. However, most groups were able to focus eventually on this aspect alone.

Some informants were particularly clear as to the importance of offering hospital based specialist nurses the appropriate knowledge and support to work in community settings. They related two types of case examples illustrating the importance. The first related to the clinical risk to the quality of care the nurse was able to offer as illustrated in Box 2. The second type of example related to the risk of high levels of staff turnover as illustrated in Box 3.

Exemplar: a chronic disease management specialist nurse, new from a hospital post, had stated to a patient with a long-term condition that they would receive substantial home alterations by the local authority on the basis of her assessment. This was unfortunately not the case. The patient and family had false expectations raised and then dashed. This affected their relationship with their social service case manager, therapists, medical consultant and the specialist nurse to the point that it was completely acrimonious.

Box 2 Exemplar of clinical risk to service quality

Exemplar: a chronic disease management specialist nurse was recruited by a service that had no experience of nurses working in the community. The nurse was offered brief orientation but no peer or more formal support. Within a month the nurse had managed to inappropriately refer patients to four other professionals, two of whom made it clear in return that they considered her incompetent and irresponsible. Within six weeks the nurse was applying for other hospital based posts.

Box 3: Exemplar of risk to increased staff turnover

Before going into the detail of the participants' responses, there are three general observations. The first concerns the level of consensus. The second concerns the issue of novice practitioner in a

new environment and the third concerns the disputed views over levels of autonomy experienced in working in primary care. Each of these will be dealt with in turn.

6.1.1. Consensus

The level of consensus between groups was striking. Irrespective of geographical area, role, context or level of experience, the same key areas of knowledge were being described.

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

However, people from different occupational positions in primary care emphasised different aspects. An example of this was concerned with working at a distance from other health professionals. Some staff nurses new to primary care emphasised the “*loneliness*” of their work environment. Some chronic disease management specialist nurses emphasised working on their own but with a more experienced colleague easily contactable in order to confirm any clinical decision making that they were uncertain about. It was apparent what some participants were calling *loneliness* others were describing as the *independence* of the role, so in effect they were describing the same experience but for one group it was positive and for the other it had negative connotations

6.1.2. Novice practitioner in the primary care environment

A number of informants were new to primary care but were very experienced as senior hospital nurses e.g. specialist unit and ward managers. They concurred with the literature that while the clinical activity was not new to them, they had become novice practitioners in this completely different environment. It was also clear in group discussions with nurses new to primary care that individuals moved through the trajectory of novice to expert at different rates. Some very new to community staff nurses described sophisticated case management and problem solving activities in the absence of the team leader district nurses. This study, however, was not able to explore systematically the features either of the nurse or the professional environment that accelerated that process.

There was no consensus within or across groups as to how long it took any nurse to move from novice to expert in the community, nor what the balance should be between formal training, mentoring and opportunities for experiential learning. There were, however, strongly held views by some groups of district nurses and district nurse educationalists as to the importance of undertaking a course of preparation for working in the community in case management roles. At the same time, new from hospital nurses reported that they were struck by the lack of role development and opportunities for community staff nurses in contrast to their experiences of equivalent level positions in hospital settings.

6.1.3 Autonomy and relationships with doctors

Autonomy was a word used in a number of groups to capture what was different about working in primary care. Interestingly, the community staff nurse groups did not articulate this as an important attribute of working in primary care. Most informants talked about it in terms of making clinical decisions without reference to another authority and saw this as a

defining feature of their work that distinguished them from hospital based nursing. While the majority of participants stated that they considered nurses in community settings as having greater autonomy, a few informants challenged this view. These nurses contrasted their experiences in hospital in senior positions with close working relationships with individual consultants. They argued that they had greater autonomy in clinical decision making in that environment than in primary care where close working relationships with multiple general practitioners were often difficult and their specialist knowledge was not valued. These nurses were male and had worked in specialist intensive care units. Other nurses in the same group who disagreed with them were female and had worked in less high technology environments. This study was not able to explore in more detail the impact of either the characteristics of the nurse, their clinical experience or their current position. However, it is an issue that is worthy of further exploration.

6.2 The perceived knowledge and support required specific to working in community settings

This section reports first on the knowledge areas and then the types of support that were ranked as most important for working in primary care settings by the study participants. Areas of knowledge could be sub-divided into three categories:

1. The service environment of working in the community and home
2. The physical environment of working in the community and home
3. The centrality of the patient/clients and informal care and family networks.

