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REVIEW OF NURSING IN THE COMMUNITY

BASELINE STUDY

Review of nursing in the community baseline study

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ABBREVIATIONS

Band	Pay structure for NHS Staff
CHNs	Community Health Nurses (new community nurse role)
CNs	Community Nurses (describes all existing nurses working in the community)
CSNs	Community Staff Nurses
DNs	District Nurses
FHNs	Family Health Nurses
HVs	Health Visitors
MRNs	Multiple Role Nurses (by MRNs we mean FHNs, and those that indicated that they had more than one post, and those who classified themselves generally as public health nurses or working in integrated teams).
RoNiC	Review of Nursing in the Community
SNs	School Nurses
SWISS	The Scottish Workforce Information Standard System. Held centrally by the Information and Statistics Division, National Services Scotland includes information about staff in post, vacancies, nursing students,
VAIC	Visible Accessible Integrated Care (VAIC) Programme Board responsible for implementing the new model of community nursing

EXECUTIVE SUMMARY

Introduction

1. This baseline study was commissioned by the Scottish Government in order to collect information which will be used in the subsequent evaluation of the new model of community nursing proposed in Scotland (Scottish Executive Health Department 2006).

2. The baseline study was designed to provide quantitative and qualitative evidence of the views and satisfaction of community health nurses with their current role and their views on the proposed model. It also gathered data on the views of their clients, particularly their experiences of receiving care and support from nurses in the community.

Method

3. The baseline study involved a survey of community nurses in the four National Health Service (NHS) development sites identified as part of the Review of Nursing in the Community in Scotland (RoNiC) during 2008. The development sites are NHS Borders, NHS Highland, NHS Lothian (North West and South East Local Health Partnerships) and NHS Tayside. Group and individual interviews were also held across the four development sites with community nurses and their clients.

4. All community nurses; district nurses, health visitors, school nurses, community staff nurses and multiple roles nurses, identified as working in the four development sites were issued with a self completed questionnaire to establish their views and satisfaction with their current role and their views on the proposed model for community health nursing. A total of 1,319 questionnaires were distributed and 742 (56%) were returned. Focus groups were held with 14 groups of community nurses and one group of managers across the four development sites. Individual interviews were held with seven clinical nurse managers and fourteen patients/clients.

How are community nurses organised?

5. Community nursing across the four development sites in Scotland represents a fairly experienced workforce. The mean age was 47 years and the average time spent working in the community was 12.5 years.

6. The organisation of community nursing teams varied between and within Health Boards areas and across disciplines. It was complex and influenced by local factors and it was not evident how team compositions emerged and were audited and monitored.

7. Community staff nurses represented the single largest group in this baseline study and most multiple role nurses tended to work in the Highlands.

What do community nurses do?

8. Community nurses in the four development sites specialised in certain areas of work, often along traditional lines. For example more district nurses worked with older people, health visitors with mothers and young children and school nurses with school children.

9. Current community roles were often blurred with more than one nursing group sharing an area of practice. For example district nurses and multiple role nurses often conducted carer assessments; district nurses, community staff nurses and multiple role nurses were often involved in protecting older people; and health visitors and multiple role nurses often encouraged self management and care at community level.

10. Community nurses in the sites worked mainly with individuals, families, or some members of a family, and less so with communities, however health visitors were most engaged in work around health inequalities.

11. Community nurses worked with and referred to a wide range of professionals from health, social and voluntary sectors. All nursing groups appeared to work less with the voluntary sector than health and social care professionals.

12. Community nurses in the sites reported that their current workload had increased in non-clinical activities such as documenting information and clinical activities such as child protection and chronic illness/palliative/end of life care.

13. Changes were being made to the organisation of community nursing services in the sites to meet local needs independently of the RoNiC developments as well as a result of the proposed model for practice.

14. Community staff nurses were the single largest group of respondents to the survey. A strong picture of their role did not emerge across any of the categories in the survey. This raises questions about their current role and where they will sit in the new model of practice.

What do community nurses think of their work?

15. In general community nurses in the development sites expressed mid range levels of satisfaction with their current role. Health visitors were the most dissatisfied group both at a general level and in five out of seven domains measured. Multiple role nurses appear to be the most satisfied. However current job satisfaction need not be related to a nurse's perception of the new model.

16. Community nurses who took part in the research felt their roles were poorly understood and much of what they do is 'invisible'.

What do community nurses think the impact of their work is?

17. Respondents thought they made a difference to areas such as child health and protection, palliative care and overall quality of life for patients, carers and communities although generally they found it difficult to identify the outcomes of their work.

18. Clients and their informal carers had positive experiences of community nursing services. Some patients and carers had less understanding of health visitor and school nurse roles than district nurse roles.

19. Patients and carers tended to know about the community nurse with whom they had contact and they knew little about other community nurse roles.

What do community nurses think about the proposed model of nursing in the community?

20. There was some support for the Scottish Government new model in the site and recognition that change was required. Approximately one third of nurses expressed at least some support for the proposed new model of community health nursing and over half were unsupportive.

21. Those expressing greater levels of support were multiple role nurses (52%) and those least supportive were health visitors (77%).

22. Participants considered the new model may work best in rural areas and could deal with staff turnover and shortages in rural areas. Some community nurses and managers thought the new model may work at the level of community staff nurse.

23. Many thought the new model would erode specialist skills by refocusing effort on more generalist skills or replicating the work of other community nurse roles and these new generalist roles would compromise patient care and safety.

24. Most community nurses in the sites were uncertain about, or poorly understood how, the new model would affect their position as part of a multidisciplinary team. This was particularly noticeable among health visitors and school nurses, 60% of whom poorly understood how the model would affect their position. However, multiple role nurses expressed a greater level of understanding.

25. Most community nurses who responded thought some nurses would find the change difficult and leave the service. Community nurses were uncertain, or thought they had not been consulted fully, about the introduction of the new model.

26. Community nurses in the sites were concerned that education and training may not equip them with the necessary knowledge and skills. Community nurses raised some concerns around losing their chosen career, focus of work and professional identity.

27. Linked to concerns about how the new model will look and work in practice, staff moral and change fatigue have affected how community nurses feel about the proposed new model.

28. Some nurses and managers who responded thought that the introduction of the new model will require strong leadership and could be implemented differently with an emphasis on gradual or staged change.

29. Participants considered the new model may work best in rural areas and could deal with staff turnover and shortages in rural areas. Some community nurses and managers thought the new model may work at the level of community staff nurse.

30. There were concerns from community nurses and managers that the skills in the community health nurse role will not be transferable to jobs in other parts of the UK, where the model is not adopted thereby affecting recruitment and employment prospects.

To what extent do community nurses already work in ways that are proposed by the new model?

31. **There is some evidence that they do.** For example the nurses' responses suggest that their teams possesses the right balance of knowledge, experience, and skills to work across the life span, protect children, coordinate services on behalf of those with complex needs, and address health inequalities. They also link with a wide range of other professionals which helps them to work more effectively with service users, improve service delivery, and achieve better partnership working.

32. As individual professionals they assess the health and support needs, and encourage self care and self management particularly among individuals and carers. They protect older people and those with mental health and learning difficulties. They also develop their understanding of health inequalities and proactively target disadvantaged groups.

33. **There is some evidence that they do not.** For example, fewer district nurses and community staff nurses (compared to other nursing groups) thought their team had the right balance with respect to child protection and addressing health inequalities. Fewer school nurses did so with respect to coordinating services for those with complex needs and working with those over the life span.

34. As individual professionals some nurses specialised in certain areas of work, often along traditional lines. For example more district nurses worked with older people, health visitors with mothers and young children and school nurses with school children. Community nurses also tended to work more with individuals, families, or some members of a family, and less so with communities.

35. Community nurses' confidence to work across range of areas was highly correlated to how often they engaged in these areas of work. Thus, those with low engagement were less confident.

Key conclusions

How are community nurses organised?

Conclusion 1: Community nurses in the four development sites constitute a fairly experienced workforce. The mean age was 47 years and the average time spent working in the community was 12.5 years.

Conclusion 2: The organisation of community nursing teams in the sites varied between and within Health Boards areas and across disciplines.

What do community nurses do?

Conclusion 3: Community nurses in the sites specialised in certain areas of work, often along traditional lines. For example more district nurses worked with older people, health visitors with mothers and young children and school nurses with school children.

Conclusion 4: Community nurses' confidence to work across a range of areas was highly correlated to how often they engaged in these areas of work. Thus, those with low engagement were less confident.

What do community nurses think of their work?

Conclusion 5: Community nurses in the sites felt their roles were poorly understood and much of what they did was 'invisible'.

What do community nurses think the impact of their work is?

Conclusion 6: In general community nurses in the sites expressed mid range levels of satisfaction with their current role.

Conclusion 7: Clients and their informal carers had positive experiences of community nursing services. Patients and carers tended to know about the community nurse with whom they had contact and they knew little about other community nurse roles.

What do community nurses think about the proposed model of nursing in the community?

Conclusion 8: Approximately one third of nurses who responded expressed at least some support for the proposed new model of community health nursing and over half were unsupportive.

Conclusion 9: Some participants considered the new model may work best in rural areas and could deal with staff turnover and shortages in rural areas.

Conclusion 10: Community Nurses' confidence to work across range of areas has implications for the education and training of community nurses to prepare them to work in the ways proposed in the new model for community health nursing in Scotland.

Recommendations for follow-up evaluation

1. Where possible, the timing of data collection exercises such as the Community Health Nursing Census and workload analysis should correspond to those of the evaluation. Mechanisms should be put in place to allow the research team access to appropriate census and workforce data for the Development Sites. There is the need to distinguish the aims of the evaluation from that of other work concerned with the routinely collated data. Finally there is the need for consistency in the type of routine data collected from each site e.g., cost data. As it stands it is highly unlikely that these data could be used in a robust economic evaluation of Community Nursing. Thus although an economic evaluation may be desirable there remains the considerable task of gathering good quality data to support such an evaluation.

2. The involvement of and implications for the NHS of data collection and the access to appropriate staff should be negotiated and agreed in advance.

3. Service user's perspectives in this baseline study were drawn from a small sample and these need to be captured in more breadth and depth in the follow-up evaluation.

4. When designing the qualitative aspect of the follow-up evaluation, the same disciplines in the same geographic areas of the development sites as took part in the baseline study, should be recruited to assess changes in practice. This reflects the great variation in structure and function of community nursing within the development sites.

5. The role of the community staff nurse and their place in the community nursing team will be important to explore.

CHAPTER ONE: INTRODUCTION

Background to the baseline study

1.1 In 2006 the Scottish Executive, as part of the modernisation of the National Health Service (NHS), began a radical and far reaching review of nursing in the community. The review responded to the health challenges faced by Scotland and many other countries, namely an ageing population, degenerative or chronic diseases, rapid technological developments and the need to change the emphasis from acute care to community care (Scottish Executive Health Department 2006; Williams et al 2004). Scotland is a small country, has a variety of population profiles ranging from densely-populated urban areas to remote, sparsely-populated and relatively inaccessible areas, which demand differing approaches to healthcare provision.

1.2 The Review of Nursing in the Community (RONIC) proposed the absorption of district nursing, health visiting, school nursing and family health nursing into a single community health nursing discipline. Within the proposed model the community health nurse would be supported by advanced practitioners and consultant nurses to provide expertise and advice, and by community staff nurses, health care support workers and administrative support to deliver care to patients and clients. Other specialists such as community children's nursing, nursery nursing, mental health and learning disability nursing will also support this proposed model. The following seven core elements identified by the Review of Nursing in the Community formed the basis of the new model:

- Working directly with individuals and their carers
- Adopting public health approaches
- Co-ordinating services
- Supporting self-care
- Multi-disciplinary and multi-agency team working
- Meeting health needs of communities
- Supporting anticipatory care

1.3 It was decided to test the new model in four development sites: NHS Borders, NHS Highland, NHS Lothian (North West and South East Local Health Partnerships), and NHS Tayside. The research team involved in this report were commissioned by the Scottish Government to collect baseline data before the model was implemented.

Literature Review

1.4 A literature review conducted by Kennedy et al (2006) aimed to identify the contribution made by nurses in the community to the shifting balance of care identified in the Kerr Report (SEHD 2005a) and Delivering for Health (SEHD 2005b). Little evidence was found which directly indicated the effectiveness of different models of community nursing. This was consistent with the findings of an international critical literature review of community nursing (Brookes et al, 2004).

1.5 Nevertheless, major issues for practice and research emerged from the literature review and these also informed the data collected by the present study.

1.6 Major issues arising from the literature review:

- Nursing in the community is based on trusting relationships with clients and an in-depth knowledge of the local population. However, nurses also need to articulate how their roles and relationships contribute to the support of service users and carers.

- There is evidence that collaborative relationships with other health and social care providers have been established in many areas of work, including liaison with specialist services. However, there is a clear tension between the need for seamless, collaborative care and the need to identify the specific nursing contribution to that care.

- Nurses in the community are ideally placed to carry out health assessments and preventative interventions. Nurses can also be pro-active in anticipating the needs of people who are at risk of being admitted to hospital and those being discharged from hospital, and in recognising risks that may lead to re-admission. This is consistent with growing recognition of the importance of anticipatory care in community nursing roles (SEHD 2005a, 2005b, Williams et al 2004).

- An important implication for practice is that little evidence emerged from the literature review of the nursing contribution to reducing health inequalities. However, such evidence as exists suggests that nurses are in a strong position to work with communities to enable them to drive change for themselves.

- Especially problematic for community nursing is the lack of research focused on evaluating the impact of nursing actions. Research is needed to assess the effectiveness of nursing interventions and to evaluate relationships between nursing outcomes and costs.

- Community nurses in Scotland have expressed anxiety about the proposed changes including the degree of complexity facing a 'generalist nurse' and the remit of the other posts planned in the new structure (QNIS 2007). Furthermore, the new family health nurse which was piloted in Scotland and found to be highly suited to rural setting was not widely accepted in practice (MacDuff 2006).

- The Republic of Ireland, Iceland and Finland have already introduced a generalist community health nursing model, but there are clear differences in its application. In Iceland few patients die at home, and child protection is not as highly developed as in Scotland (Jarvis 2007). In some areas of Finland there has been a reversion from the "population responsibility approach" adopted in the late 1980's, to separate community nursing services for home and public health, families, and children from the antenatal period to high school (Koponen et al 1997).

The decision to test the new model

1.7 In 2008 the Cabinet Secretary for Health and Wellbeing in Scotland decided that the testing of the new model would allow an informed decision to be made in two years' time about the future of the community nursing service. The first step was to commission collection of baseline information which will be used in the subsequent evaluation of the new model of community nursing.

This report

1.8 Chapter Two of this report provides details of the aims, objectives and key questions addressed in this baseline study. Chapter Three details the availability of routine data, which informed the report, but did not form part of the analysis, and the methods used to collect quantitative and qualitative data. Chapter Four reports the findings from the quantitative and qualitative analysis. The final Chapter Five provides a summary of the views of participants, draws conclusions from the baseline study and provides recommendations for the proposed follow on evaluation.

CHAPTER TWO: AIMS, OBJECTIVES AND KEY QUESTIONS

2.1 The aim was to collect baseline information before the new model of community nursing was implemented in the four development sites.

2.2 Objectives

- Where feasible, analyse existing data such as that from the NHS Information and Statistics Division (ISD) and Community Information Systems (CIS) to establish the uptake and delivery of nursing services such as numbers of visits, age groups, numbers under care packages, such as post-natal care, wound care, palliative care, health promotion and child health surveillance.

- Survey district nurses (DN), health visitors (HV), school nurses (SN), family health nurses (FHN) and community staff nurses[1] (CSN) in the four development sites to establish how community nursing currently operates, their current roles and their responsibilities. Data would also be collected on the nurses' perceptions of the advantages and disadvantages of the new Community Health Nurse model.

- Qualitative work with district nurses, health visitors, school nurses, family health nurses and community staff nurses and patients and/or carers to establish their experiences of community nursing services.

2.3 **Key questions:** Although the main aim of the study was to collect the relevant data before the implementation of the new model we sought to answer to the following questions:

  - How are community nurses organised?
  - What do community nurses do?
  - What do they think of their work in terms of satisfaction, confidence, value, and challenges?
  - What is the perceived impact of their work from their own perspective as well as that of their managers, patients, and carers?
  - What are their perceptions of the proposed model of nursing in the community?

[1] Community Staff Nurses, although not part of the Review of Nursing in the Community were included in the survey because they work closely with other community nurses and are likely to be included in the new model in all of the development sites.

CHAPTER THREE: METHODS

3.1 This chapter provides details of the methods used to gather baseline data. It describes the work undertaken to establish what service data was collected in each development site. The approaches used to quantitative and qualitative data collection and analysis are described. Data collected as part of national initiatives, which coincided with the timing of this study, are also referred to.

3.2 The study gathered baseline information from district nurses, health visitors, school nurses, family health nurses, multiple role nurses, community nurse managers, and community staff nurses about perceptions of their current and future roles between May and October 2008. Data were collected from staff and patients/clients in each of the four designated NHS development sites; NHS Borders, Lothian (North West and South East Local Health Partnerships), Highland and Tayside.

3.3 The study was scrutinised by the NHS Research Ethics Committee in each of the four Development Sites and Napier University Ethics Committee. This baseline study was deemed service evaluation by the NHS Research Ethics Committee so it was registered with the clinical effectiveness office in each of the four NHS sites involved. Napier University Ethics Committee granted ethical approval for the baseline study.

3.4 A focussed literature review (see Annex 1) was conducted and in conjunction with a review of the Policy, the Capability Framework and job descriptions (SEHD 2006, NES 2007) informed the development of the survey instrument and the qualitative interview topic schedules. In addition the survey instrument was also informed by the qualitative interviews which started before the survey began. The survey instrument was also refined during a small pilot with approximately five nurses from different professional backgrounds.

Part 1: Existing Service Data not used in this baseline study

3.5 The study team liaised closely with the organisations responsible for collating and analysing data from two key instruments, the Community Nursing Team Census and the Nursing & Midwifery Workload and Workforce Planning Project, Professional Judgement Tool. The Professional Judgement Tool was a paper based instrument designed to quantify the skills mix of nursing teams. It captured information during a two week period in early 2008 and was completed by nursing team leaders. The Community Nursing Census was based on a web-based instrument which monitored nurse activity during the course of one day in spring of 2008 (24th April). Data on the cost of community nursing were also made available from each pilot site at the end of the baseline assessment. Essentially we wanted to establish whether these data were of potential use to the baseline assessment and whether it was possible to include such data in our report. It was eventually decided that this would not be possible.

Community Nursing Team Census

3.6 This instrument collected baseline data on the types of people who used community nursing services, where they were seen, the intensity of contact, types of problems addressed, the intervention delivered, and future contact. It was completed on line by health visitors, district nurses, school nurses, family health nurses and treatment room nurses. These data differ from that collected by our survey which focuses more on how nurses approach their work (do they work in some areas of practice rather than others); team working; job satisfaction; and their attitudes to the new model of community nursing. Where possible these data are used in the current report to inform our findings, primarily in the conclusion section.

3.7 There are however limitations in using the Community Nurse Census (2008) data in the present report. First it did not collect data from staff nurses. Staff nurses represent a large group in our survey. Second was not possible to use a unique identifier to link both data sets, because the Census was completed anonymously. Third the Census report includes nurses from across Scotland whist our report concerns the four development sites only (ISD and NHS 2008). Finally the final report of the census data was released two weeks before the submission of the present report, thus providing limited time to digest and utilise these data. However, some findings from the Community Nurse Census and this baseline study complement each other. For example, both show that current community roles can be blurred with more than one nursing group sharing an area of practice (such as assessment of carers). Individual contact was the most common form of engagement in the Community Nurse Census and the baseline study.

