A Scoping Project to

Develop a Shared Purpose Framework for the delivery of First Class Community Nursing Services across Kent and Medway

Commissioned by NHS England Kent and Medway Area Team and North Kent CCGs¹

Led by England Centre for Practice Development, Faculty of Health and Social Care, Canterbury Christ Church University

Report compiled 6 December 2013

¹ Comprising Medway; Dartford, Gravesend, and Swanley; and Swale)
Acknowledgements

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Executive Summary

This summary outlines the purpose, outputs, and recommendations of a community nursing workforce planning and development scoping project commissioned by NHS England Kent and Medway Area Team and North Kent Clinical Commissioning Groups (CCGs) and undertaken by the England Centre for Practice Development, which is hosted by the Faculty of Health and Social Care at Canterbury Christ Church University. The aim of the project was the development of a Shared Purpose Framework for the workforce planning and development of community nurses and community nursing across Kent and Medway. The project was undertaken between August and November 2013 culminating in a full and final report that was submitted on 6th December 2013.

Using an emancipatory participatory methodological approach the project engaged interested parties throughout the project and research process to ensure stakeholder ownership of the project outputs. The project design and activities ultimately culminated in identifying a tool (the Cassandra Matrix tool (Leary 2011)) that can profile and raise awareness of the local community nursing’s contribution to the delivery of care, along with the development of a complementary Shared Purpose Framework that provides the foundational and edifying principles of person-centred future workforce planning and development.

The project yielded the following outputs:

- Output 1: Vision and Purpose Statement
- Output 2: Shared Purpose Framework
- Output 3: Suggested indicators/measures to demonstrate the impact of a First Class Community Nursing Service across Kent and Medway mapped to the Shared Purpose Framework
- Output 4: Cassandra Community Nursing Activity Analysis
- Output 5: Practitioner evaluation of the Cassandra Community Nursing Activity Analysis

The project Recommendations were:

For the Shared Purpose Framework

1. To consult more broadly on the vision and the framework with all key stakeholders including patients and carers.
2. For each organisation to engage their teams in embedding in practice the vision, values and framework through their HR and workforce strategies to complement what a leadership programme might offer.
3. To identify which tangible enabling factors identified in the shared purpose framework are present or absent across the three organisations involved in the pilot in Kent and Medway so as to develop an action plan for their development e.g. competence framework across NHS career framework levels.

4. To develop a dashboard of indicators of effectiveness for community nursing from the existing Shared Purpose framework, to therefore enable front line teams to gauge progress against improving and sustaining core purposes and values and services.

5. To develop case examples of best practice across Kent and Medway to illustrate the shared purpose framework in action as well as to celebrate community nursing.

6. To hold a regional launch of the vision and framework organised and hosted collaboratively with the England Centre of Practice Development.

7. To embed greater patient and public engagement at every level of practice when implementing the framework, shared vision and purpose.

For Establishing an Effective Workplace Culture

8. To develop a Kent and Medway wide accredited community nursing leadership programme to develop and embed the attributes of the framework within workplace teams and cultures.

9. To pilot a dashboard approach informed by the Indicators/measures suggested as part of a Leadership programme which enables practitioners to be exposed to a range of tools to develop transformational leadership skills and embed the framework and vision within organisations across Kent and Medway.

10. To influence the development of future HEI curricula to create the workforce knowledge, skills and competencies required for the delivery of innovative services in the future informed by the vision and shared purpose framework.

For Further Development of the Cassandra Tool

11. To modify and adapt Cassandra as a tool for capturing workforce data on a larger scale (part of next stage bid).

12. To adapt the Cassandra tool for the Mental Health context and pilot more broadly with a larger sample of mental health practitioners.

13. To develop guidance materials to prepare Cassandra for subsequent use.

14. To pilot the Cassandra tool in organisations covering a different socio-economic mix e.g. more affluent communities, to complement the findings from this pilot with its high incidence of social deprivation to see if there is any difference in activity and workload.
15. To develop a competence framework integrating Cassandra interventions, performance indicators, knowledge and know-how for community nursing across NHS career framework levels in Kent and Medway.

**Identifying other Appropriate Tools and Approaches**

16. To identify senior practitioner/team leader expertise and professional judgement around workforce planning and skill mix and triangulate with other tools to support professional judgement\(^2\) that ECPD could integrate with the next stage project bid.

17. To develop a competence framework integrating performance indicators, knowledge and know-how for community nursing across NHS career framework levels in Kent and Medway.

18. To develop an approach for identifying skills gaps in the workforce across the patient pathway.

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\(^2\) Professional judgment in relation to questions such as Do you have enough staff and staff with the right competences? What is the most important strategy when you don’t have enough staff? Where are the pinch points? What times are more staff required?
Introduction

Setting the scene
The demand for nursing services in the community is increasing (Royal College of Nursing (RCN) 2010) however the role of nurses in the community is vast; all of which encompass the promotion of health as well as prevention and treatment of disease, illness and disability (RCN 2010). Community nurses often work with individuals in their home environment which is a vital opportunity to provide the ‘soft intelligence’ needed on a population; an integral aspect at the assessment stage of the commissioning process. It is important in workforce development planning to capture the contribution that community nurses provide in order to make evidence informed decisions about the skill mix required of the future workforce to deliver safe and effective services that provide best outcomes for patients. A review of community nursing will enable the development of an evaluation framework that captures the role complexity, clinical significance, impact, and productivity benefits for commissioners of services.

It is widely recognised that recent health care reforms have caused concern for the nursing workforce in the community setting (RCN 2011). Originally, the responsibility of commissioning services was assigned solely to GP commissioning consortia, but the recognition of nursing’s contribution has since been acknowledged with the notion of ‘every contact counts’; each interaction with the individual is an important opportunity to promote healthier choices (RCN 2012; NHS Future Forum 2012). However, currently there is a lack of specific data relating to the community nursing workforce (RCN 2012) and there is a need for a more comprehensive categorisation of community nursing activity as a starting point to better understanding the contribution of community nursing.

Workforce planning for community nursing looks set to be challenged by the particular political policy and philosophy of entrenching health care reforms, and so needs to rapidly develop strategies, tools, and methods to support all stakeholders in the delivery of not only person centeredness and care quality, but also of efficiency and value for money. Much literature and material that exists currently on workforce planning is descriptive in nature. Whilst that is useful in raising awareness of concerns within healthcare workforce planning, and can promote a need for more research and development, it does not provide tangible solutions to those issues.

Within the context of current health care reforms around the quality and productivity agenda, the RCN (2009) states that nursing contributes to quality care through providing care that is:
• Person-centred that is, care experienced by each person as focused on him or her as an individual. This is an outcome in its own right but also one bound up with the achievement of health outcomes;
• Safe and effective, based on blending different types of evidence to support decision-making aimed at the achievement of health-related outcomes and quality of life, as judged by the person;
• Creating the context and culture to enable quality to be sustained by all members of the healthcare team across the patient’s pathway.

The national strategy for nursing and midwifery (Department of Health 2012) Compassion in Practice sets out a shared purpose for nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent health and wellbeing outcomes. Its six fundamental values: care, compassion, competence, communication, courage and commitment are supported by six areas of action to support professionals and care staff to deliver excellent care in any setting. The national strategy recommends that for the 6Cs to be universally adopted and embraced by everyone involved in commissioning and delivering care, they need to be an explicit part of planning guidance, NHS Operating Plans and future plans across the NHS, Public Health and Social Care.

Front line staff need to be empowered as change champions with strong and effective leadership at every level. This can only be achieved if nurses have common shared purpose, are clear about their roles and responsibilities and the contribution they make in care delivery, and the competencies required to deliver high quality person centred safe and effective care. In turn this has to be supported by high quality education and training and should be embedded throughout career pathways, organisational culture and the appraisal and development of staff.

The recent publication of both the Francis Report (2013) and the Berwick Review into patient safety (Berwick 2013) recommend that NICE undertake to develop and promulgate guidance based on science and data on staffing patterns generally in the NHS. Such guidance would include methods by which organisations should monitor the status of patient acuity and staff workload in real time, and make adjustments accordingly to protect patients and staff against the dangers of inadequate staffing. The Berwick Review also recommends that innovations should develop and continue in technologies, job designs, and skill mix that should change ideal staffing ratios. Additionally, the Care Quality Commission will require that evidence-based tools are used to determine staffing numbers in the future.

The Berwick Review (Berwick 2013) also makes recommendations for training and capacity building highlighting the need for the entire NHS to commit to lifelong learning about patient safety and quality of care through customised training for the entire workforce on such topics as safety science, quality improvement methods, approaches to compassionate
care and teamwork. The most powerful foundation for advancing patient safety in the NHS lies much more in its potential to be a learning organisation, than in the top down mechanistic imposition of rules, incentives and regulations. The report highlights that collaborative learning through safety and quality improvement networks can be extremely effective and should be encouraged across the NHS. The best networks are those that are owned by their members, who determine priorities for their own learning.

The RCN Community Nursing Workforce in England report (2012) recommends that priority should be given to better aligning the planning of the community nursing workforce with service redesign, both in the immediate and long term. This should reflect national priorities to shift the delivery of patient care from the acute to community setting. The “Right Nurse, Right Skills” campaign, launched by the Queen’s Nursing Institute in 2011 lobbies for investment in home nursing to make sure patients are able to stay at home, safe, supported, secure and comfortable, and avoid unnecessary hospital admissions. The Queen’s Nursing Institute report (2013), recommends an expansion of the District Nursing role in the community and calls for significant investment into the community nursing workforce without which it states the NHS will be ill-equipped to respond to the needs of the people it serves.

The challenge then for commissioners of community nursing services is to develop tools and methods that will inform workforce development planning for a future nursing workforce capable of delivering person centred safe and effective evidence informed care in the home or community setting. The key question is how commissioners determine the best skill mix of a workforce to deliver an increasingly complex health care model that meets the needs of an ageing population in Kent and Medway.

With collaborative support from the England Centre for Practice Development, East Kent Hospitals University NHS Foundation Trust have successfully created and implemented a shared purpose framework for practitioners working at bands 2-8 as part of their overall commitment to enhancing the effectiveness of the organisation to deliver on person centred compassionate, safe and effective evidence informed care. The framework incorporates the competences, performance indicators, knowledge, skills, and behaviours required by the workforce to deliver the organisational vision. Permission has been sought to share this tool with community leaders to consider whether a similar framework would be useful for development of a workforce planning framework.

**Project’s Purpose**

The purpose of this four month commissioned project was to:

1. Scope the models already in existence in relation to effective nursing workforce development and planning tools in the community setting.
2. Review the literature for evidence of patient related outcomes from a registered/unregistered nursing work force.