6.2.1 Knowledge: The service environment of working in the community and home

Participants identified that the new to primary care nurse/case manager has to understand and know the following:

1. They have a place in a team that functions together, as well as being part of a wider care network on which they rely to be able to provide and sustain care. In the first instance this is through knowing:
 - Key contact mechanisms and telephone numbers
 - Knowledge of how and when to meet or consult others
 - Systems of support back up and a collegiate network
2. Clinical and professional decisions are taken at a point usually physically isolated from other professionals but that does not mean others' opinions and views cannot be sought. The nurses need to know how, when and whose opinion and views they can seek.

3. Care and service decisions and implementation take longer in the community than in the hospital. Unlike the hospital, the infrastructure is diverse and variable. Consequently, every referral or request to another organisation has to be followed up.
4. The overall range of publicly funded, charitable and private funded health and social care services plus the detail of organisations, including:
 - General practice as an independent contractor and its variations
 - Social service and housing departments of Local Authorities
 - Local general hospitals
 - Care homes
5. Knowledge of local services, referral pathways, eligibility criteria, budgetary /financial processes, out of normal weekday office hours systems, for obtaining:
 - Medical consultation for the patient
 - Mainstream home nursing, therapists, mental health services
 - Provision under the NHS & Community Care Act 1990
 - Equipment for independent living, medical devices and home nursing
 - Continuing care, intermediate care palliative, rehabilitative, mental health care services, including nursing, night sitting and social care services
 - Social work and direct social care
 - Housing and housing adaptations
 - Environmental health
 - Complex care packages
 - Community resources for information, support, good neighbour activities and service delivery
 - Medicine management processes
6. Importance of networks of named, known (preferably face-to-face) contact people in the community, in statutory and non-statutory services.
7. The variety of different professionals' records of assessments, plans and actions as well as their location and the different levels of access to those for the patient and the nurse.
8. How and who makes decisions about the expenditure and delivery of public services in the local health and social care economy as well as the detail of the new GMS contract and its influence on GP and practice activities.

6.2.2 Knowledge: The physical environment of working in the community and home

The participants identified that the new to primary care nurse/case manager has to understand and know:

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005

1. How to physically get about the area safely and efficiently, and find individual dwellings
2. How to be invited into peoples homes.
3. The important dimensions of assessing and then reducing risk in environments not within the public sector control. These include:
 - Assessment and actions for personal safety
 - Assessment and actions for patient /client safety in their own home that respects the rights of the individual
 - Working safely and effectively in an unfamiliar environment that is not within the employers control
 - Specific clinical risk issues e.g. universal procedures to reduce cross infection that are applicable and acceptable in domestic settings, mechanisms for the safe and legal disposal of clinical waste and medical sharps

6.2.3 Knowledge: The centrality of the patient/clients and informal care and family networks

The participants identified that the new to primary care nurse/case manager has to understand and know:

1. The patient/client is in control of decision-making and the nurse has to respect patient choice
2. The importance of recognising and supporting the expert patient contribution
3. That adults in their own homes are willing to take risks and may have different priorities to the nurse or case manager
4. The important role of informal carers and community network in delivering care
5. The importance of the nurse or case manager being cognisant of relevant key information, **before** visiting, from those professionals already involved in delivering a service. This could be through:
 - a) Briefing from the referrer
 - b) Briefing from the GP or other health professional
 - c) Shared Single Assessment Process records
6. The presence of the nurse or case manager in the home is by invitation only
7. Assessment, care and advice giving is a negotiated act built on establishing and maintaining a good interpersonal relationship.
8. The importance of providing accurate information on service provision to ensure patient expectations are realistic

6.2.4 Skills

The participants identified that the new to primary care nurse/case manager has to refine their skills in:

1. Developing networks of named and known contacts for information, service resource and expert advice. Recognising that personal networks are built through reciprocity and consciously creating good working relationships.
2. Interpersonal skills and relationship building with the person, the family and their wider network
3. Confident decision making in the home in the absence of other professionals
4. Creativity in problem solving in the absence of specified care pathways and pre-determined infrastructure.
5. Learning from experience and acquiring heuristics ('rules of thumb') and internalised mental checklists

