

A Sustainable Future

Voices on a Vision

A companion to the RCN Vision for
Community Nursing in Scotland

Table of Contents

03	Executive Summary
05	Introduction
06	Approach
07	Participants
08	Findings: General Remarks
09	Thinking about your experience of community nursing, what is working well?
12	What, if anything, could be improved?
15	If you were designing a community nursing service in the future, how would you want it to work?
19	What do you think are the biggest challenges facing community nursing in the future?
22	Where to from here?
23	Appendix One: Approach
26	Appendix Two: Participants
30	References

Executive Summary

This document summarises the findings of a four-month consultation undertaken by the Royal College of Nursing Scotland (RCN) into the future direction of community nursing in Scotland. It is a companion to the publication, *A Sustainable Future: the RCN Vision for Community Nursing in Scotland*¹, which outlines the six key things we now believe are necessary to take a new vision for community nursing forward.

We decided to consult on this topic in the context of ongoing debate into the future direction of community nursing in this country. We wanted our position in the debate to be informed by the voices of those on the ground. So we asked you. We asked you about the current strengths of community nursing, areas for improvement, future challenges, and most importantly, your vision for the future.

The consultation began with a series of sessions across Scotland inviting RCN members to offer a vision for the future of community nursing, and ultimately expanded to incorporate the views of well over six hundred nurses, doctors, patients, allied health professionals, social workers, and voluntary sector workers. The level of interest in participating in the discussion was startling and emphasises the depth of feeling that exists about community nursing in the present and future.

What we heard during the consultation was at times bleak, but ultimately hopeful. Community nursing in all its forms is a highly regarded and strongly valued part of community health care. Community nurses are passionate about their work, and committed to the patients and communities whom they serve. Yet, our findings also suggest that the community nursing workforce has become demoralised. Many

people expressed their frustrations, anxieties, fears, and uncertainties about the future of their own services and the profession as a whole. Some of these feelings relate to changes taking place as a result of the Review of Nursing in the Community. Others relate to frustration at not being adequately 'equipped' – we have heard that community nursing capacity is stretched, opportunities for education and training are fraught, and that funding and information technology is not keeping up with increasing demand for services.

Nonetheless, there is no shortage of interest and enthusiasm for being actively involved in shaping the future of community nursing services. Far from being averse to any changes, many people expressed a real desire to see community nursing services, and the community nursing profession, refreshed and strengthened to meet the challenges ahead. A common vision was for community nursing to become more clearly integrated with other community health structures, by building on existing links to general practice, allied health professionals, social care, and voluntary agencies. Other people talked about the need to refresh education programmes and career pathways for community nursing so that the profession is well positioned to attract and retain skilled nurses. Strong community nursing leadership, at strategic and grassroots levels, was emphasised in taking these ideas forward.

The role of generic community nursing positions in future structures remains contentious. We heard a range of views presented – from those who want current posts to remain unchanged, to those who supported a generic community nurse role at staff level. Yet for many people, the fundamental issue is retaining the distinction between community nursing

¹ See: www.rcn.org.uk/community_nursing_scotland

Executive Summary

services for children and families (from early years through to young adulthood) and services for adults and older adults. The health professionals we heard from are not convinced that there is value to patient care in replacing all aspects of population-specific expertise with generic working.

Our consultation was a qualitative exercise. Using these approaches allows us to give voice to those who chose to offer us their views on this topic, whether face to face or via the online survey. However, it does limit the capacity to

report quantitatively on the findings. As such, this document gives themes and direct quotations, rather than statistics. The quotes selected are representative of the overall body of material we collected.

We wish to thank all those who have attended RCN events, provided comments, or contributed to the survey on this topic, and look forward to hearing your feedback on our findings.

Introduction

Nurses working in the community are at the coalface of evolving community health service delivery. In the last five years alone, community based nurses have seen roles, priorities, and practices begin to transform as initiatives from *Modernising Nursing Careers*, through to *Health for All Children; Rights, Relationships, and Recovery; Delivering for Remote and Rural Healthcare; Equally Well*; and *The Early Years Framework* have been introduced. Scotland has also been at the forefront in trialling new models of nursing in the community, such as the WHO pilot of Family Health Nursing², and more recently, the community health nursing model proposed in *Visible, Accessible, and Integrated Care*.

Given the many strands of activity re-shaping nursing in the community, current debates about future community nursing models, and the potential impacts on nurses and communities alike, RCN Scotland wanted to better understand grassroots views on this issue.

From November 2008 to February 2009 a number of strategies were employed to consult as widely as possible on³:

- What is working well in community nursing in Scotland
- What could be improved
- Ideas for what community nursing in Scotland should look like in the future
- The challenges facing Scottish community nursing services in the future

This paper provides an overview of the findings and emerging themes from this consultation exercise.

² *The WHO Europe Family Health Nursing Pilot in Scotland: Final Report* (Scottish Executive, 2006)

³ This consultation builds on an earlier confidential consultation exercise conducted in Spring 2008.

Approach

Our initial aim was to capture the voices of RCN members on their current experience and future vision for community-based nursing services in Scotland to help inform our own position on this topic. However, we appreciated that there was considerable interest in community nursing reform from across nursing disciplines and other health care professions, as well as amongst social care practitioners, the third sector, and users of services themselves. Consequently, during the course of our consultation process we progressively broadened the scope of our work to widen the pool of perspectives included. We used three consultation approaches:

- Eight independently facilitated World Café events around Scotland
- Five opportunistic meetings with a number of RCN Forums and other nursing groups ⁴
- An online survey, accessible to anyone with an interest in community nursing

The online survey consisted of a number of short-response questions covering demographic and professional information, and respondents' relationship with community nursing. All respondents were then invited to answer four open-ended questions:

- Thinking about your experience of community nursing, what is working well?
- What, if anything, needs to be improved?
- If you were designing community nursing services, what would they look like?
- What do you think are the challenges facing community nursing services in the future?

