Aberdeen City Health & Social Care Partnership
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Aberdeen City HSCP Health Visiting

Community Nursing Role Test of Change Evaluation

June 2025

Key Points

- In April 2024, 3 Band 5 Community Nurses (CNs) were recruited into the Aberdeen City Health Visiting team to support existing health visitors with their workload. Two CN's were unavailable to work in the service between winter 2024 and spring 2025 (reasons for which are redacted due to identifiability purposes), leaving 1 CN actively in post. Neither of the 2x CNs posts have been replaced/filled and therefore the current impact of the CNs on Health Visitor (HV) workload is likely to be minimal.

- In March 2025, semi-structured interviews were undertaken with 7 staff members across most of the Aberdeen City Health Visiting teams (2 CNs and 5 HVs, 2 of which were also Team Leads).

- A common theme identified across the feedback was centred around the requirement for clear community nurse role definition and communication of this to the wider team to enable effective partnership working.

- Staff reflected that greater clarity around the remit of CNs may have improved initial understanding and potentially increased the number of referrals to CNs at an earlier stage.

- The majority of staff agreed that the role of the CN within the team is now clearer, which has resulted in increased delegation and referral rates.

- Some staff identified that working environment and, specifically, working within the same office helped to build strong team relationships and therefore enhanced understanding of roles and responsibilities within the team.

- Some staff identified the 'new to area' contacts as being the main area that Community Nurses had been able to alleviate some of the Health Visitor workload and directly release capacity for HVs.

- In terms of role expansion, some staff identified that CNs could potentially provide support with public health-based tasks.

- Overall, feedback emphasised that the whole team is currently working at full capacity, with some acknowledging that the CNs are helping to alleviate some of the stress associated with that. As a result, feedback participants gave the test of change a mean satisfaction score of 6.6/10.

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1. Background

It is widely recognised that the early years strongly influence a child's future development.[1] Health visiting teams are uniquely positioned to improve health outcomes and reduce inequalities for children and families, by providing sensitive, responsive and proactive care.

To ensure consistency and maximise the impact of the Health Visiting service in Scotland, health visiting (HV) teams follow a routine pathway for delivery (Universal Health Visiting Pathway (UHVP)). The UHVP recommends at least eleven visits before children start school, eight in the first year of life, in addition to three child health reviews which should be carried out by a qualified health visitor.[2] The Pathway is based on several underlying principles:

- Promoting, supporting and safeguarding the wellbeing of children
- Person-centeredness
- Building strong relationships from pregnancy
- Offering support during the early weeks and planning future contacts with families
- Focusing on family strengths, while assessing and respectfully responding to their needs.[3]

In April 2024 the Health Visiting service within Aberdeen City Health and Social Care Partnership (ACHSCP) identified that they were unable to follow the UHVP for core families due to a reduction in workforce whilst being unsuccessful in recruiting experienced health visitors. To help combat the gap in health visiting time, core pathway families, were seen less frequently following the priorities of care guidance, which helps manage local pressures by reducing visits for 'core families'. The red pathway is the highest level of visit reduction, with 'core' families receiving 3 visits in the first 12 months (11–14-day, 6-8 week, and 6-month review). A development review is also conducted between 27 and 30 months.

In addition to reducing certain visits, a test of change was initiated, whereby in April 2024, three band 5 community nurses (CNs) were recruited to help support existing health visitors with their workload. Furthermore, it was proposed that introducing the CN role would help to bridge the gap between the HVs and existing band 4 community nursery nurses (NNs), who work alongside the HV to deal with suitable tasks associated with the infant/children. It was hypothesised that the CNs would be able to take on more complex cases than the NNs, therefore releasing additional HV capacity to support children and families with the most complex needs.

The CNs undertook an initial training period and started to receive referrals in July 2024. HVs direct referrals to the CNs, and can include tasks such as feeding support, complex behavioural support, sleep management and supporting families that are new to the area.

Two CN's were unavailable to work in the service between winter 2024 and spring 2025 (reasons for which are redacted due to identifiability purposes). Neither post has been replaced and therefore from April 2025 the service was reduced to have 1 CN actively in post. With the reduced level of CN staff available to the HV service, the impact on HV workload is likely to be limited based this.

As of January 2025, the health visiting team are now following the amber pathway, which may indicate the service is under less pressure as it was previously. Again, following the priorities of care guidance, the amber pathway allows for 5 visits within the first 12 months of life (11-14day, 3-5 weeks, 6-8 weeks, 6 months and 8 months) with 2 developmental reviews (13-15 months and 27-30 months).