6.2.5 Attitude

Some participants were able to relate this more specifically to the attitude and characteristics of the nurse. They suggested that those who were more likely to thrive and more rapidly adapt to working in primary care were those who had or developed positive attitudes to:

1. Partnership working with patients/ cares and other service providers
2. Working with uncertainty and changing situations, priorities and services
3. Respond quickly and flexibly to changing priorities
4. Negotiation as a main structural element of all work
5. Assertiveness to negotiate on behalf of patient/client

6.3 Issues of support

The participants were explicit about the levels of support that they considered imperative to ease the transition from hospital to community. Many of those new to primary care were clear that this was no different from the support required to orientate and induct any nurse into a new post and new work environment. Some of those in case manager roles felt that this had not been thought through clearly enough for their posts. Others were clear that the very structured orientation process they had been offered was helpful but they had on-going support needs to work in this new setting.

Many of those in commissioning and service development roles argued that the employing organisation and lead managers needed to have a clear strategy for the introduction and ongoing support of hospital nurses new to primary care. Some viewed this as particularly important in the context of new roles, arguing that in their experience ongoing support, or at least minimal challenge, from the full range of stakeholders was important. The participants identified an overarching set of responsibilities for the employing organisation, which included providing mechanisms for supported learning. The informants also specified the detail of these mechanisms.

The participants identified that the employing organisations had overarching responsibilities to:

1. Demonstrate overt support for the new roles and new to primary care post holders
2. Specify the outcomes, scope of functions and activities expected of the role
3. Gain support for the role and activities from key stakeholders preferably before they are in post
4. Prepare the public and patients to receive a new health care professional
5. Prepare the likely network of health and social care professionals to receive a new member
6. Ensure the range of mechanisms for learning for the post holder are in place and resourced
7. Ensure the new to primary care nurses recognise that they are part of the organisation and not alone
8. Create feedback mechanisms to the stakeholders in order to learn from critical incidents and successes

Participants suggested that a range of **mechanisms for supported learning** were necessary.

They identified the need for

- a) Access to expert advice
- b) Access to daily support in problem solving
- c) Orientation and induction processes and
- d) A process of staggered introduction to the full caseload of work.

When pushed to prioritise, participants would rank the orientation and induction process highest but most argued that all were necessary. They suggested detailed mechanisms in each of these categories as listed below.

1. **Overt mechanism(s) for expert advice**
 - Mentors i.e. access to expert mentors with different skills and knowledge, possibly an expert resource group
 - Working with role models and practice educators
 - Clinical supervision activities with mentors, or peers or through an action learning set

2. **Overt mechanism (s) for daily support and problem solving in client based activities**
 - A 'buddy'/peer/supervisor to have daily de-briefing, reflect on activities of the day with, ask questions of and help place the role and any related stresses in context

3. **Orientation and induction processes**
 - Orientation
 - Tangible orientation: map, directory of local services, key team contact numbers and back up information
 - Geographical and community orientation: guided as to how to physically get about and the socio-demographic nature of the area
 - Shadowing others in the care network to observe and understand roles as well as facilitate networking
 - Detailed learning needs assessment at an individual level should guide the induction process

4. **Build confidence and competence through a process of induction and staggered introduction to the work role or caseload numbers.**

7. Discussion and conclusion

This was a small-scale study, based on the perceptions of key informants and as such has limitations. However, the level of consensus identified in the literature and expressed by participants regardless of geography and occupational focus was striking. It was also noticeable that participants confirmed the literature in describing a process of moving from being a novice practitioner in the community environment, irrespective of past experiences, to expert. Like the literature, participants were not able to provide firm evidence or consensus on the length of time that process took and which factors speeded or hindered it. It was salutary to discover how little research evidence existed to support or refute different types and methods of educational and clinical learning programmes.

The study revealed some important issues for employing organisations to consider in order to ensure the successful transition and retention of these nurses as well as the delivery of safe and effective services for their patients. To those who have worked for a long time in primary care and been involved in the support of nurses making the transition to primary care the content of the report may appear self-evident. However, the collective knowledge held by this group is often invisible to those professionals and managers who have never worked in primary care and domiciliary settings. Consequently, it is knowledge that needs to be made explicit to all.