Analysis approach

A detailed description of the methods used to collect and analyse the results of the various consultation approaches can be found in Appendix One. In summary, a thematic content analysis was undertaken of the online survey results to identify key themes. Summaries of feedback from the direct engagement events were also reviewed. The findings of all three approaches have then been interwoven to produce this final paper.

⁴ The World Café events and other sessions are referred to generically as 'direct engagement events' for the remainder of this paper.

Participants

Participation in the various approaches was mixed. Despite considerable interest, attendance at the World Café events was generally low (81 attendees overall), whilst the online survey attracted high rates of response.

For the purposes of this paper, the primary sources of data are the direct engagement events and online survey. The latter received 1086 responses, of which 667 were selected for inclusion in the final analysis on the basis of having answered one or more of the four key questions outlined on page 6.

The table below summarises the most common characteristics of online survey participants. A complete table can be found in Appendix Two.

Profession	N ⁵ =	% ⁶
Nurse / Midwife / Specialist Public Health Nurse	491	74.7
District Nurses	117	17.5
Health Visitors	102	15.2
Senior Nurses / Matrons / Nurse Managers	37	7.3
Clinical Nurse Specialists	36	7.1
Community Psychiatric Nurses	19	3.8
Allied Health Professionals	26	3.9
General Practitioners	48	7.3
Other Doctors	52	7.9
Health Care Support Workers	6	0.9
Patients / Carers	17	2.6
Other	17	2.7
Setting		
Community	370	73.3
GP practice	33	6.5
Hospital	42	8.3
Geographic Area		
Mixed urban / rural	292	43.8
Rural / remote	116	17.4
Urban	196	29.4
RCN Membership (Nurses and HCSWs only)		
Yes	298	65.5
No	157	23.5

⁵ Note, throughout this paper 'N' refers to actual responses regardless of whether respondents were individuals or groups. Responses have not been weighted to take into account group memberships.

⁶ In interpreting % total, note that this depends on total response to each demographic question. In some cases respondents chose not to answer some questions, so total N will be less than 667.

Findings: general remarks

For the purposes of clarity, the findings of the survey responses and direct engagement events have been grouped under the four open-ended survey question headings. The quotes selected were chosen as they best represent the breadth of material collected. They should be read as illustrations of the key themes.

However, many of the themes that emerged under each question were interrelated. In particular, themes related to community nursing roles and identity, the shape of future services, management and leadership, education and training, resourcing, and challenges for the future workforce featured frequently across all four survey questions and in the direct engagement events. Likewise, it is worth mentioning at the outset that many responses, particularly to the first two questions, expressed strong feelings about changes to community

nursing, both past and present, and the proposed community health nurse role. This was also evident in the direct engagement events.

Finally, it is interesting to note the degree of convergence amongst different professional, regional, and disciplinary groupings. Chi-square goodness-of-fit tests were undertaken where appropriate to test for variations between themes generated. With a few minor exceptions, themes did not significantly differ between geographic regions, NHS Scotland Board areas, age groups, and RCN members and non-members. Where differences were evident these tended to be between professional groupings or nursing disciplines, but effect sizes were relatively small.



Thinking about your experience of community nursing, what is working well?

Our findings show that community nursing is held in high regard by many non-community nursing respondents. Community nurses themselves were also enthusiastic about their work and proud of their contribution to health care.

The nurse is an integrated, essential part of the medical team bringing skills and knowledge which are practical and complimentary to the rest of the team...Her role is diverse and is expanding to take on more responsibility than ever before and rightly so.

(General Practitioner)

She has become like a friend and comes into hospital when I am ill. She provides continuity and is warm and friendly. She is sensitive and tactful and compassionate and for a time provided the rock that kept me going....

(Patient)

I am able to use my expertise, knowledge and skills in my field of work. I have developed good working relationships and trust within the school community so that my expertise is sought by others to provide assessment, support, and advice. Community nursing takes a holistic approach and is able to provide a service that meets individual needs or involve other services/agencies where deemed to be appropriate.

(School Nurse)

Three key themes emerged across responses as areas where community nursing is working particularly well: being based in the community, teamwork, and community nursing 'specialities'.

The benefits of being based in the community

Being based in the community is regarded as one of the most useful elements of community nursing roles. Community nurses themselves felt that being based in the community facilitated closer relationships with patients and families, and allowed them to be a more visible part of community health care. Non-nursing respondents commented similarly, noting that nurses are sometimes considered more approachable due to their familiarity with individual patients, or non-stigmatising position in the community.

Community nurses are able to provide services that are responsive to local need...Community nurses very often get to know families really well over a sustained period of time. Families value that input and prefer to relate to someone who does know the families circumstances without having to explain everything from scratch.

(Nurse Lecturer / Tutor)

Links to community nurses on a regular basis have been essential for breaking down barriers to health a lot of the young people we work with are facing. Many service users are reluctant to attend hospitals/health centres and a person within the community who is easily accessible has real benefit...The CPN attached to local homelessness services is a great link for young people who are fearful of the term 'mental health issues' and is a starting point for linking them to services which they would otherwise not access.

(Voluntary Sector Worker)

Likewise, some respondents, particularly in district nursing, noted that their roles benefited from the flexibility to identify and respond to changing community needs. By adapting skills or practices to meet local or individual requirements, respondents



Thinking about your experience of community nursing, what is working well?

felt they are better able to deliver a truly patient-centred approach to care.

...the nurse is available to patients in the community, we provide patient-centred care to individual patients and their carers. District nurses take on new skills to benefit their patients, not just for the sake of it...