2. Methodology

This evaluation aimed to explore the impact of CNs on HV workload via referral data. It also sought to understand the experiences of the CN and HV staff in Aberdeen City with respect to the CN role test of change. Specifically, it explored:

- How the CN role has embedded within the team and to what extent it has impacted upon health visitor workload.
- The level of staff satisfaction with the test of change overall and learnings for the future.
- What financial impact the introduction of the CN role might have had.

A working group was developed, containing representatives from the ACHSCP Health Visiting Leadership team, ACHSCP Transformation team and Public Health Scotland (PHS) Local Intelligence Support Team (LIST). An evaluation framework was subsequently developed based on a proportionate approach, prioritising existing internal data and staff feedback.

Due to the small cohort of CNs, it was deemed appropriate to conduct semi-structured interviews to gain detailed feedback that reflected their individual experiences. Furthermore, maintaining a consistent approach, all health visitors were similarly provided the opportunity to provide feedback via a semi-structured interview. This approach provided valuable insights into both the experiences of the community nurses, and those of the wider team. For the purposes of this evaluation trainee Health Visitors were excluded as they cannot compare experiences prior to the test of change.

As requested by ACHSCP, PHS LIST conducted 7 semi-structed interviews between 17th March- 4th April 2025. Prior to conducting the interviews, questions were developed dependant on the respondent's role; CNs were asked one set of questions, while HVs (& Team Leads) were asked another, both sets followed common themes within the questions to allow for comparable results where possible.

These were focussed around the key themes of:

- Training and Development
- Integration and Communication
- Current role
- Impact on workload
- Overall satisfaction

Due to the small staff cohort, all information collected during the interviews was anonymised and aggregated to the level of role. All notes and quotes transcribed from the interviews were validated and approved by the interviewee at the end of each feedback session. A systematic thematic analysis was carried out, to explore the impact of the test of change and identify areas for future improvement. Themes and data interpretation were crossed checked by multiple project team members. This process was a service evaluation therefore no ethical approval was required.

In addition to staff feedback, internal CN referral data was analysed to help understand their caseload and provide quantitative context to the qualitative feedback collected.

3. Results

3.1. Participant demographics

In total, 7 staff chose to feedback about their experience as part of the Health Visiting test of change, split by role as per Figure 1. Feedback from both community nurses in post at the time (n=2) was received which accounted for 29% of the total feedback. The remaining 5 interviewees (71%) were health visitors. Furthermore, two of the Health Visitors interviewed were also team leaders.

Figure 1: Interview Participants by Role

Feedback was captured from the majority (n=4) of area teams across the HSCP, staff within the 'red' and 'purple' teams chose not to participate and therefore any observations will not reflect those teams.

3.2. Community Nurse Role Definition

A common theme that emerged throughout the feedback interviews and indeed across multiple question areas centred around community nurse role definition. Specifically, 86% of participants (n=6) felt the community nurse role within this test of change had not been clearly defined prior to them coming into post.

The feedback highlighted the impact this was perceived to have had on a number of areas. Some staff felt that insufficient role definition had an impact on the recruitment and initial training processes, feeling that the previous experience or training required by the post holder was not initially clear.

> *"… Didn't have the training/knowledge/skills to take off and had to wait months for training. When we did get [guidelines] for the referral process … wasn't at the stage where we could refer work … didn't have the required skills. Management hadn't defined what their role was yet."*

CNs felt they had been given referrals without having the required training to fully help children/ parents. In those situations HVs may have contacted families to provide additional support and therefore adding to their caseload. If training had been identified and provided to CNs earlier this may have limited the additional contact from HVs.

> *"I had areas of knowledge lacking in terms of quality of knowledge needed to help parents"*

Many staff reported feeling confusion initially around what tasks could be referred on to CNs. In particular, expressing initial confusion around what would be within the remit of a CN compared to a NN. Respondents did however reflect that the role is now more defined, and the referral guidelines now in place are clear to follow.

" When the community nurses came in place there was a bit of confusion about when to refer to a CN or a nursery nurse…the referral process is clearer now though."

"Having more structure would have made the transition easier. I don't think they had a clear vision for the role before we started, it was shaped as we went along. Confusion around the role came from this. I think people coming into the role now would have an easier process. This is what the role is, this is what gets referred, this is the type of work we see - and carry out the training from there."