Nursing & Midwifery Workload and Workforce Planning Project, Professional Judgement Tool

3.8 This tool was designed and rolled out by the workforce subgroup of the nursing in the community programme and gathered data on the nursing team skill mix. It was completed by managers or team leaders as a management tool which should be used in conjunction with other information (e.g. managerial judgement and case load data) to determine the level skills in nursing teams and provide a baseline against which change can be assessed. The data from this is intended to be used on an ongoing basis, thus although relevant to the review of nursing in the community it was not designed solely for it. There are also other systems which collect workforce data and these may also be used in conjunction with the Professional Judgement Tool. These are the Scottish Workforce Information Standard System (SWISS) and personal staff records kept by each Health Board. Together these sources collect an extensive and range of work force data. The SWISS system is held centrally by the Information and Statistics Division, National Services Scotland. It includes information about staff in post, vacancies, nursing students, agency and bank nurse usage, and clinical nurse specialists. These data are not matched by our survey. For example our survey collects very limited data the sample characteristics, the types of nurses in each team and their grade. Thus work force data collected elsewhere is more sophisticated and is capable of answering completely different questions.

3.9 There were a number of limitations in using the Professional Judgement Tool and other workforce data in the present report. First it was not possible to use a unique identifier

to link these data sets, a) because the Professional Judgement Tool was completed by a manager and not individual nurses, b) we would need ethical guidance and permission to join these data sets to our survey. Second, the time and effort required to collate and analyse these disparate sources of data are beyond that set by the baseline evaluation and were overseen by the Visible Accessible Integrated Care (VAIC) Programme Board who were ultimately responsible for implementing the new model. Indeed the workforce and planning issues were addressed by a subgroup of the Visible Accessible Integrated Care (VAIC) Programme Board which has met to consider a modeling approach to identify the workforce needs in relation to the new model of nursing in the community. As part of their overall approach, baseline profiles of community nurses within the scope of VAIC have been developed. These data include e.g. headcount, whole time equivalent, roles, working patterns, and demographics. Also common workforce metrics such as turnover and retrials have been agreed across the test areas. These data should prove useful to consider alongside the baseline evaluation report and also as a benchmark for comparison as the workforce as the Programme unfolds.

The Cost of Community Nursing

3.10 The total estimated annual cost of providing community nursing in the four pilot areas is £28.8 million pounds. This figure consists of mainly ongoing costs such as salaries rather than capital costs. Costs were calculated differently across areas. For example staff costs for Lothian included treatment room staff. Tayside made no mention of treatment room staff and included specialist cancer care nurses, evening and overnight services. Highland and Borders did not specify which nurses were included. Some areas explicitly mentioned travel costs whilst others did not. Two areas provided ‘supply’ costs, and two areas provided travel costs. Thus it was difficult to reach a meaningful conclusion about the overall costs of community nursing and of the differences in costs across the four pilot sites.

Conclusion

3.11 In conclusion although these data are extremely useful and can be used during the follow up evaluation alongside the baseline evaluation; it was not possible to include these in the present report. Whilst there were some technical limitations which would affect interpretation, essentially there were two key issues: timing, and the complex task of analysing often disparate sources of data which led to the decision not to include these sources. The additional issue of whether these data will be collected at the time of follow-up may affect whether these sources are useful for evaluation purposes. There were also limitations regarding the scope and robustness of cost data which were provided by Health Boards. These data related mainly to salaries and on going expenditure, did not include capital costs, and were not standardised. Data was not linked to the survey data or any other routine data. Consequently, careful thought will be needed to determine whether a robust economic evaluation of Community Nursing as part of the follow-up evaluation will be possible.

Part 2: Quantitative and qualitative data used as part of the baseline study

Quantitative survey

3.11 The first method used to collect information from the four development sites was a quantitative survey of community nurses (see Annex 2). The research team took the decision to survey all community nurses in the development sites rather than obtaining a random sample. In some areas we had to work with administrative staff in the NHS to distribute the questionnaire. Ultimately the team did not want to complicate this process by adding a random sampling frame. The lists of nurse contacts were drawn up by the lead nurses in each of the development sites. The team then reviewed the lists and discussed obvious anomalies such as duplicate records, uncertainty about the professional status, and missing contact details. These were then rectified during the course of further discussions with the lead nurses or other named contacts within each Health Board.

3.12 Distribution of the survey questionnaire was conducted according to local agreements with each Health Board. Two Health Boards agreed to provide the research team with complete lists of nurses including their contact details. This meant the research team distributed the questionnaires directly to the nurses. Two Health Boards preferred the research team to work alongside administrative staff in their headquarters and thus retained the lists within the NHS. This meant a researcher labelled envelopes and sent these from Health Board premises. The reasons cited by the Health Boards for adopting this approach were either data protection or the sensitivity of distributing lists to external research agencies. The numbers of questionnaires distributed and returned are given in Table 3.1. The response rate was 56% (range 48% to 67%). These response rates are comparable with other self-administered community nurse surveys which range between 35% and 72% (Annex 1 Literature Review).

Table 3.1 Number of questionnaires sent and received by development site

Development Site	Sent	Q's Return	Response Rate
Borders	124	58	47%
Highlands	417	266	64%
Lothian	205	138	67%
Tayside	573	280	49%
Totals	**1319**	**742**	**56%**

3.13 Direct control of the mailing list also meant we could contact nurses by telephone to remind them to return the questionnaire. (Table 3.2)

Table 3.2 Status of each development site

Development Site	Q. Sent	1st Letter Reminder	Phone Call reminder	2nd Letter Reminder
Borders	✓	✓		✓
Highlands	✓	✓		✓
Lothian	✓	✓	✓	
Tayside	✓	✓	✓	

3.14 A total of 39 questionnaires were excluded from the analysis because they were either from non-nurses, from the wrong types of nurses (e.g., enrolled nurses or practice nurses), or the post was not specified. This left 703 cases in the analysis. Much of the analysis of this data was using descriptive statistical techniques, however statistical tests were conducted where appropriate to establish whether the observed relationships in the data were worthy of note (see footnote below for a technical description of what analysis was undertaken [2]).

Qualitative interviews and focus groups

3.15 The second method used to collect information from the four development sites was focus groups. In each of the four development sites a single discipline focus group was held with district nurses, health visitors and school nurses. A focus group was held for family health nurses in the one development site where they practised. Community staff nurses and community nurse managers emerged as important to current and future roles so a focus group with community staff nurses was held in one area and one focus group. A total of fifteen focus groups were conducted. Thirdly, seven individual interviews with community nurse managers representing each of the four areas were also undertaken and individual interviews with patients and clients of district nurses, multiple role nurses, health visitors and school nurses.

Table 3.3 Nurse Participants involved in focus groups* and interviews**

		DNs	HVs	SNs	FHNs
Borders	Number of participants	3	2	2	None in area
	Range of Agenda for Change Bands	All 6	6-7	All 6	
	Range of experience (years)	5-8	21-25	9-12	
	Range of ages (years)	41-59	53-56	46-51	
	GP or area-based	All GP	All GP	All area	
	Rural or Urban	All rural	All rural	All rural	
	Mixed/affluent/deprived area	All mixed	All mixed	All mixed	
Highland	Number of participants	4	4	3	3
	Range of Agenda for Change Bands	6-7	6-7	5-6	6-7
	Range of experience (years)	8-20	15-20	8-35	5-6
	Range of ages (years)	44-57	43-55	46-58	35-43
	GP or area-based	3 GP, 1 area	1 area, 3 both	1 area, 2 both	2 area, 1 GP
	Rural or Urban	I rural, 2 mixed, 1 urban	1 mixed, 3 rural	2 urban, 2 rural	All rural
	Mixed/affluent/deprived area	1 affluent, 3 mixed	All mixed	1 deprived, 2 mixed	All mixed
Lothian	Number of participants	6	6	6	None in area
	Range of Agenda for Change Bands	All 6	6-7	5-6	

[2] Data were computerised and cleaned using SPSS V 16. Analysis was restricted to mainly descriptive statistics such as frequencies and cross-tabulations, with associations and relationships tested using Chi-square tests and Gamma coefficients respectively. Gamma coefficients are used to assess the association between two variables. Where comparisons were made these focussed on the differences between nursing professions and in these instances the non-parametric, Kruskal-Wallis and Mann-Whitney post hoc tests were conducted. The Kruskall Wallis and Mann-Whitney tests are non-parametric tests that examine differences between 3 or more, and 2 independent groups respectively. A level of $p<0.05$ was used throughout to determine statistical significance.

	Range of experience (years)	2-26	8-27	2-22	
	Range of ages (years)	44-57	43-55	46-58	
	GP or area-based	All GP	1 area, 5 GP	All area	
	Rural or Urban	All urban	All urban	4 urban, 2 mixed	
	Mixed/affluent/deprived area	All mixed	3 mixed, 1 affluent, 2 deprived	All mixed	
Tayside	**Number of participants**	7	5	7	None in area
	Range of Agenda for Change Bands	5-7	5-6	6-7	
	Range of experience (years)	7-32	2-25	4-7	
	Range of ages (years)	43-60	40-52	39-51	
	GP or area-based	5 area, 2 GP	1 area, 4 GP	All area	
	Rural or Urban	All rural	2 urban, 1 mixed, 2 rural	All urban	
	Mixed/affluent/deprived area	6 mixed, 1 affluent	4 mixed, 1 affluent	All mixed	
	Total numbers of participants	**20**	**17**	**18**	**3**

* This table provides details of the nurse participants in the thirteen cross discipline groups originally planned.
** Hereafter quantitative and qualitative findings are reported across the sample and not by Development Sites.

3.16 Community nursing project leads in each of the four NHS areas organised recruitment of focus group participants. The research team asked them to distribute a booklet which explained the baseline study, the purpose of the interviews and contained a form to gather demographic data and written consent. All focus groups were set up by administration staff in the NHS and held at lunch time, with lunch provided, to reduce the impact on clinical practice and workloads.

3.17 At the start of each focus group meeting the process of obtaining informed consent and ensuring participants were clear about the purpose and focus of the groups was undertaken. Confidentiality was assured and participants were reminded that they could withdraw from the study at any time without having to give a reason. Additionally, patients and carers were reassured that care provision would not be affected in any way should they decide to withdraw.

3.18 At the end of the focus group, community nurse participants were asked to identify patients and clients who were currently receiving their service. The community nursing staff were provided with patient and consent information and asked permission from the patient and/or carer for the research team to contact them to make arrangements for interview. Individual arrangements were made and fourteen interviews were carried out with patients and clients of district/family health nurses (4 interviews), health visitors (4 interviews) and school nurses (6 interviews).

3.19 All focus groups were conducted by two researchers, one of whom took field notes. Each group was digitally recorded and transcribed verbatim. Individual interviews with clinical nurse managers and patients/ and or carers included a mix of face to face and telephone interviews and these were also digitally recorded and fully transcribed.

3.20 The topic schedules for the focus group interviews examined the participants' attitudes and perceptions of their existing and proposed new role. The researchers prepared

separate interview schedules for staff interviews and patient and carer interviews. The patient interviews examined their experiences of receiving care and/or support (Annex 3).

3.21 Nurse participants included nurses in the community who worked within their professional boundaries of district nurse, health visitor, family health nurse, school nurse or community staff nurse and those who worked across boundaries such as in rural areas. There are variations in terms of length of service and caseload characteristics.

3.22 Once participants were recruited and the focus group and individual interviews were set up no particular problems were experienced and all participants seemed to appreciate the opportunity to give their views. A small number of nurse participants did not attend as expected. They were followed up and the reasons for non-attendance were workload or lack of information from the administrators setting these up.

3.23 Patient and client interviews were conducted in a location suitable and chosen by the patient. Half of the individual interviews (7 interviews) were conducted by telephone due to geographical spread and for the convenience of the patients and clients, whilst the remainder were conducted face-to-face.

3.24 Qualitative data were subject to constant comparative analysis[3]. The emerging findings from the focus group interviews informed adjustment of some survey questions. Data were analysed with a structured approach that involved an initial sorting and coding that made the data more accessible for deeper analysis and interpretation.

3.25 Each transcript was analysed to identify emerging concepts and themes. Transcripts were then analysed by professional group to identify emerging themes. A meeting was held to discuss the emerging themes and a thematic framework agreed to facilitate further analysis across disciplines. A further meeting was then held to discuss and refine the emerging themes and key messages. This approach to analysis resulted in a full, rounded interpretation and enhanced the overall scope of the analysis.

3.26 Data from staff participants were organised in a word table around the following categories: how staff are currently organised; current roles and responsibilities of teams and role focus and activities within the team; perceived impact of team on patients, carers' experiences and outcomes, views on plans for community health nurse role, how they see the new role developing alongside the existing role and views on how the role will look on the new model.

3.27 From early analysis of nurse interview data the researchers identified the complexity of nursing teams in the community, evidence of some changes within the grade, skill mix and activities of teams, difficulties in articulating the impact of community nursing roles on the outcomes for patients and strong views on the plans for the community health nurse role.

3.28 These themes have been refined and the perceptions of staff and patients interpreted and presented as a substantial part of this report.

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[3] An approach to qualitative analysis which is ongoing, critical and creative throughout the data collection process to ensure meaningful interpretation of data e.g. emerging views on the new model for CHN across disciplines

Conclusion

3.29 This chapter has reported the approaches to data collection used in this baseline study. It has identified that existing service data, such as that collected through the Community Nurse Census and the Professional Judgement Tool could not be analysed as part of this study. Rather the findings have informed the work and informed recommendations. The approaches to quantitative and qualitative collection and analysis have been described and the findings are now presented in Chapter Four.

CHAPTER FOUR: FINDINGS

4.1 This chapter presents the findings from the baseline study. A quantitative analysis of the responses submitted by the 742 respondents to the survey is presented alongside a qualitative analysis of the views of those who participated in the open questions in the survey and the group and individual interviews conducted across the four development sites. Tables and illustrative quotes provide detailed information.

How are community nurses organised?

Their profession

4.2 The data indicate a fairly experienced workforce. The mean age was 47 years and the average time spent working in the community was 12.5 years. Approximately 50% work full-time, but this ranges between 20% for school nurses and 65% for district nurses. (Table 4.1)

Table 4.1 Survey sample Characteristics

	District Nurses	Health Visitor	School Nurse	Staff Nurse	Multiple Role Nurse*
Percentage female	98%	98%	97%	97%	100%
Mean age	48	49	46	44	48
Mean years worked in community	16	15	11	7	15
Percentage working fulltime (>=35 hours per week)	65%	58%	20%	37%	58%

* Multiple Role Nurses: Consists of Family Health Nurses, those that indicated that they had more than one post, and those who classified themselves generally as public health nurses or worked in integrated teams).

4.3 Of the total sample 34% were community staff nurses, 28% were district nurses, 22% were health visitors, 7% school nurses and 9% were multiple role nurses. Most multiple role nurses (79%) worked in the Highlands (Table 4.2).

Table 4.2 Post by development site

	District Nurses N=196	Health Visitor N=158	School Nurse N=47	Staff Nurse N=236	Multiple Role Nurse N=66
Borders	10%	10%	13%	6%	2%
Highlands	38%	29%	32%	35%	79%
Lothian	18%	25%	13%	22%	3%
Tayside	38%	37%	43%	37%	17%

Nursing teams

4.4 As highlighted in Table 4.3, nursing teams consisted on average of six or seven members. All nursing groups indicated a wide range in the size of their nursing teams; this was particularly evident for district nurses and multiple role nurses.

Table 4.3 Size of Nursing Teams

Number of nurses in team	District Nurses (N=189)	Health Visitors (N=155)	School Nurses (N=46)	Staff nurses (N=230)	Multiple Role Nurses (N=66)
Mean	6	6	7	6	7
Minimum	1	1	1	1	1
Maximum	35	21	21	26	32

Composition of nursing teams

4.5 Although nursing teams are comprised mainly of nurses they also include a range of other professionals.

4.6 When asked to detail the composition of their nursing team, district nurses cited staff nurses most and their own nursing profession less frequently (8%). It is clear from Table 4.4 that a variety of nursing groups, (i.e. CNs, HVs, SNs, and MRN) and administrative and management level staff appear in district nursing teams.

Table 4.4 Composition of District Nursing Team

District Nurses	Number (n)	Percentage (%)
Staff Nurse	352	36%
Health Care Assistants	125	13%
Managers	95	10%
District Nurses	82	8%
'SN'*	57	6%
Community Nurses	43	4%
Health Visitors	42	4%
Admin	22	2%
School Nurses	15	2%
Multiple Role Nurses	14	1%
Other**	118	12%
Totals	**965**	**100%**

* The term 'SN' was used by some nurses, but it was not clarified whether this meant school nurses or community staff nurses.

**'Other' category includes:

Allied Health Professions, breast feeding support, community MacMillan nurses, CPA, early years worker, enrolled nurse, integrated care team, midwife, nursery nurse, out of hours staff, practice nurse, public health nurse, mental health nurses, cardiac nurses, paediatric nurses, specialist practitioners, stroke liaison nurses, link nurses, COPD nurses, psychiatric nurses, LAAC nurses, support workers, treatment room staff, young people's health workers, counsellors, guided self help

Table 4.5 Composition of Health Visiting Team

Health Visitors	Number (n)	Percentage (%)
Health Visitors	255	33%
Staff Nurses	136	18%
Admin	69	9%
Health Care Assistants	53	7%
District Nurses	35	5%
Community Health Nurses	32	4%
Managers	26	3%
School Nurses	25	3%
Multiple Role Nurses	21	3%
'SN'*	16	2%
Others**	99	13%
Totals	**767**	**100%**

* The term 'SN' was used by some nurses, but it was not clarified whether this meant school nurses or community staff nurses.

**'Other' category includes: Allied Health Professions, breast feeding support, community MacMillan nurses, CPA, early years worker, enrolled nurse, integrated care team, midwife, nursery nurse, out of hours staff, practice nurse, public health nurse, mental health nurses, cardiac nurses, paediatric nurses, specialist practitioners, stroke liaison nurses, link nurses, COPD nurses, psychiatric nurses, LAAC nurses, support workers, treatment room staff, young people's health workers, counsellors, guided self help

4.7 Similarly, health visitors cited a variety of nursing professionals in the make up of their team (Table 4.5). However, unlike district nurses, health visitors cited their own profession most (33%).

Table 4.6 Composition of Staff Nursing Teams

Staff Nurses	Number (n)	Percentage (%)
Staff Nurses	403	33%
Health Care Assistants	167	14%
District Nurses	156	13%
Managers	136	11%
Health Visitors	97	8%
'SN'*	58	5%
Community Health Nurses	51	4%
Admin	33	3%
Multiple Role Nurses	15	1%
School Nurses	11	1%
Other**	81	7%
Totals	**1,208**	**100%**

* The term 'SN' was used by some nurses, but it was not clarified whether this meant school nurses or community staff nurses.

**'Other' category includes: Allied Health Professions, breast feeding support, community MacMillan nurses, CPA, early years worker, enrolled nurse, integrated care team, midwife, nursery nurse, out of hours staff, practice nurse, public health nurse, mental health nurses, cardiac nurses, paediatric nurses, specialist practitioners, stroke liaison nurses, link nurses, COPD nurses, psychiatric nurses, LAAC nurses, support workers, treatment room staff, young people's health workers, counsellors, guided self help

4.8 Staff nurses' cited their own nursing profession most (33%). However, staff nursing teams also comprised of a range of nursing professionals (Table 4.6).