(District Nurse)

Teamwork

'Teamwork' emerged consistently across responses as an integral, and enjoyable, part of effective community nursing. The teamworking theme encompassed working as part of primary care or multi-disciplinary teams, working with other agencies, and sharing knowledge and ideas with colleagues, and was the most commonly cited positive feature of community nursing.

[What works well is] working within a team of mixed skills and working towards the same philosophy and aims....

(Staff Nurse)

More specifically, working with or being linked to general practice is considered highly beneficial by many respondents for fostering multi-disciplinary working, which in turn is perceived to be associated with more holistic care for patients and families.

Being based in a GP practice enables good communication with the GP and other health professionals. It also enables the right person with the most appropriate nursing skills to deliver the care to the patient.

(Health Visitor)

We work very closely as a team, sharing care with GPs, health visitors, school nurses, mental health, Marie Curie, Macmillan, social work and others. The expertise of each individual and the support makes it work well for patients, clients and professionals.

(Treatment Room Nurse)

Outwith general practice, multi-disciplinary and multi-agency working was also cited as beneficial. Community mental health care and community learning disability services both featured as areas where positive outcomes are resulting from community nursing participation in multi-agency teams.

In regard to learning disability the nurse co-ordinated the care plan and convened regular meetings, holding the various agencies to task. She also had a good relationship with the service user and was able to articulate her needs on her behalf...In regard to mental health community nurses have helped parents, which in turn then benefits the children with whom I am concerned.

(Nurse Lecturer / Tutor)

Community nursing specialties

The final theme of note identified by respondents as working well was existing community nursing 'specialties'⁷. Respondents who raised this issue emphasised the unique contributions made by existing community nursing specialties to the specific populations they serve, and expressed concern that moves to re-configure existing roles will 'dilute' expertise.

I think having separate specialist areas e.g. district nursing or health visiting in a large urban

⁷ 'Specialties' in this sense refers to existing community nursing disciplines or roles, such as health visiting or district nursing. Though the term will have different meanings to different readers we have retained 'specialties' as it was the term most commonly used by respondents to describe these role distinctions.



Thinking about your experience of community nursing, what is working well?

area is the most effective way to deliver care, enabling the practitioner to develop focus on areas of need in the specialist area.

(Health Visitor)

I feel that taking away specialties waters down services...Expecting nurses to be skilled in all areas of nursing is unrealistic...Health visitors, District Nurses, School Nurses, are specialties with special skills to be celebrated.

(Sexual Health Nurse)

The largest area of concern was the potential impact that re-configuring existing roles could have on services for infants, children, young people, and parents – populations considered particularly vulnerable and for whom existing services are highly regarded.

The health visiting service as it stands (in our practice) is vital to caring for the needs and protection issues of the children in our practice. We were dismayed to learn about plans for the generic community nurse it totally undermines the years of experience particularly in the area of children protection which health visitors have built up....

(Sister / Charge Nurse / Ward Manager)

However, not all respondents who commented on this theme agreed. A small number of respondents commented optimistically about the opportunities presented by working across a number of specialty areas. Integration of public health nursing across age groups, and input from mental health nursing into physical health care were both considered valuable resources by those who mentioned them.



What, if anything, could be improved?

This question elicited strong emotions from attendees at direct engagement events, and fiercely worded responses to the online survey, despite the positivity expressed in the previous question. Considerable anxiety and frustration were evident. Three clear themes emerged from responses: the need for community nursing to be better 'equipped', the need to be better 'connected' with other parts of health and social care, and management issues.

Equipping community nursing

The most prevalent theme in response to this question encompassed the different ways that community nursing could be better 'equipped' as a profession. This included increasing community nursing capacity through growth in staff numbers, support for education and training, and appropriate resourcing.

Increasing nursing numbers to boost capacity was the most consistent concern, featuring in responses from across professions. There was a feeling that despite growing demand for community health services, an associated shift in resources and rise in nursing staffing levels has not occurred, placing pressure on existing staffing capacity.

I do feel that the size of our teams could be improved upon for the complexity of our work. The funding from hospital to community has never been adequately carried through.

(District Nurse)

The shifting the balance of care into the community has resulted in an influx of frail elderly patients with complex medical and social needs. End of life care has also encouraged patients who want to be at home to die to make that choice. This is wonderful for the patient if

the staffing levels and expertise can support their needs; however this has not happened with money continually being ploughed into acute care and reduction of district nursing senior staff here in the community....

(District Nurse)

A number of respondents raised concerns about the impact this is having on staff stress levels, 'burn-out' and absenteeism. Concerns were also expressed about the impacts for patients as a result of capacity restrictions, particularly in deprived areas where caseloads are high and issues complex. Consequently, some respondents feel that opportunities for preventive work are being lost.

Staffing is always an issue within community as if your team has sickness etc it is difficult for other team members to pick up your client caseload and there are no alternatives i.e. drop-in clinics etc.

(Community Learning Disability Nurse)

Need more staff...as chronic staff shortages lead to low morale, higher sickness rates and poor patient care.

(General Practitioner)

At present we are one [Health Visitor] down and have been informed that she will not be replaced. The emphasis has thus been on vulnerable families, no time for preventative work.

(Health Visitor)

A number of respondents posed potential solutions to the staffing situation. Of these, some favoured greater clarity of roles and responsibilities, particularly between nursing, social work, and allied health professionals; while others supported greater use of generic staff members within nursing teams. Practical supports, such as administrative



What, if anything, could be improved?

assistance and improved IT infrastructure were also noted as ways to enable community nurses to work more efficiently and spend more time engaged directly with patients and communities.

Interlinked with issues of staffing were resourcing and education. Nurses described being caught in a cycle of resourcing pressures and staffing shortages, making access to protected time for supervision or further education problematic.

We are continually told that there is no money for extra staff and when we are expected to do more training to gain new skills for our new roles we are not given time or incentives to work towards these goals...I care for my patients very much and want to give them the best care possible but am completely frustrated.