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Appendix 1 Systematic review of the literature

Scope of the review

The review aimed to identify studies that had as their focus the experience, preparation, training or evaluation of nurses who were new to working in primary care. This included studies that focused on specialist nurse roles, the preparation of students and nurses within established programmes of education for community nursing and qualifications and the experiences of community nurses. The review encompassed studies published in English and included research undertaken in the UK and North America. The review proceeded in two stages.

1 Search and classify the literature

2 Review of impact of key contextual factors

The search covered a wide range of health and social care databases

Search Strategies. Our search strategies generated as comprehensive a list as possible of primary studies, both published and unpublished. The following sources were searched from 1990, or the start date of the database, whichever was earlier:

Electronic searches of databases:

Bibliographic databases: MEDLINE, EMBASE, CINAHL, PsycINFO BNI, Cochrane Library, Social Science Citation index, HMIC, British Education Index, National NHS Research Register, NHSEED (NHS Economic Evaluation Database), Dissertation abstracts, ASLIB index to theses
Cochrane Controlled Trials Register, DARE (Database of Abstracts of Reviews of Effects),
Grey literature (System for Information on Grey Literature in Europe), conference proceedings (Conference Papers Index) and Internet searches. Using single and combined search terms that included: Community Health Nursing/ district nurse\$.mp.Clinical Nurse Specialists Advanced Nursing Practice, Expert Nurses/Novice Nurses/ Family nurse practitioners Primary Health Care (primary adj3 care). Family Practice/ general practice Office Nursing community.

Personal searches:

Authors and experts in the field were also contacted (see below nominal group with expert researcher group) to enhance the search for publications and to identify additional unpublished material.

Reference lists from relevant primary and review articles were examined. Name searches of key authors known to have ongoing research interests and programmes of research in this area.

Abstracts and brief records from databases, hand searches and reference lists were assessed and filed in a bibliographic management package (RefMan 10). No methodological selection criteria were applied, as the purpose was to identify and describe what was known about the experience, knowledge, skills and support that nurses moving from a hospital setting require to be able to work effectively within a primary care setting. In total 231 papers were identified. The abstracts of these were independently and jointly reviewed and of these 23 were selected as relevant, empirically based studies. Findings were classified into a primary framework the key dimensions were

Knowledge

Skills

Attitude

Methods of Learning

Reference	Empirical work	Country
Battle S A study of curriculum innovation in district nurse education and training PhD 1989 Surry University 40-351	A descriptive study of the impact of curriculum innovation through the perceptions of students, teachers, supervisors and managers in one University and linked NHS sites in England	UK
Bishop, T Report of the introduction to practice nurse course and apprenticeship scheme. 2004. Unpublished report Anglia Polytechnic University	Evaluation of an introduction to practice nurse course and apprenticeship scheme thorough course up take and student evaluations over 4 years	UK
Bugge C., Smith L. N, and Shanley E. A descriptive survey to identify the perceived skills and community skill requirements of mental health staff. <i>Journal of Advanced Nursing</i> . 29(1):218-28, 1999.	Questionnaire survey of 659 (respondents 251) multidisciplinary mental health staff in Scotland including 19 community psychiatric nurses.	UK
Drennan, V and Catterson, J. Evaluation of the Pilot for Creating Career Pathways into Primary Care Nursing. 1998. Camden & Islington Health Authority & Dept. of Primary Care, UCLMS, London. &	Evaluation of pilot scheme for apprenticeship posts and course for hospital nurses seeking posts in general practice in three Health Authorities in England . Data collection through course participant (n=11) , practice nurse mentors and general practice manager interviews and questionnaires .	UK
Ewens, A , Howkins, E. and McClure. L. Fit for purpose: does specialist community nurse education prepare nurses for practice? <i>Nurse Education Today</i> . 21(2):127-35, 2001 Feb.(23 ref) (2):127-135, 2001.	Action research study in England involving 21 community specialist students, 50 community practice teachers, 9 lecturers, 1 nurse practitioner.	UK
Ewens E. A. The changing role perceptions of students on integrated courses in community health care nursing. PhD Reading University. 1998 49-437e	A comparative case study of two integrated courses in community health care nursing in England. Data collection methods included observation, interviews and repertory grid technique of 26 students plus repertory grids with a further 38 students and 24 community practice teachers.	UK
Forbes A. While A., and. Dyson L. A multi-method examination of the views of community nurses on the core skills of community staff nurses... including commentary by Bryar RM. <i>NT Research</i> .6(3):682-95, 2001.	Multi method study of 68 community nurses, health visitors and managers in one English NHS Trust. Data collection by semi-structured interview, focus groups and postal questionnaire.	UK
Hallet C E and Pateman B The `invisible assessment` : the role of the staff nurse in the community setting. <i>Journal of Clinical Nursing</i> 9 (5):751, 2000.	16 qualitative interviews with district staff nurses in two NHS Trusts to identify perceptions of and satisfaction of role. Participants compared and contrasted their experiences in hospital working to the community environment.	UK
Howkins A and Ewens.A How students experience professional socialization.. <i>Int J Nursing Studies</i> 1999. Feb. 36 (1):-9	Repertory grid elicitation on role perception of 49 specialist community nurse students during and after their qualifying course	UK