Some staff members noted that clearer job definitions would have improved the referral process. It should be noted that CNs came into post with differing experience and therefore different capabilities. This led to some element of flexibility on how the role was defined over time.

"The role was being moulded the more staff got to know the community nurse's capabilities."

3.3. Training and Development

When evaluating the implementation of the CNs within the health visiting team, it was fundamental to understand the initial training period and subsequent continued development in role. CNs were asked to provide details of their training experience and what improvements could be made, with HVs providing additional feedback on their experience of supporting training (where relevant).

Although some staff felt that greater clarity of CN role would have improved the initial training process as noted previously, staff overall felt satisfied with the initial training provided. This consisted of an induction pack with self-study materials and links to online study. It was noted however that one CN self-funded some of their own courses as a result of having a gap in knowledge and experience. They identified these gaps to be around sleep issues and neurodiversity. NHS courses are availability within these topic areas however may not be as in depth as the staff member desired.

The shadowing process offered was noted to be particularly beneficial to new staff. From those participants who were involved in receiving or providing training n=4 (57%), all noted that they were involved in shadowing, where CNs would come out on visit(s) with the HV or the NNs. Respondents found shadowing to be particularly beneficial to gain experience of the role and referrals they may receive. These visits helped to identify strengths and gaps in CN knowledge that could then be addressed.

> *"I was able to go out with health visitors to shadow and went out once with nursery nurse. With the knowledge I have now, absolutely this was useful".*

Staff did suggest that shadowing at a later stage could have been even more beneficial to their learning. Furthermore, CNs felt that shadowing the NNs provides great benefit in addition to shadowing HVs due to perceived overlap in elements of their roles.

"I think more shadowing later after courses might have been better…and I would benefit a lot from shadowing the nursery nurses- my role very much reflects their role. There is quite a significant amount of overlap."

3.4. Integration and Communication

It was evident that many staff felt initial integration into the team was challenging due to the previously mentioned uncertainty around CN role and how this fit within the existing team structure. Furthermore, it was felt that early communication could have been stronger from senior staff to help existing roles embrace the new CN role within the team. Despite this, most staff felt the CN role had now integrated well within the team and CNs felt well supported by their colleagues. Both roles found communication was working well and a good structure had been developed for CNs to update HVs and vice versa.

"Once there was better clarification of the role the service was used more by health visitors… everyone now works together well."

Staff identified that working within the office has helped to build relationships but understood this isn't always realistic especially as the CNs tend to work across teams in different offices. Staff felt working in the same office had been beneficial to building professional relationships and this was certainly encouraged going forward. In particular, the CNs working closely alongside HVs was felt to improve knowledge across the whole team. HVs in particular noted the benefits of CNs being 'visible' to the team.

"I feel supported by colleagues now…they are very supportive and very happy to help and answer questions. We work in the same office together so [are able to] build up those professional relationships."

Despite CNs now being described as well integrated within the team, staff highlighted the need for improved delegation of tasks by HVs, with some acknowledging that

they can be reluctant to delegate some tasks to the CNs which could reduce their workload. It was reported that this has already begun to be actioned by the health visiting team to address this training need and improve confidence.

3.5. Community Nurse Experience of Role

Staff were asked to comment on how the CNs role compared to their initial expectations, and, for CNs, what they enjoyed most about the role.

Overall, staff were happy within their role when providing feedback. In particular, CNs most enjoyed the opportunity to build relationships with families to help support families and build parent confidence. Again, the observation was made from respondents that the initial integration of the CN role into the team was commonly felt to not be clear, which some felt made it difficult to manage clear expectations within the new role. However, CNs reported having high levels of satisfaction within the role.

> *"I really enjoy that I have my own caseload of kids and have the ability to create professional working relationships with the families… It's been really rewarding, really lovely."*
>
> *" It's magical to see parents grown in their confidence and see children blossom [with the advice and strategy you give them]."*

