



Responses to 'Visible, accessible and integrated care' – the practitioners' voice.

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A report commissioned by the Queen's Nursing Institute Scotland of the views of community nurses concerning the introduction of the new Community Health Nurse role

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Responses to 'Visible, accessible and integrated care' – the practitioners' voice.

Background.

The final report of the Review ¹ of Nursing in the Community in Scotland, entitled 'Visible, accessible and integrated care' was published in November 2006 by the Scottish Executive. It proposes a new service model for nursing in the community.

Central to the new service model for nursing in the community is the creation of the Community Health Nurse (CHN). The Review recommends that the disciplines of district nursing, public health nursing (health visiting and school nursing) and family health nursing be absorbed into a new single community health discipline. It is anticipated that the CHN discipline will build on the strengths of nursing in the community and a "new nursing team will incorporate strong professional leadership provided through the introduction of **Community Nurse Consultant** posts and through enhanced co-ordination of care (particularly for people with complex care needs) by **Clinical Team Leaders / Advanced Practitioners. The Community Health Nurse** ² will be the visible access point for people to the nursing service, providing care through a team of **appropriately trained nurses** backed by **Health Care Support Workers** and **administrative support.**" (Bold font is in the original text: SEHD 2006:15). See attached illustration of the model (SEHD 2006:16).

The Queen's Nursing Institute wished to identify the implications of the Review report for community nursing, explore a range of solutions that need to be addressed to implement the role of the Community Health Nurse (CHN) safely, and identify the strategic role and actions that QNIS should take to support community nurses, in Scotland, during this major period of change.

QNIS Focus Groups.

Thus, in early 2007, four focus groups were held with managers and senior nurses, practitioners, staff nurses and educationalists. Over sixty participants, from almost every Health Board in Scotland took part. A series of questions were used to structure the focus groups and ensure consistent coverage of discussion of the anticipated new roles within the service model. The emerging themes and concerns about the Review were collated from each focus group and the initial findings presented at the QNIS Conference on 22nd March.

Findings.

The findings from the focus groups, using direct quotes from the attendees, can be found in the full report ³ where a range of issues that need to be addressed to implement the new model of community nursing are fully explored. This summary details some of the

¹ The term Review in this paper refers to the aforementioned report (SEHD 2006).

² The abbreviation CHN will be used in this report to refer to the Community Health Nurse.

³ Can be downloaded from the QNIS website or a copy can be requested directly from the main office.

key themes emerging from the focus groups, and identifies the strategic role and actions that QNIS intends to take to support community nurses.

Key Themes emerging from the focus groups.

The Review report was perceived negatively by group attendees who questioned the evidence base for the model, and all felt that they had not been listened to in the consultation process. The following sums up the views of participants well:

“Yes, there is a need for change; yes, redesign – change is part of our everyday life – we are enlightened to and feel passionate about the job, core professional work – we are thinking about where we sit – we need to modernise and be fit for purpose

Attendees were concerned about the term ‘development’ sites and felt it implied that the role of community health nurse was “going to be introduced no matter what, and that the proposed evaluation of the development sites is a foregone conclusion”.

Engagement.

The first key theme emerging was engagement: the need to *‘bring folk on board’*. Primarily, there was a need to engage with community nurse practitioners. All participants in the groups wanted more information about the new model. They wanted answers to, as yet, unanswered questions about the registration status of the CHN, the nature and level of the new training, and who would be eligible for it. In addition, frontline staff wanted to be convinced of the advantages of the proposed changes. They wished to be listened to, and participate in putting the flesh on the bones of the new model.

Secondly, there was also a need to engage General Practitioners and practice nurses in the proposed changes. The participants assumed the model would mean a fundamental move from GP, practice-attached nurses to geographical / neighbourhood alignment. Participants felt that social care, local authority partners, as well as voluntary organisations, should be aware of the proposed new model as part of joint working.

Thirdly, focus group attendees felt that social care, the local authority and the voluntary sector all need to be engaged to address boundary issues and streamline the foundation between health and social care. It was felt that “meaningful improvement cannot be done by health alone – housing, jobs, and social care, literacy education and training have links to poverty, and evidence needs to be used to decide who does what health care improvement activity.

Finally, the public should be involved in decision making, “patient and public involvement needs to be fully developed and the complexities of healthcare highlighted so the public are involved in decision making – we are using limited resources in a targeted way and we need to be up-front.”

A great deal of work needs to be done to engage the hearts and minds of existing stakeholders and practitioners if the anticipated model outlined in the Review report is to be implemented successfully.

Shifting the balance:

A recurring theme was the need to shift the balance of care from hospital to community, especially as patients are in the acute sector for a short time. Hospital-based specialist staff, it was felt should ‘come out’ of the acute sector (to increase community capacity); existing primary care staff could provide an ‘*assisted passage*’ to up-skill hospital nurses and enable them to acquire competencies to work in the community setting.

Education to Deliver:

The crucial importance of education to support practice and deliver the new service model. was highlighted in all groups. Undergraduate nursing programmes needed to have more emphasis on the community; certainly ‘Flying Start’⁴ should continue. Employers and the Scottish Executive did not understand the Specialist Practitioner Qualifications (SPQ),⁵ and that this qualification prepared nurses to be community specialists, whilst assuming leadership and decision making roles. A universal approach across Scotland to develop a consistent CPD Framework for the CHN role was required. Prescribing from the limited formulary was considered necessary for all future community nurses rather than independent prescribing.