Table 4.7 Composition of Multiple Role Nursing Teams

Multiple Role Nurses	Number (n)	Percentage (%)
Staff Nurses	81	22%
Health Visitors	54	15%
Health Care Assistants	38	10%
Managers	29	8%
District Nurses	25	7%
Multiple Role Nurse	20	5%
Community Health Nurses	16	4%
School Nurses	16	4%
Admin	14	4%
SN*	6	2%
Other**	71	19%
Totals	**370**	**100%**

* The term 'SN' was used by some nurses, but it was not clarified whether this meant school nurses or community staff nurses.
**'Other' category includes: Allied Health Professions, breast feeding support, community MacMillan nurses, CPA, early years worker, enrolled nurse, integrated care team, midwife, nursery nurse, out of hours staff, practice nurse, public health nurse, mental health nurses, cardiac nurses, paediatric nurses, specialist practitioners, stroke liaison nurses, link nurses, COPD nurses, psychiatric nurses, LAAC nurses, support workers, treatment room staff, young people's health workers, counsellors, guided self help

4.9 Multiple role nurses cited a variety of professionals, both within and out with nursing professions in the composition of their teams. Multiple role nurses most frequently cited community staff nurses (22%) within their team (Table 4.7).

Table 4.8 Composition of School Nursing Teams

School Nurses	Number (n)	Percentage (%)
School Nurses	86	37%
Health Visitors	33	14%
Health Care Assistants	22	9%
Staff Nurses	22	9%
Admin	15	6%
District Nurses	14	6%
Managers	12	5%
Community Health Nurses	6	3%
SN*	3	1%
Multiple Role Nurses	1	0.40%
Other**	20	8%
Totals	**234**	**100%**

* The term 'SN' was used by some nurses, but it was not clarified whether this meant school nurses or community staff nurses.
**'Other' category includes: Allied Health Professions, breast feeding support, community MacMillan nurses, CPA, early years worker, enrolled nurse, integrated care team, midwife, nursery nurse, out of hours staff, practice nurse, public health nurse, mental health nurses, cardiac nurses, paediatric nurses, specialist practitioners, stroke liaison nurses, link nurses, COPD nurses, psychiatric nurses, LAAC nurses, support workers, treatment room staff, young people's health workers, counsellors, guided self help

4.10 Similar to the nursing groups above, school nurses cited a range of nursing professionals within their nursing teams. The most commonly cited profession was their own school nursing profession (37%).

Balance of knowledge, experience and skills across the teams.

4.11 We asked nurses to indicate the extent to which their team had the right balance of knowledge, experience, and skills across a number of areas: work with individuals across the lifespan, child protection, coordinating services for those with complex needs, and addressing health inequalities (Tables 4.9 to 4.12). Broadly most nurses indicated their teams possessed the right balance in these areas of work. However fewer district nurses and school nurses did so with respect to child protection (Table 4.10) and addressing health inequalities (Table 4.12). Fewer school nurses did so with respect to coordinating services for those with complex needs (Table 4.11) and working with those over the life span (Table 4.9).

Detailed findings

4.12 Most nurses thought their teams possessed the right balance of knowledge, experience and skills to work across the lifespan. However many more multiple role nurses (94%) did so, (Chi-square p=0.000), (Table 4.9).

Table 4.9 Work with individuals across the lifespan

	District Nurses N=194	**Health Visitor N=155**	**School Nurse N=44**	**Staff Nurse N=228**	**Multiple Role Nurse N=62**
Very much/to some extent	69%	71%	64%	71%	94%
Very little/not at all	30%	28%	27%	27%	7%
Don't know	1%	1%	9%	2%	0%

4.13 A large majority of district nurses (67%) and half of community staff nurses (50%) indicated that they did not think their nursing teams possessed the right experience, knowledge and skills to deal with child protection issues (Table 4.10). However, almost all health visitors (99%), 94% of school nurses, and 89% of multiple role nurses felt that their teams were equipped to work in child protection.

Table 4.10 Child protection

	District Nurses N=192	**Health Visitor N=155**	**School Nurse N=46**	**Staff Nurse N=229**	**Multiple Role Nurse N=62**
Very much/to some extent	32%	99%	94%	46%	89%
Very little/not at all	67%	1%	6%	50%	11%
Don't know	1%	0%	0%	4%	0%

4.14 A total of 94% of district nurses and multiple role nurses, 90% of school nurses, and 87% of health visitors indicated that their team possessed the right balance, knowledge and skills for co-ordinating services for those with complex needs (Table 4.11). However fewer school nurses (72%) thought so.

Table 4.11 Coordinating services for those with complex needs

	District Nurses N=193	Health Visitor N=155	School Nurse N=46	Staff Nurse N=229	Multiple Role Nurse N=62
Very much/to some extent	94%	87%	72%	90%	94%
Very little/not at all	6%	12%	26%	9%	6%
Don't know	0%	1%	2%	1%	0%

4.15 When asked whether respondents felt that their teams were equipped to address health inequalities 91% of school nurses, 88% of health visitors, 84% of multiple role nurses thought so. Fewer staff nurses (72%) and district nurses (66%) thought so.

Table 4.12 Addressing health inequalities

	District Nurses N=193	Health Visitor N=156	School Nurse N=45	Staff Nurse N=225	Multiple Role Nurse N=62
Very much/to some extent	66%	88%	91%	72%	84%
Very little/not at all	32%	10%	9%	24%	15%
Don't know	2%	2%	0%	4%	1%

4.16 Qualitative data provided insights to the diversity of the team's community nurses currently work in.

4.17 The key messages were that organisation of community nursing services varied between and within Health Board areas and across disciplines. It was complex and influenced by local factors and it was not evident how team compositions emerge and were audited and monitored.

4.18 Changes were being made to the organisation of community nursing services independently of the RoNiC developments as well as a result of the proposals:

> *"We have been going through a process of change for quite a while for the past two or three years, when I first started in this role I was, working in my area, the only school nurse for all my schools. … With the changes and with the vision ahead, we have now got skill mix which is fantastic and that consists in our team of a staff nurse, an area worker and we also work corporately within the team…"* (School nurse)

4.19 The main staff configurations were variously described across both rural and urban areas and existing models included:

- Single discipline teams attached to single GP surgeries
- Single discipline clusters such as five groups of district nurses from five practices working together.
- Integrated teams of district nurses, public health nurses, school nurses, health visitors, midwives and allied health professionals.
- Clusters of one or more discipline working across a number of GP practices
- Geographical zones where one or more disciplines work across a number of GP practices.

4.20 An example of an integrated team was a cluster of two disciplines including a district nurse team leader, district nurse (Band 6), community staff nurses and unregistered nurses, public health nurse team manager, health visitors (Band 6), community staff nurses and nursery nurses.

4.21 Integrated teams may be at different stages of development. For example, the skill mix of HVs and SNs in one area was managed in an integrated way but the caseload populations (GP Practice and School) were not yet managed in an integrated way.

Integration and joint working was facilitated by:-

- Joint meetings of different disciplines.
- Cluster meetings which bring together nurses in the same discipline but from different practices.
- Recruitment of Staff Nurses to work with both HVs and SNs.
- Training

4.22 There were plans to amalgamate community mental health staff into one rural integrated team which was one example of local variations.

4.23 Some community nurses worked in specialist teams such as Long Term Conditions Teams.

4.24 Some teams have adopted ‘corporate’ working where the caseload was shared across a number of nurses. Measures taken to facilitate this included the co-location of nurses (as opposed to being spread across a number of GP practices) and cross covering so nurses from different practices get to know each others’ caseload.

4.25 The areas and patients/clients covered by community nurses were determined by a number of factors, for example:-

- Patient list of GP practices
- Geographical areas
- Boundary of the Local Health Partnership
- Social Services boundaries for Children and Family Services

4.26 There was evidence of flexible working patterns and adaptations to local circumstances to meet patient needs. For example in one rural area district nurses reported a local alteration of shift hours to ensure palliative care patients were covered during the gap between the end of the day shift and the start of the evening shift.

4.27 Nurses were working flexibly across teams to cover staff shortages in neighbouring areas particularly in rural areas:

> "*So there's been a lot of … I would almost say, robbing Peter to pay Paul and there needs to be a lot of organisation*" (District nurse).

4.28 Cross covering in rural areas was a means of dealing more efficiently with patients spread over a large geographical area. Nurses' will arrange to visit each others patients if they are visiting patients of their own nearby.

4.29 Rural areas were more likely to have joint /dual roles than urban areas:

> "*There are only one or two who have actually got separate disciplines. And that was in response to the reducing numbers of young people. It was felt to actually keep that public health perspective and keep that identified role most jobs have been combined as they've been advertised now*" (Multiple role nurse).

4.30 School nurses tended to work in isolation and management and contractual arrangements may vary to term time only for some, and so may leave vulnerable children with less support if school nurses were not integrated within nursing teams.

4.31 Multiple role nurses appeared to have the broadest range of patients and clients.

4.32 Community Nurses appeared to be accustomed to changes. Satisfaction with how community nurses were organised was related to the amount of input and clarification that had been received from managers. This varied between areas.

Working with other professionals

4.33 We asked nurses to name up to five professionals they currently worked with. Table 4.13 provides the number of times each profession was cited. These range from other specialist nurses to a mix of community organisations. Most contacts are with health professions and less with social services or the voluntary sector. Nevertheless in total they represent a wide range of expertise.

Table 4.13 Working with other professionals

	District Nurses N=820	Health Visitor N=742	School Nurse N=219	Staff Nurse N=1050	Multiple Role Nurse N=315
Specialist Nurses*	23%	22%	23%	30%	31%
Allied Health Professionals**	22%	7%	5%	20%	11%
GP/Paediatricians	20%	19%	18%	18%	17%
Education	0.4%	12%	26%	1%	6%
Social Work/Social Services***	26%	26%	18%	24%	22%
Other****	8%	14%	9%	8%	13%

* Cardiac Specialist Nurse, Child Protection Nurse, Continence Nurse, Diabetic Specialist Nurse, MacMillan Nurse, Marie Curie Nurse, Mental Health Nurse, Midwife, Paediatric Nurse, Respiratory Nurse, Breast Feeding Nurse, Nursery nurse, Urology nurse, Vascular nurse.
** Dietician, Physiotherapist, Podiatrist, Occupational Therapist, Speech and Language Therapist.
*** Social Work, Home care.
**** Children's Reporter, Alcohol service, Psychiatry, Psychologist, Community Education, Sure Start, Homeless Officer, Acute Care, Crisis Care, Police, Dental Practitioner, Home Start, Voluntary Organisation, Youth worker.

The effect of linking with other professionals

4.34 We asked nurses to indicate the extent to which linking with these professionals helped in three domains: working effectively with service users, improving service delivery, and good partnership working between the nurses and these professionals. They were asked to tick one of four boxes were 1= 'helped a lot', 2 = 'helped a little', 3 = not helped, 4 = 'made worse' (Table 4.14). Generally most (between 87% and 99%) thought that linking with other professionals helped (at least a little) to work more effectively with services users, improve service delivery, and help partnership working.

Table 4.14 Affect on service users, service delivery, and partnership working

	Helped a lot	Helped a little	Not helped	Made it Worse
Working effectively with service users				
Individuals	91%	8%	0.3%	0%
Carers	73%	25%	2%	0%
Mothers and children	74%	22%	4%	0%
Families	71%	27%	2%	0.4%
School children	58%	36%	6%	0%
Communities	46%	44%	10%	0%
Improving service delivery				
Reducing delays in access	52%	39%	9%	0.3%
Increasing the referrals to specialists	43%	44%	12%	0.2%
Better coordination of services	71%	25%	5%	0.1%
Partnership working				
Establishing good team working	82%	17%	2%	0%
Having a common purpose	79%	19%	3%	0%
Learning together	64%	29%	7%	0.1%
Understanding each others contributions	71%	27%	2%	0%
Providing services for hard to reach people	53%	37%	11%	0%

What do community nurses do?

Assessing health and support needs

4.35 Almost all community nurses assessed the health and support needs of individuals and carers. However this was not the case with other areas of assessment where the number conducting assessments was lower, particularly school children (40%) and communities (40%) (Table 4.15).

4.36 These responses also varied across nursing type. Fewer health visitors conducted carer assessments compared with the other nursing groups. Fewer district nurses and staff nurses conducted assessments of mothers and children, families, school children and communities compared with the other nursing groups, (Table 4.15).

Table 4.15 Assessing health and support needs

	District Nurses saying yes	Health Visitor saying yes	School Nurse saying yes	Staff Nurse saying yes	Multiple Role Nurse saying yes	Total saying yes
Individuals	100%	99%	98%	100%	99%	99%
Carers	98%	86%	89%	94%	92%	93%
Mothers & Children	18%	99%	98%	24%	89%	51%
Families	67%	99%	98%	60%	96%	77%
School children	10%	82%	100%	15%	72%	40%
Communities	49%	84%	79%	38%	925	40%

4.37 Perhaps the most sensitive measure is how often nurses conduct assessments in each area. We asked each respondent to indicate how often they did so by ticking either 'never', 'sometimes' or 'often'. A total of 69% of district nurses and 65% of multiple role nurses (65%) did so most frequently ('often'). Those most frequently involved in assessing mothers & children, and families were health visitors (97%). Those most frequently involved in assessing school children were school nurses (96%) and those most active in assessing communities were health visitors (22%) and multiple role nurses (20%).

Protecting against harm and neglect

4.38 A total of 85% of nurses were involved in the protection of those with mental health problems or learning difficulties whilst a half said they protected young people. As with assessment there was variation in the responses over nursing groups. Fewer district nurses and community staff nurses were involved in the protection of children and young people compared with other nursing groups. Health visitors and school nurses were involved in the protection of older people compared with other nursing groups (Table 4.16).

Table 4.16 Protecting from harm and neglect

	District Nurses saying yes	Health Visitor saying yes	School Nurse saying yes	Staff Nurse saying yes	Multiple Role Nurse saying yes	Total saying yes
Children	30%	100%	100%	31%	91%	57%
Young people	27%	88%	100%	28%	81%	51%
Older people	97%	34%	9%	88%	65%	71%
Those with mental health problems or learning difficulties	86%	87%	100%	79%	83%	85%

4.39 We also asked how often nurses practiced this. Those most frequently ('often') involved in protecting children were health visitors (81%) and school nurses (78%). Those most frequently involved in protecting school children were school nurses (76%). In older people it was district nurses (40%) and to a lesser community staff nurses (31%) and multiple role nurses (33%). Those most frequently involved in protecting those with mental health problems or learning difficulties were school nurses (42%).

Enabling self management and self care

4.40 Practically all community nurses encouraged self management and self care with individuals and most encouraged it with carers (Table 4.17). Fewer did so with school children, and mothers and children.

4.41 As with other areas of practice responses varied across nursing groups. Fewer district nurses and community staff nurses engaged in this work with mothers and children, families, school children, and communities compared with other nursing groups.

Table 4.17 Enabling self management and self care (or with communities improving public health)

	District Nurses saying yes	Health Visitor saying yes	School Nurse saying yes	Staff Nurse saying yes	Multiple Role Nurse saying yes	Total saying yes
Individuals	98%	99%	98%	99%	99%	99%
Carers	97%	81%	77%	91%	92%	90%
Mothers & Children	12%	100%	98%	21%	86%	48%
Families	59%	100%	98%	50%	94%	71%
School children	9%	78%	100%	18%	67%	39%
Communities	41%	88%	74%	39%	80%	57%

4.42 Nurses were asked to say how often they practiced this. Those most frequently ('often') engaged in this practice with carers were district nurses (54%) and multiple role nurses (50%). Those most frequently engaged in this practice with mothers and children, and families were health visitors (93%). Those most engaged with school children were school nurses (94%). Those most engaged with communities were health visitors (19%) and multiple role nurses (17%).

Coordinating services on behalf of those with complex needs

4.43 Most nurses (90%) coordinated services on behalf of individuals with complex needs and less (69%) did so, on behalf of families with complex needs (Table 4.18). Those most frequently ('often') involved in doing so on behalf of individuals were district nurses (73%) and those most frequently involved in doing so on behalf of families were health visitors (30%) and multiple role nurses (26%).

Table 4.18 Coordinating services on behalf of those with complex needs.

	District Nurses saying yes	Health Visitor saying yes	School Nurse saying yes	Staff Nurse saying yes	Multiple Role Nurse saying yes	Total saying yes
Individuals	96%	92%	77%	86%	92%	90%
Families	64%	96%	67%	50%	83%	69%

Health inequalities

4.44 Most nurses (93%) developed their understanding of the causes of health inequalities, and 83% thought they actually addressed health inequalities (Table 4.19). Fewer (62%) proactively targeted those whose health was affected negatively by either their social, cultural or economic circumstances. Health visitors were most frequently ('often') involved in developing their understanding of health inequalities (67%), addressing health inequalities (67%), and proactively targeting disadvantaged groups (45%).

Table 4.19 Health inequalities

	District Nurses saying yes	**Health Visitor saying yes**	**School Nurse saying yes**	**Staff Nurse saying yes**	**Multiple Role Nurse saying yes**	**Total % saying yes**
Developing an understanding of the causes of health inequalities	90%	99%	98%	87%	100%	93%
Proactively targeting disadvantaged groups	38%	89%	91%	51%	83%	62%
Addressing Health inequalities	82%	97%	93%	77%	92%	83%

Which groups do you target?

4.45 The questionnaire asked nurses to state if they proactively targeted those people whose health may be negatively affected by their social, cultural or economic circumstances. Of those who answered they 'often' or 'sometimes' did this, the questionnaire allowed them to detail which groups of people they targeted. It should be noted that some nurses stated that they could only be 'reactive' and not 'proactive' to a community's needs. This was mainly cited as being due to job pressures such as time constraints.

> *"I don't feel I target any group in particular. My caseload is presented by the general requirements of the population which may or may not include all of the above groups of people. My job entails a non-judgemental approach and not proactively targeting but accepting all and promoting health to all"* (Community Staff Nurse).

> *"Never had time since joining NHS* [name of Health Board] *two years ago, due to covering two vacant posts, sickness and no backfill provided"* (Health visitor).

4.46 The groups of people who appeared to be targeted by all disciplines of nurses were: people who were vulnerable, people who were living in poverty, ethnic groups or people of a different religion (particularly immigrants, travellers and people who did not speak English as their first language), people and households where drug and / or alcohol misuse was taking place, people or families who were socially excluded or geographically or culturally isolated, and people or households where an occupant had mental health difficulties.

> *"We would target any of the above. Poverty is the most frequent and we would give advice and refer for example to a housing or benefits agency for assessment"* (District nurse).
>
> *"Travelling community, substance misusers, low income families, socially isolated and those with a limited support network, single parent families, male and female immigrants"* (Health visitor).

Health Visitors

4.47 As well as the above, health visitors stated that they targeted: new parents, single parents, young mums and families with complex needs. The sort of vulnerable families which they specifically targeted were: women's aid, foster carers, children brought up in residential homes, victims of domestic abuse and people who were homeless. There also appeared to be a focus on men's health and women's health (e.g. depression, weight management and smoking cessation) and children who were not immunised.

District Nurses

4.48 District nurses emphasised that they mainly targeted elderly people, particularly people in the over 75 age group. They also mentioned working with men, women and children. Many of the people they targeted were palliative care patients or patients who had (often multiple) chronic illness or morbidities (e.g. multiple sclerosis, cancer). They also targeted people who had mental and physical disabilities, who were smokers, who were obese, or in households where there was alcohol misuse. Vulnerable people in the district nurses' discipline tended to be described as vulnerable because: they lived alone, they lived remotely or they lived in unsuitable accommodation.

School Nurses

4.49 School nurses stated that they targeted children and young people under the age of eighteen. The types of vulnerable groups identified by school nurses were children with learning disabilities and those who were sexually active, lived away from home or were registered under the Child Protection Act. School nurses also targeted children who required immunisation, teenagers requiring health promotion (such as testicular and breast awareness) and young people with different sexual orientations.

Multiple role nurses

4.50 Multiple role nurses stated that they aimed to target many different types of patients in comparison to the above nursing disciplines. All age groups were mentioned and a variation of groups including: smokers, families with heart disease, deprived mums, diabetics, disabled people and young and pregnant women.