(District Nurse)

Connecting community nursing

The second theme to emerge was a strong desire to better 'connect' community nursing with other parts of health and social care. This was surprising given that teamwork had featured prominently as an aspect of community nursing working well, in the previous question. However, whereas the majority of responses to that question referred to working within primary care, the focus for improvement was predominantly directed at multi-agency working. 'Joint working and communication between agencies', and 'more sharing of information and databases' were both common threads of comments.

I feel it is important to maintain involvement in multi-disciplinary / interagency teams, not just be part of nursing team.

(Other Doctor)

The overwhelming majority of respondents who identified this as an area for improvement were nurses, with respondents from the voluntary sector and allied health care making up the balance.

Greater integration of health and social care to provide individuals and families with the right support, care and treatment at the right time...

(Senior Nurse / Nurse Manager)

A number of respondents also feel that community nursing could benefit from better connections with other health services, notably acute services, general practice and the work of allied health professionals. There was a feeling from these responses that referral pathways, discharge practices, and rehabilitation could be better managed through improved linkages with these services. However, some respondents feel that this needs to be accomplished through better reciprocal understanding and appreciation of different roles, rather than formal linkages.

Communication between tertiary and secondary care to primary care. Better understanding by hospital staff – secondary and tertiary – of the roles of the professionals in the community...

(Community Childrens' Nurse)

Management issues

The third theme to emerge in response to this question related to 'management'. Given the considerable frustration expressed throughout the survey about proposed changes to community nursing roles, and pressures on the existing service, this was perhaps not surprising. It was interesting to note however, that many comments did not blame managers for change taking place in principle. Instead, respondents tended to express frustration at the way in which that change was taking place. Communication and consultation, or lack of,



What, if anything, could be improved?

between 'management' and 'staff' were key threads throughout responses. There is a perception amongst many who mentioned this issue of not being engaged or heard in discussions about the future of services.

Our service is being re-designed in the future but management are making the decisions without the community team being consulted. We find this unacceptable for our service.

(Community Childrens' Nurse)

Management transparency and working with staff to bring about change instead of railroading change in...

(Health Visitor)

We are going through massive change at present and as usual it is from top down, which I feel is not good as the people doing have more insight into what is going on in ground level therefore some input from us would be better.

(Health Visitor)

Other respondents felt that management issues are more ingrained - that there is a history of poor communication with or support of staff. As with capacity pressures, some respondents commented that poor staff-management relations are impacting staff in terms of morale, health, and wellbeing.

Line management show little or no interest in their staff. In my experience over the last 10 years – they show no respect, do not wish to listen to their staff and certainly give no support.

(Health Visitor)

...No one at organisational level seems to act on high turnover of staff or staff sickness due to stress. Staff carry on suffering or get out if they can – no one addresses their problems....

(Health Visitor)

Recognition of staff value was considered important for improving this situation.

...for staff to be valued by the top echelons of management for the very hard work they do and go above and beyond the call of duty.

(Senior Nurse Manager)

...how about the patient and staff coming first for a change...being appreciated for what we do, and feeling supported. Staff morale could be improved by listening to us...what is the point in asking staff their opinions but doing the opposite?

(Staff Nurse)

These feelings were not expressed only by nurses directly impacted by proposed changes to community nursing. General practitioners, allied health professionals, and other doctors expressed similar concern about the impacts of management-related issues on community nursing services. Likewise, responses were consistent across NHS Board areas.



If you were designing a community nursing service in the future, how would you want it to work?

Balancing the level of frustration expressed in response to the previous question, was considerable enthusiasm for providing suggestions on the way community nursing services should work in the future. This was not only evident from survey responses. Feedback from the direct engagement events was that participants were energetic in coming up with ideas about future services. Across all approaches employed in this consultation there was a general sense that some re-design is necessary – very few comments favoured retaining the exact form of the current model of community nursing.

However, whatever the shape of future community nursing services, respondents highlighted that planning should start by asking service users, communities, and staff - ‘the ones doing the job’ - what they thought.

The three major themes that emerged from responses to this question were not surprising in light of earlier comments. Team structure, particularly in terms of integration featured prominently, as did debate over the best shape for future community nursing roles. A well-equipped service, supported by sufficient community nursing capacity was the third key theme to emerge.

Team structure

An integrated community health team structure, based on community needs, with strong links to general practice and related agencies, and supported by credible community nursing professional leadership, was the most commonly expressed ideal for future community nursing services.

A team of individuals who have the skills to meet the health needs of the community they

serve. The team would consist of members who were clear about their roles in interagency working. Each member of the team having the opportunity to develop in specific directions to improve their skills in specific areas of care that relate directly to the health needs of the community. There should be reciprocal arrangements between teams to provide all skills required across a greater area.

(Nurse Consultant)

[The] model needs to be responsive to local need – no one size will fit all. Multi-agency teams to ensure the most appropriate service is provided to meet need – this should include the co-location of staff as long as professional leadership for nurses is clear...

(Senior Nurse / Nurse Manager)

Integration was consistently mentioned as an important aspect of these structures so that a ‘seamless’ or ‘holistic’ service’ would be experienced by patients. Some respondents felt that it would be important to enhance links with general practice, while others highlighted the need to improve working with allied health professionals and other nursing disciplines.

Integrated in primary care teams with other professionals – GP, pharmacy, physio, podiatry, speech/language therapy, OT etc – with flexibility to blur role margins appropriately according to local circumstances to provide a seamless patient service.

(General Practitioner)

...Community Nurses could be better integrated in the community i.e. attached to specific GP practices etc. This would provide a more seamless service for adults with Learning Disability, allowing those who may not have



If you were designing a community nursing service in the future, how would you want it to work?

a named community nurse to better access health care facilities.