3. Align this to similar work undertaken elsewhere e.g. EKHUFT shared purpose framework- nursing workforce skills, knowledge, competences to deliver person centred safe and effective evidence informed care.

4. Develop a shared purpose framework for piloting as a potential community nursing workforce development tool. This framework identifies the enablers, attributes and consequences of effective community nursing.

5. Undertake a specialist community nursing review using the Cassandra Matrix to capture the specialist nursing contribution in the delivery of person centred safe and effective evidence informed care in two pilot sites.

6. Produce a project report that makes recommendations for a future community nursing workforce shared purpose framework to support the commissioning process and development of leadership potential that impacts on education commissioning.

Commissioners Questions Guiding the Project

The commissioners asked the following questions:

• What models/tools/frameworks are already in existence and what are their strengths and limitations? Where are the gaps?

• What would a community nursing workforce look like to deliver this model?

• How can existing frameworks/models/tools be used as a benchmark for effective workforce development planning for nursing services?

• How can a benchmark tool be used by commissioners to lobby for nursing skill mix, delivering value for money, effectiveness, and economic benefits for patient outcomes?

Project Activities/Processes

The project activities focused on gathering, analysing and interrogating data from a programme of collaborative activities with stakeholders to generate a vision and shared purpose framework for community nursing. These activities included:

1. A Stakeholder Consultation Workshop to develop a draft Shared Purpose Framework, Vision and Purpose statement

2. Pilot of the Cassandra Matrix tool across three organisations in Kent and Medway over a 10 day period with a sample of community nurses;

3. Individual practitioner self-assessment pre- and post- pilot of the impact of the Cassandra Matrix tool on their own awareness of the contribution they make as a community nurse to the delivery of the service.
4. Stakeholder survey to further develop and strengthen the Shared Purpose Framework and Vision and Purpose statement.

At each phase of the project data has been used to check that the enablers, attributes and consequences of delivering a First Class Community Nursing Service across Kent and Medway are robust and representative of all stakeholder contributions and values.

This report now moves on to provide a comprehensive literature review of workforce planning and development, which includes a contextualisation of community nursing. It then provides an outline of the methods and methodology the project employed, moving on to discuss the project findings and from there make conclude by making recommendations.
Literature Review
This literature review aims to examine contemporary research and writing on the workforce planning and development tools and methods currently used within a community nursing context. In order to do this the search strategy, detailed below, was devised and implemented. Beyond the search strategy this review offers context into the current community nursing workforce, although little space is devoted to this as the greater concern is with providing an understanding of the tools and methods that are currently being used and developed for workforce planning and development.

In a systematic way the main themes, which are explicitly identified in the ‘Search strategy’ section, are laid out within the review, where there is discussion of their content and gaps in knowledge highlighted. Whilst much of what already exists on the subject is descriptive of the issues and challenges facing workforce planners and decision makers, and so serves mostly only to situate, there is evidence of significant efforts to provide frameworks of reference, and beyond this, a number of tangible tools and models that are available for adoption. In this sense what could be referred to as current best practice, or as is more the case a developing practice, is definable within this review.

The various concepts, tools, and models are deliberately set out in a linear way so to give rise to the explicit way each concept, model, or tool works; and to delineate them from each other to more easily be able to develop something similar, derived, or distinct. In this sense, the layout of this review follows the four main themes identified as significant within the literature, working to discuss systematically what the various writers and researchers focus upon and propose, whilst also offering some assessment of their value; and by way of conclusion, some understanding of how the current literature may be usefully built upon to provide for more dynamic and progressive ways forward, with particular reference to the importance of utilising combined and mixed methods approaches to workforce planning and development.

Project’s Search Strategy
The Literature search strategy involved using Canterbury Christ Church University’s (CCCU) LibrarySearch facility, which allows for the search of literature across a wide range of resources. Internally it searches the university library for books and e-books, and in addition also searches the university’s research repository (CReaTE) for journal articles, conference papers, and theses produced by CCCU researchers. Beyond the university the facility also searches for journal articles, conference papers, and newspaper articles in the wider national and international academic community using a variety of search engines. Essentially LibrarySearch catered for peer reviewed literature, so to be able to also include
grey literature, such as reports, Google Search, Google Books, and Google Scholar were searched for relevant material.

The search was limited to literature from 2006 onwards so the most recent developments in workforce planning and development could be considered. Using Boolean operators the search terms used, to be search by scanning titles, were ‘community nursing and workforce planning’, ‘community nursing and development’, but with few results being yielded, especially those that included ‘workforce development’ within their remit, the terms applied were altered to be more general, being modified to, ‘healthcare and workforce planning’, and ‘nursing and workforce planning’. With more returns, although still not an abundance, from the widened search criterion the literature abstracts were reviewed for significance and then themed according to their purpose. Table 1 shows the returns for the search terms. Table 2 displays the number of citations noted on Google Scholar for each author cited within this review.

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Table 3 defines the literature by being research, study, discussion/theory, literature/systematic review, commentary, or book to outline the evidence base included in this literature review.

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The literature tended to fall in one of four main areas:

- Contextual understandings of the current situation in relations to workforce planning and development, both within community nursing and, although more often than not, nursing generally.
- Technical solutions as an effective workforce planning strategy.
- Theoretical and conceptual approaches.
- Advocating a mix of the technical and conceptual as the best way forward.

Due to a lack of specific literature into nursing workforce planning and development tools and models (Buchan & Seecombe 2012), and especially so within the community context, this review has chosen to draw on significant and potentially appropriate material from wider contexts, including international studies and those not always specifically looking at issues within a community setting, to offer insight into what is being used more generally and yet may be appropriate for consideration.

**Definitions**

The Centre for Workforce Intelligence’s (CfWI 2013) understanding of what is meant by workforce planning provides a useful definition for its meaning within the context of this review. The CfWI (2013) understand that workforce planning is about ensuring that:

‘The right people with the right skills are in the right places at the right time…. [with a focus] around cost, productivity, safety and quality’ (CfWI 2013).

By definition then, the notion of a nursing workforce, including narrowing that down to a particular setting, extends beyond just the registered nurse role because a setting will always comprise of a range of registered and unregistered nursing roles that do not exist as

³ Peer reviewed
mutually exclusive. Nursing roles cannot exist in isolation and so must be considered within the context of other evolving roles that are mutually constitutive. Whilst this review is looking at community nursing workforce planning and development it does not consider registered nurses only, but also considers where the literature mentions non-registered nursing and care provider roles.

Community Nursing Context
This section of the review offers some insight into the current situation with community nursing in England in order to provide some context and background to the overall review.

The current community nursing context results, to a large extent, from the government white paper *Equity and Excellence: Liberating the NHS*, (Department of Health 2010) which is broadly about creating the largest social enterprise in the world, in which frontline workers have been identified as requiring the social entrepreneurial skills to deliver it. It also asks employers to re-examine their current workforce and determine how it will need to change to meet future demands, but to do so in line with the Quality, Innovation, Productivity and Prevention (QIPP) agenda, which sets patients at the centre of services, so to bring about efficiencies without compromising on quality.

There has been scepticism and resistance to the reforms (RCN, 2012), although these have been placated to some extent by the government implementing a ‘listening exercise’. The clinical commissioning groups (CCGs) that emerged from the listening exercise, which broadened the base of commissioners, must now be representative of local stakeholders and have a nurse and specialist doctor as members.

However, despite the latest policy, since 2000 there has been a move towards shifting many more services away from acute environments to community nursing services, bringing about transformation and lengthy processes of change. This has meant the development and expansion of local services, which are not hospital based, on the premise that such a shift would facilitate a more responsive and enabling service to users by combining choice and information for users that better lends itself to a personalised service. More latterly localised commissioning has been introduced to reform procurement and tendering processes, adding a more competitive element than was previously present, which it is assumed will allow for a greater plurality of provision that is designed to ensure greater service user choice. Injecting more competition into the service provision market is also designed to ensure efficiency and quality of service (Stubbs & Forbes-Burford 2009). Stubbs & Forbes-Burford (2009) have highlighted that constant changes and reform require a continuous change in leadership and management styles at a system, person, and organisational level.
The ‘liberating’ of the NHS (Department of Health 2010), towards a greater sense of the liaise faire and entrepreneurial, suggests the growth of services, and particularly in the varied and localised community nursing context, more as social enterprises than public healthcare provision. For many nurses this is unfamiliar as social enterprises have more extensively existed so far within the voluntary sector. Nurses may view social enterprises as care provision based on a business model with the soft approach of enabling and empowering features added in. However, many nurses, especially community nurses, may already be extensively doing the work of social enterprise without knowing it – of tackling social issues in new and more egalitarian ways. But questions remain around how nurses are supported to become social entrepreneurs, and move away from the public towards the private, whilst also maintaining their rights to public pensions and more ensured financial stability (RCN 2012). This is more principally relevant when factoring in the gendered nature of nursing, and the likelihood that many women workers have domestic responsibilities that necessitate the stability offered by public service employment, or indeed may not want to essentially set up new businesses, whether for a social good or not. Also there may be a lack of confidence and likely a lack of mentorship, appropriate support, and guidance; although there are signs of growing support structures. Further, it is not clear that nurse education adequately provides graduates with the business or leadership skills, together with enthusiasm for entrepreneurship, and the willingness to establish social enterprises (RCN 2007).

Against this backdrop healthcare provision failings have come under particular scrutiny (Francis 2013; Berwick 2013), and government commissioner reports have identified complacency within workplace cultures and risks to patient safety. The Francis (2013) Report into the Mid Staffordshire NHS Foundation Trust failings has called for the greater accountability of healthcare professionals, and for both effective leadership and more effective workplace cultures that are person centred and based on shared principles and values. Reports into significant healthcare deficiencies have compelled the transformation of healthcare provision towards an emphasis on quality, safety, effectiveness, and the patient experience. And they have driven the current political imperative for change, not only within the NHS more generally, but also within the nursing profession, where the strategy on Compassion in Care and The Principles of Nursing Practice reflect the same emphasis (Department of Health 2012; RCN 2013a).

More locally, and in direct relation to the Community Nursing Workforce Scoping Project, it can be said that the East Kent Hospitals University NHS Foundation Trust’s Shared Purpose Framework is an embodiment of the principles and values driving the current context of NHS healthcare provision, identifying how both registered and unregistered practitioners should be delivering person centred, safe, and effective care. And
so, given the consensus and the central driving forces, both nationally and locally, behind future healthcare provision, the fundamental question remains as to how to implement effective workforce planning and development strategies that are appropriate to the current political rhetoric. This review seeks to examine the current literature on workforce planning and development within the nursing context and identify concepts, strategies, methods, and tools that are compatible, and may usefully inform the wider project work; but prior to this there is more to be said about the particularities of the current community nursing context.

