CHAPTER 5

1990s: The Introduction of the Internal Market

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

Keywords Internal market • Purchaser • Provider • Crisis • Workforce

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5.1 Historical Context

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

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

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

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

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

5.1.1 The Role and Function of Community/District Nursing Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1.2 The Management of Community/District Nursing and Population Covered

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

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

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

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

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

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

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

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

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

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

5.1.3 Financing Community/District Nursing Services

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

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

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

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

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

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

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

5.1.4 Summary

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

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