Staff Nurses

4.51 Community staff nurses stated that they targeted similar groups of people to the district nurses, particularly people with chronic conditions and those who were vulnerable e.g. recently bereaved, no family living nearby, patients who were unable to look after themselves. There appeared to be some patients who they monitored or 'kept an eye on' e.g. those with cardiac risks, patients taking Warfarin or people at risk of flu.

Techniques to identify and engage people and groups

4.52 All nursing respondents to the question about roles stated they used specific techniques to identify those whose health may be negatively affected by their social, cultural or economic circumstances. Those techniques which were common across all nursing groups were: frequent home or one-to-one visits/face-to-face meetings; drop-in clinics and health promotion days (sometimes at community events) and posters; liaising with other health professionals and professional agencies (e.g. the police, social work, women's aid, and voluntary organisations). Rural nurses also stated that they engaged people through local knowledge gained by living in smaller, more intimate communities.

4.53 There were some differences between nursing groups. Health visitors stated that they offered health needs assessments to all family members, and used vulnerability indices. District nurses stated that they identified some people during the 'flu vaccine and over 75s check'. School nurses stated that they identified people through school referrals and emotional health questionnaires, and by running small groups at school. Community staff nurses identified vulnerable people though home visits, elderly screening and Scottish Patients at risk or readmission. Multiple role nurses were likely to see people who had been referred to them, by networking and through group sessions. Many of these nurses worked in more remote areas where networking was viewed as important to decrease social exclusion and isolation.

4.54 Many nurses felt the following qualities were important when working with disadvantaged groups: good verbal and written communication, being available, listening and being open, honest and non-judgemental (e.g. recognising different religious beliefs), encouraging, building trust and confidence, and assessing and using interpreters where required. Some nurses stated that they tried to get groups of similar types of people together. This suggested that close and trusted relationships between the nurses and their patients were paramount to engaging the most vulnerable patients.

Overall conclusion to this section

4.55 There were three main findings. First, nurses specialised in certain areas of work, often along traditional lines. For example more district nurses worked with older people, health visitors with mothers and children and school nurses with school children. Second, roles were often blurred with more than one nursing group sharing an area of practice. For example district nurses and multiple role nurses often conducted carer assessments; district nurses, community staff nurses and multiple role nurses were often involved in protecting older people; and health visitors and multiple role nurses often encouraged self management and care at community level. Finally nurses tended to work more with individuals, families, or some members of a family, and less so with communities, however health visitors were most engaged in work around health inequalities. A majority (62%) of community nurses target specific groups of disadvantaged people and use a variety of innovative techniques to do so.

Their roles

4.56 Qualitative data provided insights to the diversity of roles carried out by community nurses. The full range of activities identified by focus group participants are detailed in Annex 4.

District Nursing

4.57 District nurses reported a broad range of skills in assessment, care management of long term conditions and post-hospital discharge. Education of patients and families, working with older people and palliative care were all key aspects of their role.

> *"Mind you I think we are a Jack of All Trades…" "I mean District Nurses, we all know you can be in palliative care one minute, you're taking stitches out the next, you might do leg ulcer care, you might be looking at an acute wound, catheters, absolutely...I mean it's almost you name it and the District Nurses will do it"* (District nurse).
>
> *"I think we have a big knowledge, we do ourselves down a lot of the time, it's just what we do, you know?"* (District nurse).

4.58 Some have developed specific interests in areas such as palliative care or tissue viability and may take on the role of link nurses where they provided additional advice and support for colleagues in that particular area of practice.

4.59 Management of the nursing team, caseload and complex care may take up most of their time but this varied between nurses; some might have a more clinical role and within the clinical work the focus may vary according to their caseload, one may be focused on

palliative care whilst another on chronic disease management. Urban district nurses appeared to be particularly frustrated by time constraints.

4.60 Some district nurses felt they were working out-with their job descriptions in order to achieve what needed to be done, especially in rural areas.

> *"I think we have jagged edges, I don't think that we have a line that we could work within…I think we have a sort of clouded area and we sort of … we go where the need is and I think that's what attracts us to the rural areas"* (District nurse).

4.61 Many district nurses were qualified to prescribe a range of medications and they saw this part of their role as particularly helpful to the GPs:

> *"Most of the team, the District Nursing team, are extended nurse prescribers, so we have taken on the whole holistic care of the terminally ill. We prescribe and manage symptoms ourselves. The GPs have even less and less input into that. So we've taken over a huge amount of work from the GP"* (District nurse).

Health Visiting

4.62 The role of health visitor has expanded and consequently their responsibilities were increasing.

> *"Responsibilities have increased greatly. When you first started you were really just in charge of yourself and had to organise yourself and now you are kind of left organising often quite a few different people within your team"* (Health visitor).

4.63 Their activities appeared to vary across teams and areas and the focus of the roles was changing and was in some cases becoming specialised in child protection;

> *"I suppose my current role has come right away from the public health model and health promotion to child protection"* (Health visitor).

4.64 Emotional support in cases of post natal depression was a key role.

> *"…we try to offer many services like baby massage and we've got a lot of, I think, post natal depression. Because a lot of these families, because of the geographical area, the husbands work away…so they're quite like single parent families and feel you need more input sometimes because of that"* (Health visitor).

4.65 It was important to many health visitors to be regarded as a 'health care' rather than 'social care' service.

School Nursing

4.66 The school nurse role had an emphasis on health promotion and preventative work but it had expanded over the years to deal with increasing social problems.

> *"I think that there are a lot of behavioural problems now. Maybe it's just that they're more recognised, I don't know, but they seem to, like because their profile's higher, teachers want things sorted out pretty quickly … we're inundated with referrals that are behavioural problems"* (School nurse).

4.67 Referrals were taken from a variety of sources such as parents, teachers and pupils. Activities undertaken also depended on population needs and so varied between areas.

> *"I think if you were to go to those twenty-five primary schools you might get a slightly different answer. Because we do not… if there is not a problem, if it's a middle class school, those are the schools we don't go in. Those are the schools that we offer the core service"* (School nurse).

4.68 Training teaching staff was an important role for the SN;

> *"In schools we also do training with the teachers around complex or health needs, maybe on medication, that's right. If they've got EpiPens… children with epilepsy or diabetes. So we do some training for teachers about the use of complex medication really"* (School nurse).

Multiple Role/Family Health Nursing

4.69 The family health nurse is a rural practitioner who dealt with individuals and families and communities. The caseloads and activities of the nurses interviewed were very much a result of local circumstances. One had clients who were traditionally seen by health visitors and school nurses and another caseload was described as being similar to that of a district nurse with the majority of patients in the over seventy age group. Some had dual roles and staffing pressure in an area could influence the range of work undertaken, for example, some reported undertaking a practice nurse role in the absence of a practice nurse.

> *"…the Family Health Nurse, it's more in name than actually being able to do the Family Health Nurse Role"* (Family health nurse).

Community Staff Nurses

4.70 The role of the community staff nurse included assessment, communication and collaboration and also anticipatory care. As a group they worked across the whole range of ages from children to the elderly. Staff Nurses worked with the other community nursing professions to provide continuity of care; role overlap with the community nurses could be considerable but this depended on the discipline.

4.71 The overlap between school nurses and school staff nurses was seen as extensive.

> *"And there are no restrictions on the school staff nurses at all; it depends on their training, on their expertise and their confidence"* (School community staff nurse).

4.72 Much of the role was hidden, misunderstood and complex.

> *"I find it difficult to discuss my role because we do so much but you don't think you do. Its only when you actually sit back, maybe put pen to paper and then you start to realise 'Oh God! I do that and I do that and I do that"* (Community staff nurse).

4.73 In terms of disparity between roles, community staff nurses saw district nurses as having more responsibility and experience; they undertook care management as well as more administrative work and, in some cases, prescribing.

4.74 Staff nurses will consult with a district nurse if, for example, a patient's needs became more complex. Otherwise they will deal with situations themselves

> *"Nine times out of ten you just use your own initiative!"* (Community staff nurse)

What do community nurses think of their work?

Job Satisfaction

4.75 Job satisfaction was measured by the 'Measure of Job Satisfaction' which was developed by Traynor and Wade for Community Nurses in 1993.[4] Satisfaction is measured over seven domains: Personal satisfaction; workload; professional support (team working); training; pay; career prospects; and standard of care provided to services users. Scores from

[4] Traynor M. and Wade B. (1993) The development of a measure of job satisfaction for use in monitoring the morale of community nursing in four trusts. Journal of Advanced Nursing, 18, 127-136. This is a 43 item likert scale (where 1 = very dissatisfied, 2 = dissatisfied, 3 = neither satisfied nor dissatisfied, 4 = satisfied, 5 = very satisfied). Satisfaction is measured over seven domains (scored 1 to 5): Personal satisfaction; workload; professional support (team working); training; pay; career prospects; and standard of care provided to services users. Scores from each section can be combined to give a general score (ranging from 1 to 5).

each section can be combined to give a general score (ranging from 1 to 5). Higher scores signify greater satisfaction. Table 4.20 provides these scores by nursing post.

4.76 There are three key messages from these statistics. First, the general scores suggest medium levels of job satisfaction across all nursing groups. Second, the general score indicates that health visitors are least satisfied with their job (mean 3.1) whilst multiple role nurses are most satisfied (mean 3.5). The difference between these groups was large enough to be of statistical note.[5] Third, health visitors are also the most dissatisfied group in four of the seven work domains namely personal satisfaction, professional support, training, career prospects, and joint bottom in another one domain, namely pay. Again these differences were of statistical note.[6]

Table 4.20 Mean Job satisfaction score by post

	District Nurses	Health Visitor	School Nurse	Staff Nurse	Multiple Role Nurse
	Mean	Mean	Mean	Mean	Mean
Personal Satisfaction	4.0	3.7	4.0	3.8	4.0
Workload	2.9	2.4	2.3	3.2	2.9
Professional Support	3.8	3.5	3.8	3.9	3.6
Training	3.1	2.9	3.6	3.2	3.5
Pay	2.7	2.6	3.0	2.6	3.1
Career Prospects	3.2	2.7	3.1	3.2	3.2
Standard of Care	4.2	3.7	3.6	4.2	3.9
General Score	3.4	3.1	3.3	3.4	3.5

How confident were nurses in their ability

4.77 We asked nurses to assess their confidence in their ability to conduct a range of community nursing tasks. Responses were measured thus: 'very confident', 'mostly confident', a 'little confident', and 'not confident'. We correlated their responses with their reported level of engagement across the same range of community nursing tasks (Table 4.21). Engagement was measured as 'often', 'sometimes' and 'never'.

4.78 Broadly both scores were positively correlated[7]. In other words, the higher level of engagement the greater their confidence. This also meant the reverse was true; that is lower levels of confidence were associated with lower levels of engagement. Given the differences in engagement across nursing groups (noted in the section 'What do community nurses do?'), this may mean that, as it stands, some nurses will lack confidence to work in certain areas of community nursing as advocated by the new model. Table 4.21 provides the statistical data to support these conclusions. This indicates the strength of the association between the how often each nursing task was carried out and how confident nurses were about conducting these tasks. This is measured between 0 and 1 and higher scores indicate a stronger relationship. Although the strength of the relationship differed across nursing tasks, all were of statistical note (see footnote 6). Thus, if nurses conducted a task most often then they were more confident about doing so.

[5] Mann Whitney, $p=0.001$.
[6] Mann Whitney, $p<0.05$.
[7] All Gamma coefficients $p<0.05$.

Table 4.21 Association co-efficients for conducting a task and confidence in doing so

	Strength of association[8]
Assessing health and support needs	
Individuals	0.88
Carers	0.84
Mothers & Children	0.98
Families	0.94
School children	0.96
Communities	0.94
Protecting from harm and neglect	
Children	0.92
Young people	0.93
Older people	0.87
Those with mental health problems or learning difficulties	0.90
Enabling improvement or management of health	
Individuals	0.82
Carers	0.88
Mothers &Children	0.98
Families	0.96
School children	0.97
Communities	0.94
Coordinating services for those with complex needs	
Individuals	0.90
Families	0.95
Health inequalities	
Developing an understanding of the causes of health inequalities	0.93
Addressing Health inequalities	0.91

4.79 Qualitative data indicated that despite increasing workload pressures, which were undoubtedly decreasing job satisfaction, many nurses appeared to enjoy and be satisfied with the nursing aspect of their role. Many commented that they were particularly happy working with the type of patients they saw currently and the support offered by colleagues.

> *"We're very, very, very well managed in this team. … And the way that we… we are allowed to work… we're trusted and we're all good at our jobs"* (Community staff nurse).

> *"I know that I have the support of colleagues from all over the city. And I do occasionally pick their brains and things like that. But I at least know that they're there for me. And any of them would come and help or pick up the phone and support and things like that. So I think… I found that when I joined school nursing that it was very… it was really quite… like a big family really*" (School community staff nurse).

[8] Gamma association co efficient

What nurses think of their role / work

4.80 Some nurses felt that they were taken advantage of and their service filled gaps.

> *"I think it's a lack of respect for the District Nurses as well at times, isn't it? The District Nurse never says no. We always do and therefore everyone, and I don't want to use the word 'dumps' – but they 'dump' everything on our desk and dump everything at our door because we won't say 'no'."* (District nurse)

4.81 A number of nurses commented on the change in their roles over the years. For example, Staff Nurses may support students by taking them out on visits to gain experience; they were also doing work which was traditionally the domain of health visitors.

> *"In our team if there is an additional or intensive [case] then normally the Health Visitor would try and do the visits but we are drawn into visit. But we do get a lot of support and if we don't know we can always run it by a Health Visitor and they will follow up."* (Community staff nurse)

4.82 It was felt that roles have been expanding due to staffing pressures and the introduction of new ways of working.

> *"I think it's when you realise all the things we do is when you have a bank nurse who really does the basic things and you realise how complex the things that we do are, because I think we get so used to having an extended role that we don't actually really acknowledge."* (District nurse)

4.83 There was a perception that the workload has increased, for example, in terms of non-clinical activities such as documenting information and clinical activities such as care of the terminally ill (with more people wanting to stay at home to die). This had an impact on the number of hours nurses work.

> *"…and if I didn't do the odd weekend there would be a horrendous backlog of paperwork*." (District nurse)

> *"I never get away on time. I've got to work through my lunch. I mean I just work till midday but I am doing a full time job in a part time role."* District nurse)

4.84 Other ways that nurses viewed that their role had increased was through having a more extended role, a perception that the workforce was decreasing and was not being suitably replenished and a changing, more 'needy' population.

4.85 The introduction of a new role, the family health nurse, had to some extent been challenging.

> *"I think that, at the end of the day, the biggest problem for us is they changed us as individuals in how we kind of functioned and how we could function, and how we thought about how we were going to work, but they didn't change the structures that we went into. So we were like sort of square pegs in round holes…"* (Family health nurse)

4.86 Engaging their teams in this new way of working was hampered by the pressure of their colleagues' workload and their approach to family nursing.

> *"…it is hard to go from that traditional sort of task-orientated approach where the priority is getting the work done, to looking at the bigger picture where you look at health promotion, you look at families and communities, and that's, I think, what we've all found is the big problem."* (Family health nurse)

What is the perceived impact of their work from the perspectives of managers, nurses' themselves and patients and clients?

Managers

4.87 According to managers' perceptions:

- It could be difficult to measure impact of community nursing in terms of outcomes.
- In some areas where there were multiple role nurses, they considered that patients benefited from the wider role of these nurses who were more likely to engage with the whole family.
- They considered that patients may become confused over roles and ask

"*What role are you coming in today? Are you the Smoking Cessation Advisor today or are you my District Nurse?"* (District nurse manager)

- Some managers felt that illness was being prioritised over proactive work and children.
- Within health visiting there was the fear that under the Health For All Children framework, that those families coming under the 'core category' (i.e. do not have needs that require additional or intensive intervention) were not receiving the quality of service that they once did.

Nurses

4.88 In terms of the impact of the service from a nursing perspective several commonalities emerged across all disciplines:

- The service provided by staff was stretched.
- There was less time for social contact with patients.
- There were fewer opportunities to build up relationships with patients.
- It was difficult to measure the impact of what they do in terms of outcomes but they think they make a difference to children and young people's health and help people cope with illness and disabilities.

4.89 Health visitors and school nurses felt that the community nurse role had become more targeted to vulnerable individuals and families and less proactive working in communities as a whole.

4.90 In school nursing most of the client group will not have had contact with the SN:

> "*…if you were to go out there to any area of the city and do a survey about what you think the school nurse does there will be a complete lack of understanding…So if your client group has not come in contact with school nurse they won't have a clue what you do*" (School nurse) .

4.91 They considered that the impact of the school nurse role may not become visible until the long term or if the service was unavailable.

4.92 Recent changes to the health visiting service meant that staff were faced with a lot of uncertainty leading to fear over competency in the current role:

> "*The job feels at the moment that it is almost changing on a weekly basis that you are either having something new added that you need to do or there's just some kind of change that just completely comes out of the blue and you have to change your way of working again and sometimes you feel that things are spiralling out of a control a little bit and then nobody actually has a handle on it*" (Health visitor).

4.93 District nurses reported that service limitations were frustrating for patients who didn't fully understand the pressures that they faced.

> *"You go to a patient sometimes though and they can see you're in a rush and you can't hide that. And they say 'Oh, I'm so sorry to bother you'…and you can't help it. But you've been called out to something that actually probably isn't your problem. Someone else is probably more appropriate, but they know that you'll give them the service quicker"* (District nurse).

4.94 However they felt as long patients managed to see someone who could fulfil their needs they didn't mind level of qualifications so the role of the community staff nurse was valued.

Patients and carers

4.95 A small number of patients and carers (14) reported their experiences of the work of community nurses which were generally positive across all community nurse disciplines. Patients and carers had knowledge of the discipline of community nursing with who they were in contact but did not know very much about other disciplines.

District Nursing and Multiple Role Nursing

4.96 District/multiple role nurse patients expressed that the service had *"… made such a difference."* (District nurse patient) and that the service exceeded their expectations and was described as

> "*a level of service that I didn't know existed until I got into this state, and… I'm just delighted that there is this kind of support available"* (Multiple role nurse patient).

4.97 Patients and carers identified that in their experience district nurses have been responsible for identifying additional needs and coordination of other health services and have been described as "*supplying the hub of my treatment."* (District nurse patient). Patients saw district nurse staff as an asset to the service and perceived them to be accessible, approachable, willing to work alongside the patients and families involving them in discussions and decisions surrounding their care plan. Apart from perhaps limited staffing, patients were very pleased with the service and could not find areas needing improvement,

> *"like I said, it just, it staggers me that it's so good as it is. So I would be very loath to change it in case I broke it!"* (Multiple role nurse patient)

4.98 Overall, the district/multiple role nurse was one that was extremely valued and patients commented that they:

> *"would just love to see them get the recognition that they do so rightly deserve."* (District nurse patient)

School Nursing

4.99 We spoke to parents, school teachers and school pupils. The impact of the school nurse role was less evident and a lack of awareness existed among parents on what this role had to offer other than immunisations:

> *"… I think this is where the role is a little bit ambiguous in the school…"*(School nurse client).

4.100 School pupils were also uncertain about the SN, in terms of access and role remit. Where pupils had been in contact with the SN for immunisations or education talks their

experiences were positive and in cases where the school nurse had been contacted for specific reasons the feedback was positive:

> *"Very good, very efficient and very helpful*" (School nurse client).

4.101 Among those who had a more heightened awareness of the role, the view was that service was valued and the service should not be diluted,

> "*It's like everything I don't think there are many people in the school nursing profession who work any harder than they do particularly when you think about the geography of how much an area they have to cover in every week and I just think you can't … if you start to spread it too thinly then inevitably something has to give"* (School nurse client).