Community nursing has been recognised as providing workers with flexible working conditions as well as opportunities to be leaders and to contribute to the direction of services, because of the tendency for community nursing to be carried out within small organisations. Harris et al (2010) have pointed out that the expansion and extension of those more flexible ways of working could have cost implications and that, because community nursing has a larger proportion of older workers, it may be the older working force that are relied upon to support that extended and expanded flexibility. This presents problems because it is precisely the older working population that needs more, not less, incentive to remain in the work place because, as skilled nursing numbers continue to decline, there is urgent need to retain their skills and maintain their job satisfaction beyond the traditional retirement age (Storey et al 2009). It is not certain that as hospital based services and acute setting staff dissipate in to the community that personnel will have the requisite skills required to successfully drive forward what the government reforms propose (Harris et al 2010).

Storey et al (2007; 2009) has investigated more closely the issue of an ageing workforce in terms of UK primary and community nursing. They have identified gaps in data collection and collation that are leading to failures in effective workforce planning for both settings, but acknowledge that within the community setting the collection of data could be difficult to coordinate, or even to access, given that community based nurses are working in wide ranging locations and for many different organisations. Data collection within the community context could prove to be a complex and fragmented undertaking as the workforce is oftentimes difficult to reach. Storey et al (2007) also point out that use of the term ‘community nurse’ is problematic because it works to homogenise and conceal the very diverse range of nursing roles that exist within communities. It also leads to generalisations where, because of the very diverse nature of community nursing necessarily requires, more individualised approaches and understandings. Storey et al’s 2009 paper talks specifically about the issue of retaining community nurses aged 50 + as a strategy for preventing the foreseeable shortfall in skilled community nurses. Also pointing out the dearth of research not only into an ageing nursing population, but research that acknowledges the differences between community and acute settings, and that focuses on solutions for the community
sector given this is likely to be the most critical point for shortages. Storey et al (2009) espouse the benefits of older workers and suggest de-emphasis of recruitment in favour of a comprehensive retention approach that specifically targets older community based nurses.

Smith & Jack (2012) have called for a reconsideration of how services are configured as they identify the need for better integration of primary and secondary care, not only as Harris et al (2010) have pointed out because of personnel issues, but also because of changing demographics towards longer life expectancy and a likely increase in ill health and declined quality of health. The Royal College of Nursing (RCN) (2011) have highlighted the changing working environment and the increasing use of skill mix within community nursing teams, as well as the expanding role and remit of unregistered healthcare workers, emphasising how that increased remit may well be incommensurate with their unregulated status. And The Queen’s Nursing Institute (2010) has noted how unregistered healthcare workers need appropriate education that is in line with the often complex and autonomous nature of their work.

The community nursing workforce is seen as an important and critical element to the success of the holistic development of services (RCN 2011), but often the community workforce are written out of literature, or are homogenised and/or often described as an add on to acute settings, rather than as the ground swell of inter-professionals that they constitute (RCN 2011). Because of this concealment there is a need for the community nurse workforce to be aware, and raise awareness, of their capability to galvanise, assert, influence, and transform, or risk further marginalisation (Smith & Jack 2012).

There is agreement among writers, researchers, and affiliated organisations, that given changing demographics and the current political imperatives, healthcare services must respond and be modernised (Buchan & Seccombe 2012), developed (RCN 2013b), and transformed (Francis 2013; RCN 2013a); but there is not alignment necessarily over how that should happen in terms of workforce planning and development. The following sections of this review seek to present the various stands of thinking and approaches that aim to transform and reconfigure through workforce planning and development.

**Literature Situating Current Workforce Planning and Development**

The demographic and settings of community nursing is diverse and varying, and the range of roles runs from district nurses, community health care assistants (HCAs), practice educators, child community nurse specialists, school and nursery nurses, health visitors, mental health workers, occupational health nursing, community learning disabilities nursing, practice nursing, nurse students, to community nursing managers, just to name some. Community based nursing tends to be roles that are more autonomous than those based in acute settings, and involve more engagement with the most vulnerable in society. Because of
these attributes the work community nursing does is of profound social value and is imbued with a sense of being a political as well as a social activity. Community nursing, especially at the current time, needs to be seen more as a movement rather than simply a professional setting (Chilton, 2012).

This overview of recent literature on workforce planning and development considers contributions from the following areas:

- Chilton (2012)
  - On the necessity for a multidimensional approach to workforce planning and development.
- Buchan & Seccombe (2012)
- Centre for Workforce Intelligence (CWfI) (2012)
- Kelly et al (2009)
- Hurst (2006)
  - On the shift from primary to more community based nursing and the underdevelopment of workforce planning and development.
- Kmielowicz (2007)
  - On the failure of workforce planning.
  - On staff turnover, recruitment and retention issues.
- Curson (2012)
- Hurst (2006)
  - On combined and mixed methods approaches.
- Ettelt et al (2012)
  - On a role delineation model.
- Flynn & McKeown (2009)
  - On staff to patient ratios and skill mix.
- Beck & Boulton (2012)
  - On data tracking input and outcomes.
- Curson et al (2012)
  - On providing insight through a UK based literature review and the need for exemplars and more research.
Chilton’s (2012) work specifically focuses on community nursing defined workforce planning and development as contributing towards the forecasting of future requirements for staff education, recruitment, and continued professional development (CPD). From this it can be understood that workforce planning and development is multidimensional, encompassing a broader range of consideration beyond simply a game of numbers.

There is much consensus among researchers and writers that health care services are dissipating away from acute into community settings with a main perceived challenge being whether the shift in services and activity will be followed by adequate investment in human resources in terms of skill mix, staff ratios, and professional development (RCN 2010, 2012, 2013b; Buchan & Seccombe 2012). Back in 2009, Kelly et al pointed towards an increased need for 24 hour care and around the clock service provision as government policy, underpinned by an ethos of service user enablement and care/health ownership, drives current acute based services out into community settings. The RCN (2012) conclude that as the shift gathers momentum there is likely to be a lack of the necessary skills needed to effectively deliver the widening provision together with a lack of commensurate vacancy growth to fulfil the growing need. Buchan & Seecombe (2012) note that the shift towards more community based practice is compounded by continuing pressure to be financially austere, something also highlighted in the work of Hurst (2006), by the underdevelopment of effective workforce planning and development.

In 2007 Kmietowicz reported on the failure of NHS workforce planning. At this time Kmietowicz reported disordered and inconsistent hiring and firing of staff that was commensurate only with levels of cash flow, and further identified unjustifiable pay increases that were not linked to any productivity gains. The trend, at the time, in hiring many overseas staff also left new UK trained staff with less employment opportunities and made nonsense of ideas that workforce planning would facilitate effective supply and demand needs. Kmietowicz (2007) noted a lack of coordinated workforce and financial planning, which led to reactionary decisions and actions being taken; and this despite government rhetoric that it was developing clear plans to the contrary. The parliamentary report entitled Workforce Planning (2007), which Kmietowicz’s commentary refers to, points to continuous change and micromanagement as influencing factors for failings.

In 2006, Hurst carried out a UK based review of primary and community based workforce planning. Hurst (2006) recognised that workforce planning in the community setting has been too little considered despite the growth in services within this area. The paper identifies the lack of workforce planning and development tools, although concedes, there is more availability and development of them internationally. Hurst (2006) predicts workforce planning and development increasing in complexity as the variables affecting it proliferate with the pace of services. Hurst’s (2006) paper is significant because it illuminated
how community nursing workforce planning has been treated as having the same issues as those existent in primary care, pointing out that there are a number of differences between the settings that needs to be considered; namely that staff work autonomously, and in diverse and unique ways. Further, Hurst (2006) names problems with the recruitment and retention of staff as an issue for the community environment, not least because of the aging workforce, lack of investment, and the expected enormity of change occurring that may led to workers’ dissatisfaction where it did not previously exist. Within the paper Hurst (2006) also investigates the implications of moving towards more highly skilled specialist nurses, warning that the move is problematic for un-registered generalist workers whom will be left with mundane unsatisfactory jobs, thereby compounding issues around recruitment and retention of staff.

In particular Hurst (2006) spends time identifying the four main methods used to inform decision making about workforce planning and development; namely professional judgement or management consensus, workload analysis, population needs, and community dependency. The first Hurst (2006) views as too subjective, but the second is seen as more useful for it provides a good understanding of staff numbers, skill mix, and the elucidation of workloads. Ultimately what Hurst (2006) posits is the use of a combination of methods that include staff perspectives as well as community and service user dimensions, because this provides a rounded approach that is informed by the interconnected nature of service provider and service user.

At the same time as Hurst (2006), Gould (2006) was looking at the recruitment and retention of nurses. Although Gould (2006) did not specifically focus on community nursing, the paper does make the point that a drive towards expanding community nursing services that is not coordinated across regional levels, could have the effect of loss of acute setting staff to emergent community vacancies; and especially so if neighbouring trusts adopt individualised recruitment drives. There is also recognition of the lack of research and of a sharing of best practice around the recruitment and retention of nurses, and this is understood to be largely due to strategies having become localised and therefore varied. The suggestion is for national approaches, but for national approaches that are also reflective of diverse settings, and in that sense necessarily have integrated into them a degree of flexibility and the capability to be easily modified.

There has been little work done since the publication of Gould (2006) and Hurst’s (2006) papers and many of the issues raised within them are current and on-going, and some of the emerging issues still exist or indeed have come to fruition. The papers raises awareness of workforce planning and development concerns, but beyond suggestions of overarching ideas about possible approaches do not offer detailed frameworks, models, or tools that could readily be employed.
More recently in 2012, Ettelt et al. undertook a comparative study of health care service planning in New Zealand and Germany, identifying the use in workforce planning in New Zealand through a role delineation model, although this was largely only used to describe the working landscape rather than utilised specifically as a workforce planning tool. Its usefulness as a tool is currently being evaluated, but whether it can translate across primary and community services is unknown because it may be too unmanageable a fit across the vast and varying community settings. The paper talks broadly about primary and community services without particularly taking the time of differentiating them, although this is because it is set within the context of a drive towards integrating workforce planning for primary, community, and tertiary services in New Zealand. As a describer of services the role delineation model offers no insight into cost implications, efficiency, or consideration of service user or patient benefit as it focuses largely around staff roles and service provision.