(Community Learning Disability Nurse)

...Having some integration of mental health nurses within this group of community nurses would be an advantage (currently, one of our health visitors was previously a mental health nurse and her experience is invaluable to our team and to our patients – but not every team has this)...

(General Practitioner)

The potential 'fit' with social care was also discussed by some respondents. Many expressed enthusiasm for the idea of shared community health and social care teams. However, some respondents also acknowledged that employment conditions and regulations may present a barrier, and others rejected the notion outright. Co-location between community health teams and related social agencies was suggested as an initial step by those who favoured closer relations.

Community nursing roles

The second key theme, community nursing roles, was often interrelated with discussions about team structure, although views were considerably more mixed. The focus of the debate was the benefit in retaining existing community nursing roles, or whether generic community nursing roles – of any nature – could add value to future services.

The majority of respondents who raised this issue favour retaining at least some elements of the existing community nursing role structure, particularly the distinction between health visitors and district nurses. Nurses currently holding those positions were the strongest advocates for

this – although clinical nurse specialists, senior nurses, and some staff nurses also supported this perspective in notable proportions.

I would want to keep health visitors as health visitors, district nurses as district nurses, and school nurses as school nurses. Each individual has valuable experience in their area.

[Health Visitor]

However, closer readings of the responses and reflection on feedback from the direct engagement events, suggests that concerns are more subtle. At heart, the issue seems to be about retaining the distinction between population cohorts, rather than the specifics of existing job titles. The majority of responses favour distinguishing between services directed at the early years through to young adulthood and services that cater for adults and older adults (with a particular focus on long-term conditions). The reasons for this were divided. Some highlighted the unique needs of each cohort, and therefore the unique nursing skills required. Others fear that community nurses would be 'spread to thin' or risk being a 'jack of all trades, master of none' if they were required to cover all age groups.

I would want it to continue to be split into sectors that are birth to 18 and Adult. I feel that by asking community nurses to cover problems that arise over the birth to death continuum would spread their skills too thinly and that effective care would not be provided.

(District Nurse)

I would want a workforce that focused on early years, children, young people and families, providing a universal service but targeting extra resources to support vulnerable families. Another part of the workforce would work with



If you were designing a community nursing service in the future, how would you want it to work?

those requiring care in their own homes... supporting self-care, anticipatory care and case management as appropriate.

(Senior Nurse / Nurse Manager)

Within this, some respondents see the potential for a generic community nurse role at a staff nurse level, as long as it is within one or other of the population cohort 'specialties'.

Generic junior nurses / health care assistants, but retain the specialist nature of children's care...and the community nurse (District Nurse) role.

(Nurse - Primary Care Manager)

Would leave structure as is but develop the community staff nurse role....

(Clinical Case Manager)

If the community health nurse role is to be developed, this should be done at the staff nurse level. Integrated community nursing teams could be developed with a District Nurse and Health Visitor/School Nurse leading [each part of] the team. The rest of the team could work across both services, but this model would allow us to maintain the expertise at senior level within the team...

(District Nurse)

A well-equipped service and profession

The final theme emerging from this question related to equipping community nursing services, and the profession, in the future. Many responses echoed earlier concerns about capacity issues, resourcing, and education and training options within community nursing. There were frequent references to increasing or having adequate numbers of nursing staff, including relief staff. One respondent highlighted the need to 'consider population

statistics and projections' so that workforce planning for services allowed for sufficient capacity as time goes on.

Ensure that the community based workforce is sufficiently numerous to provide early intervention and reduce, as far as possible, the incidence of health risks, illnesses, and impairments....

(Voluntary Sector Worker)

Education and training, including the development of a clear career pathway for community nursing, was a particularly common thread within these responses. Opportunities to enhance education and training throughout the careerspan were identified, although a number of respondents also commented that protected time would be needed to allow community nurses to take up opportunities.

Stability of community nursing education programmes was also considered important. Some nurses used the example of the Family Health Nurse role to illustrate their anxieties about ending up with 'another unrecognised qualification', and urged decision-makers to decisively resolve questions about community nursing education and qualifications.

Again, there was support for generic community staff nurse posts as a way to support team capacity and grow the community nursing career path. However, the need for development opportunities that grow nursing leaders was also acknowledged.

Bring staff nurses out onto the community and then allow them to branch off...with the appropriate specialist training. Then and only then will we establish a career pathway that truly recognises the merit and significance of each of the nursing roles.

(Health Visitor)



If you were designing a community nursing service in the future, how would you want it to work?

Better career pathways with recognition of the responsibility and accountability nurses actually take on. Investment in proper career pathways with investment in nurse consultants who work within teams....

(Senior Nurse / Nurse Manager)

A number of respondents also advocated secondment or rotation opportunities between acute and community settings to support better understandings by both community and acute staff of one another's roles and the challenges faced by each sector.



What do you think are the biggest challenges facing community nursing in the future?

When asked about the biggest challenges facing community nursing in the future, survey respondents emphasised four main issues – population health, workforce, impending change to the community nursing profession, and resourcing.

Population health

Respondents were well aware of the potential impacts of changing demographics on health needs and service demands. The 'ageing population' was the most commonly cited population health challenge facing community nursing, followed by the interrelated issue of increasing rates of complex health needs (including long-term conditions). Increasing rates of survivorship from previously life-limiting illnesses, domestic abuse, parenting issues, and socio-economic pressures on families were also highlighted as increasing overall demand for community nursing services and complexity of cases.

The rising elderly population and the demand for more care at home is becoming a big challenge especially working in such a remote area...we are also being asked to carry out more technical care at home i.e. intravenous antibiotic therapy, so there is a worry we will not be able to deliver more basic nursing care to the really needy.

