Study of the Implementation of a New Community Health Nurse Role in Scotland

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In 2006 the then Scottish Executive proposed the absorption of district nursing, health visiting, school nursing and family health nursing into a single Community Health Nurse (CHN) role. The new role was piloted in three Health Boards across Scotland. This report summarises the findings of a study which was commissioned to provide insight into the structural and other issues which affected the uptake and implementation of the new role.

Main Findings

- Nurses and their managers participating in the study questioned the strategic vision of the new Community Health Nurse (CHN) role or to be more precise the model of nursing upon which the role was based.

- The CHN role challenged more traditional nurse boundaries which formed strong professional identities and were highly valued. For some it represented the return to a previous model which in their view had 'failed' ie double and triple duty nurses.

- Another important issue was a lack of critical mass in support of the new role; many nurses returned to their original teams following the transition training and experienced opposition to the new role and sometimes lack of managerial support.

- The educational programme helped heighten nurses' awareness and re-engagement in the wider aspects of health and social care, particularly in public health, including community health profiling and health promotion.

- It also helped nurses to reflect upon their role and led some to change their practice, however these were often viewed as opportunistic rather than systemic changes and there was little discernible impact on patient experience.

- There was broad support for the core elements of the new role such as promoting self-care, adopting a public health approach to nursing, developing community profiles, and preventing unnecessary hospital admissions.

- There was a strong sense that the new role was introduced from the top and had not fully considered the views of nurses to which it was directed. Thus, many felt the need for greater consultation before new policies were introduced.

- There was little doubt that the introduction of the CHN gave rise to extensive debate within the nursing professions in Scotland. While there was broad support for the core elements of the role, the study participants thought that, rather than focussing on changing nurse roles, more should be done to improve interagency working and foster better collaboration among the existing nursing disciplines.

The Scottish Government

Background

In 2006 the then Scottish Executive, as part of the modernisation of the National Health Service began a radical and far reaching review of nursing in the community. 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 Nurse (CHN) role. The new role was piloted in three Health Boards across Scotland, namely Highland, Borders and Tayside. This research was commissioned to provide insight into the structural and other issues which affected the uptake and implementation of the CHN.

Methods

The evaluation comprised focus groups and interviews in the three pilot areas. In total 75 nurses participated in the study which included: 20 nurses who completed the transition education for the new role, 35 nurses who did not transition and 20 nurse managers. Those transitioned were mainly Health Visitors, District Nurses and Public Health Nurses.

Main findings

Strategic vision

Nurses and their managers participating in the study questioned the strategic vision of the new Community Health Nurse Role or to be more precise the model of nursing upon which the role was based. For many it represented a return to a previous model which in their view had 'failed' i.e., double and triple duty nurses. Furthermore it was strongly associated with the extended family which was thought to be outdated and no longer fitted modern family structures. The CHN role challenged more traditional nurse boundaries which formed strong professional identities and were highly valued. Some concerns were raised regarding the effectiveness of transition education in helping nurses change their identity and sustain their new role. Another important issue was that of critical mass. Many nurses returned to their original teams after the transition education and experienced opposition to the new role. In some instances they also lacked managerial support.

Reported impact on knowledge and practice

The transition education helped heighten nurses' awareness and re-engagement in the wider aspects of health and social care. This was particularly so in public health, including community health profiling and health promotion. It also helped them to reflect upon their role and led some to change their practice. Notable examples included district nurses, public health nurses and health visitors conducting immunisation programmes; health visitors taking on district nurse duties such as taking bloods and changing dressings; and health visitors and public health nurses visiting schools. However these were often viewed as opportunistic rather than systemic changes and there was little discernible impact on patient experience. There was support for the notion that the new role could be more easily accommodated in nursing teams that already worked with a range of health professions and other disciplines.

Their view of the future

There was little doubt that the introduction of the CHN gave rise to extensive debate within the nursing professions in Scotland. There was broad support for the core elements such as promoting self-care, adopting a public health approach to nursing, developing community profiles, and preventing unnecessary hospital admissions. However nurses thought that, rather than focussing on changing nurse roles, more should be done to improve interagency working and foster better collaboration among the existing nursing disciplines. Some examples were offered including identifying a single point of access to health and social care, greater liaison with nursing colleagues to improve patient management, and multidisciplinary team meetings to improve communication. There was a strong sense that the new role was introduced from the top and had not fully considered the views of nurses to which it was directed. Thus, many felt the need for greater consultation before new policies were introduced.

Conclusions

Changing existing roles is difficult and there were three related areas which we think proved extremely problematic in doing so: the strategic vision of the new role, ownership of the new role, and critical mass. These tended to outweigh the reported benefits of the transitional education. Participants thought that more could be done to foster collaboration within multidisciplinary settings.

Future changes could focus on co-constructing new roles with nurses which, in turn, may help to develop critical mass and secure support for a new policy. A crucial part of this is how the roles fit with existing teams particularly within the multidisciplinary team setting. Plans should include details on how new skills and knowledge are best promoted and how such changes are sustained.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: http://www.scotland.gov.uk/socialresearch. If you have any further queries about social research, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131-244 7560.

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