Capacity within community nursing

An over-riding concern of group attendees was the existing community nursing capacity to accommodate the new model and they asked ‘*will it stack up?*’

Group attendees were worried that the new model was a cost-cutting exercise; existing workforce pressures on an ageing and depleting workforce needed to be addressed if the model was to be introduced successfully. In some areas, vacancies existed in response to budget constraints and recruitment was problematic; in others, trained district and family health nurses were working as staff nurses, and nursing assistants replacing qualified community nurses. Patient demands were increasing due to community management of long term conditions and earlier hospital discharge. Investment was required to facilitate release of staff for training for new roles, to ensure that new teams are properly staffed and caseloads allocated appropriately. Capacity planning and mapping of community needs were both seen as essential to re-design the existing workforce, to ensure that resources address local demands, deprivation and inequality issues. The implementation sites were welcomed as an opportunity to develop the CHN role and evaluate the changes. For the role to be sustainable in the longer term, Health Boards must carry out a needs assessment and invest in new roles, IT and administrative support.

CHN and Juggling Priorities:

Group participants felt that the generic nature of the CHN role, as currently outlined, will have problems. Many were concerned that it was not feasible to be competent in more than one discipline, and that the public health roles would lose out to the high demands of clinical priorities. Participants did not feel that the creation of this role would promote self care for patients, nor did they think that a ‘single access point’ would reduce the need for other specialist nurses.

⁴ This initiative funded by the Scottish Executive and supported by NES is designed to encourage newly qualified staff nurses to work directly in the community setting.

⁵ SPQ is the additional post-registration education, recorded by the NMC, for RGNs to become district and public health nurses.

Key Messages from the QNIS Focus Groups.

- ❖ Role titles and remits within the service model should be standardized.
- ❖ Training and education needs to be available to support changed roles. A universal approach to developing a Capability and CPD Framework for the CHN role was required.
- ❖ Nurses should be managed by nurses and the line management clarified.
- ❖ Clarification was required of the terms care co-ordination, case/care management in the context of the new roles within the service model.
- ❖ The roles of Clinical Team Leader role and Advanced Practitioner should be separate.
- ❖ The Nurse Consultant and Advanced Practitioner roles were welcomed to facilitate career pathways.
- ❖ Staff nurses working in the community are valued, and they currently see district nurses and health visitors as their role models.
- ❖ The staff nurses were the group that felt most threatened by the creation of a CHN role.
- ❖ The generic CHN role may result in lack of capacity to deliver anticipatory and public health interventions. Steps should be taken to protect these public health roles that are currently valued.
- ❖ Existing district nurses and health visitors did not have the expertise to care for sick children.
- ❖ The increase in the number of health care assistants should not be at the expense of trained staff. The latter would provide supervision / monitoring of unqualified staff, staff nurses, students, and any acute staff allocated to them.
- ❖ Administrative and IT support is necessary to support the model.
- ❖ Financial investment in training was also considered necessary to develop new roles and to create a career structure for community nursing staff.
- ❖ Successful roll-out of the new service model for nursing in the community will require investment in change management (as in the development sites) to generalize roles to all Health Boards in Scotland.
- ❖ Consideration should also be given to long term evaluation of the new nursing roles to collect valuable data about nursing outcomes over a sustained period from role inception.

Recommendations.

Engagement of Community Nurses.

- QNIS will be a voice for existing community nursing staff through regularly meeting with nurses, and collecting their views via its website.
- QNIS will voice the views of community nurses at the Programme Board meetings, and organize consultation events as required.
- QNIS will produce literature reviews / briefing papers on particular aspects of emerging roles to ensure that roles are based on available evidence and good practice.
- Further QNIS focus groups will be held with trained family health nurses, nursing assistants /auxiliaries, school nurses, and community nurses who have carried out double / triple duty roles.
- QNIS is developing a communication network of CHP lead nurses in Scotland to disseminate information and engage with frontline community nurses.
- QNIS will provide local roadshows, workshops, and conferences to facilitate role development and support for community nurses during the changes.
- The QNIS will repeat its four focus groups (for practitioners, staff nurses, educationalists and managers) in the summer of 2008, to gauge feedback about the implementation of the Review.

Capacity planning and community nursing.

- The QNIS Nurse Director will highlight the importance of workforce planning.
- The QNIS Nurse Director will recommend that 'shifting the balance' issues of relocation and support of 'acute' nurses to work in community settings are highlighted.
- QNIS will develop joint working alliances with other organizations e.g. the Royal College of General Practitioners, and other unions e.g. the Royal College of Nursing, CPHVA, and Amicus to ensure support for community nursing.

Education to Deliver.

- QNIS will be a voice for existing community educationalists and researchers to feed in comments from them directly to the NES Project Officers.
- QNIS will ensure that community nursing conferences, workshops and educational forums are created
- The QNIS Nurse Director will make sure educational support is available for changed roles that including the creation of the CHN.

Reference

Scottish Executive Health Department (SEHD 2006b) *Visible, accessible and integrated care. Report of the review of nursing in the community in Scotland.* Edinburgh: The Stationary Office

The new Service Model