A published paper by Flynn & McKeown back in 2009 questioned the usefulness of using skill mix and staff to patient ratios in workforce planning strategies. They suggest that consideration of skill mix along with staffing levels has been what much of workforce planning has been informed by to date, and that the evidence to bear this out as a useful way forward is found wanting. Further, they are critical of the variation of systems, approaches, consistency of application, and lack of evaluation used in current workforce planning, and acknowledge that little research and literature is available about community settings. Patient outcomes cannot for Flynn & McKeown (2009), although Hurst (2006) also states this, be necessarily associated with staffing levels and skill mix ratios because these are oftentimes only historically based. What they propose is that use of them, at the very least, needs to be a part of an integrated approach that also considers wider social and cultural contexts.

Beck & Boulton (2012) carried out a literature review based on the public health workforce in the USA. Similar to the situation in the UK the review points to a dearth of empirical research and studies about workforce planning and development that offer implementable tools and methods. The paper also applauds approaches that work by being informed by the association between staffing levels and patient outcomes. Beck & Boulton (2012) stress that the current economic climate of austerity is a challenge to further research into workforce planning and development, warning that healthcare systems will become the priority and that workforce size and effectiveness and its impact on patients will become secondary. In solution to this they suggest that meaningful data collection, which tracks input and outcomes, is a place to start from in attracting what will be much needed funding for further research to take place.

Curson et al (2010) carried out a similar UK focused literature review that talks generally about what workforce planning works well. Again they point to the lack of research
based literature on effective workforce planning and of best practice, noting much that
describes the problems and difficulties, but little real evaluation of practices or sharing of
methods, tools, and best practice. What is more useful is that Curson et al (2010) identify the
complexity and difficulty of workforce planning and development within a UK, and specifically
English, context because of the enormity of the NHS, the lengthy process of training staff,
together with the political milieus. For contextual reasons Curson et al (2012) promote the
idea that effective workforce planning and development consists of a continuous on-going
process based on an integrated approach that is necessarily informed by a mix of other main
planning drivers, such as that of services, finances, and demography.

Like Hurst (2006), Curson et al. (2010) recognise the multiple practices and ways of
working that happen within a community setting, and find that contrary to this there is
generally consensus in supply and demand being a main tenant of current workforce
planning practice, despite disaggregated internal market economies. Both qualitative
(conceptual and/or theoretical) and quantitative (technological data based) approaches are
discussed as having merits, with a strong call for complex integrated approaches. But there
is an understanding that such approaches are not likely to be possible given the devolution
of systems and processes and the effect of current economic austerity and cost cutting. The
advantages of competency based workforce planning are also discussed because they tend
to be service user centred due to the focus on quality and patient outcomes. However,
Curson et al (2010) point out the frequent unavailability of data that makes skill acquisition
planning difficult and oftentimes impossible. Further, there is also recognition that community
nursing is made up of many single professions, and that therefore workforce planning and
development within the setting must have a familiarity with the associations, as well as
differences, between those professions.

Ultimately no exemplars of comprehensive operative workforce planning and
development were identified, although there was acknowledgement that good practice
exists, but that it remains hidden because of the lack of published literature. For Curson et al
(2010) workforce planning cannot be an exact science, suggesting that it may not be
possible to ever make predictions successfully. They also advise that much of the literature
to be found is about general principles that underpin workforce planning rather than tangible
tools and methods that offer firm direction and guidance. The final counsel is of
dissatisfaction with current literature on the subject, especially within the healthcare realm,
and a proposal to look to other industries and sectors for possible exemplars.

Currie & Carr Hill (2012) have looked at reasons for nurses leaving the profession
and at other current issues relating to the high turnover of staff. Their paper attends equally
to community as well as primary nursing workforces, and gives some insight into the
associative factors between the two settings, like administrative workload affecting retention,
and older age relating to a sense of job satisfaction (also been noted by RCN (2010; 2012) and Storey et al (2007; 2009)); which means community nursing workforces tend to reflect a higher level of job satisfaction compared to other settings because there are a higher proportion of older personnel working within it. Specifically on workforce planning and development, Currie & Carr (2012) talk about a need for flexibility that is attentive to the fluid nature of the nursing workforce market, as well as to local, national, and international factors that may also have an impact. They suggest that no one strategy is sufficient and propose a mix of strategies relevant to local areas and more diversified workforces because such strategies are more responsive; making particular reference to nurse education and the nursing student body as a locus of diversification from where a transformed workforce can develop. Further, they suggest person centred approaches that recognise the necessity for job satisfaction and how it intersects with other more complex factors, such as personal circumstances and workplace and organisational cultures. In addition they identify some ways in which flexibility, as a way of attending more to individual circumstances, has been introduced so far, but indicate that more flexibility is yet needed.

The Centre for Workforce Intelligence (CfWI) (2012) has recently undertaken a horizon planning review of community nursing. They forecast that community nursing will likely look more like acute setting nursing in terms of hours of work, which it is assumed will negatively decrease the flexibility currently enjoyed but the existing workforce. They also expect that the acute setting workforce, as they move into a more autonomous working setting, may not have the skills or experience to deal with the transition. Workforce planning and development modelling is currently being evolved by CfWI (2012) as it works towards considerations of different and varying social, economic, technological, ethical, and political driver scenario combinations. It is unclear how they plan to do this and what methods or tools they will be using, but elucidation is anticipated with completion and publication.

Workforce planning for community nursing looks set to be challenged by the particular political policy and philosophy of entrenching health care reforms, and so needs to rapidly develop strategies, tools, and methods to support all stakeholders in the delivery of not only person centeredness and care quality, but also of efficiency and value for money. Much literature and material that exists is descriptive in nature, and whilst that raises awareness of issues, and of a need for significant research and development in healthcare workforce planning, it goes little way in actually providing tangible solutions. The following sections look at methods and approaches that researchers and writers working in healthcare workforce planning and development, with some centring specifically on community nursing, have proposed as useful for planning and developing effective future nursing workforces.
Technology Based Tools and Methods

This section of the literature review offers an overview of more recent publications and research that has highlighted how, and which, technologies can assist in providing improved workforce planning.

Initially, and as a precursor to more specific and detailed writings, an Australian study by Colley & Price (2012) that looks at the mass of ineffective workforce planning and development that happens within the public sector currently, despite some renewed interest in it, offers a flavour of a growing body of literature advocating new technologies as the way forward for workforce planning and development. This study in particular offers, a somewhat isolated view of, technological solutions to workforce planning and development, but does so, as do some other papers discussed further into this section, without pinpointing specific named technologies.

Along with the Royal College of Nursing (RCN) (2012) Colley & Price (2012) are attentive to the fact that data collection and collation gaps are a barrier to effective workforce planning and developing. Colley & Price (2012) propose better central workforce data collection as an antidote to gaps in data relating to, for example, skills and emerging threats relating to personnel. For them devolved human resource datasets are disaggregated and problematic because their importance and emphasis is dictated by local agendas leading to disjointed information, no overview, and the rise consequently of issues like staff shortages. Colley & Price (2012) believe that data collection can allow for an apolitical way of workforce planning that negates the vexations of policy changes. Whilst other writers, which are discussed below, espouse the merits of technological solutions, there is always a hint that new technologies cannot offer a complete, and socially and politically removed answer, but edifying the benefits of a culturally devoid solution is a somewhat naïve perspective and an impossibility because of the unavoidably contradictory concealment of the cultural, social, and political that such a position engages in.

With already acknowledged declining skilled nurse numbers, and a somewhat opaque understanding of individual personnel skills and qualifications, Gould (2012) suggests a need for greater transparency and awareness of skills, knowledge, and qualifications, so that the right people can be allocated to the right roles. Some suggested tools for delivering this are held by Skills for Health (SFH), which is a web resource, and yet more held within the NHS Institute for Innovation and Improvement Productive Communities Services Toolkit (NHS Institute for Innovation and Improvement 2013a). These tools are seen as beneficial as accountability and regulation rises, in order that staff themselves can assess, verify, and record. Green et al (2010) reviewed and evaluated the SFH resources, reporting that SFH provide tools that are competency based, so they look towards improving skills, behaviour, and productivity. Green et al's (2010) evaluation noted positive feedback.
about the tools and their usefulness in providing forms of standardised and consistent approaches, but with alternatives lacking it is not possible to offer a comparative appraisal. Basing workforce planning and development upon competency alone, which focuses on roles, service provision, and productivity, excludes more participatory approaches that look to include all stakeholders in the development of whole communities of care rather than the development of silos of particular professions.

Abernethy et al (2010) conducted a community based piece of research in the USA that espoused the benefits of employing health information technology (HIT) to community workforce planning. The research focused on the use of HIT in a community hospice and palliative care setting, and offers insight into how HIT can be used to gather and collate valuable data to measure patient care quality and outcomes. The research took steps to employ ‘champions’, people, whom comfortable with technology, would promote the use of HIT and thereby assist in bringing about cultural change in terms of negative attitudes about technology. Establishing ‘buy in’ by users of the technology was a major contributing factor to the success of the research. But beyond the users themselves, the research noted that the involvement of all stakeholders was necessary for complete and comprehensive ‘buy in’ and subsequent successful data collection. After trial and error the research team ultimately made use of direct data entry via electronic pens because tablets were found to be cumbersome. Outcomes demonstrated an awareness of, ‘improved symptom management, assessment of psychosocial needs, completion of advance care planning, and reduction in costs of care.’ (Abernethy 2012:223).

Abernethy et al’s (2012) research proposes that HIT easily enabled the establishment of joint practice and academic partnerships, which they identified as essential for ensuring the production of meaningful research initiatives and data analysis towards patient benefit. They also suggest the establishment of collaborative networks that share data to offer broader pictures; and see a variety of platforms for data collection as positive because such variety will enable tailored individual settings and users to be catered for. But, suggesting transposable technologies that can interface with each other is not straightforward and is likely to have cost implications, which Abernethy et al (2012) do not acknowledge. They do, however, point out that both academic and technical support is necessary in order to sustain the use of HIT systems, as well as to promote and demonstrate the value of HIT.

Very recently in Canada Bloom et al (2012) have carried out a case study of a technology based model for workforce planning. They identified that the lack of effective workforce planning in relation to demand and supply is a current worldwide issue and that there is a need for an effective model to be developed. Further, they recognise the need for the commitment that development of such models will be transparent about the ethos and
policies that inform them, so that adopters can more easily identify what is appropriate for their needs. Despite being a Canadian study the relevancy is associative because it took place during time of financial recession. The study centred around linking workforce planning to training and education establishments, as is the case in the UK, by emphasising the importance of workforce balance, and thereby the connection between the supply and demand of various professions and skills mixes; ultimately seeing productivity and effectiveness as a key variable for predicting supply numbers i.e. the number of students and graduates needed at any particular time. Moreover, the study recognised the need for developments in sustainable and tangible workforce planning and development models. The study proposed the dissolution of local planning in favour of a more centrally based approach, which sits in opposition to the current UK localised commissioning process. However, the research recognised a need for flexible technologies capable of testing and evaluating various scenarios of altering demographics relating to staff, population, and economics.