4.102 The consensus between parents and pupils was that the impact of the service could be improved through more contact in terms of information about their role and availability, and increased presence in the classroom.

Health visiting

4.103 Patients had mixed views of the health visiting service and in some cases the service had been highly valued and clients described the service as:

> "*…a really, really important part of, for me, my progression from being just a normal person, and then to being a mother"* (Health visitor client).

4.104 The familiarity between the patient and HV, was described as an asset to the service. Patients have also described staff as being

> *"quite opinionated and I don't think she was of great help to me personally"* (Health visitor client).

4.105 Other patients have also said that they would prefer regular visits and prefer to see the same person in order to build up a relationship. In some cases it was felt that the health visitor needed to be more knowledgeable about their family circumstances,

> *"we had a lady phone up a week before (child's name) third birthday to say that she was phoning to do her two year check!"* (Health visitor client).

4.106 In some cases patients did not feel that the HV was equipped to deal with all their queries,

> "*I really struggled with breastfeeding and I felt that they didn't have a lot of knowledge about that. The health visitor I had at*

the time when I would ask a question she would open a text book." (Health visitor client).

4.107 In conclusion, the small number of patients and clients interviewed valued the work carried out by all the community nurse disciplines. In terms of impact, the role of the district/multiple role nurse appeared to have the greatest affect on the patients. This may be linked to the reasons for interventions as district nurse and multiple role nurses were more likely to be involved where physical illness and disability affect individuals. It is renowned that patients are reluctant to criticise health professionals, so, coupled with the small number of patient/client participants interviewed for this study, these findings should be viewed in this context.

What are nurses' perceptions of the proposed model of Nursing in the Community?

Their attitudes towards it

4.108 General support for the new model was low with approximately one-third of nurses expressing at least some support for it and over half unsupportive (Table 4.22). Those expressing greater levels of support were multiple role nurses (52%) and those least supportive were health visitors (77%) (Table 4.23). The difference between Health Visitors and other nurses was of statistical note.[9]

Table 4.22 Support for the new model

	Total Sample
Very Much	3%
To some extent	29%
Very Little	26%
Not at all	29%
Don't Know	12%
Total	**696**

Table 4.23 Support for the new model by post

	District Nurses N=194	Health Visitor N=155	School Nurse N=46	Staff Nurse N=235	Multiple Role Nurse N=66
Very Much/ To some extent	33%	18%	41%	35%	52%
Very Little/ Not at all	54%	77%	52%	49%	41%
Don't Know	14%	5%	7%	17%	8%

[9] Chi-square p=0.001 A Chi-square test was conducted to determine whether the responses across nursing groups differed. The relatively low level of support for the new model as expressed Health Visitors was notably different from that of other nurses.

Why nurses supported the model

4.109 Respondents were asked to expand on their answers by writing in an open box. Responses from those supporting the new model comprised three categories: responding to demographic changes in the population, new ways of working with service users, and better team working.

Responding to demographic change

4.110 Some thought community nursing should change to meet the changes in the general population:

> *'Change is required to address the demographic changes, aging workforce and extra demand for community based services'* (District nurse).
>
> *'I think community nursing needs to change in line with the changing needs of the community. The new model will encourage more planned proactive nursing'* (Multiple role nurse).

Working with service users

4.111 To others the new model represented the opportunity to work in a different way with service users:

> *'Open to improvement in current service provision, this may include opportunities to participate in improving health not just treating ill health'* (District nurse).
>
> *'I feel that it is the way forward. Looking after a family unit. Give confidence to the family to access services'* (Community staff nurse).
>
> *'Because the small rural area that I work in lends itself to the CHN role. Holistic care from the cradle to the grave.'* (District nurse)

Team Working

4.112 Better team working was also connected with the new model.

> *'My understanding of the new model of nursing in the community is that the skill mix of nursing staff will improve and*

therefore be beneficial to the client and those working within the community.' (Community staff nurse)

Why nurses do not support the new model

4.113 Many thought the new model would erode specialist skills by refocusing effort on more generalist skills or by replicating the work of other community nurse roles.

> *'We currently give very good care to patients and their families. With new role model there will be less specialist practitioners and patients will not get as good care. Staff will not have as much specialist knowledge as they do now*.' (District nurse)
>
> 'I *think it dilutes the expert knowledge of nurses, health visitors and school nurses. Crossing over boundaries has limited benefit to patients. Much or all of the work currently undertaken by HV, DNs and school nurses already fits into the seven core elements described in the new model* ' (Community staff nurse)
>
> *'HV will be the Cinderella service fitted in when there is time available, or gradually phased out. Specialities exist for a reason - I would not want brain surgery from a generic specialist. There are not enough HV hours to do the pro-active work we should be doing, increased housing/caseloads have not increased HV service hours, we are constantly playing catch-up* (Health visitor)
>
> *'I have spent years working and studying to gain experience in my chosen field of nursing. I have no interest or experience in health visiting at all (if I had I would have elected to go down that career path). To start what will effectively be a brand new career at this stage is both frightening and daunting. One doesn't become an expert in a job overnight. It takes years.* (District nurse)

4.114 To some these new generalist roles would also compromise patient care and safety.

> *'The public deserve a better service than the one recommended, dilution of specialist knowledge, unsafe practice, unable to keep up high level of skills if doing DN and HV, reduction in quality of care'* (Health visitor).
>
> *'This will be the end of specialist care to child & family's school children and the needs of elderly. Chronic illness management will become the priority and children will lose out'* (Health visitor).
>
> **'***I feel district nursing is a unique post which is being eroded. 'Watering down' of a service is never a good way of progress*

and I feel patients/carers will have less skilled staff attending to their needs which in turn will compromise the safety of vulnerable people' (District nurse).

4.115 For others the new model lacked clarity and was introduced without proper consultation.

> *'We are getting such mixed messages about what the new model might entail. This varies from 'only your job title will change' to 'you'll need to shadow other professionals' to develop our roles. I am the most positive of people and change doesn't phase me - but no one gives us any straight answers'* (District nurse).

> *'I feel the consultation process was flawed. Have not had contact with a single person who has been consulted either in a professional and personal capacity. I fully appreciate the need for change but consider the new model to be ill thought out and the whole process rushed'* (District nurse).

Understanding how the new model might affect nurses.

4.115 Nurses were asked a series of questions which assessed their understanding of the new model, particularly how it affected their role, their position as part of a multidisciplinary team and how it would affect service users. Community nurses were uncertain about, or poorly understood how, the new model would affect their role. Half (53%) of multiple role nurses expressed a greater level of understanding Table 4.24).

Table 4.24 Understanding how the new model affects their role

	District Nurses N=193	**Health Visitor N=156**	**School Nurse N=46**	**Staff Nurse N=236**	**Multiple Role Nurse N=66**
Wholly Agree/ agree	36%	36%	46%	31%	53%
Neither agree/disagree	22%	22%	15%	26%	20%
Disagree/wholly disagree	42%	42%	39%	43%	27%

4.116 Most community nurses were uncertain about, or poorly understood how, the new model would affect their position as part of a multidisciplinary team. This was particularly noticeable among health visitors and school nurses, 60% of whom poorly understood how the model would affect their position. However a substantial number (44%) of multiple role nurses expressed a greater level of understanding (Table 4.25).

Table 4.25 Understanding how the new model affects their position as part of a multidisciplinary team

	District Nurses N=193	Health Visitor N=156	School Nurse N=46	Staff Nurse N=235	Multiple Role Nurse N=66
Wholly Agree/ agree	28%	26%	20%	26%	44%
Neither agree/disagree	24%	14%	20%	24%	23%
Disagree/wholly disagree	48%	60%	61%	50%	33%

4.117 Community nurses were uncertain about, or poorly understood how, the new model would affect service users. This was particularly noticeable among health visitors, 65% of whom poorly understood how the model would affect service users. However a substantial number (39%) of multiple role nurses expressed a greater level of understanding (Table 4.26).

Table 4.26 Understanding how the new model affects service users

	District Nurses N=192	Health Visitor N=156	School Nurse N=46	Staff Nurse N=234	Multiple Role Nurse N=66
Wholly Agree/ agree	27%	22%	22%	22%	39%
Neither agree/disagree	21%	13%	20%	27%	20%
Disagree/wholly disagree	52%	65%	58%	51%	41%

How the new model was introduced

4.118 We were also interested in their perceptions of how the new model was introduced, particularly the extent to which they felt consulted, whether they thought those introducing the model were aware of what was required, and whether some nurses would find the change difficult and leave the service.

4.119 Community nurses were uncertain, or thought they had not been consulted fully, about the introduction of the new model. This was particularly noticeable among health visitors, 50% of whom did not think they were fully consulted. A similar number (50%) of multiple role nurses said they were consulted (Table 4.27).

Table 4.27 Whether nursing staff felt fully consulted about the new model

	District Nurses N=193	Health Visitor N=157	School Nurse N=45	Staff Nurse N=233	Multiple Role Nurse N=66
Wholly Agree/ agree	32%	32%	44%	28%	50%
Neither agree/disagree	26%	19%	18%	34%	12%
Disagree/wholly disagree	42%	50%	38%	38%	38%

4.120 Community nurses expressed uncertainty, or thought those responsible for leading the new model were not fully aware of what was required of nurses on the ground. This was particularly noticeable among health visitors, 76% of whom did not think the leaders were fully aware, (Table 4.28)

Table 4.28 Whether leaders are fully aware of what is required

	District Nurses N=192	Health Visitor N=156	School Nurse N=46	Staff Nurse N=233	Multiple Role Nurse N=66
Wholly Agree/ agree	12%	3%	17%	12%	17%
Neither agree/disagree	27%	21%	17%	31%	27%
Disagree/wholly disagree	62%	76%	65%	56%	56%

4.121 Most community nurses thought some nurses would find the change difficult and leave the service, particularly health visitors (96%), (Table 4.29)

Table 4.29 Some nurses will leave the service.

	District Nurses N=195	Health Visitor N=157	School Nurse N=46	Staff Nurse N=234	Multiple Role Nurse N=66
Wholly Agree/ agree	83%	96%	85%	80%	79%
Neither agree/disagree	10%	1%	9%	14%	12%
Disagree/wholly disagree	7%	3%	7%	6%	9%

What will hinder the introduction of the new model?

4.123 Most (75%) of the nurses thought something would hinder the introduction of the new model and 49% thought something would help its introduction. We asked them to expand on their responses. Many of the concerns reflected those previously raised by those opposed to the new model such as, the perceived erosion of specialist skills and knowledge, compromising patient care and safety, the lack of clarity of the new model, and its introduction without proper consultation. However, a new theme emerged; staff moral and change fatigue:

> *'Low staff morale, poor communication, lack of staff on the ground and therefore increased workload. Low pay band compared to hospital counterparts, therefore no new public health /DN students'* (District nurse).
>
> *'Older nurses like myself have been through so many changes by successive governments and initiatives that we are all saying 'here we go again'. There is very little we feel able to do as this change will go ahead we think - but will it help our patients? This is obviously a change to solve the perceived shortfall of nurses in the future and save money'* (District nurse).
>
> *'Lack of support for team working. Lack of support for following the process through until it becomes embedded. Change - causes stress - causes sickness more work for those left'* (School nurse).

What will help the introduction of the new model?

4.124 Some nurses thought that the introduction could be implemented differently with an emphasis on gradual or staged change:

> *'Allow current roles to continue but introduce more skill mix first. Develop cluster working away from GP attached model. Nursing teams work in neighbourhoods with local authority partners*.' (Health visitor)
>
> *'Phased introduction - with new staff first. Community divided into the sections 0-18 years, 18-end of life'* (District nurse)
>
> *'Listening and addressing concerns properly. Giving people the training they need to do the job.* (Health visitor)

4.125 Others stressed stronger leadership would help:

> *'Strong positive management who are approachable and listen to relevant concerns. express their fears without being ridiculed by other colleagues in different areas.' Each should be addressed individually.* (Multiple Role Nurse)

What the new model will look like

Managers' Perceptions

4.126 Managers held the following views on how team might look in the new model:

- It is not possible for one person to do everything. For example, district nurses will not have expertise in child protection; someone else such as the health visitor will have those skills.
- The new community health nurse will be a generalist but still retain specialist areas of practice such as adults or children, child protection or palliative care.
- A new management layer in the proposed model may result in current community nurses' specialist areas of work being transferred to a lower grade of staff such as the staff nurse.
- Some suggested they cannot see scope for district nursing and health visiting cross boundary working out with care and rehabilitation of cardiac patients
- They thought health visitors should not be GP attached but rather work with communities.
- Community staff nurses could take on specialist skills across the current disciplines
- Individual Health Boards want a community nursing model to suit their population needs and these may not be met by a generalist nursing service.

Nurses' Perceptions

4.127 There was a lot of uncertainty among staff in all disciplines about how teams will look in the new model

> *'My feeling is it's taken all these years. We used to be triple duty and then it's all these years to develop the three specific disciplines. Now that happened for a reason, but you can't go into that depth of work if you're doing too many things. It's just how life is. You know, you can't stretch elastic so much that you do everything, you can't. One of the things I've found about the review is that there isn't any real concrete evidence that this model is going to work. And nobody's able to tell us exactly how they want it to work'* (Health visitor).

4.128 Participants thought skills will be spread across the team, as it is not possible to train one person to do everything. They think that there will be community health teams consisting of generic staff nurses and there will also be individuals with specialist skills,

> *'I think being in teams but with each specialist and then generic staff nurses that when they work cross boundary or whether your work is with school nurses or health visitors'* (School nurse).

4.129 Some community nurses think not much will actually change as teams will have to consist of generic and specialist staff. HVs and SNs were concerned that the new model will introduce a dangerous level of skill mix into community health teams,

> *'I think we may be heading towards a very dangerous level where we're letting about six hours go and replacing it with less skilled practitioners*' (Health visitor).

4.130 DNs thought that HVs and SNs may work with the under 25s and DNs will work with the over 25s.

Attitudes towards implementation and change

Managers' Attitudes towards implementation and change

4.131 Managers considered the new model may be appropriate and achievable at staff nurse and healthcare support worker levels as they are not caseload holders so they don't have the same responsibility as the district nurse, health visitor, school nurse and multiple role nurse. In one development area staff nurses are already working across district nursing and health visiting caseloads so the opportunities are more apparent. Managers thought the new model could foster positive links with social services, as they prefer community nurses to work geographically rather than being GP attached. Whilst managers were positive about some aspects of the new model they had reservations over the time frame:

> *"I'm positive, yes I'm positive about the changes. It's the time scales that I'm really apprehensive about. I think we can make it happen, I think there's leadership around to make it happen. I think if you're asking me if it can be done in a year, or two … it's a cultural shift and that takes a long time"* (Manager).

4.132 They were concerned that current community nurses may lack the skills and knowledge to work across disciplines and would be de-skilled and lose their discipline specific knowledge.

4.133 The provision of additional training and education to meet the requirements of the new community health nurse role was another concern of managers. There are concerns the community health nurse role will focus on illness as a priority over health promotion and progress such as that made in relation to the role of the school nurse would be lost. The dangers of staff burnout were identified, as easier tasks may be passed down to community staff nurses and support workers leaving the community health nurse to deal with complex care and protection of vulnerable individuals. Fears were expressed over the impact on working relationships between nurses and GPs if they were not GP attached and the multiple role will mean community health nurses will have to engage with lots of other local authorities, which would be an added strain

4.134 Managers considered the new model may make it difficult to recruit nurses from other countries in UK. Managers' views on implementation of the new model are that:

- Implementation will be difficult for all disciplines, especially older staff

- Implementation will be gradually phased in and it may take up to 10 years to fully integrate the new model
- Team leaders are beginning to have integrated team meetings
- Workshops are being held so nurses can discuss new role, perceptions of what it is and identify gaps in their knowledge base
- Job shadowing should be implemented across disciplines
- Nurses are willing to share knowledge and step in to help other disciplines to aid implementation of the new model

Nurses' attitudes towards implementation and change

4.135 Multiple role nurses were the most positive and health visitors the least positive group in their attitudes towards the new plans but there exists a range of positive and negative views in each discipline. Positive attitudes were:

4.136 Participants considered the new model may work best in rural areas and could deal with staff turnover and shortages in rural areas:

> *"I think it's a bonus in the rural areas especially. And you're always sort of thinking ahead I think…with palliative patients, and knowing that you know, if somebody's syringe driver needs refilling, you know, at midnight, that there is staff in the house and you're not going to have to call somebody out from …the nearest city or whatever"* (District nurse).

4.137 Those who support the new model thought it's a good idea that will be difficult to implement:

> *"I still think that the idea, the ethos of being accessible to every single member of the community, regardless of their age or what their need is, their perceived need is. And that I'm no longer going to be out there doing things for people, and that requires a complete change in how you think…but it takes an awful lot of time for me to change, or an individual to change as well as the other of being, as well, we need the communities to think differently about what we do"* (Multiple role nurse).

4.138 Some opportunities for improved communication between the disciplines was noted

> **"***We cannot afford to have three separate disciplines that really don't speak to each other very much."* (School nurse)

4.139 Health visitors felt that the policy makers didn't really understand their role and the new model would have negative effects on clients as they prefer to see the one person.

General fears about the new model include:

4.140 They thought there could be a loss of preventive work in health visiting and school nursing. Some respondents suggested it may not be practical to merge disciplines in an urban area. They thought it might be possible to combine health visiting with school nursing but not district nursing:

> *"I think a big fear is we don't know what HVs do and what SNs do, it's un-chartered territory to us. Equally they don't understand what we do"* (District nurse).

4.141 Fears over increased education and training and resources were expressed and staff are afraid that they cannot be competent in all areas. They think this will put patients at risk and could put a barrier to the career choice of staff nurses.

> *"Yeah well from my point of view the other, what I can see is there's going to be a few of the community health nurses and then the staff nurses, the other problem is there's no where for those staff nurses to go. There's going to be a whole group of them underneath this umbrella and there's nowhere for them to move on. There's not much of a career"* (Health visitor).

4.142 They think the new model does not consider staff choice of career path.

> "*I think you get the best out of staff if they're doing something that they've chosen to do, that they're interested, that they're motivated and that they're keen"* (School nurse).

4.143 Like their managers, they have concerns that the skills in the community health nurse role will not be transferable to jobs in other parts of the UK, where the model is not adopted.

4.144 Many nurses felt that whilst their roles need to develop to cope with demographic and service changes and expectations the community health nurse role isn't necessarily the correct way to move forward.

4.145 Across all community nursing disciplines the general view is that development and implementation of the new model will:

- Be implemented gradually and evolve over time
- Require time, education and training

> *I wouldn't feel confident at this stage now, not having done hands on nursing, going in and doing dressing, etc. Would need a full refresher, and even then you build up a game like health visiting with district nursing, you have to build up that expertise where you're observing and learning, observing, and that happens over a period of time, not overnight.* (Health visitor)

- Be possible at the staff nurse level
- Be easier to implement in small rural areas

4.146 Within each nursing discipline views about the development of the new model were that:

- Health visitors thought that it will be difficult to merge the disciplines together due to differing approaches to practice
- School nurses don't understand how it will be possible to keep up competencies in all areas
- School nurses could see how they could join up with health visitors but not district nurses.
- School nurses thought that development of the new role may lead to specialists leaving the service, however it may be appealing to new graduates or staff who have yet to specialise
- Some district nurses were less worried about implementation as they had received good communication on development of the new role
- Other district nursing staff felt that a top down approach will not work
- Community staff nurses thought that under the new model they would adopt the most holistic role between the existing disciplines
- Multiple role nurses thought that health visitors will be most concerned about development of the new model:

> *"Health visitors are obviously very concerned because they have to do a very specialist skill as in for child development, child health and child protection. But at the end of the day, its how they can…how they can devolve some of that work throughout the team, and I think its trying to make the mix a bit better, you know? The elements are all there, we just need to mix it around a bit better" (Multiple role nurse)*

Conclusion

4.147 The analysis of quantitative and qualitative findings from this baseline study provides a detailed picture of community nursing in the four Development sites across Scotland. Community nurses identified aspects of their current role, levels of satisfaction with their current role and their thoughts for the proposed model of community health nursing. This is discussed further in Chapter 5.