(District Nurse)

Volume of patients in an ageing society...more complex care patients being discharged and earlier discharges from hospital. Increase in palliative care patients wishing to die at home. Increase in dementia with ageing population.

(District Nurse)

Increase in children surviving with complex health needs, inclusion agenda means that children access mainstream provision and often need support for their health needs in their educational placement. Managing care packages for children at home. Transition to adult services.

(Sister / Charge Nurse / Ward Manager)

Many respondents also mentioned that the shift in the 'balance of care' from hospital to community is adding to demographic driven population health challenges.

As more clients are to be cared for at home, staffing levels, training and resources will, in my mind, be the biggest challenge facing the community nurse in the future.

(Community Health Nurse)

More and more patients leaving hospitals earlier and earlier, putting the work of aftercare onto community staff...it means more responsibility and knowledge required for nursing staff to look after more acute patients in the community. More [learning disability] patients are (re-) settled in community settings, who need to be supervised also by health service staff...

(Other Doctor)

Workforce challenges

However, the strongest theme to emerge from survey responses related to workforce challenges. The most common challenges raised were recruitment and retention. Underpinning these comments were concerns about the ageing workforce and the 'large number of community nurses soon to retire'. Similarly, there were concerns about low morale within the existing community nursing workforce, and feelings that attrition will compound pressures on community nursing numbers.



What do you think are the biggest challenges facing community nursing in the future?

A rapidly decreasing experienced workforce due to ageing and lack of investment in succession planning. The ability to offer nurses a variety of experiences and career pathways that will improve retention....

(Nurse Consultant)

Mass retirement of an ageing workforce providing further pressure on existing staff that lack experience and mentorship....

(District Nurse)

Exploring ways to improve retention of the current workforce, and recruitment of the future workforce was considered a priority for future planning. There is a clear sense amongst respondents that the community nursing identity needed to be clarified, and a clear training and career structure developed to attract nurses to the profession. These views were echoed in many of the direct engagement events.

If the career prospects and training opportunities for community nursing are made more attractive, more defined and more accessible there are plenty of nurses who would move into these field of nursing... Encouraging people to choose community as their career option would quickly address the 'ageing' population of community nurses.

(District Nurse)

Change and change management

A more immediate challenge to community nursing is proposed changes to community nursing roles at local levels. As with previous questions, respondents expressing these concerns were not limited to those areas piloting the Scottish Government's community nursing model. Responses from across the country contained significant anxieties about future roles. For

some, this was based on their current experiences of piloting the community health nurse, while for others general uncertainty about the future was perceived as most challenging.

Uncertainty as to where community nursing IS going and therefore a really low morale amongst staff. Lack of communication and consultation ends up leaving staff behind, whereas managers will get much further if they listen to their staff and take them with them in any agreed changes.

(Health Visitor)

Staff are facing the unknown. Staff are concerned that they may be doing district nursing in the morning, then some health visitor work in the afternoon, and the next day might have to stand up in front of a class of 30 doing sex education. They may also have more child protection issues to deal with and not have the knowledge or experience to say so.

(School Nurse)

Again, fears were expressed that anxiety and uncertainty about the Government's model would lead to loss of experienced staff, adding to capacity pressures and reductions in quality of services for patients.

Keeping staff – many of my colleagues are demotivated and disillusioned by the changes in teams. The staff have the potential to meet the health care needs of their patients but only if their teams are not eroded.

(District Nurse)



What do you think are the biggest challenges facing community nursing in the future?

[Visible, Accessible, Integrated Care] – complete uncertainty about what our jobs/roles will be in the future...the danger that generic working will mean staff lack any specialist knowledge in any area and will not be skilled enough to detect serious problems with their patients/families.

(Staff Nurse)

[The pilot] has been an unmitigated disaster and we have seen fragmentation of our team, loss of district nursing personnel due to disenfranchisement and loss of the working links we had with them. In particular, the lack of clear structure and changing role has led to the loss of a valued health visiting colleague... she has now secured a job elsewhere as a direct consequence of the breakup of our team approach to care and the risks to patients....

(General Practitioner)

However, not all responses discussing the challenges of change couched this in such emotive terms. A number of respondents provided a reflective perspective on what the challenge of change meant for community nurses as a profession. Many recognised that having a 'voice' was a challenge that the profession needs to act on.

In the near future, [gaining] confidence in ourselves as community nurses despite conflicting direction/information. Adapting to constant change in structure and political emphasis and intervention. Adopting a positive approach, making ourselves heard through exacting representation at all decision making forums....

(Health Visitor)

Resourcing

Finally, appropriate resourcing and infrastructure (such as IT and facilities) to support high quality community-based practice, featured repeatedly in responses. Comments re-iterated views expressed in previous questions about the challenge presented by the changing demands of community health services, and the need for this to be appropriately reflected in funding and infrastructural configurations.

Where to from here?

The findings from the three consultation approaches presented in this paper have informed the RCN Scotland publication, *A Sustainable Future: the RCN Vision for Community Nursing in Scotland*. That publication should be read as a companion to this paper as it outlines the six key things we believe are necessary to take a new vision for community nursing forward. As such, we will not dwell extensively on them here.

In summary however, our findings suggest that a wide-ranging programme of action will be necessary to build on the strengths of community nursing already present, and the positive steps that are already being undertaken in some communities. Elements of this will need to be driven at a strategic and/or national level. Final decisions about community nursing roles, community nursing education, and development of career pathways for community nurses, will need to be agreed nationally to give community nurses clarity and confidence in the future professional direction that our findings suggest is currently lacking.

Local actions appear to be equally necessary. A recurring theme in responses to all four questions was the importance of developing local solutions to the different challenges that different communities face. Respondents were clear that no one model will work in every area. Sufficient flexibility for local implementation will be key.