The model itself was built originally using Excel, with the final version developed using SAP\(^4\) Business Objects Xcelsius Enterprise, which has the capacity to produce images of data interpretations. The values grounding the development of the model were of respect, accountability, transparency, and engagement, and based on a whole workforce plan that included the variables of skill mix, staff turnover, vacancy rates, effect of economic recovery, average FTE worked (including part-time to fulltime ratio), number of graduate, number of health care assistants (HCAs) trained, and graduate retention. In conjunction the tool/model also considered population demographics in terms of both aging and growth of population because Bloom et al (2012) wanted to produce a workforce planning model that operated at the junction between supply and demand, which Holloway et al identified as critical back in 2009. Notably contrary to this, Buchan (2007) and Curson et al (2010), have highlighted the impossibility of supply and demand ever being a harmonised process, instead proposing it illusionary and always deficient.

The Bloom (2012) model was used in consultations with stakeholders to illustrate the various ways in which care could be delivered in a variety of different situations; offering the following six scenarios as illustrations:

- ‘Baseline (the status quo)
- Right care. Right place (a scenario based on changing the way aged care services are provided)
- Full time work for full time pay (increasing average FTE worked)
- Retirement impact – ageing workforce (changing assumptions about impact of retirements)

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\(^4\) SAP is a company names which stands for ‘Systems, Applications, and Products in Data Processing’.
Right care, right place, right skill (version i, based on expansion of Licensed Practical Nurses LPN workforce)
Right care, right place, right skill (version ii, based on expansion of HCA workforce)

What is proposed is that the model can provide flexibility and appeal to different stakeholders with different agendas. For Bloom et al (2012) workforce planning and development models must reflect the need for complexity, and must be transparent so that stakeholders can observe the motivations for why modelling variables are made. This will allow them to assess if their interests are served by the model, and if so in turn help to inform the decisions they make or the actions that they take.

The Bloom et al (2012) paper demonstrates that technology can now easily produce complex modelling that allows for understandings to be shared and considered, and for a greater capacity for projections to be made that can better inform policy decisions. The model is now currently being used to inform policy decisions and student numbers. Some of the limitations of the model include that it only considers nursing staff, and the assumption that other professions’ roles remained static. Also, technology works to produce rational statistics and cannot be relied upon to predict unusual patterns. Bloom et al (2012) acknowledge the limitations of the model, such as not being able to factor in estimates, i.e. the future availability of casually contracted staff, and of the assumption made that economic good time would see the workforce reduce hours, with vice versa being the case during economic hardship.

Ball & Catton (2011) offer UK based research that recognises a link between patient outcomes and staffing levels, and that also identifies a number of technological tools that are available to support workforce planning and development, ‘(for example, eCAT, the Brighton Method, GOSHman PANDA)’ (Ball & Catton 2011:55); advocate that technological tools in particular offer good solutions. However, they also point out that so far the use of technologically gathered data on staff has not in general been joined up with measuring patient outcomes, nor has it been used to provide local as well as national pictures. Ball & Catton (2011) argue for an integrated systematic approach that can offer a baseline from which better informed workforce planning and development can take place.

Ball & Catton’s (2011) paper mostly addresses acute settings, but does mention community nursing ratio to population levels and the numbers of caseloads as the way current staffing metrics in the setting work. They note that Scotland has refined and centralised workforce planning tools that work to offer overarching approaches, but as yet England still has no national reference point and so instead has a hotchpotch of tools being used, with decisions being made at a number of different levels. They also point out that the employment of technology has cost implications and that often this can be the reason behind
resistance to adoption. Further, there has been no evaluation of the effectiveness of most of the technology tools that Ball & Catton (2011) cite; and that lack of evaluation coupled with cost implications equates to the absence of any current evidence base that is likely to motivate take up.

A data collection process that is both flexible, because it has been devised in relation to specialist nursing and is therefore transferable to a community nursing setting because it has been designed for nurses working in wide ranging and often autonomous roles, and is also inexpensive because it uses existing technologies, is the Cassandra Matrix (Leary 2011). Leary (2011) developed the resource as a way for specialist nurses to evidence their value and sometimes unique contributions, something recognised as essential in the current economic climate of austerity and government cuts. The Cassandra Matrix enables nurses to identify the context of the work they do against the interventions they carry out, and so looks at developing a picture of the ratio of work interventions. Because of the particular data the Cassandra Matrix is looking to capture it may be necessary to include addition and differently focused data collections to inform, and provide for, more comprehensive analysis. However, the Matrix lends itself well to community nursing because it can be adapted to reflect the many and varying contexts within which community nurses work. It also provides data not only on what activities nurses are engaged in, but also offers a nuanced understanding of the situation in which it takes place. Figure 1. shows the Cassandra Matrix, which can be completed using either pen and paper or a computer tablet. The collated data can then be transferred into Excel for further analysis and/or for exportation into reports. Leary (2011) suggests an on-going and efficient approach to data collection by recommending that a sample from the working week or month is sufficient, and so this does not lend itself to being onerous for practitioners. Firstly, as other writers have suggested, Leary (2011) advises that an investigation and evaluation is made of what information already exist, so to avoid duplication of already existent valid and reliable data. Secondly Leary (2011) suggests data collection is carried out before any changes are implemented to establish gaps in the needs and delivery of current service provision. And thirdly that data collection is carried out after changes have been introduced as an effective way of measuring and evidencing the effects of initiatives and new ways of working. What the Cassandra Matric offers is an economic, yet effective and insightful method of data collection that can inform and support decisions about workforce planning and development through continual and sustained processes.
NHS Employers (2013) are currently designing a more consistent way for technological workforce data to be recorded on the Electronic Staff Record system (ESR). The aim of the development is also to improve accuracy and quality through the use of a new coding process. They hope to have the system available for use in late 2013.

Locally, East Kent community nursing currently uses a dated system of data collection called ComCare. It is a legacy system that is used to capture practitioner activity to support internal performance management and externally contract management mechanisms. The system was implemented in the mid-1980s and is a very basic system which enables nurses and therapists to capture activity data such as the following:

- Patient details such as; NHS number, name, address, sex, date of birth, registered GP etc.
- Referral date, source and reason for referral
· Contact date, location, treatment given, limited very basic outcome data (for some services)
· Discharge date and details of any onward referrals

The system requires clinical staff to complete manual returns that are then submitted to central data capture team for inputting into the system with varying quality of data returns. East Kent are beginning to implement an electronic patient record system which it is believed will greatly improve the availability and quality of the data; however, extensively these tools are linked to performance management and there is little acknowledgment of any foundational values or principles, or use of it as an effective and useful workforce planning and development tool.

For technological solutions to be in any way effective the data gathered and input into the systems needs to be representative of a quality that can provide meaningful analysis, on this there is consensus (Abernethy 2012; Ball & Catton 2011). But calls in some of the current literature for development and investment in centralised and interfacing technologies that can offer overviews remain somewhat unconvincing visions, because they exist amidst an era of localised commissioning in England where there is no national review of current systems and a good deal of pressure to cut costs.

What these calls can offer is the notion that collection, collation, and analysis of staffing data done in conjunction with patient and quality outcomes can provide an essential first step; but much of the literature covered fails to address how the use of new technologies can contribute effectively, positively, and meaningfully to workplace cultures, or to socio-political and socio-cultural associations between service providers and service users, which is something especially relevant to community settings. There is a real disproportionate lack of philosophical underpinnings in many of the technologically based tools and methods discussed so far, and in the following section of this review approaches to workforce planning that place far greater emphasis on their philosophically transforming features are evaluated.

**Conceptual and Theoretical Approaches**

Cummings et al (2010) undertook a systematic review of literature that looks at the effects of leadership on nursing workforces and working environments in Canada. This review is critical because it illuminates that an orientation on task completion and workforce statistics has less meaningful impact for the workforce and for patients than a focus on relationships and individuals. More instructive styles of leadership and workforce planning led to greater staff attrition rates and job dissatisfaction, as well as negative workplace cultures. The suggestion from Cummings et al (2010) is that the way in which workforce planning is carried out, the philosophy behind and informing it, should be a fundamental part of any tools
and methods. With transformational leadership comes increased nurse empowerment, along with significantly improved staff health and well-being and consequently better outcomes for patients. The Cummings et al (2010) publication is not specifically about particular workforce planning tools and methods, but it is nevertheless a useful demonstration of arguments that call for reflection on the significance of the philosophical nature of approaches to workforce planning and development.

A workforce planning systems review for the RCN was reported on by Buchan back in 2007. The report was not specifically drafted to look at the community nursing workforce, but it gives an overview of nursing more generally on issues that may yet be transferrable. Along with Curson et al (2010) and Parsons (2010), Buchan (2007) understands that there cannot be exact answers in workforce planning, despite it oftentimes being thought of as sitting within an illusionary realm of scientific certainty. Instead it should be used to inform and guide decisions and not claim to provide answers. Supply and demand for Buchan (2007) cannot be synchronised because synchronicity between the two is not possible in what is an ever changing healthcare environment. Workforce planning as it currently stands can only be used in the short term, or for immediate responses according to Buchan (2007), because effective and sustainable workforce planning and development is about an approach that is grounded by a set of values or principles. Along with Parsons (2010), Buchan’s (2007) notion is much more sustainable than technologically based solutions, which may be based marginally on a set of values but ultimately are about statistical projections that profess a positivist scientific truth that in reality is no kind of truth or prediction at all. Buchan (2007) is critical of previous workforce planning approaches that are driven only by staff number analysis and do not include any interrogation of significant impact factors. Buchan (2007) recommends that information needs to be drawn from a number of different sources, and so alludes firmly to a combined approach to workforce planning and development as being a more positive and successful method. Further, the criticism is levelled in particular at England for not having a national plan, nor for facilitating and recognising the importance of sharing ways of working, which has led to a lack of transparency and non-participatory methods. Buchan (2007) does caution that this is not necessarily an indication that workforce planning processes do not work per say, but is more a case of those processes suffering from gaps in information that make them ineffective and not fit for purpose. The proposal is for:

- A joined up workforce planning and development model that includes, as mandatory, service planning and funding impacts.
- And, along with the RCN (2012) the initiation of data and information collection to fill the current gaps in knowledge.
The above points Buchan (2007) suggests should be informed by the following synthesised principles:

- ‘1. The main functions/stakeholders (e.g. finance, service planners, education providers, public/private sector employers) are committed to and involved in the planning process, with clear lines of responsibility and accountability being defined.
- 2. Build from a structured information base on current staffing, staff budgets and relevant activity whether planning for a ward, organisation, region or country.
- 3. Assess workforce dynamics and “flows” between sectors and organisations within the system being planned for – assessing sources of supply and turnover.
- 4. Develop an overview analysis to identify need for, and scope for, change.
- 5. Develop and agree a set of planning parameters linking workforce and activity data.
- 6. Use “what if” analysis to model different scenarios of demand for services, and related staffing profile.
- 7. Develop an agreed workforce national plan which aggregates local/ regional plans.
- 8. Establish a framework to monitor staffing changes in comparison to the plan – develop a cycle of review and update.’