CHAPTER FIVE: CONCLUSIONS

5.1 This chapter presents the findings from this baseline study. Ten key conclusions are drawn and recommendations are provided for the planned follow up evaluation.

Key areas of current practice

5.2 Community nursing in the four development sites in Scotland consists of a fairly experienced workforce. The mean age is 47 years and the average time spent working in the community is 12.5 years. Community staff nurses represent the single largest group in this baseline study and most multiple role nurses are working in the Highlands. A strong community focussed picture of the community staff nurse role did not emerge. This raises questions about their current role and where they will sit in the new model of practice. A similar issue was raised in the findings of Community Nurse Census regarding treatment room nurses whose most common role was to provide assessment and maintenance for patients (ISD and NHS 2008).

5.3 Community nurses within the sites work with a wide range of professionals from health, social and voluntary sectors. All nursing groups appear to work less with the voluntary sector than health and social care professionals. Community nurses refer to a wide range of specialist nurses and other professionals' out with their own community nursing teams.

5.4 The organisation of community nursing teams within the sites varies between and within Health Boards areas and across disciplines. It is complex and influenced by local factors and it is not evident how team compositions emerge and are audited and monitored.

5.5 Changes are being made to the organisation of community nursing services in the sites to meet local needs independently of the RoNiC developments as well as a result of the proposed model for practice. Community nursing roles are also changing in response to increasing patient and population needs, staffing pressures and the introduction of new ways of team working.

5.6 The current workload of community nurses within the development sites has increased in non-clinical activities such as documenting information and clinical activities, and in child protection and care of the terminally ill. In the Community Nurse Census 76% of nurses engaged in non-patient activity (ISD and NHS 2008). Community nurses specialise in certain areas of work, often along traditional lines. For example more district nurses worked with older people, health visitors with mothers and young children and school nurses with school children. The work with certain age groups also concurs with Community Nurse Census data (ISD and NHS 2008)

5.7 Current community roles in the sites were often blurred with more than one nursing group sharing an area of practice. For example district nurses and multiple role nurses often conducted carer assessments; district nurses, community staff nurses, and multiple role nurses were often involved in protecting older people; and health visitors and multiple role nurses often encouraged self management and care at community level. Again the overlap in roles

was noted in the Community Nurse Census where, for example, health visitors and school nurses were most involved in assessment, enabling, and prevention (ISD and NHS 2008).

5.8 Community nurses within the sites work mainly with individuals, families, or some members of a family, and less so with communities, however health visitors were most engaged in work around health inequalities. Individual contact was the most common form of engagement in the Community Nurse Census (ISD and NHS 2008).

5.9 In general nurses express mid range levels of satisfaction with their current role. Health visitors were the most dissatisfied group both at a general level and in five out of seven domains measured. Multiple role nurses appear to be the most satisfied.

5.10 In the main, clients and their informal carers had positive experiences of community nursing services. Some patients and carers had less understanding of health visiting and school nursing roles than district nursing roles and identified areas where they thought they could offer more or different support to users of their services. Support for breast feeding by health visitors and proactive classroom work by school nurses were given as examples.

5.11 Patients and carers tend to know about the community nurse with whom they have contact and they know little about other community nurse roles.

Lessons learnt from baseline assessment

5.12 Community nurses who responded feel their roles are poorly understood and much of what they do is 'invisible'.

5.13 There is some support for the new model and recognition that change is required from respondents. Approximately one-third of nurses who responded expressed at least some support for the proposed new model of CHN and over half were unsupportive. Those expressing greater levels of support were multiple role nurses (52%) and those least supportive were health visitors (77%). Health visitors were also the most dissatisfied group when it came to job satisfaction, thus represent a group that needs to be brought on board. It should be noted, however, that current job satisfaction need not be related solely to the new nursing model. Automatically placing this interpretation on the findings would be misleading. Linked to concerns about how the new model will look and work in practice, staff also think it may affect current moral

5.14 Community nurse managers within the sites have mixed views about the proposed model of practice. It is not clear to many community nurses and their managers how the new role will look and work in practice. Many thought the new model would erode specialist skills and their professional identity by refocusing effort on more generalist skills or replicating the work of other community nurse roles. They thought these new generalist roles would also compromise patient care and safety.

5.15 Most community nurses who responded were uncertain about, or poorly understood how, the new model would affect their position as part of a multidisciplinary team. This was particularly noticeable among health visitors and school nurses, 60% of whom poorly

understood how the model would affect their position. Multiple role nurses expressed a greater level of understanding.

5.16 Most community nurses within the sites thought some nurses would find the change difficult and leave the service.

5.17 Many community nurses within the sites also believe that they have not been consulted adequately about the introduction of the new model.

5.18 Community nurses within the development sites were concerned that education and training may not equip them with the necessary knowledge and skills. Some nurses and managers thought that the introduction of the new model will require strong leadership and could be implemented differently with an emphasis on gradual or staged change.

5.19 Participants considered the new model may work best in rural areas and could deal with staff turnover and shortages in rural areas. Some community nurses and managers thought the new model may work at the level of staff nurse.

5.20 There are concerns from community nurses and managers that the skills in the CHN role will not be transferable to jobs in other parts of the UK, where the model is not adopted, thereby affecting recruitment and employment prospects.

To what extent do community nurses already work in ways that are proposed by the new model?

5.21 **There is some evidence that they do**. For example the nurses' responses suggest that their teams possess the right balance of knowledge, experience, and skills to work across the life span, protect children, coordinate services on behalf of those with complex needs, and address health inequalities. They also link with a wide range of other professionals which helps them to work more effectively with service users, improve service delivery, and achieve better partnership working.

5.22 As individual professionals they assess the health and support needs, and encourage self care and self management particularly among individuals and carers. They protect older people and those with mental health and learning difficulties. They also develop their understanding of health inequalities and proactively target disadvantaged groups. The Community Nurse Census also suggests that prevention is the most common care aim when working with groups and clinics and family health nurses engaged with patients with a wider age range (ISD and NHS 2008).

5.23 **There is some evidence that they do not.** For example, fewer district nurses and community staff nurses (compared to other nursing groups) thought their team had the right balance with respect to child protection and addressing health inequalities. Fewer school nurses did so with respect to coordinating services for those with complex needs and working with those over the life span.

5.24 As individual professionals some nurses specialised in certain areas of work, often along traditional lines. For example more district nurses worked with older people, health

visitors with mothers and young children and school nurses with school children. Community nurses also tended to work more with individuals, families, or some members of a family, and less so with communities. The Community Nurse Census also suggests that skin and wound care is also the highest reported category of nursing problem particularly among district nurses and treatment room nurses (ISD and NHS 2008).

5.25 Finally confidence. CNs' confidence to work across range of areas was highly correlated to how often they engaged in these areas of work. Thus, those with low engagement were less confident.

Recommendations for follow-up evaluation

5.26 Where possible, the timing of data collection exercises such as the Community Health Nursing Census and workload analysis should correspond to those of the evaluation. Mechanisms should be put in place to allow the research team access to appropriate census and workforce data for the Development Sites. The work of the evaluation needs to be distinguished from that of others who work with routinely collected data. Furthermore there is the need for consistency in the type of data collected from each site e.g., cost data. Work will be needed to determine whether a full economic evaluation will be possible as part of the follow up evaluation.

5.27 The involvement of and implications for the NHS of data collection and the access to appropriate staff should be negotiated and agreed in advance.

5.28 Service user's perspectives in this baseline study were drawn from a small sample and these need to be captured in more breadth and depth in the follow-up evaluation.

5.29 When designing the qualitative aspect of the follow-up study, the same disciplines in the same geographic areas of the development sites as took part in the baseline study, should be recruited to assess changes in practice. This reflects the great variation in structure and function of community nursing within the development sites.

5.30 The role of the community staff nurse and their place in the community nursing team will be important to explore.

Key conclusions

How are community nurses organised?

Conclusion 1: Community nurses in the four development sites constitute a fairly experienced workforce. The mean age was 47 years and the average time spent working in the community was 12.5 years.

Conclusion 2: The organisation of community nursing teams in the sites varied between and within Health Boards areas and across disciplines.

What do community nurses do?

Conclusion 3: Community nurses in the sites specialised in certain areas of work, often along traditional lines. For example more district nurses worked with older people, health visitors with mothers and young children and school nurses with school children.

Conclusion 4: Community nurses' confidence to work across a range of areas was highly correlated to how often they engaged in these areas of work. Thus, those with low engagement were less confident.

What do community nurses think of their work?

Conclusion 5: Community nurses who responded felt their roles were poorly understood and much of what they did was 'invisible'.

What do community nurses think the impact of their work is?

Conclusion 6: In general community nurses in the sites expressed mid range levels of satisfaction with their current role.

Conclusion 7: Clients and their informal carers had positive experiences of community nursing services. Patients and carers tended to know about the community nurse with whom they had contact and they knew little about other community nurse roles.

What do community nurses think about the proposed model of nursing in the community?

Conclusion 8: Approximately one third of nurses who responded expressed at least some support for the proposed new model of community health nursing, and over half were unsupportive.

Conclusion 9: Some participants considered the new model may work best in rural areas and could deal with staff turnover and shortages in rural areas.

Conclusion 10: Community Nurses' in the sites confidence to work across range of areas has implications for the education and training of community nurses to prepare them to work in the ways proposed in the new model for community health nursing in Scotland.

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ANNEX ONE – LITERATURE REVIEW WHICH INFORMED THE SURVEY INSTRUMENT

Aims of the Review
To inform the development of a survey instrument measuring nursing practice in the community and contribute to topic schedules for focus groups and interviews exploring practitioners' and service users' experiences of community nursing.

Objectives

- To complete a scoping exercise of the literature relating nursing in the community.
- To review the literature relating to nursing practice in the community.

The Search for Literature

Search strategy
A combination of free text and thesaurus terms were entered into the following online bibliographic databases: British Nursing Index, Cinahl Plus, Medline and Psychinfo. The search strings were tailored according to each database, search strings consisted of keywords reflecting the following terms:

- Community nurse
- District nurse
- School nurse
- Health visitor
- Professional practice
- Nurse role
- Review
- Questionnaire
- Survey

Additionally members of the research team identified papers that may be of potential relevance to the review. For more details of the online search strategy, please see the search strategy at the end of this appendix.

Search strategy results
Table 1 below illustrates the results of the search strategy from each of the bibliographic databases.

Table 1: Search Results

Database	Number of Citations
British Nursing Index	47
Cinahl Plus	667
Medline	342
Psychinfo	21

Total	1077

The findings of the search strategy were imported into Reference Manager, and the titles and abstracts were screened against the selection criteria.

Criteria for considering studies for this literature review

Types of studies

- literature reviews
- questionnaire/survey designs

Topic areas

Nursing practice in following areas:

- public health nursing
- community health nursing
- district nursing
- school nursing
- health visiting

Initial screening of the titles and abstracts narrowed the list down to 35 studies which could potentially be included in the review. Table 2 summarises the 35 studies according to the different nursing disciplines.

Table 2: Summary of Studies included in initial screening

Community Nursing	**District Nursing**	**Health Visiting**	**School Nursing**	**Public Health Nursing**	**Other***	**Total**
11	2	6	3	5	8	35

Refers to categories such as home health nursing, family nursing, multiple role etc.

Further screening of titles and abstracts by a second researcher with specialist expertise in this topic area narrowed the list down to 9 studies to be included in this review. Studies that narrowly focussed on nursing practice within specific areas (e.g. smoking cessation or learning disability) were excluded from the literature review. Members of the research team identified 2 potentially relevant studies not identified in the online searches. The full reports of each of these studies were retrieved for inclusion in the literature review. A total of 11 studies were included in the literature review. Table 3 below summarises the papers according to topic area and type of study.

Table 3: Summary of Studies included in the review

Type of Study	**Nursing Discipline**						
	Community Nursing	**District Nursing**	**Health Visiting**	**School Nursing**	**Public Health Nursing**	**Other***	**Total**
Review	1	0	1	2	0	0	4
Questionnaire	3	0	2	1	1	2	9
Total	4	0	3	3	1	2	13**

* This category refers to home health nursing and family nursing

**Some studies cover more than one discipline therefore categories are not mutually exclusive

Summarising Findings
Once the full reports for all the papers have been obtained, data was extracted from each of the papers and summarised using the framework from the Nursing in the Community Literature Review (Kennedy, Christie, Maxton et al. 2006). Findings from included studies were tabulated under the following framework:

- Type of study
- Aim
- Method
- Findings
- Limitations
- Key Messages

REVIEW OF THE FININDGS

This review included 8 questionnaire studies and 3 literature reviews relating to nursing in the community (Table 4). Of the included questionnaire studies, 3 of these looked at aspects of the community nurse role, 1 study surveyed aspects of the home health nurse role, 1 study explored the role of the family health nurse, 1 study looked at the roles of health visitors and school nurses in managing children's mental health. One study explored the public health role of health visitors, while another study looked at public health competencies in nursing.

The reviews included in this literature review consisted of a systematic review of workload assessment tools in community nursing, 1 review scoping school nurse practice, and 1 review of the public health roles of health visitors and school nurses.

The findings of these papers are summarised in brief paragraphs under the following headings:

- Community Nursing
- Health Visiting
- School Nursing
- Public Health Nursing
- Other

Community Nursing
Findings from studies relating to the community nursing role in general revealed a lack of consensus over roles. For example, one study exploring the practice of community health clinical nurse specialists, illustrated differing interpretations of community health clinical nursing (Logan 2005). A survey of the health promotion work of community nurses with older people, revealed an overlap of health promotion work between HVs, DNs and PNs. There are also issues relating public health work, there is no agreed definition of this role and the sort of activities involved (Runciman, Watson, McIntosh & Tolson 2005).

With regards to assessing community nurse practice a recent review in this area, recommends that assessment tools reflect the diversity of community care across different community care

areas. Due to the varied nature of community health nursing, it is very difficult to quantify the different types of care, therefore activity based instruments are inappropriate for measuring the work load of this discipline (Brady et al. 2007). In one of the studies mentioned previously in this section survey respondents who had additional responsibilities were also confused when responding to items requesting an indication of the percentage of responsibilities within a given area (Logan 2005). The most effective tools are those that measure direct and indirect care simultaneously across care groups (Brady et al. 2007). A job satisfaction instrument sent out to community nurses has been shown to be a valid and reliable measure for use with community nursing staff. This tool was also found to be sufficiently sensitive to discriminate between different nursing disciplines within community nursing (Traynor & Wade 1993).

Health Visiting

A literature review of the public health roles of health visitors suggests most of the public health work by health visitors is carried out at the level of individuals and families (Hawksley, Carnell & Callwood 2003). However, a survey of the public health role among health visitors uncovered a great deal of confusion over new and existing roles, training and job descriptions. Furthermore, this survey revealed health visiting to be an ill defined and complexed activity. Therefore there is a necessity for greater clarity over roles, training and development (Wilson, 2006)

School Nursing

The reviewed literature on school nurse practice refers to the changing role of school nurses. A review on school nursing suggests that the practice of school nursing in the UK has shifted from the generic healthcare of children in schools to a specialised role focusing on the individual child (DeBell 2006). A survey of the workload of school nurses found that they had a substantial number of mental health case loads. Furthermore, school nurses reported a great deal of uncertainty in their practice and voiced concern over their degree of knowledge and skill when dealing with challenging cases (Wilson et al 2007).

One review in the area of school nursing suggests that while the role of the school nurse now sits within the social model of medicine, the literature suggests that school nursing has yet to contribute to public health. However development plans suggests trends towards more public health initiatives in school nursing (Hawksley, Carnell & Callwood 2003). Another review in this area states that although there is general agreement that school nurses have a role in the public health arena, however, there is confusion over what this role actually entails (DeBell 2006).

Public Health Nursing

Within public health nursing this literature review identified one study that developed a research tool to assess public health competencies across community nursing. While, the focus of this study was limited to one aspect of community nurse practice, the findings of the study report the difficulties of assessing new competencies that are merged into the nursing role. Therefore authors developed a tool that measures competencies for practice rather than public health (Poulton & McCammon 2007).

Other

A study surveying home health nurses reported that nurses required a clearer understanding of advanced care planning for end of life treatment. This would enhance nurses comfort level improving practice and increasing families' participation in advanced care planning. Healthcare personnel must be aware of these issues in order to overcome potential barriers to community nursing activities, such as advanced care planning (Badzek et al 2006.)

The findings of a survey of the family health nurse role in Scotland, suggests that this role has contributed to the production of generalist community health nursing services in remote and rural areas. Secondly, when developing new roles (e.g. family nursing and community health nursing) previous roles (e.g. district nursing, health visiting, etc.) are likely to remain dominant during the first year of implementation of the new role. Finally, the success of the new role is likely to be affected by changes elsewhere in the health service (MacDuff 2006).

DISCUSSION

The general theme that has emerged from this literature review is that nursing in the community consists of a range of varied and complex activities. From the studies reviewed it would appear that there is no shared definition of many of the activities associated with community nursing. Within the studies falling under the categories of community nursing and health visiting there is no consensus over what activities are regarded as public health work. Furthermore, findings of included studies described nursing disciplines such as health visiting and school nursing as ill defined or uncertain. As a result these roles required greater clarification with regards to job descriptions, training, required skills and knowledge, etc. From the reviewed studies it would appear that role ambiguity may occur due to changes in current roles. Findings from included studies suggests that when new roles are created on top of existing ones, the older role tends to be more dominant in the first year.

The reviewed studies covered various nursing in the community activities and have some implications for the quantitative and qualitative phases of this study.

Implications for Focus Groups

The focus groups should explore current views on roles and responsibilities and community nursing activities. Potential topics include exploring how merging new and existing roles will impact upon community nursing activities.

Implications for Questionnaire

From the literature included in this review, there is no existing measurement tool that measures the diverse workload of community health nurses. Therefore for the purposes of this baseline study of community health nursing it will be necessary to develop an assessment instrument of community health nursing practice. However, the studies reviewed point to the necessity of developing a tool that that is sensitive enough to capture the complexity of community nursing care and able to measure care across diverse groups simultaneously. This literature review revealed the existence of a reliable and valid job satisfaction measure that is suitable for use with community nursing staff. Therefore the measurement tool that is developed to measure community nursing in this study will include the job satisfaction measure as a sub-scale.

Table 4 Summary of papers

Reference	Summary
Badzek, L.A., Leslie, N., Schwertfeger, R.U., Deiriggi, P., Glover, J., & Friend, L. (2006). 1. Advanced care planning: a study on home health nurses Applied Nursing Research 19: 56-62	**Type of Study:** descriptive correlational design **Aim:** To assess home health nurses knowledge, comfort levels, barriers and personal participation in advanced care planning for end of life treatment. **Method:** The Advanced Care Planning Nursing Inventory was sent out to 1,394 eligible nurses. Questionnaires were returned by 621 nurses (response rate of 44%). Data from 519 usable questionnaires were included in the analysis. **Findings:** Knowledge – Nurses' perceptions of their knowledge of advanced care planning was greater than their actual knowledge level. Comfort – Nurses were most comfortable discussing specific treatment decisions over general end of life issues with patients and families. Barriers – Lack of time, education, written models and support were frequently reported as barrier to discussing advanced care planning with patients and families. Along side patient reluctance and family problems hindering the arrangement of meetings. Heavy patient case loads were also reported as barriers. **Limitations:** US study focusing on specific area (advanced care planning) of community nursing. **Key Messages:** Nurses require a clear understanding of advanced care planning. This would enhance nurses comfort level and participation of families in advanced care planning. Healthcare personnel must be aware of the barriers to advanced care planning in order to overcome these barriers and facilitate discussions about advanced care planning.