3.6. Impact on Health Visitor Workload

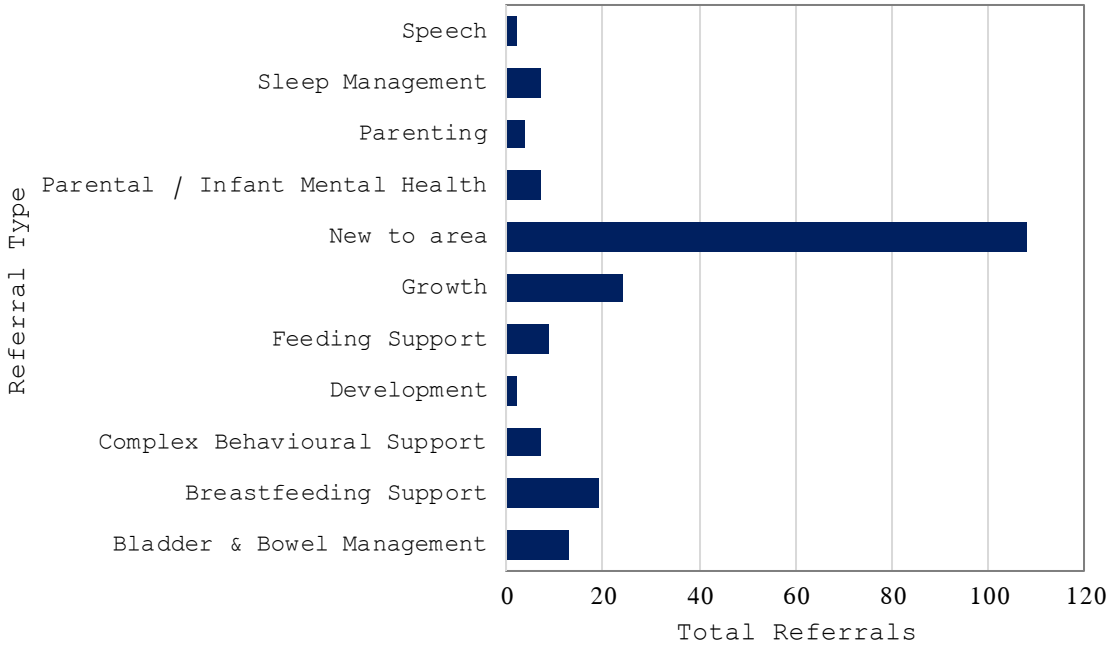
A core objective of this test of change was for CNs to help alleviate some of the HVs workload. In respect to this, staff feedback was mixed, with both roles appreciative that CNs can only undertake certain tasks. Review visits for example must be completed by a HV as per Scottish Government guidance.

The area where HVs felt CNs had a direct impact upon their own workload was in carrying out 'new to area' visits. While several staff felt the CNs may have had more of an impact on the NNs workload as the two roles have similar types of referrals,

HVs noted that the CNs could bring enhanced professional accountability and academic rigour to more complex tasks.

Between 31st July 2024 and 31st March 2025, the CNs received 202 referrals. Referrals for new to area visits accounted for 53% of the CN workload during this time (n=108), while Growth, Breastfeeding support and Bowel and Bladder management accounted for a combined 28% of total referrals (n=56) (Figure 2).

Figure 2. Total Number of Referrals by Referral Type (source: Health Visiting Service Community Nurse Referral Data)



Focussing on the 'new to area' visits as these were reported by HV staff to be directly releasing capacity for HVs, during this 8-month period the CNs completed 108 of these visits. Assuming (based on participant estimates) each visit takes approximately 90 minutes, over 8 months this has saved the HVs approximately 162 hours of caseload. Taking top-point hourly rates by band (with on-costs) from the NHS agenda for change 2024/25 we can see that this could be estimated to equate to a saving of approximately £18.09 per visit, or £1,953.72 over the 8-month period (Table 1).

Table 1. Approximate cost comparison for 'new to area' visits

AfC Band 24/25	Hourly rate (with on-costs)	Cost per new area visit (1.5 hours)	Saving (per new area visit)	Total saving over 8 months (108 visits)
Top-point Band 5 (CN)	27.53	41.30	£18.09	£1,953.72
Top-point Band 7 (HV)	39.59	59.39	n/a	n/a

> *"I think CNs have definitely reduced HV workload especially when it comes to new to area contacts. These take approx 1.5 hours."*

Overall, feedback emphasised that the whole team is currently working at full capacity, with some acknowledged that the CNs are helping to alleviate some of the stress associated with that.

> *"Whole team is very stressed at the moment, CNs are helping that- would be worse if they weren't there."*

Furthermore, many HVs note that the CNs are able to dedicate more time to family visits and build strong relationships that the HVs themselves may not have time to do. With the ability to refer to CNs, this may improve initial access to care.