(Buchan 2007:8).

Bloom et al's (2012) model, which was discussed earlier, proposed a base of informing principles, but with a technologically based statistical emphasis it admittedly fails to include important nuances, such as broader cost, social, or economic implications within its scenario productions. As a tool that offers a self-confessed ‘kind of truth’ it lacks qualitative credibility and seems always to be running to catch up (statistically) with what is likely to have already happened. Buchan (2007) suggests that what is needed is more than data on just what nurses are doing (skills, working and employment and retirement patterns, locations, and mobility), and for there to be more focus on who the personnel are; because this will attend better to issues relating to equal opportunities, recruitment, and the creation of workforces that are reflective of demographics. Further, the suggestion is for greater attendance of pre-registration attrition and employment take-up rates. Buchan (2007) also recommends use of the Nursing and Midwifery Council register and RNC membership to gather this data, either at the point of registration or through periodic surveying. Unfortunately, as Buchan (2007) points out, this does not solve difficulties in surveying or accessing information about non-registered staff, which would necessarily require negotiations with multiple employers and as a consequence is likely to be costly and complex. Data access and analysis, although identified as a cost implication, it is proposed should happen through strengthened partnerships with high education institutions to ensure robustness and to further support and extend joined up ways of planning.

Whilst conceptual, theoretical, and underdeveloped combined qualitative (sociocultural understandings) and quantitative (data/statistical gathering) approaches to workforce planning and development offer a way of injecting understandings of the
significance of the socio cultural, political, and economic, it cannot be said that they provide structured frameworks that planners and decision makers can use as tangible ways forward; they are zeitgeist like in that they advocate the spirit of progressive, broad-minded, and transformative workforce planning and development. And so there remains a need for comprehensive combined approaches that seek to recognise the complex nuances concealed by previous workforce planning efforts, but that also cater for those looking for more direction and guidance, and that can denote a significant shift towards much needed progression in the area of healthcare workforce planning and development. The next section of this review looks at combined approaches, some of which offer the beginnings of progress towards palpability, and some that are much more advanced and already exist in practical and functional forms.

**Combined Approaches**

Hurst (2006) and Reid (2008) propose that the most effective approach to workforce planning and development is through use of mixed methods approaches, because they allow for broader considerations of the increasing variables and growing complexities within the community nursing environment. To the universal quest for effective workforce planning (Parsons 2010), whatever the setting, it is conceivable that a generic framework of empirical data collection can be used in combination with local socio economic, cultural, and political awareness to provide significant value for planners and decision makers. Parsons (2010) has described this as a mixture of art and science whereby principals, values, and philosophies come together to form a creative approach to working with data and statistical information.

The situation in New Zealand is discussed by Holloway et al (2009), echoing much about the need for collective frameworks that are user centred, citing current disjointed approaches to workforce planning and development as inefficient for longer term planning purposes. Their paper talks about the anticipated growth of nurse specialists within the community as more care takes place beyond acute settings, and sees standardised frameworks of reference, including the collation of uniformed workforce data sets, as key to developing appropriately enunciated skill grades that can provide clarity and consistency in meeting community’s needs.

Fraher & Jones (2011) carried out a USA based study of the North Carolina nursing workforce. The study is a broad overview of nursing workforces, but it recognises the need for more research into community based workforces, as the authors understand that there are differences in configurations between acute and community settings. The paper endorses a system of five recommendations towards planning for the future workforce:

- A commitment to engage and collaborate with stakeholders.
• To build datasets and analysis facilities that can inform planning decision making.
• To set up a research division that can provide an independent evidence base.
• Commensurate with the research division, to actively secure funding for such a division of operation.
• The research division to be housed as an institution that has a neutral interdisciplinary team who can ask broader questions in regard to planning, and offer analysis that takes account of other associated professions and of the wider social, economic, political, and cultural contexts.

Disappointingly Fraher & Jones (2011) are yet to produce a definitive model or design, but the basis to the steps for a more representational or figurative mixed methods tool is clear and ready for progression.

In a paper based on community nursing leadership in Scotland, Haycock-Stuart & Kean (2011) point to the need in workforce planning and development for increased quality of care and skills to be an essential part of any increase in workforce numbers, because it cannot be assumed that higher ratios of staff necessarily equate to higher quality and standards of care; although the RCN (2012) argue that investment into community nursing is imperative, talking of a connection between increased community care needs and lack of investment equating to decreased quality of care. Beyond this point, Haycock-Stuart & Kean (2011) agree with many other writers that patients and service users should be central to any understanding of quality of care, pointing out that there should not only be a focus on user/professional relationships, but a focus equally on evaluating competencies and technical capabilities. This suggests involvement and participation of service users, and also of nurse leaders in the assessing of competencies. Viewing these as mutually exclusive can, for example provide data that reflects high quality care through interpersonal relationships, but that also works to exclude less favourable technically, or knowledge based processes and behaviours. This would particularly mean difficultly in unravelling whether the right people are in the right roles (Hurst 2006; Storey et al 2007; Reid et al 2008). Haycock-Stuart & Kean’s (2011) paper pay attention to the community nurse setting and understands it as diverse and complex, as well as anticipating a need for workforce planning and development that accounts for such variations. They conclude by stating that quality measurements cannot be the only driver in workforce planning and development, going on the state that quality of care must only be a part of a framework that also incorporates the workforce and organisational cultures and the educational base.

Farmer et al (2012) examined data from both Australia and Scotland to raise awareness of the sustainable impact of health care workforces within rural communities. The
thrust of their argument was that philosophical underpinnings to workforce planning and development are critical because that provide for the illumination of the wider socio-economic benefits afforded by health professionals’ inputs; and this they assert is particularly relevant to community settings. The paper offers a framework of ‘capital’, laid out in the form of a table with simplistic descriptors (Figure 2. below), from which it is possible to generate measurable individual and institutional social, economic, and human benefits. The framework moves through a ‘capital’ type descriptor to consideration of issues raised by the study participants that relate to the ‘capital’ type descriptors. From here demonstration of measurable ‘capital’ indicators can be identified, such as educational, economic, and social capitals. The final stage is provision of an accumulation of all the ‘capital’ type sections, which in turn can be used to describe and evidence more symbolic and abstract capitals of equal significance. Farmer et al’s (2012) framework is a commencement towards tangible tools for gathering quantitative data, which is informed by a philosophy that provides gravitas to the qualitative information by seeking to disclose, and not conceal, the broader social and cultural perspectives within which health services are delivered, and within which both health professionals and service users live and work.

Figure 2. Capitals framework linking rural health services inputs with impacts on community sustainability (example of the table showing for the ‘individual’) (Farmer et al 2012:1906)

<table>
<thead>
<tr>
<th>Type of capital</th>
<th>Link between empirical data and theoretical capital category</th>
<th>Measurable indicator(s) (examples of previous use given)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic</td>
<td>-Personal choices about economic contribution to community</td>
<td>-Personal spending locally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Use of local services &amp; amenities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Property ownership</td>
</tr>
<tr>
<td>Social</td>
<td>-Formal &amp; informal social participation in community</td>
<td>-Type, number &amp; frequency of network contacts</td>
</tr>
<tr>
<td></td>
<td>-Formal &amp; informal civic participation in community</td>
<td></td>
</tr>
<tr>
<td>Human</td>
<td>-Capacity for work</td>
<td>-Age</td>
</tr>
<tr>
<td></td>
<td>-Level of education (mediated by: willingness to apply knowledge, skills, and abilities for community)</td>
<td>-Educational achievement (mediated by: sense of belonging &amp; social/civic participation)</td>
</tr>
</tbody>
</table>

Although these calls for combined approaches offer good rhetoric, there still remains a dearth of complete combined approaches that can be immediately and effectively
employed in practice. The following examples are fully developed models that lend themselves to instant usability.

Leach & Segal (2011) developed a workforce evidence-based model to assist planners in assessing patients/user attributes that are both medically and socially based (Figure 3.). The model considers the stage of illness or disease, disease complications, and factors influencing capacity for self-care. Whilst specific to diabetes, the intention is that the model can be translated across a variety of care needs, as well as be supplemented with guidelines for clinical practice, and be used to inform research, education, and workforce planning and development; and in this sense is a palpable method amongst, what remains in many commentaries, as the conceptual or rhetorical.

**Figure 3.**

Masnick & McDonnell (2010) offer a dynamic wide ranging ‘endogenous systems model’ (Masnick & McDonnell 2010:9) (Figure 4.), which is a structural map that was

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5 ‘Figure 1 Workforce evidence-based (WEB) model* for diabetes mellitus. *The workforce evidence-based (WEB) model assists clinicians, researchers, educators, and health services and workforce planners to recognise, and effectively manage, the complex needs of individual patients with chronic disease. The model takes into account three key elements that necessitate a significantly different approach to the management of chronic disease, including: (i) types and/or stages of the disease, (ii) complications and/or morbid events associated with the disease, and (iii) factors impacting on the patient’s capacity to self-care. Essentially, a person with chronic disease may experience one or more of these factors, at any period of time, throughout the life of the disease - accounting for literally millions of individual patient types; each with distinctly different care and service requirements.’ Leach & Segal, 2011, P. 4).
developed exponentially from ideas about a basic tool for planning workforce supply and demand.

Figure 4.