Reference	Empirical work	Country
Mackenzie. A.E Learning from experience in the community: an ethnographic study of district nurse students. 1990. PhD Surrey 41-3537 Also reported in A. E. Mackenzie. Learning from experience in the community: an ethnographic study of district nurse students. J Adv Nurs. 1992 Jun;17(6):682-91.	Data collected through interviews and observation with Identifies the difficulties experienced by new district nursing students in fitting into new settings and trying out change, to the detrimental effect on learning of rigid practice routines and to the powerlessness of the practical work teachers to influence the learning environment.	UK
McKoy H 2003 Description and process evaluation of rotation placement scheme for registered nurses in primary care. North East London WDC Unpublished report	Evaluation of process data in a rotation placement scheme for new to primary care nurses	
Oberski, I M., Carter, D E Gray M, and Ross J. The community gerontological nurse: themes from a needs analysis. <i>Journal of Advanced Nursing</i> 29 (2), 1999.	Multi method study of educational needs analysis using 8 focus group interviews with 51 nurses from hospitals, nursing homes and primary care practice in one area of Scotland. Interviews of 12 key informants in managerial, medical and social work positions A questionnaire survey of 62 nurses and managers 4 group interviews with older people	UK
Procter S, Campbell S, Butt C, Edward, S Moran M, Redpath N, and Stejes J . Preparation for the developing role of the community children's nurse., 1998. English National Board for Nursing Midwifery and Health Visiting. Research Highlight 32	A study designed to elicit the training need analysis for community children's nurses. Interviews and group interviews conducted in 6 sites across England. Informants included community children's nurses, managers and families receiving care at home.	
Stark,S., Warne,T., & Street, C. Practice Nursing: An Evaluation of a Training Practice Initiative. <i>Nurse Education Today</i> . 2001 21(4):287-96.	An evaluation (carried out over 1 year) of a pilot scheme in one health authority of a training practice initiative aimed at hospital nurses returning to practice offering an experiential and supportive pathway into primary care. Evaluation drew on interviews and questionnaires with those involved in the initiative--the trainees, educators and general practitioners.	
Twinn S F Change and conflict in health visiting practice: dilemma in assessing the professional competence of student health visitors. 1989 PhD London Institute of Education 43-3203	Multi-staged research design used to explore the different interpretations of professional practice between student health visitors, health visitors , and field work teachers and the process of assessing competence.	
North America		
Brown Ceslowitz S (1991) Easing the Transition from Hospital Nursing to Home Care: A Research Study. <i>Home Healthcare Graduate Nurse</i> 9 (4) 32-36	A qualitative study of 80 registered nurses in a 6 week home care clinical rotation as part of a bachelors degree in nursing.	USA