Brady, A, Byrne, G., Horan, P., Griffiths, C., MacGregor, C., & Begley, C. (2007) 2. Measuring the workload of community nurses in Ireland: a review of workload measurement systems. Journal of Nursing Management 15: 481-489	**Type of Study:** Systematic Review **Aim:** To review the varied approaches to measuring nurse workload in an attempt to find a suitable tool to apply to public health nursing in Ireland. **Method:** Systematic review using databases (Pubmed, Ovid, Cinahl, Biomed, Synergy and the British Nursing Index). **Findings:** Activity based systems – the simplest method of this type is to record the number of visits. However, this method does not capture the complexity of nursing and the quality of care. It is difficult to quantify different types of care. Recording activities is another method which although task oriented does not measure professional interaction and the less tangible aspects of nursing such as emotional support. Often time taken to complete a task is a function of client care needs. Frequently many activities can be performed simultaneously. Overall these approaches cannot measure indirect care, which make up the work of the professional nurse. Dependency-based systems – Patient classification systems offer two major advantages; they determine the care needs of individuals and offer data on populations of patients. Although theses systems must be sufficiently developed to capture details of the psychosocial support to patients and families, education of the patient and family, and coordination and planning of care. The district nurse dependency system (Freeman et al 1999) allows for correlation between frequency and duration of visits and care categories. However, this is limited to the work of the district nurse in the UK. The Easley-Storfjell Instrument for Caseload/Workload Analysis used in USA and Canada combines assessment of direct and indirect nursing care. This tool measures caseload according to time, type of intervention and complexity of care. The instrument provides a framework that is capable of measuring both direct and indirect components community nursing and is applicable to Irish public health nursing context. **Limitations:** Recommends material for community nursing in Ireland which may not be directly applicable to this context. **Key Messages:** Evaluation of community nursing should focus on effectiveness of and organisation of care activities. Assessment tools must be modified to reflect the diversity of community care across different community care areas. The ideal workload measurement tool is able to measure the direct and indirect nursing care and to also be able to measure the

	diverse care groups simultaneously. The adaptation of the Easley-Storfjell Patient Classification Instrument (Anderson & Rokosky 2001) will provide a workload measurement tool that can capture the variation in diverse public health nursing and is applicable to public health nursing in Ireland.

DeBell, D. (2006) 3. School nurse practice: a decade of change Community Practitioner 79 (10): 324-327	**Type of Study:** Literature Review **Aim:** To complete a scoping review of the evidence around school nurse practice. **Method:** Data analysed by extracting repetitive themes and classifying to the point of saturation. **Findings:** School nurses have begun to incorporate family and community settings into their practice. There is general agreement that school nurses have public health role, however there is confusion over what this actually entails. Evidence base suggests that the school nurse has often been the first point of contact for children with emotional problems. However, school nurses need training and development as well as referral skills to appropriately respond to the mental health needs of children and young people. **Limitations:** Focus entirely on school nurses but within the UK **Key Messages:** School nurse is no longer a generic role that involves general health care of children on the school premises. School nurses now work in teams with highly specialised agendas. Their practice sits in the social model of medicine, the preventive agenda changes how these nurses are trained and how they perceive their work. The emphasis is now on the child rather than the school, which is a radical shift in focus. The practice of school nursing has changed in all 4 UK countries.

Hawksley, B., Carnwell, R. & Callwood, I. (2003) 4. A literature review of the public health roles of health visitors and school nurses British Journal of Community Nursing 8 (10): 447-454	**Type of Study:** Literature review **Aim:** To identify national and local trends concerning the family centred public health role of health visitors and the child-centred public role of school nurses. **Method:** Consisted of a literature review and documentary review of community trust development plans. Literature search using Cinahl and Medline databases and two models to frame the literature analysis. **Findings:** Public health work appears to be shifting from individual work to work with families and populations. Current literature indicates that current public health work is concentrated at the level of individuals and families at the cultural behavioural focus. There is little evidence of the shift in public health work towards the population level. Analysis of development plans demonstrated an emphasis of practice development, with particular focus on managing change at the community level. **Limitations:** Reviews the activity of health nurses and school nurses within two theoretical frameworks. Authors state that it is not clear how these finding relate to reality of school nurse and health visitor practice. **Key Messages:** Literature suggests that much of health visiting and school nursing is concentrated in the cultural-behavioural model and the individual and community level. From the literature it would appear that school nursing and health visiting is yet to contribute to public health or social functions. Although development plans do suggest a trend towards public health initiatives.

Logan, L. (2005) 5. The practice of certified community health CNSs Clinical Nurse Specialist 19 (1): 43-48	**Type of Study:** Descriptive, survey **Aim:** To explore the practice of community health clinical nurse specialists (CNSs) **Method:** A survey was developed and sent out to 209 certified community health CNSs. A total of 111 surveys were completed for a response rate of 53%. **Findings:** Demographic data – Majority of respondents were white female with very little representation across ethnic groups such as Black, Hispanic, Asian, Native American and Alaska Native. Practice and Employment – 72% of respondents indicated that they were currently practicing as Community Health CNS, 50% responded that they practiced in another specialty, 25% of this group indicated that they practised in nursing education. Spheres of influence - Respondents indicated that 39% of their practice responsibilities were in the patient/client sphere. While 35% of their responsibilities were in the organisation/network sphere and 25% of their responsibilities were in the nursing personnel sphere. Sub-roles - Respondents indicated that on average 21% of their activities were within the sub role of clinician, 22% within administrator/leader sub-role, 14% of activities represented the sub role of consultant, 8% represent by the sub role of researcher and 35% represented the sub-role of educator. **Limitations:** US study, targeting those already equipped with a Community Health qualification. Excludes those without this qualification, who may be practising in this area. Author states that respondents had differing interpretations of CNS. There was also confusion for those who practiced in additional roles outside CSN when indicating the percentage of their responsibilities under each spheres. **Key Messages:** Findings indicate a typical profile of Community Health CNS who is female, white middle aged and has practiced as a nurse for more than 20 years. They are likely to work in a full time salaried position in nursing education or in governmental agency. This professional profile is not representative of the different ethnic groups served in the US by CNS. This could also be a disadvantage to the professional group, as many appear to be nearing

	retirement. Recruitment should target a younger and more ethnically diverse group of nurses.

MacDuff, C., (2006) 6. A follow-up study of professionals ' perspectives on the development of family health nursing in Scotland: A questionnaire survey International Journal of Nursing, 43: 345 – 356.	**Type of Study:** Mixed methods; Questionnaires with follow-up telephone interviews. **Aim:** Study aimed to follow up healthcare professionals perspectives on the development of the FHN role in remote and rural areas in Scotland. **Method:** Questionnaire survey of all established FHNs in remote and rural areas and other health and social care professionals that they were in contact with. In novel circumstances follow-up telephone interviews were conducted. **Findings:** Gradual and positive development of a role which maintained community nursing provision supplemented with a limited expansion of family health nursing and public health activities. FHN role has flexibility and wide scope in producing generalist community health nursing services. FHN role is now consolidating and developing, although it is difficult to engage with whole families. **Limitations:** Very small numbers of Family Health Nurses **Key Messages** • Emphasis on health and family care was seen by the Scottish Executive as being most suitable for remote and rural areas; and was thought to address recruitment and retention issues in these areas by addressing the need for multi-skilled health and social care professionals. • When developing a new role (e.g. FHN, CHN) from a previous one (e.g. DN, HV) the previous role is likely to maintain dominant especially during the first year of practice. • New roles require facilitation. • Practice change was seen as gradual but appropriate • PHCT was fundamental in delivering a family health approach • Considering local circumstances was important in understanding the nuances of the role. • Predominantly a more positive role, although more stressful due to the implementation of the role. The majority of FHNs felt that the role was an improvement on previous methods of practice. • New FHN role was not seen as taking away from current service provision. Almost half of colleagues felt that there was a need for the role. • There was little momentum behind the development of

	the FHN role that was independent to the traditional DN role. • Since the original evaluation there is gradual positive development which maintains established service provision , supplemented with a limited expansion of the FHN role. The role has a wide scope and is viewed as being very flexible which is valued by colleagues. Most FHN prefer the new role to their previous role. • The comparatively unbounded nature of the role can be problematic when explaining it to a professional colleague & the general public. • The success of the FHN role and indeed the Community Health Nursing role is like to be impacted by other changes to Health Services and UK/Scotland primary care policy. **Issues and information which may be relevant to CHN study** • FHN role has been developed on top of a DN workload. What lessons might have been learnt from this role which may be of use to the CHN role. i.e. how easy is it to develop into a new role whilst trying to continue an existing one? Might it be worth exploring these in interviews?? • Questionnaires sent to FHN and the professionals that they worked with shared common content. • In this study the questionnaire response rate was 52%. This was thought to be because the FHNs distributed the questionnaires themselves as in previous (baseline?) studies direct mailing had been more successful and response rates of 74% and 79% had been achieved. • Results from the questionnaire and interviews were discussed under a few main headings. It may be useful to consider these themes when developing our questionnaires and interview schedules: o Evaluation of the local FHN service o Professional and personal impacts of the role o Nature of the work itself o Aspects of the service delivery in terms of magnitude and practice change • Article also tries to drill down to see what kind of a role they see themselves providing. Table 1 provides estimates by the FHNs of the proportion of their work time spent on their three core functions. This table might be useful for the questionnaire.

Poulton, B., and McCammon, V., (2007) 7. Measuring self-perceived public health nursing competencies using a quantitative approach Nurse Education Today, 27 : 238 – 246.	**Type of Study:** Quantitative study. Questionnaire considering the impact of public health programmes within the nursing curriculum for increasing self-assessed public health competencies. **Aim:** To report on the development of a research tool to assess self-perceived public health competencies of community nursing students, pre and post studying on a community and public health nursing programme. **Method:** Pre and post graduation a questionnaire was conducted with community nursing students who were studying on a public health programme. **Findings:** Students self-perceived competences in public health had improved by going on the course. **Limitations:** • No common agreed definition of 'competency' • Limited national and international literature on the use of competency frameworks • Small number of responses from nurses other than DNs/HVs. • Results aren't generalisable to the whole of the UK **Key Messages** • Difficult to assess new competencies that are merged into nursing, so authors developed competencies for practice to understand competencies in public health. • No uniformity amongst EU states with regard to nursing competencies. UK Government commissioned the development of a competency framework that could be used to inform all public health programmes. • Need to produce nurses with the knowledge and ability to deliver the public health agenda. • There has not been enough attention to the achievement of public health programmes in improving competencies. • There are few psychometrically tested competencies in nursing, especially public health nursing. **Issues and information which may be relevant to CHN study:** Table 3 includes a list of public health competencies. Used factor analysis to reduce the multiple dimensions of public health to a more manageable size

Runciman, P., Watson., H., McIntosh, J., and Tolson, D., (2005) 8. Community nurses' health promotion work with older people Issues and Innovations in Nursing Practice, 46 -57	**Type of Study:** Descriptive and Questionnaire **Aims:** To describe community nurses' health promotion with people over 50; to explore health promotion initiatives for older people which might be transferable. **Method:** Questionnaire to over 1,000 CHN in 6 health boards. 35% response rate. Follow-up telephone interviews. **Findings:** Community nurses in primary care settings have a key contribution to make to the health improvement agenda. Health Visitors (HVs) are health promotion experts. Their role is currently in transition – strengthened in public health and emphasising community development. Main constraint in health promotion work is that other work takes priority and thus there is a lack of time. It is difficult to evaluate health promotion because of its embeddedness within daily work. There is overlap of health promotion work between HVs, DNs and PNs. There are problems relating to a lack of a shared definition of 'public health', technology and a lack of shared understanding. There is considerable scope for health promotion work with older people. There is a need for more obvious audit and evaluation as there is a lack of skills which needs to be addressed. *'Expertise of experienced nurses rests on a complex blend of skills and knowledge-in-action acquiring evidence of outcomes of health promotion work with older people'*. **Limitations:** Questionnaire may need to show more sensitivity to local issues. **Key Messages** There is wide scope of health promotion; some of it is embedded and unrecognisable which hinders audit and evaluation. Evidence of audit, evaluation and active involvement of older people in planning health promotion was limited. Funding for health promotion initiatives was vital for their sustainability. Need to make the health promotion work of CHNs more visible through audit and systematic evaluation as it promotes involvement of older people, strengthens partnership working and raises the profile of health in older people. Community nurse education should be reviewed to raise the profile of health later in life.

Traynor, M. & Wade, B. (1993) 9. The development of a measure of job satisfaction for use in monitoring the morale of community nurses in four trusts. Journal of Advanced Nursing, 18: 127-136.	**Type of Study:** Questionnaire **Aims:** To develop and pilot a measure of job satisfaction suitable for community nursing staff and to establish it's reliability and validity **Method:** A review of relevant literature informed the development of a 50 item job satisfaction assessment instrument. A total of 723 questionnaires were sent out and 489 questionnaires eligible for inclusion were returned. Therefore the response rate was 72%. **Findings:** Less than 3% of community nurses are male and 45% of the sample was aged 45 or more. The instrument was shown to have internal consistency and test-retest reliability. Tests for discriminant validity indicated that practice nurses, clinical nurse specialists, district nurses and school nurses had significantly higher personal satisfaction than health visitors. Practice nurses were most satisfied with workload than all other nursing groups. This group also reported more satisfaction with professional support than health visitors and school nurses. They were also more satisfied with training than district nurses, health visitors and school nurses. In terms of pay and prospects, practice nurses were more satisfied than health visitors and school nurses. Nurse managers and district nurses were also more satisfied with pay and prospects than school nurses. Overall practice nurses appeared to have more job satisfaction than school nurses, health visitors, clinical nurse specialists and district nurses. **Limitations:** Instrument does not address different dimensions of job satisfaction. **Key Messages**: This measure of job satisfaction has been shown to be a valid and reliable measure for community nursing staff. Furthermore, it has the sufficient sensitivity to discriminate between different nursing disciplines within community nursing. This measure of job satisfaction has been shown to be a valid and reliable measure for community nursing staff. Furthermore, it has the sufficient sensitivity to discriminate between different nursing disciplines within community nursing.

Wilson, P., Furnivall, J., Barbour, R.S., Connelly, G., Bryce, G., Phin, L. & Stallard, A. (2007) 10. The work of health visitors and school nurses with children with psychological and behavioural problems Jan Original Research, September: 445 - 455	**Type of Study:** Survey **Aim:** To describe the workload of health visitors and school nurses in relation to children and young people with psychological, emotional or behavioural problems. **Method:** Analysed the data of 71 health visitor questionnaire respondents from a targeted 140 and 100 school nurse questionnaire respondents from a targeted 230. There were a total of 170 analysable responses as one of the respondents held a combined health visitor/school nurse post. **Findings:** Workload – both nursing disciplines have substantial but different mental health case loads. More than half (53%) of health visitors saw 21-50 children weekly, while almost half (46%) of school nurses saw 50-99 children each week. Five health visitors and four school nurses working in specialist settings saw fewer than 6 children each week. Barriers – Both disciplines reported making referrals, difficulties or delays in accessing specialist services or lack of local specialist support as the most common barriers. Of the 22 school nurses who reported referral difficulties, 20 described their most worrying cases which included self-harm, aggressive behaviour, abuse and depression/suicidal feelings. Second most commonly reported barrier for school nurses was lack of time and heavy case loads. For health visitors this was lack of cooperation by the child or parents. Training – School nurses and health visitors responded differently regarding the extent to which they felt ill prepared through lack of knowledge or appropriate training to support families. This was reported by 17% of school nurses and only 7% of health visitors. Only 24% of Health visitors and 30% of school nurses reported ever receiving specific training in mental health problems in children and young people. Nearly all the respondents in each group (88% of health visitors and 94% of school nurses) desired training in mental health of children and young people. Impact – School nurses experienced a great deal of uncertainty in their practice and were concerned about their lack of knowledge and skill to deal with the number and complexity of cases. Several school nurse respondents (28%) felt that lack of time impeded the service they provided. Many were frustrated about their limited access to external resources for young people and their own limited access to professional advice and support. In contrast health visitors felt less uncertain in their practice. However, cases that caused them

	the greatest concern were those that challenge normal work boundaries, this includes school age children with behavioural difficulties such as self harm, aggression, substance misuse and fire setting. Similar to school nurses, health visitors required a professional advice to support their direct work with children and families. **Limitations:** Non-completion on some questionnaire items. Specific to health visitors and school nurses working with children **Key Messages:** Both health visitors and school nurses appear to be regularly involved with the management of mental health problems in children and young people. While neither discipline have objected to this role, both groups express concern over access to appropriate training to adequately deal with complex mental health problems.

Wilson (2006) 11. Health visitor or public health nurse? A Scottish Study. Community Practitioner, 79 (9): 289-292.	**Type of Study:** Questionnaire **Aim:** To review the uncertainty surrounding what the public health role means for HVs. Study aims to ascertain what is happening in theory and practice. **Method:** Self administered postal questionnaire collected data on the role of HV and their routine activities. Can obtain questionnaire from author if required. **Findings:** Uncertainty about what the public health role means for HVs. A change in policies advising public health in HV has not been accompanied by changes in job descriptions or previous traditional roles. Public health is about improving the health of populations and reducing health inequalities. HV is an ill-defined and complex activity. There is no concise job description capable of explaining the complexity of the role. Current training needs should be adapted to take account of public health function. **Limitations:** **Key Messages** • Confusion over new roles, existing roles, training and job descriptions. There is a need for greater clarity about roles and role development. • Lack of time to develop a new concept. • Need to ascertain the training needs of HVs currently in post and more strategic direction is needed. • Need to encourage HVs to work in new and more innovative ways. • The proposals for the new CHN role need to be given careful consideration prior to implementation. Inappropriate to implement another new role of community nursing when public health role has not yet been fully developed. • It is essential that clear direction is given to staff by the Government or Health Board on the development of a new role.