The model shows the complex nature of workforce planning and development and the interconnectedness of health systems, not only to each other, but also to the wider world. It recognises individuals as social and political beings, and importantly makes the connections between health and healthcare, and social and political theory, and social and political realities. The consideration now is for Masnick & McDonnell (2010) to develop the model along with appropriate technologies for use on a national level to work to inform, not just about supply and demand, but also about healthcare education, training and development with patients and service users the central consideration. Masnick & McDonnell (2010) do caution that the model is limited to use within over-developed, opposed to under-developed, countries because of the likely differentiation in availability of resources. Like Leach & Segal (2011) the Masnick & McDonnell (2010) structural map goes some way to providing rather more than an ethos, philosophy, or theory for workforce planning and

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development, in that it actually illustrates the way in which a holistic and patient centred concept can be elucidated for those requiring more than just a set of notions to plan by. Manley et al’s (2011a) work has also ardently advocated the necessity for effective workplace cultures that operate at the microsystem levels illustrated within the Masnick & McDonnell (2010) model in order to bring about meaningful and consequentially transformational healthcare. Beyond identifying the need for effective workplace cultures Manley et al’s (2011b) work on practice development provides a clear intervention for facilitating the transformative nature of workplaces, providing tangible direction for workforce planners and decision makers looking to transform workplace cultures in line with recent political imperatives. Focusing on individuals and teams at the interface of service provision across all healthcare settings, practice development is the application of a person centred and creative approach that is designed to empower and engage those individuals and teams in a process that drives sustained and continuous agitation of shared principles and values, which culminate in the bottom up and top down embodiment of them.

A Canadian study by Tomblin Murphy et al (2012), whilst not based on community nursing per say, does provide a conceptual framework and analytical model, which the authors call a simulation model for workforce planning. The main focus of the study was on eliminating nursing shortages and is based upon an understanding of the requisite for health human resources based on population needs. In this sense it is user centred, but the developers themselves confess that it falls short of a more holistic and comprehensive multi-dimensional model, such as that proposed by Masnick & McDonnell (2010). Figure 5 shows the simulation model.
Figure 5. (Tomblin Murphy et al 2012).

The simulation model has been developed specifically for scenario generation and Tomblin Murphy et al (2012) conclude that, as seems to be the consensus with many researchers working in this area, high quality data and data collection methods are key to effective workforce planning and development, along with assessments of population needs informing the supply and demand of human resources. Tomblin Murphy et al (2012), along with others, point out that oftentimes data sets have been incomplete and fragmented, and that they cannot necessarily be assumed to be un-widely varying, especially data based on perceptions or examples. But despite potential problems with the quality of data Tomblin Murphy et al (2012) still believe it is important to push forward with work, which has so far been very limited, beyond conceptualisation of workforce planning approaches towards practical applications, because it illustrates progression through refinement and usefulness to planners and decision makers.

Combined approaches that consider the quantitative and the qualitative are at the forefront of ideas around effective workforce planning and development. Many remain somewhat underdeveloped, and crucially many more remain unused, which means it is not possible to assert thorough evaluations their quality and operational effectiveness. What is certain however, is that healthcare workforce planning and development, and more
especially that of the community nursing sector, continues to require radical and rapid progression if it is to be successful in delivering consistent continuous change that is relevant and appropriate to the communities that it serves. What is clear is that the innovation of a successful workforce planning and development tool requires the combination of a cost effective and meaningful system of data collection with philosophical approaches that deliver on current political imperatives.

Conclusion
The biggest challenge facing the current community nursing workforce is that it is not large enough to meet demand as populations overall increase in age, live longer, and as ever more complex co-morbidities rise. In addition the political rhetoric and imperatives currently surrounding healthcare provision are compelling workforce planning and development to implement strategies that will deliver on effectiveness, safety, and person centeredness.

What is clear from this review is that community nursing workforces do, and will continue to, constitute a critical mass able to influence edifices of care structures and processes (Gould 2012), but how to positively and progressively support, develop, and transform this significant, yet diverse, group of individuals in times of change and reform remains, to some extent, mixed within current literature. Much of that literature only recites the pertinent issues, offering glimpses of some trends in approaches used to date. This provides context and raises awareness, but does not afford progress or deliver solutions, which runs contrary to what oftentimes the authors of such descriptive and situating papers are calling for.

The use of health information technology (HIT) systems to capture community nursing data and activity are advocated as useful tools in much of the literature, either as a single strategy, or combined with a philosophical grounding that provides for more meaningful data to be captured, and for the inclusion of methodologies aimed at evolving more holistic workforce planning and development. There is general consensus that auditing and community profiling are valuable tools for monitor demographics and aiding proactive response to change. Yet there are also persuasive arguments that quantitative data collection alone as inadequate for offering evaluation of qualitative staff and service user perspectives. There are concerns that increasing competition through commissioning will lead to ‘any qualified provider’ undertaking service provision, and that this could mean ever more disparate workforces from which the creation of an overview on staffing data would be problematic. In addition, if increased technology is not tracked by resources then economic restraint may lead to workforce planning that emphasises affordability rather than what is best in terms of care provision.
A number of writers and researchers have proposed the use of mixed methods that involve both quantitative (data collection and analysis) and qualitative (philosophical and theoretical) approaches to workforce planning and development, through their recognition of the varied and complex impact factors; and moreover, of recognition that those impact factors are mutually constitutive and not mutually exclusive. And these calls for combined strategies have ranged from a step just beyond the conceptual to detailed operational models and tools.

Community nursing workforce planning and development needs to allow for recognition of differences as well as the building of associations across and within communities, together with integrated flexibility for ever changing environments and associations, in order to facilitate cooperation and empowerment across pluralities of responsibility and accountability. More explicit recognition of the politics of healthcare through the engagement of conceptual ideologies can assist in highlighting previously concealed socio-cultural, socio-economic, and socio-political subjectivities and as a consequence allow for expedition towards greater equities of association.

Ultimately, due to the lack of research and literature in general in the area of health workforce planning and development, and more specifically within community nursing, there are opportunities abound to lead on research and development, with the possibility of effective tools, models, and conceptual frameworks providing exemplars for best practice both locally, nationally, and internationally. However, it is important to highlight that workforce, as well as populations and policy, are likely to endure as fluid, unfixed, and changeable; and it is against these conditions that effective workforce planning and development needs to be understood as necessarily continually progressive. And for evolved methodologies, methods, and tools to be visionary by being designed to always allow for a filtering of context and a responsiveness to wider socio-cultural, socio-economic, and socio-political subjectivities, so ultimately for workforce planning and development to possess transposable rudiments from which contextually relevant supplementary impacts can be assimilated.

The Community Nursing Workforce Scoping Project will take a combined approach by utilising a data gathering method that can raise awareness of the contribution of community nursing alongside a conceptual vision and framework that can provide underpinning shared principles and values. By adapting the Cassandra Matrix tool (Leary 2011) for the community setting the project can initiate the collation of data that will elucidate what it is that community nurses are doing in the three pilot sites. The Cassandra Matrix tool (Leary 2011) will provide a visual representation of the interventions and the ratio of activities that nurses are engaged in. It is being used because it can offer a starting point from which community nursing’s contribution can be explicitly demonstrated. The Cassandra Matrix tool
(Leary 2011) will be complemented by the development of a Vision and Purpose Statement, which is supplemented by a comprehensive Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent and Medway developed by key stakeholders. Both the vision and framework will provide the conceptual foundation for the workforce planning and development of community nursing across Kent and Medway, but will also suggest tangible indicators and/or measures as further sources of data collation from which to demonstrate the effectiveness of Kent and Medway community nursing services. Likely measures will include the national Public Health Outcomes Framework (Department of Health 2013) with its emphasis on ‘increased life expectancy’ and ‘reduced differences in life expectancy and healthy life expectancy between communities’, as well indicators of patient experience, safety, effectiveness, and workplace culture embedded into the project Vision and Purpose Statement and Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent And Medway. Other measures might include CQUIN (Commissioning for Quality and Innovation) measures (NHS Institute for Innovation and Improvement 2013b), which is a scheme that sees a proportion of income given to healthcare providers conditional upon quality and innovation improvements.
Project Design, Methods, and Methodology

This project and its processes were based on the principles of emancipatory practice development. Practice development (PD) is defined as “a continuous process of improvement toward increased effectiveness in person-centred care. This is brought about by helping health care teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change that reflects the perspectives of service users’ (Garbett & McCormack, 2002).

PD focuses on understanding the social system of practice as well as empowering individuals and teams to understand their practice and to take action to change (rather than be led others). It also fosters a transformational culture (Manley & McCormack, 2003). Successful practice development and implementation of change takes account of evidence, context and facilitation (Rycroft Malone et al 2002).

The successful implementation of evidence into practice (through practice development) is more likely to occur in situations where the research evidence is strong (‘high’), there is consensus about it and it matches peoples’ preferences, the context is conducive to change/the new practice (‘high’), and appropriate approaches and mechanisms of facilitation are in place (‘high’). The process of emancipatory PD enables person-centeredness (including the flourishing of people), commitment to action in the long term, involvement of all stakeholders to foster collaboration, inclusion and participation, working with and clarifying values and beliefs, defining issues and best practice locally from the practitioner and patient’s experience, and understanding context and culture of care to enable transformation. Developing a shared vision is crucial with stakeholders, and agreeing and implementing a systematic and evaluative approach focused on the process of achieving outcomes rather than simply achieving outcomes. The approach supports and challenges individuals, teams and practice to creatively find alternative ways of working and thinking in order to promote sustainable transformation in practice.

This approach fitted with the expectations and aims of project commissioners who wished to develop a shared purpose framework for creating a clear vision for the future delivery of community nursing services in Kent and Medway and to gather supportive evidence from a systematic review of existing literature about what works and does not work in terms of understanding what tools, frameworks and processes might assist in supporting future workforce planning to deliver a transformed service.

The project was divided into 5 stages of data analysis, then synthesis and testing as follows:
1. Systematic literature and policy review to identify what is known about community workforce development tools, identify gaps and make recommendations for the next stage of the project.

2. Regional community stakeholder workshop to undertake values clarification, visioning for the future and development of criteria for a shared purpose framework for community nursing.


4. Pre and Post Cassandra Matrix evaluation with community nurse participants across the three pilot sites.

5. Survey of stakeholders to gather their views and feedback on the draft shared purpose framework, vision and purpose statements.

At each stage of the project the project steering group were asked to provide peer review and feedback on the outcomes of each stage of development.

Lincoln & Guba (1985) posit that trustworthiness of a project or research study is important to evaluating its worth. Trustworthiness involves establishing:

- Credibility - confidence in the ‘truth’ of the findings
- Transferability - showing that the findings have applicability in other contexts
- Dependability - showing that the findings are consistent and could be repeated
- Confirmability - a degree of neutrality or the extent to which the findings are shaped by the respondents and not researcher bias, motivation, or interest.