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005 Draft

Reference	Empirical work	Country
Bryant S and Cloonan P Graduate home health education: a survey of home health educators and agency personnel. <i>J Nurs Educ.</i> 1992 Jan;31(1):29-32.	Questionnaire survey of 118 nurses (educators and administrators) in Virginia	USA
Davis J H. Evaluation of novice home visitor preparation strategies. <i>Journal of Community Health Nursing</i> 1993 10 (4):-258	Questionnaire survey of 33 public health nursing students evaluation home visit preparation methods in Chicago	USA
Murray. T. A From outside the walls: a qualitative study of nurses who recently changed from hospital-based practice to home health care nursing. <i>Journal of Continuing Education in Nursing.</i> 29(2):55-60, 1998 Mar-Apr.(23 ref) (2):55-60, 1998.	Semi structured interviews with 25 baccalaureate prepared nurses who had switched from hospital to home care nursing in the past 6 months in St. Louis Missouri	
Murray O'Shea A (1994) Transitioning professional nurses into home care: a 6 month mentorship program. <i>Journal of Home Health Care practice</i> 6(4) 67-72	A survey of unspecified number of new to home care nursing staff in Androscoggin Home Health Services Reports that the attrition rate from staff has dropped and the clinical staff trebled in the two years the programme has been established.	USA
Selby M. L., Riportella-Muller R., Quade D., Legault C., and Salmon M. E. Core curriculum for master's-level community health nursing education: a comparison of the views of leaders in service and education. <i>Public Health Nursing.</i> 7(3):150-60, 1990 Also reported in Riportella-Muller R., Selby M. L., Salmon M. E, Quade D., and Legault C.. Specialty roles in community health nursing: a national survey of educational needs. <i>Public Health Nursing</i> .8(2):81-9, 1991	Postal survey of views on educational needs analysis from 588 community health nursing national leaders in service and education	
Smithbattle L., Diekemper M, and Leander S.. Getting your feet wet: becoming a public health nurse, part 1. <i>Public Health Nursing</i> 2004. Jan, Feb. 21 (1):-11 And Smithbattle L., Diekemper M., and Leander S.. Moving upstream: becoming a public health nurse, part 2. <i>Public Health Nursing</i> 2004. Mar, Apr. 21 (2):-102	A convenience sample interview study of 28 public health nurses and observation over 18 months of a sub sample of inexperienced public health nurses in St. Louis Missouri.	USA
Bramadat I. J., Chalmers K., and Andrusyszyn M. A.. Knowledge, skills and experiences for community health nursing practice: the perceptions of community nurses, administrators and educators. <i>Journal of Advanced Nursing.</i> 24(6):1224-33, 1996 Dec.(39 ref) (6):1224-1233, 1996.	Action research study involving 118 participants in 27 focus groups of community nurses, administrators and educators in Manitoba	Canada

Supporting experienced hospital nurses to move into primary care.

Drennan V, Goodman C and Leyshon S 2005 Draft

Appendix 2 Expert researchers and educationalist group

Dr Alison Bryans	Glasgow Caledonian University
Professor Ros Bryar	City University
Dr Ann Ewens	Oxford Brookes University
Rick Fisher	Brunel University
Dr Angus Forbes	Kings College London
Dr Annette Lankshear	York University
Prof. Ann Mackenzie	Kingston University
Prof. Fiona Ross	Kings College London
Dr Ann Skingley	Christchurch College, Canterbury
Prof. Alison While	Kings College London

Other expert researchers consulted but unable to attend:

Prof. Kate Gerrish, Gill Hek, Prof. Jean MacIntosh, Prof. Sue Read

Appendix 3 A brief history of district nurse education

In 1862 William Rathbone established a training school attached to Liverpool Royal infirmary to supply trained nurses for the district, for private work and for the hospital. 14 years later the first formal apprenticeships to district nurse scheme for trained nurses was established in London. This training included a four to six-month apprenticeship to an experienced district nurse, supported by lectures. This training format was taken up by visiting nurse organisations across the UK. It was established before the regulation of general nurse training. In 1955 a national certificate of district nursing for state registered nurses was introduced. The courses for this certificate were validated and quality assured by a national panel of assessors against an agreed national syllabus. The mix of in-service supervised practical training and assessment with study days over four months remained the same. In 1963 a ten-week course for enrolled nurses was introduced, which was in-service practical training and assessment with study days. Following the establishment of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1979, a new national curriculum for district nursing was established, which required the nurse to be supernumerary for six months. The award of the Certificate of District Nursing was noted by the UKCC against the individual nurses' record. At this point the Nursing and Midwifery Board of the Whitley Council agreed that it was mandatory for a district nurse to hold the national certificate to gain a specific grade of salary remuneration as a district nurse employed in the NHS (Kratz 1982). The introduction of a new system grading clinical salaries in the NHS removed that requirement in the mid-eighties. Following the revision of the curriculum and requirements for registration as a nurse, the UKCC stated that the post registration specialist courses in the community, including for nursing in the home were to be at degree level, taking one academic year full time (UKCC 1993). The course was to include both theoretical and practical components. The overall guidelines for the content were very broad. The new Nursing and Midwifery Council established in 2002 does not note whether an individual nurse has undertaken a district nursing qualification.