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Search Strategy

kw – refers to free text terms entered by researcher
MH – thesaurus terms predetermined by the database

British Nursing Index
#1 community nurse* in kw
#2 community health nurse* in kw
#3 health visitor* in kw
#4 #1 or #2 or #3
#5 professional practice in kw
#6 nursing practice in kw
#7 nursing role in kw
#8 #5 or #6 or #7
#9 review in kw
#10 survey in kw
#11 questionnaire in kw
#12 assessment in kw
#13 #9 or #10 or #11 or #12
#14 #4 and #8 and #13

Cinahl Plus - **Limiters** - Publication Year from: 2000-2008; Language: English

#1 Patient Admission in MH
#2 Patient Discharge
#3 Decision Making in MH
#4 Nursing Interventions in MH
#5 Community Health Nursing in MH
#6 Nursing Practice in MH
#7 Nursing Role in MH
#8 Professional Practice in MH
#9 practice development in kw
#10 generic nursing role in kw
#11 #1 or #2 or #3 or #4 or #5 or 6 or #7 or #8 or #9 or #10
#12 school nurse* in kw
#13 health visitor* in kw
#14 district nurse* in kw
#15 practice nurse* in kw
#16 community health nurse* in kw
#17 #12 or #13 or #14 or #15 or #16
#18 Adult in MH
#19 Frail Elderly in MH
#20 Aged, 80 and Over in MH
#21 Health Services for the Aged in MH
#22 Child Health Services in MH
#23 Adolescent Health Services in MH
#24 Parents in MH
#25 Child in MH
#26 Child, Preschool in MH
#27 Infant in MH

#28 Adolescence in MH
#29 #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28
#30 #11 and #17 and #29

Medline
#1 Community Health Nursing in MH
#2 School Nursing in MH
#3 Public Health Nursing in MH
#4 practice nurse in kw
#5 district nurse in kw
#6 #1 or #2 or #3 or #4 or #5
#7 Professional Practice in MH
#8 Nurses Role in MH
#9 nursing practice in kw
#10 or #8 or #9
#11 Review in MH
#12 Questionnaires in MH
#13 assessment tools in kw
#14 quantitative in kw
#15 #11 or #12 or #13 or #14
#16 #6 and #10 and #15

Psychinfo
#1 School Nurses in MH
#2 Public Health Service Nurses
#3 Nurses in MH
#4 School Nurses in MH
#5 Community nurs* in kw
#6 community health nurs* in kw
#7 health visitor* in kw
#8 practice nurs* in kw
#9 district nurs* in kw
#10 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9
#11 professional practice in kw
#12 practice in kw
#13 nursing role in kw
#14 nursing practice in kw
#15 #11 or #12 or #13 or #14
#16 Literature Review in MH
#17 Surveys in MH
#18 Questionnaires in MH
#19 Quantitative Methods in MH
#20 #16 or #17 or #18 or #19
#21 #10 and #15 and #20

ANNEX TWO – SURVEY QUESTIONNAIRE

Review of Nursing in the Community

Baseline Survey

Date issued:
Date returned:

June 2008

A – YOU and YOUR POST

1.	**Are you?**

Female ❐ 1 Male ❐ 2

2.	**What is your age?**

3.	**What is your current post?**

	Current post
District Nurse	❐ 1
Health Visitor	❐ 2
School Nurse	❐ 3
Family Health Nurse	❐ 4
Staff Nurse	❐ 5
Other (please specify)	❐ 6

4.	**What nursing qualifications do you hold?**

5.	**How many years have you worked as a nurse in the community?** (please calculate to the nearest year)

6.	**On average how many hours do you work per week in your current post?**

7.	How many people are in your nursing team (including you) and what posts do they hold? Please include support and administrative staff

	Post	Grade	Average hours worked per week
You			
2			
3			
4			
5			
6			
7			
8			
9			
10			

8.	**How often do you work with the following in your current post?** (Please tick ✓ ONE box on each row)

		Almost all of the time	Most of the time	Some of the time	Never
a)	0 to 5 years	☐ 1	☐ 2	☐ 3	☐ 4
b)	6 to 10 years	☐ 1	☐ 2	☐ 3	☐ 4
c)	11 to 17 years	☐ 1	☐ 2	☐ 3	☐ 4
d)	18 to 65 years	☐ 1	☐ 2	☐ 3	☐ 4
e)	65 to 84 years	☐ 1	☐ 2	☐ 3	☐ 4
f)	85 years and over	☐ 1	☐ 2	☐ 3	☐ 4
g)	Individuals	☐ 1	☐ 2	☐ 3	☐ 4
h)	Mother and children	☐ 1	☐ 2	☐ 3	☐ 4
i)	Families	☐ 1	☐ 2	☐ 3	☐ 4
j)	Carers	☐ 1	☐ 2	☐ 3	☐ 4
j)	School children	☐ 1	☐ 2	☐ 3	☐ 4
k)	Local community groups	☐ 1	☐ 2	☐ 3	☐ 4
l)	Those with chronic physical conditions	☐ 1	☐ 2	☐ 3	☐ 4
m)	Those with mental health problems	☐ 1	☐ 2	☐ 3	☐ 4
n)	Those with learning disabilities	☐ 1	☐ 2	☐ 3	☐ 4
o)	Providing care at the end of life	☐ 1	☐ 2	☐ 3	☐ 4

B – YOUR WORK

In question 9a, we would like to learn about the current contacts you have with professionals who are not part of your nursing team.

9a.	**Could you name up to five professionals you currently contact who are not part of your nursing team?** **Could you also indicate:** • **How frequently contact occurs?** • **What are the main reasons for contact?** • **How important your relationship is with each in relation to your post?** (Please write your response the appropriate boxes on each row)

Professional **(if you can't remember the name of their post please give name of organisation)**	**Frequency of Contact** 1= daily 2=weekly 3=monthly 4=less frequently	**Main Reasons**	**Importance** 1= not important 2= little importance 3= important 4= very important
1			
2			
3			
4			

5			

In question 9b, we would like learn about the impact these links have on you.

9b	**Has linking with these professionals <u>generally</u> resulted in the following?** (Please tick ✓ ONE box on each row)

	Helped a lot	Helped a little	Not Helped	Made it worse	Not relevant to my role
Working more effectively with individuals	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Working more effectively with carers	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Working more effectively with mothers and children	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Working more effectively with families	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Working more effectively with school children	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Working more effectively with Communities	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Reducing delays people face in accessing services	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Increasing the number of referrals to specialists	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Establishing good team working	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Having a common purpose	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Learning together	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Understanding each others contributions	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Better coordination of services	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Providing services for hard to reach people	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5

PLEASE TAKE YOUR TIME IN ANSWERING THE FOLLOWING QUESTIONS

10.	• **Do you currently undertake any of the following as part of your post?** • **How confident are you in your ability to carry out each of the following?**

	Often	Some-times	Never		Very confident	Mostly confident	A little confident	Not Confident
Assess individuals' health and support needs	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Assess carers' health and support needs	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Assess the health and support needs of mothers and children	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Assess families' health and support needs	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Assess the health and support needs of school children	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Assess communities' health and support needs	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Protect children from harm and neglect	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Protect young people from harm and neglect	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Protect older people from harm and neglect	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Protect those with mental health problems <u>or</u> those with learning difficulties from harm and neglect	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Work with individuals to enable them improve or manage their health	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Work with carers to enable them improve or manage their health	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4

PLEASE TAKE YOUR TIME IN ANSWERING THE FOLLOWING QUESTIONS

11.	• **Do you currently undertake any of the following as part of your post?** • **How confident are you in your ability to carry out each of the following?** (Please tick ✓ even if your answer to the first part is 'almost never')

	Often	Some-times	Never		Very Confident	Mostly Confident	A little Confident	Not Confident
Work with mothers and children to enable them improve or manage their health	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Work with families to enable them improve or manage their health	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Work with school children to enable them to improve or manage their health	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Work with communities to enable them to improve public health.	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Health Promotion	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Develop your understanding of the causes of health inequalities	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Address health inequalities	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Co-ordinate services on behalf of individuals with complex needs	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Co-ordinate services on behalf of families with complex needs	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Use electronic health record systems to aid practice	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4
Evaluate the potential impact of your work on the end users	❒ 1	❒ 2	❒ 3	→	❒ 1	❒ 2	❒ 3	❒ 4

12.	**How often do you proactively target those whose health may be negatively affected by their social, cultural, or economic circumstances?** (These might include: specific genders, ethnic groups, those with specific sexual orientations, those in poverty, those holding certain cultural or religious beliefs) (Please ✓ ONE box)

Often	Sometimes	Never
❐ 1	❐ 2	❐ 3

Which groups (if any) do you target?

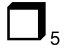
Could you indicate what techniques you use to identify and engage with them?

13.	**What is your response to the following statements?** (Please tick ✓ ONE box on each row)

	Wholly agree	Agree	Neither agree nor disagree	Disagree	Wholly Disagree	Not relevant to my role
I spend most of my time working with people who are unwell and don't have much time for primary prevention	❒1	❒2	❒3	❒4	❒5	❒6
Caseload management prevents me from working in other ways with people	❒1	❒2	❒3	❒4	❒5	❒6
I spend most of my time encouraging self-care	❒1	❒2	❒3	❒4	❒5	❒6
I work in specific areas which demand expert knowledge and experience	❒1	❒2	❒3	❒4	❒5	❒6
My job demands that I work across a range of health areas and I find doing so difficult	❒1	❒2	❒3	❒4	❒5	❒6

14.	**Do you think your nursing team has the right balance of knowledge, experience, and skills to work in the following areas?** (please tick ✓ ONE box on each line)

	Very Much	To some Extent	Very Little	Not at All	Don't Know
Working with individuals across the life span	❒1	❒2	❒3	❒4	❒5
Working with people from different social backgrounds	❒1	❒2	❒3	❒4	❒5
Working with families or carers	❒1	❒2	❒3	❒4	❒5
Working with community groups	❒1	❒2	❒3	❒4	❒5
Child protection	❒1	❒2	❒3	❒4	❒5
Co-ordinating services for those with complex needs	❒1	❒2	❒3	❒4	❒5
Supporting self care	❒1	❒2	❒3	❒4	❒5

Addressing Health Inequalities 1 2 3 4  5

C – SATISFACTION WITH YOUR WORK

How satisfied are you with the following aspects of your post?

15.	**Personal Satisfaction** (Please tick ✓ ONE box on each row)

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
The feeling of worthwhile accomplishment I get from my work	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The amount of personal growth and development I get from my work	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The extent to which my job is varied and interesting	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The amount of independent thought and action I can exercise in my work	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The extent to which I can use my skills	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The amount of challenge in my job	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5

16.	**Workload** (Please tick ✓ ONE box on each row)

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
The time available to get through my work	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The amount of time spent on administration	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
My workload	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
Overall staffing levels	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The amount of time available to finish everything that I have to do	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
What I have accomplished when I go home at the end of the day	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The hours I work	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The time available for patient/client care	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5

How satisfied are you with the following aspects of your post?

17.	**Professional support** (Please tick ✓ ONE box on each row)

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
The degree to which I feel part of a team	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The opportunities I have to discuss my concerns	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The amount of support and guidance I receive	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The people I talk to and work with	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The degree of respect and fair treatment I receive from my boss	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The support available to me in my job	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The overall quality of the supervisions I receive in my work	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The contact I have with colleagues	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5

18.	**Training** (Please tick ✓ ONE box on each row)

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
Being funded for courses	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The opportunities I have to advance my career	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The extent to which I have adequate training for what I do	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
Time off for in-service training	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
The opportunity to attend courses	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5

How satisfied are you with the following aspects of your post?

19.	Pay	(Please tick ✓ ONE box on each row)

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
Payment for the hours I work	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
My salary/pay scale	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The degree to which I am fairly paid for what I contribute to this organisation	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The amount of pay I receive	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5

20.	Prospects	(Please tick ✓ ONE box on each row)

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
My prospects for promotion	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
My prospects for continued employment	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The amount of job security I have	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The possibilities for a career in my field	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The outlook for my professional group/branch of nursing	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
How secure things look for me in the future of this organisation	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5

21.	Standard of care	(Please tick ✓ ONE box on each row)

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
The quality of work with patients/clients	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The standard of care given to patients/clients	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The way that patients/clients are cared for	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The standard of care that I am currently able to give	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
The general standard of care given in this unit	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Patients are receiving the care that they need	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5

D–YOUR VIEWS ON THE SCOTTISH GOVERNEMENT'S MODEL OF NURSING IN THE COMMUNITY WHICH IS BEING TESTED

22.	**What is your response to the following statements about the new model of nursing in the community?** (Please tick ✓ ONE box on each row)

	Wholly agree	Agree	Neither agree nor disagree	Disagree	Wholly disagree
I understand how the new model affects my role as a nurse	❒1	❒2	❒3	❒4	❒5
I understand how the new model affects my future career pathway	❒1	❒2	❒3	❒4	❒5
I understand how the new model affects my current salary	❒1	❒2	❒3	❒4	❒5
I understand how the new model affects my position as part of a multi-disciplinary team	❒1	❒2	❒3	❒4	❒5
I understand how the new model affects the people I work with (service users)	❒1	❒2	❒3	❒4	❒5

23.	**Do you support the new model of nursing in the community?** (please tick ✓ ONE box)

Very Much	To some Extent	Very Little	Not at All	Don't Know
❒1	❒2	❒3	❒4	❒5

Why do say this?

24.	**What is your response to the following statements regarding the introduction of new model of nursing in the community?** (Please ✓ ONE box on each row)

	Wholly agree	Agree	Neither agree nor disagree	Disagree	Wholly disagree
I have been fully consulted about the introduction of the new model	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Those responsible for leading the introduction of the new model are fully aware of what is required of nurses on the ground	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5
Some nurses may find the change difficult and leave the service	❐ 1	❐ 2	❐ 3	❐ 4	❐ 5

25.	**Do you think anything will hinder the introduction of the new model of nursing in the community?**

Yes ❐ 1 No ❐ 2 Don't know ❐ 3

If yes, could you state what?

26.	**Do you think anything might help the introduction of the new model of community nursing?**

Yes ❐ 1 No ❐ 2 Don't know ❐ 3

If yes, could you state what?

THANK YOU FOR YOUR COOPERATION!

When you return the questionnaire you will be entered into a raffle and the chance to win a gift voucher worth £50

PLEASE PROVIDE US WITH:

Your name:

Work telephone number:

E-Mail Address:

NOW PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE IN THE ENVELOPE PROVIDED AND ADDRESSED TO:

MARTINE MILLER
RESEARCH ADMINISTRATOR
SCHOOL OF NURSING, MIDWIFERY AND SOCIAL CARE
NAPIER UNIVERSITY
COMELY BANK CAMPUS
EDINBURGH
EH4 2LD

m.miller@napier.ac.uk

tel: 0131 455 5379

ANNEX 3 PROTOCOL AND TOPIC GUIDES FOR QUALITATIVE INTERVIEWS

Review of nursing in the Community baseline evaluation - Protocol for Focus Groups and patient interviews

- Ask participants to introduce themselves.
- We will e-mail information sheets and consent forms prior to interview and check each participant has received these. Provide copies as necessary to those who do not have this information.
- Answer any questions from participants on project
- Ask participants to provide or sign two consent forms. Leave a copy with each participant.
- Ask participants to provide demographic information on the mix of the group: age, gender, post, grade, time in post
- Give date of interview at the start of recording.
- Explain that we have a list of questions that we have to answer so that we might have to guide the discussion to cover all topics.
- Assure that we will finish by agreed time.
- Explain the second researcher will be taking notes
- Debrief. Offer to send feedback/ copy of the report to groups
- The researchers will write up notes on the discussion
- Download the interview and send directly to the transcribers 1st Class http://www.1stclass.uk.com/

Protocol for Patient interviews

- Hand out information sheet.
- Give brief introduction on project and give participants time to read it themselves.
- Ask participant to sign two consent forms. Leave a copy with patient.
- Give date of interview at the start of recording.
- Debrief. If the patient raises any particular issues regarding their treatment then suggest they discuss this with their GP/community nurse.
- Offer to send feedback/ copy of the report to patients
- Complete expenses sheet if necessary.
- Ask if patient would like to be contacted if there is a follow up study
- The researcher should write up notes on the discussion
- Download the interview and send directly to the transcribers 1st Class

Topic Schedule for Focus Group Interviews

Review of Nursing in the Community Baseline Study

<u>Topic Schedule for Focus Group Interviews</u>

Issues to be explored:

- How staff are currently organised
- Current roles and responsibilities
- Perceived impact on patients, carers experiences, outcomes
- Role focus and activities
- Views on plans for CHN role and how they see new role developing alongside existing role

Intended outcomes of these sessions:

- An examination of nurses' attitudes and perceptions of their existing roles and the new role
- A description of how their roles contribute to the team and patient/client care
- A means of looking at diversity of the different areas

Topic Schedule for Focus Group Interviews

Review of Nursing in the Community Baseline Study

Topic Schedule for Interviews with nurse/team leaders

Issues to be explored:

- How staff are currently organised in teams
- Current roles and responsibilities of teams
- Perceived impact of team on patients, carers experiences, outcomes
- Role focus and activities within the team
- Views on plans for CHN role and how they see new role developing alongside existing role

- Views on how teams will look in the new model

Intended outcomes of these sessions:

- An examination of existing team structures and roles and responsibilities
- A description of how the teams contribute to the team and patient/client care
- A means of looking at diversity of the different areas
- Perceptions of new teams and where they fit in the model

Topic schedule for patient interviews

Review of Nursing in the Community Baseline Study

Topic Schedule for Patient Interviews

Can you tell me what you know about Community Health Nursing?

What does your Community Health Nurse/School Nurse/Health Visitor/District Nurse do for you?

Does the nurse work with other members of your family?

If so do you know what he/she did and if/how this helped?

Can you say something about the service you have received from the nurses?

Did the nurse refer you to any other services?

If so, were these helpful and are there any others you think would have been helpful?

Does the nurse help to coordinate these other services?

Are there things that the community nurse does not do for you that you would want/expect him or her to do?

Do you think the nurse had the knowledge and skills to help you?

If yes, please tell me why, if no please tell me why?

Did/does the nurse involve you in making decisions about your care/actions to meet needs? If so, please describe

Are they approachable and work alongside you? If so can you tell me how this works?

Do they give you advice and information about how to maintain or improve your health/deal with your condition? If so can you give me some examples?

Tell me about your overall experience of your contact with the Community Health Nurse/School Nurse/Health Visitor/District Nurse?

Are there aspects of the service you have received that need to be changed or improved?

What is the most helpful thing about the service for you and your family?

Is there anything else you would like to add?

ANNEX FOUR – CURRENT ACTIVITIES OF COMMUNITY NURSES AS REPORTED BY FOCUS GROUP PARTICIPANTS

District Nursing – Activities and interventions

- Assessment
- Care management: liaison with people to set up complex care for patients: ordering equipment for patients
- Intermediate care
- Post-operative care
- Managing long term conditions: care of housebound diabetic patients
- Clinical care of older housebound patients
- Well elderly clinics
- Medication work with patients who have dementia
- Wound management
- Leg ulcer clinics
- Taking blood samples
- Continence assessment clinics
- Bowel care
- Public health activities e.g. smoking cessation classes; health promotion with cardiac patients
- Educating patients and carers
- Some practice nursing activities
- Assisting with emergency cases when waiting for air ambulance
- Palliative care
- Prescribe medication
- Counselling and bereavement support
- Organising and managing the team; multi-disciplinary meetings, case conferences, liaison with other services
- Mentoring staff nurses and students (including trainee GPs)
- Keeping up-to-date with new research and putting it into practice

Public Health Nursing – Activities and interventions

- Health promotion including in primary schools
- Baby clinics
- New births
- Contacts with individual families – post and ante natal

- Emotional support in cases of post natal depression
- Risk assessments
- Home visits
- 0-5 year olds (in some areas up to 3yrs)
- Complex needs
- Migrant workers needs (e.g. immunisation)
- Childhood immunisations
- Baby massage
- Family skills programmes
- Child protection
- Liaison with GPs and other agencies
- Look at joint initiatives with early years cluster group (parenting, postnatal)
- Vulnerable families
- Anti-coagulation work
- Cardiac rehabilitation with adults post MI
- Working with older people and doing District Nurse discharge facilitator role

School Nursing – Activities and interventions

- Immunisation programmes
- Sexual health and relationship education
- Monitoring specific children
- Child protection
- Oral health programme
- Work with specialist services e.g. the specialist dietician on 'Rising Stars' programme; family mediation; social work; children's panel
- Work with main stream schools and schools for special needs children.
- Group work with vulnerable children who may have missed out on development work in the school curriculum
- Training teaching staff
- Home visiting
- Administration – paperwork and organisation

Staff Nursing – Activities and interventions

- Deal with less complex cases the the DN or HV
- Dressings
- Taking blood samples

- Palliative care
- Anticipatory care
- Provide emotional support to patients and give advice.
- Staff nurses may accompany District Nurses on visits to complex or palliative care patients so that a second person is familiar with the case (it also provides an opportunity for learning)
- Role being expanded so they can work with School Nurses as well as Health Visitors
- Work with 0-16yrs and able to assist with School Nurse immunisation programmes
- Specialist team of staff nurses do anti-coagulation work
- Assist GP
- Conducts a treatment room clinic
- Some involvement with parenting programmes
- Work with elderly.
- Staff nurses in one area cover weekends; they are supported by the Out of Hours service as no District Nurses are on shift.
- Staff nurses are involved in cross-disciplinary working.