Fortunately, our consultation suggests that there is no shortage of willingness to contribute to planning community nursing services. The high level of interest in participating in our survey and other events suggests a real depth of feeling about the future of community nursing. This needs to be harnessed positively so that community nurses, colleagues, and users of their services are meaningful partners in the change process. In this, the Royal College of Nursing and other such organisations also have a role in supporting the ‘voice’ of community nurses to develop and be heard.

Once again, thank you to all those who have contributed their voices to our consultation. We also offer our thanks to Abi Masterson, Brenda Jackson, and the Queen’s Nursing Institute Scotland for their valuable support.

Appendix One: Approach

Three different approaches were used in this consultation to gather perspectives on community nursing. There were:

- Eight independently facilitated World Café events around Scotland
- Five opportunistic meetings with a number of RCN Forums and other nursing groups⁸
- An online survey, accessible to anyone with an interest in community nursing

World Café events

Eight three-hour World Café events were held in different locations around Scotland. Seven events – one each in Aberdeen, Perth, Inverness, and two in Glasgow and Edinburgh respectively – were held for RCN members. An open invitation was issued to all RCN members to attend one of the events to ‘share (their) vision for community nursing in Scotland’.

One event, in Stirling, was hosted jointly with the Queen’s Nursing Institute Scotland.

The events were co-ordinated by RCN Scotland, but led by an independent facilitator, who used three interlinked methodologies – Appreciative Inquiry, World Café, and The Art of Powerful Questions - to aid the participants in exploring intractable issues, opening up possibilities, and generating actions.

- Appreciative Inquiry (Cooperider & Srivastva, 1987) is used to value the best of what is happening at present. This was used first to help participants get to know each other, open conversations, and focus quickly and positively by sharing the good things in their work place.

- The World Café approach (Brown, 2005) is designed to generate input, share knowledge, stimulate innovative thinking, and ‘explore action possibilities’ around real work issues and questions. Participants were presented with a number of statements from recent Scottish Government publications as a means of sparking and connecting ideas about the future of community nursing, and then generating possible actions.
- The Art of Powerful Questions (Vogt, Brown, & Isaacs, 2003), a part of the World Café methodology that has been developed further, was used to facilitate participants in moving their ideas from the World Café session forward and articulating necessary changes. Five focus questions were crafted prior to the sessions and were used in different ways, according to conversations and the numbers attending the events.

As the purpose of World Café approaches is to capture voices rather than undertake detail interpretive analysis, the themes from these events have been interwoven with the results of the other approaches used by RCN Scotland in producing this paper, rather than as a separate report.

Online survey

An online survey, accessible to anyone with an interest in ‘community nursing’ in Scotland, was available for completion through Survey Monkey from 15 January to 23 February 2009. The survey link was initially sent to an extensive mailing list, including RCN Scotland Board members, key nursing stakeholder groups, professional

⁸ The World Café events and other sessions are referred to generically as ‘direct engagement events’ for the remainder of this paper.

Appendix One: Approach

organisations and Royal Colleges, third sector organisations, HEIs, and patient groups. The survey link was also available via the RCN website, and advertised in RCN membership publications. All forms of advertising encouraged participants to pass the link on to others who may be interested in participating. Those completing the survey had the option of responding on an individual basis or on behalf of a group.

The survey consisted of a number of short-response questions covering demographic and professional information, and respondents' relationship with community nursing. Respondents were streamed based on answers, so that professional questions were relevant to respondents. All respondents were then invited to answer four open-ended questions:

- Thinking about your experience of community nursing, what is working well?
- What, if anything, needs to be improved?
- If you were designing community nursing services, what would they look like?
- What do you think are the challenges facing community nursing services in the future?

'Community nursing' was purposely not defined for respondents to avoid limiting the scope of respondents' comments.

Analysis approach

Analysis of the survey employed a mixed methods approach. Given the open-ended nature of the survey questions, the original intention was to undertake a grounded theory analysis to identify and analyse key themes as they emerged, and test theoretical interpretations (Glaser & Strauss, 1967). Grounded theory was considered appropriate as it is useful for generating theories of phenomena

grounded in data (Braun & Clarke, 2006). It also has the benefit of being applicable in both qualitative and quantitative studies (Boychuck Duchschur & Morgan, 2004).

However, the volume of responses to the survey was considerably higher than initially anticipated, making comprehensive application of grounded theory considerably more complex. As a result, a thematic analysis was undertaken instead. Thematic analysis is a widely used, qualitative analytic technique that can also be useful in analysing larger sources of qualitative data. The flexibility of the method allows for a wide range of analytic options. Though less frequently acknowledged than more theoretically driven methodologies, such as grounded theory, it can produce insightful analysis when used with particular research questions (Braun & Clark, 2006).

Analysis and coding procedure

Thematic analysis involves an initial reading of the material in order to familiarise reviewers with the data, during which points of interest are noted. During a second reading of the material, the data is summarised and text assigned to thematic categories. An interpretation of the meaning of themes is then developed.

During this process, survey responses were coded using both manual techniques and statistical software. Initial coding was undertaken by hand to identify potential themes and categories. These themes then formed the basis for a second round of coding into SPSS. This proved useful given the volume of responses, in providing a better appreciation of the magnitude and frequency of responses under each theme. It also allowed themes produced during manual coding to be

Appendix One: Approach

checked against the data to ensure that other notable themes had not been missed. SPSS coding was undertaken by a research assistant independent of the overall study.

The use of SPSS enabled a number of descriptive analyses to be undertaken, including chi-square goodness-of-fit tests which were used to test for differences in responses across respondent groupings (i.e. by profession, nursing discipline, geographic area, NHS Board area etc).

Limitations

There are several limitations to this study. Given the nature of our organisation and the methodology employed, the opinions expressed are dominated by nursing perspectives and interests. However, this does mean that the perspectives of others interested in community nursing, most notably

those of users (of whom we had only very few respondents) are not as strongly represented. It should be noted though, that there were no indications that views across groups participating were at any stage strongly divergent. In fact, we were surprised to learn that the themes in the findings emerged so consistently.