Since the nineteenth century nurses in domiciliary settings have been both self-employed, and employed by a number of different types of organizations, predominately the NHS after 1945. There has never been a legal requirement that nurses working in domiciliary settings have a specific qualification nor has the central administration of the NHS insisted on a specified qualification for working as a district nurse. The majority of nurses working in the district nursing service in England have not undertaken an education programme for working in community settings (Drennan et al 2004a).

Timeline

1862 The first nurse training for working on the district and the hospital was created in Liverpool.
1874 Metropolitan District Nursing Association (London) established the first training school specifically for working on the district. It required that nurses new to domiciliary nursing were required be apprenticed to a more experienced district nurse for up to 6 months and attend lectures to supplement their hospital knowledge. This model was replicated as in other metropolitan areas.

1919 The Nurse Registration Act

1925 Queen's Institute of District Nursing and other voluntary organisations, such as the Ranyard Mission, accepted responsibility for training the district nurses. It was six months training under supervision of an experienced district nurse and attendance at a course of lectures provided in 18 lecture centres across the country. The Institute set examinations four times a year simultaneously throughout Great Britain and practical examination was conducted by an inspector from the Institute.

1953 Working Party into the training of district nurses (Ministry of Health)

1955 National Certificate of District Nursing introduced. A national Panel of Assessors was also introduced responsible for approving all district nurse training courses. Local Health Authorities were now able to develop their own schemes. Practical experience and theoretical programme over six months.

1967 Queens District Nursing Institute withdrew from training responsibilities.

1967 The Panel of Assessors suggested that training should be offered to all those working on the district. Ministry of Health Circular 23/67 Training of District Nurses proposed that all local health authorities should arrange for training in their area. Local health authorities grouped together to provide these through external education colleges. Practical experience and theoretical programme over six months.

1968 The Panel of Assessors introduced a syllabus and a new national certificate for district enrolled nurses. 10 weeks, emphasised practical experience with theoretical study days. Continuous assessment of practical experience and a written examination.

1972 Syllabus of training revised (Ministry of Health 25/72) for SRN and Enrolled nurse

Emphasised it should be in-service training over ten weeks with 10 study days. Examination by practical assessment throughout the course and by written examination at the end of the course.

1976 Report of the Panel of Assessors for District Nurse Training on the education and Training of District Nurses SRN/RGN replaced the previous syllabus with an outline curriculum

1979 The Nurses, Midwives and Health Visitor Act introduced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as one single central body responsible for professional standards, education and discipline in nursing midwifery in the UK. Four National Boards were responsible for the validation of courses and accreditation of institutions providing nurse education.

1979 Panel of assessors for District Nurse Training re-constituted. It covered the whole of the UK. Terms of Reference 'to advise Health Ministers on the standard of education and training of district nurses and on the provision of courses and to ensure on behalf of ministers that such courses meet the standard approved by Ministers'. Quoted in Kratz 1982 p87

1981 A new curriculum was introduced for the National Certificate for District Nursing. Six months course during which the students are supernumerary. Two-thirds theory to one third practical. Continuous assessment of practical work and a final examination

1981 Nurse and Midwives Whitley Council stated that remuneration as a district nurse within the NHS was dependent on holding the district nurse certificate. This was widely reported as stating that the certificate was mandatory.

1992 All schools of nursing were transferred to Higher Education

1993 UKCC post registration qualifications guidelines issued. This specified that the specialist community practitioner, district nurse pathway, qualification had to be at degree level.