> *"Been supporting families who require quite intense help which HVs might not have the time for. Able to build up a relationship with the families and the families trust them [CNs]."*

> *"The [CN] role has impacted [HV] role because they can distribute service to the families who can get to them quite quickly, improved access."*

Since certain visits can only be conducted by HVs e.g. reviews and more complex issues as per Scottish Government guidance, we asked both roles if there would be other tasks which the CN could take on to support with the HV caseload. Some staff

identified that CNs could potentially support with public health-based tasks e.g. talks in primary schools, supporting toileting in nurseries.

"I don't know how else [CNs] could support [HV] visits; [CNs] aren't qualified to support the core pathway."

" [CNs] could do more public health work, HVs don't have capacity to do that currently.

3.7. Test of Change Satisfaction

All staff who provided feedback were asked on a scale of 0-10 how they would rate their satisfaction with the test of change. Satisfaction varied across all teams and roles; scores ranged from 2 to 10.

The mean satisfaction score was 6.6/10.

● Positive

Some staff acknowledged that the test of change had been successful, and that the CN role had been a beneficial addition to the team. Those staff felt the CNs had integrated well and had defined their role as time progressed, with that identifying any limitations in their knowledge and experience.

"Would like more of them [CNs]. [They] have made a big difference. They are approachable, they feed back to us. If they come across something they don't feel they can deal with they will get in contact."

"It would be a loss if they [CNs] were stopped. It's taken a while to get used to the referrals and accept they were qualified…"

● Mixed

As the service is at such high demand and roles within the team do not have enough time to train or further develop CNs in order for the role to be more impactful on the HV workload.

> *"Mostly positive but I don't think we are making the necessary changes that are essential for the HVs as a service e.g. doing more of what they do. Time and training are not there for that."*
>
> *"At the start HVs were a bit wary of using them but they have built up a relationship with families. Initially some early confusion."*

● Negative

For some staff, definition of the CN role still causes an element of confusion, in-particular the difference in roles between CN and NN and knowing who and what to refer. Some staff had previously worked with a similar structure but felt the remit of the NNs now covers the need.

> *"Our perception of what we thought their job role would be didn't match what their job role was. Role wasn't defined at first. Always felt they had been employed before we knew what their role was. In the end seeing it as very similar to the nursery nurse"*

4. Conclusions and Observations

Overall, findings from the feedback sessions attended by both Health Visitors and Community Nurses suggest that the majority of those staff are generally more satisfied with the test of change as time has progressed.

The feedback from staff has, however, highlighted a number of potential areas to be considered which may improve staff experience and team relationships as well as support delivery of a more defined and equitable service. It should be noted that the small sample size (n=7) should be taken into consideration when interpreting these results.

1. Explore communication and clear vision of roles within the health visiting team with all Health Visitors, Community Nurses and Nursery Nurses going forward. Ensure the whole team gains understanding of how their role and the role of colleagues help to deliver the service in partnership.

"There was some early confusion- some thought [CNs were brought in] because HVs were not doing their job properly."

"Some felt [CNs] were coming in and taking over work they [NNs] used to do. A lot of time was put in to earning their trust and respect. Thankfully now respect is there but the first year was difficult."

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2. Explore the caseload of the health visitors to potentially identify further tasks/referrals which may be appropriate for Community Nurses and therefore further reduce Health Visitor workload.

"There are things that would be nice to add on [to CN workload] e.g. public health messages at playgroups, school induction days, vaccine centre opening days. Things that wouldn't need a [HV] but would need a public health voice at. Scope that they could expand into."

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3. From the Health Visitor tasks identified (as above) have open discussions with Health Visitors and Community Nurses to gain clear understanding of any new training required for Community Nurses to take on new referrals. Ensure clear training plans are developed and communicated to the whole team to ensure consistency and understanding across the service.

> *"Conversations about the job role with the wider team could have been had at the start to reassure the team and provide clarity."*

4. Identify and keep open communication with Community Nurses about realistic potential progression routes within which they can work towards becoming a Health Visitor in future.

> *"Initially went into the post to get a better understanding of Health Visiting and its complexity with the aim of going into Health Visiting. Believe progression is still an option but I am unclear on it."*

Furthermore, by regularly engaging and seeking the views of all staff, service leads should continue to seek opportunities for service improvement.

Acknowledgements

With thanks to all those who either attended or provided feedback through colleagues. All the community nurses and health visitors/team leads who took the time out of their busy schedules to provide feedback to help identify learnings which can help the service to grow in the future. Additionally, all those staff who assisted with referral data collection which provided integral understanding to the caseload of community nurses.

References

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