Secondly, this is a qualitative study. We chose this approach deliberately so that the views of respondents would not be restricted by specific questions. We did not want any pre-conceptions we may have had to influence responses, but for issues, concerns, and preferences about community nursing to emerge naturally from the data. However, a quantitative approach employing a more formal questionnaire and response scales would have allowed for linkages between findings to be tested statistically. This could be usefully undertaken by researchers interested in further understanding these findings.

Appendix Two: Participants

For the purposes of this paper, the primary sources of data are the eight World Café events, five opportunistic meetings, and online survey. The latter received 1086 responses, of which 667 were selected for inclusion in the final analysis on the basis of having answered one or more of the four key questions outlined above. Chi-square analysis found no significant differences in the characteristics of the 667 respondents, and the 419 respondents excluded for not to answering one or more of the key questions.

Survey respondents included a wide range of individuals and groups, including nurses, GPs, carers, patients, voluntary organisations, academics, social workers, allied health professionals, and many more. Whilst many chose to respond to the survey as individuals (N = 578, or 86.7 percent of responses), there were a notable number of groups (N = 27, or 4 percent

of total responses), including formal groups and professional colleges (for example, the Royal College of General Practitioners) as well as informal groupings such as medical practices or nursing colleagues.

Responses were submitted from people living or working in all of the 14 NHS Health Boards, with Tayside (N = 146, 21.9 percent) and Greater Glasgow and Clyde (N = 98, 14.7 percent) producing the highest number of responses. Responses were also submitted from across age groups, although over 60 percent came from respondents aged over 41 (N = 412, 61.8 percent).

The table provides respondent characteristics. Highest values are shaded:

Appendix Two: Participants

Which of the following best describes you, or your organisation?	N ⁹	% ¹⁰
Nurse / Midwife / Specialist Community Public Health Nurse	491	74.7%
Health Care Support Worker	6	0.9%
Allied health professional	26	4.0%
GP	48	7.3%
Other Doctor	15	2.3%
Carer	2	0.3%
Patient	3	0.5%
Social Worker	3	0.5%
Voluntary sector worker	11	1.7%
Other (please specify)	52	7.9%
Did not answer	10	1.5%
Which of the following best describes your job title for your main job?		
Community children's nurse	15	3.0%
Community learning disability nurse	6	1.2%
Community psychiatric nurse	19	3.8%
District nurse	117	23.1%
Family health nurse	5	1.0%
Midwife	0	0.0%
Health visitor	102	20.2%
Practice nurse	8	1.6%
Public health nurse	13	2.6%
School nurse	16	3.2%
Staff nurse	48	9.5%
Treatment room nurse	3	0.6%
Enrolled nurse	0	0.0%
Health care support worker/assistant/nursing auxiliary	5	1.0%
Sister/charge nurse/ward manager	9	1.8%

⁹ 'N' refers to actual responses regardless of whether respondents were individuals or groups. Responses have not been weighted to take into account group memberships.

¹⁰ In interpreting %, note that this depends on total response to each demographic question. In some cases respondents chose not to answer some questions, so total N will be less than 667.

Appendix Two: Participants

Senior nurse/matron/nurse manager	37	7.3%
Clinical nurse specialist	36	7.1%
Consultant nurse	7	1.4%
Nurse practitioner	3	0.6%
Lecturer/tutor	9	1.8%
Retired	1	0.2%
Other (please specify)	47	9.3%
Did not answer ¹¹ / Was not streamed to this question	161	24.1%
Which of the following best describes the field of practice for your main job?		
Primary health care	157	31.5%
Community health care	188	37.7%
Older people's nursing	9	1.8%
Mental health	15	3.0%
Learning disabilities	6	1.2%
Adult critical care (eg.ITU,A&E)	2	0.4%
Adult general/medical/surgical	5	1.0%
Rehabilitation/longer term care	3	0.6%
Paediatric critical care (eg.ICU)	1	0.2%
Paediatric general	19	3.8%
Women's health/midwifery	3	0.6%
Oncology/palliative care	13	2.6%
Long term conditions	14	2.8%
Education/research	8	1.6%
Several specialties	6	1.2%
Non-nursing work	1	0.2%
Other (please specify)	49	9.8%
Did not answer / Was not streamed to this question	168	25.2%
What would you describe your local area as?		
Urban	196	32.5%
Mixed urban/rural	292	48.3%

¹¹ Also, respondents were streamed so that not all groups answered all questions. High 'did not answer' values tend to indicate that not all respondents were streamed to answer that questions.

Appendix Two: Participants

Rural/remote	116	19.2%
Did not answer	63	9.4%
What is your age?		
18-24 yrs	1	0.2%
25-30 yrs	15	2.6%
31-35 yrs	33	5.7%
36-40 yrs	57	9.9%
41-45 yrs	144	24.9%
46-50 yrs	152	26.3%
51-55 yrs	116	20.1%
56-60 yrs	48	8.3%
61-65 yrs	8	1.4%
65+	4	0.7%
Did not answer	89	13.3%
Where do you work? If you are not working, where do you live?		
Ayrshire and Arran	25	4.4%
Borders	2	0.4%
Dumfries & Galloway	7	1.2%
Fife	64	11.3%
Forth Valley	54	9.6%
Grampian	27	4.8%
Greater Glasgow & Clyde	98	17.3%
Highland	42	7.4%
Lanarkshire	13	2.3%
Lothian	52	9.2%
Orkney	13	2.3%
Tayside	146	25.8%
Shetland	13	2.3%
Western Isles	3	0.5%
Other (please specify)	6	1.1%
Did not answer	102	15.3%

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