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Appendix 4 A brief history of health visitor education

The first training for those employed as health visitors (not necessarily nurses) was introduced in 1893 in Buckingham. By the early nineteenth hundreds, the pattern of a six month course for nurses and two years for those without nurse training was established. The course was structured to have two-thirds theoretical learning and one-third practical learning. By 1928 most health visitors were employed by local government and legally required to have Royal Sanitary Institute Certificate, which was altered to become the National Certificate in Health Visiting the following year. The 1948 NHS Act stipulated that only those with the National Certificate could undertake health visiting duties. The Councils for the Training of Health Visitors and Social Workers took over the role of validating courses in 1962. The course was now one full academic year, and while the students were supernumerary, half of the course was practical experience supervised by a training health visitor known as a fieldwork instructor. In 1964 the Ministry of Health reiterated that only those who held the National Certificate could undertake health visiting duties. A separate Council for the Education and Training of Health Visitors was formed in 1975, but its responsibilities were subsumed into the UKCC in 1979. A register of those who held the Certificate in Health Visiting was maintained by the UKCC. Legally, only those whose names were on this register could use the title 'health visitor'. In 1993, the UKCC specified that the post registration specialist course for community public health (health visiting) was to be at degree level (UKCC 1993). The legislation for the establishment of the Nursing & Midwifery Council removed the health visitor register replacing it with a specialist public health practitioner register open to a wider group of nurses. The qualification for health visiting, unlike other nursing posts in primary care, has historically been a mandatory requirement. All nurses employed by the NHS and other bodies such as the armed forces as health visitors have health visitor qualifications. The nineties have seen increased employment of nurses and nursery nurses working to the direction of health visitors who do not have qualifications specific to working in the community (Drennan et al 2004).

Timeline

1893 Buckingham County Borough was granted powers by an act of parliament to train ladies as health missionaries.

1907 A number of training schemes were established offered including two year courses for those with no previous experience at Bedford College for Women and Battersea Polytechnic. Six month courses were offered to nurses. It included practical work as well as lectures. The Royal Sanitary Institute also course leading to offered a health visitors certificate.

1909 Local Government Board 'Health Visitors' (London) order introduced the first statutory qualifications for health visitors

1919 The requirements set out by the London county Council were set out as the standards across England by government circular. The Ministry of Health and the Board of Education were jointly responsible for two year courses were offered through Universities and colleges.

1925 State registration of nurses and midwives to the General Nursing Council established

1928 Ministry of Health stated that all health visitors had to hold the Royal Sanitary Institute certificate.

1929 Board of Health 'Health Visitors' Training Regulations were introduced and the Royal Sanitary Institute became the examining body for the National Certificate in Health Visiting (continued until 1965) Length of course was set at a minimum of six months for nurses and midwives, and two years for other entrants without this qualification. (Statutory Rules and Orders of the Local Government Act 1929). Courses were run in Local health authority bases as well as further and higher education.

1946 All health visitor students were required to be state registered nurses and hold part of the Central Midwives Board Certificate.

1950 Syllabus revision but the length of study remained the same

1962 The Health Visitors and Social Workers (Training Act) set up two linked councils for the training in health visiting and social work. Responsible for the syllabus and examinations. Possession of a State

Registered Nurses Certificate was made mandatory for entry to training. The courses were based in local health authorities, colleges of further education and universities. The course lasted an academic year and half was practical experience supervised by a training health visitor known as a field work instructor.

1964 Ministry of Health Circular 9/64 Qualifications of Health Visitors. Only qualified health visitors were able to undertake health visiting duties

1965 Council for the Training of Health Visitors introduced a new syllabus for a "family " visitor (HV/SY/1/67)

1972 Department of Health and Social Services Circular 48/1972 Qualifications of health visitors. Provision made to enable men to be trained and employed as health visitors.

1974 Separation of the Health Visitor Training Council from the Social Work Council. Re-named: Council for the Education and Training of Health Visitors and dissolved five years later. During this period all courses were placed in colleges of further or higher education.

1979 The Nurses, Midwives and Health Visitor Act introduced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as one single central body responsible for professional standards, education and discipline in nursing midwifery in the UK Four National Boards were responsible for the validation of courses and accreditation of institutions providing nurse education. The Health Visiting Joint Committee retained control of all matters concerning health visiting . The UKCC held a separate register for those with the health visitor certificate

1992 All schools of nursing were transferred to Higher Education

1993 UKCC post registration qualifications guidelines issued. This specified that the qualification had to be a degree level and reduced the length of the course

2001 Nursing and Midwifery Council established.

2005 The Health Visitor Register ended and a new third part of the register established for those demonstrating the competencies in specialist community public health.

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