It was essential for the project team to engage with and understand the context and culture of community nursing speaking with a range of people, and developing relationships and rapport with expert practitioners in the field in order to facilitate understanding and co-construction of meaning in the 5 stages of the project. The project used triangulation as a method to ensure that an account of the project is rich, robust, comprehensive and well-developed. The process of member checking enabled the project team and an independent expert group of community nursing academics to check data, analytic categories, interpretations and conclusions with all core stakeholders throughout the project as a technique for establishing the validity of the outcomes of each stage. Lincoln & Guba (1985) posit that this is the most crucial technique for establishing credibility of a project. Member checking gives participants opportunity to confirm particular aspects of the data, correct errors and challenge what are perceived as wrong interpretations, provides the opportunity to volunteer additional information which may be stimulated by the “playing back”
process, as well as a means to summarize preliminary findings keeping participants engaged in and stimulated by the process.

Ethical Approval for Stage 3 of the Project
Ethical approval for piloting the Cassandra Matrix tool in three community health care organisations in Kent and Medway at stage 3 of the project was provided by the University Ethics Committee (Appendix 5). Anonymity for community nurse participants was outlined in the participant information sheet (Appendix 6) and consent was informed by self-selected participant uptake. Participants received a letter of thanks following their participation to enable them to request a copy of their Cassandra Matrix data for their own records and interest and to determine whether they wished to receive a full copy of the report (Appendix 7). Individual participant data is not readily identifiable in the organisational analysis provided for each Trust in the data analysis charts provided.

Limitations of the Project
The project team acknowledge the following limitations:

1. The number of self-selected participants in stage 3 of the project is small and there were less people than we had hoped for, with an uneven distribution across the three pilot sites.
2. The timeframe of four months and funding available did not enable the project team to scale this project to a wider stakeholder group although it is anticipated that the project recommendations will inform the next phase of development and funding application.
3. The shared purpose framework requires broader engagement to include patient and carer voice and it needs to be further tested across the region with a broader sample of practitioners involved in delivering community nursing services.
4. We have used the Cassandra Matrix tool because we have tried and tested it elsewhere and there is a scarcity of suitable workload analysis tools currently available. More choice would have yielded a broader spectrum of tools to pilot.
5. Access to the community nursing workforce in stage 3 and 4 of the project was determined by administrative gatekeepers within each organisation.

Project Methods
The following section outlines the methods used to collect and synthesize data in stages 2-5 of the project, following the systematic literature review presented in stage 1.
Stage 2: Community Stakeholder Workshop Event (Appendix 5)

28 Managers, Chief Operating Officers, Directors, Chief Executives and senior managers and leaders from across Kent and Medway participated in a community stakeholder workshop in September. The aims of the workshop were to

• Develop a shared understanding of project purpose and anticipated outcomes.

• Present an overview of the literature review findings and a conceptual framework.

• Review a Shared Purpose framework tool developed by EKHUFT and consider whether this approach would meet the requirements of community nursing roles.

• Look at Cassandra Matrix interventions for relevance to community nursing and identify potential people to pilot the tool for 10 days.

• Focus on current experience of staff skill mix to identify what is working, what are the concerns in practice, what questions are being asked. Develop an action plan.

The methods used to achieve the development of a common vision and shared purpose framework were a Values Clarification tool, an analysis of an existing Shared Purpose Framework developed by East Kent University Hospitals NHS Foundation Trust, and a Concept Analysis framework to enable stakeholders to identify the enablers, attributes and outcomes of delivering a community nursing service across Kent and Medway.

Values clarification is frequently used within practice development for developing a common shared vision and purpose (Warfield & Manley 1990; Manley 1992) and is helpful particularly in areas as different as development of role definitions, competency, or curriculum frameworks, to, effective team working, and developing strategic direction for different purposes. A values clarification exercise is the starting point for cultural change, as values and beliefs influence behaviour. A match between what we say we believe and what we do is one of the hallmarks of effective individuals, teams and organisations (Manley 2000). Developing a common vision is a behaviour associated with transformational leadership (Manley 1997).

Walker & Avant's (1995) framework for concept analysis was used as the organizing framework to enable the examination of the attributes and consequences of delivering the shared vision developed by stakeholders as an outcome from the workshop.

Stage 3: Pilot of the Cassandra Matrix Tool

The Cassandra Matrix tool was selected as a means of illuminating activity and ratios of activity in a sample of community nurses across three pilot sites in order to build profiles that contribute to an understanding of the value and significance of community nursing. The purpose of the Cassandra Matrix tool (Leary 2011) is to capture what interventions
community nurses are engaged in, as well as express the ratio of those activities, through visual representations. The tool plots the context of work against a range of community nursing interventions and is not used as a form of performance indicator. This tool was selected as it has previously been used successfully in a large regional NHS Teaching hospital to highlight the contribution of the specialist nursing workforce. As identified by the systematic literature review, in the absence of any other tool for community nurses the rationale was to pilot its suitability and applicability for this context. The tool offers value for money, is quick, and user friendly and enables nurses to define and evaluate their contribution very easily. The tool offers a swift visual representation of what community nurses do.

In order to test the validity of the tool for the community nursing context it was piloted in one health care trust and reviewed by all members of the steering group to ensure that the interventions appropriately described community nursing activities and interventions.

Data was captured over a 10 working day period between October and November 2013. Each activity was ticked every time it occurred against an inventory of 34 tasks. Each participant was responsible to completing daily record sheets and then adding up the total of activities for each day. Once 10 days of data had been completed the data sheets were returned to the Research Fellow and inputted into an Excel spreadsheet which provided an instant analysis of key activities for individuals and organisations.

**Pilot Sites and Sampling Strategy**

Three self-selected organisations participated in piloting the tool – Kent Community Health Care Trust (KCHT), Medway Community HealthCare Trust (CIC), Kent and Medway Partnership Trust (KMPT). Each organisation had a self-selected coordinator who recruited a sample of community nurses willing to pilot the tool for a period of 10 days. The total sample size for the pilot was 24 self-selected participants, determined by the organisation.

**The BOS survey**

A Bristol Online Survey (BOS) (BOS, 2013) was launched following the Community Nursing Workshop as part of the continual participation process. Participants of the workshop were asked to comment on the initial development of the *Vision and Purpose Statement* and the *Shared Purpose Framework for Delivering First Class Community Nursing Across Kent and Medway* and to offer an evaluation of the workshop itself. The results can be seen in Appendix 3. BOS is a secure way of allowing surveys to be disseminated via the web, and is used by over 300 organisations, including 130 academic institutions, one of which is the Higher Education Academy. The BOS survey was limited to 11 questions requiring open text responses and 1 question requiring a yes or no response. It was designed to take
approximately 15-20 minutes to complete as it needed to be both brief enough to appeal to busy working respondents, but also provide enough data to allow for the potential further development of the Vision and Purpose Statement and the Shared Purpose Framework for Delivering First Class Community Nursing Across Kent and Medway.
Findings – Vision and Purpose Statement and Shared Purpose Framework

The Vision and Purpose Statement and Shared Purpose Framework have been developed through an iterative advancement influenced by other findings. What follows are the final versions of this incremental and progressive process.

Vision and Purpose Statement

Vision:
Providing first class compassionate, safe and effective care close to home

Purpose:
The purpose of community nursing across Kent and Medway is to provide: first class compassionate, safe and effective care close to home enabling people to make choices, self-manage and maintain control over their quality of life, through:

Compassionate positive cultures and relationships that implement person centred values

Understanding the criteria for an effective skilled and competent workforce

Leadership, courage, clear vision, motivated, committed and engaged staff

Telehealth and integrated IT infrastructure

Unified systems for effective communication, engagement, information sharing and decision making with stakeholders

Right skill mix and staffing levels

Enabling workplace learning, peer review, supervision, and career development

Recognised by

Integrated working with MDT and other agencies

Services and care pathways across sectors underpinned by effective commissioning and funding

Effective care and pathway management and evaluation, risk assessment and strategies for admission avoidance

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7 First class care means holistic person and family centred care
## Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent and Medway

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Attributes</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Motivated, courageous, committed staff</td>
<td>Person Centred Compassionate Care (PCCC)</td>
<td></td>
</tr>
<tr>
<td>➢ Values compassionate person centred, safe and effective care, life-long learning and development</td>
<td>i. Developing person centred compassionate, caring relationships and partnerships that build trust between service users and stakeholders</td>
<td>Service Users</td>
</tr>
<tr>
<td>➢ Role clarity</td>
<td>ii. Implementing a personal plan of care delivered close to home and evaluating this against agreed objectives</td>
<td>➢ Positive patient, family, carer experience</td>
</tr>
<tr>
<td><strong>Organisational Culture and Leadership</strong></td>
<td>iii. Evaluating and acting on patient experience and monitoring outcomes</td>
<td>➢ Positive outcomes and quality of life reflecting personal objectives</td>
</tr>
<tr>
<td>➢ Commitment to enabling leadership development, collaborative working and public/community engagement</td>
<td></td>
<td>➢ Maintenance of choice in relation to self-management, independence and recovery</td>
</tr>
<tr>
<td>➢ Positive organisational culture that embraces shared values, creativity and innovation</td>
<td></td>
<td>➢ Preferred place of care or death achieved</td>
</tr>
<tr>
<td>➢ A clear vision and organisational objectives</td>
<td><strong>Safe and Effective Care</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i. Documenting case management with individuals, families and carers based on assessment, planning and evaluation of complex health and social care needs, risk and admission avoidance</td>
<td></td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>ii. Interdisciplinary working and effective evidence informed decision making to provide integrated care and services across patient pathways</td>
<td><strong>Staff-Individual/Team Effectiveness</strong></td>
</tr>
<tr>
<td>➢ Appropriate skill mix and staffing levels linked to investment in workforce planning and development</td>
<td></td>
<td>➢ Increased staff satisfaction, recruitment and retention</td>
</tr>
<tr>
<td>➢ Outcome competence framework for community nursing</td>
<td></td>
<td>➢ Opportunities for career and leadership development</td>
</tr>
<tr>
<td>➢ Dashboard and tools to demonstrate community nursing contribution and effectiveness</td>
<td></td>
<td>➢ Demonstrating the contribution of community nursing to person centred safe and effective care</td>
</tr>
<tr>
<td>➢ Commissioning and funding of services, workforce and education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Learning and development strategy with integrated peer review, supervision and appraisal systems</td>
<td><strong>Organisation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Organisational Systems</strong></td>
<td></td>
<td>➢ Appropriate escalation and referrals to services and other agencies</td>
</tr>
<tr>
<td>➢ Comprehensive range of integrated care pathways that enables a person centred and evidence informed approach</td>
<td></td>
<td>➢ Admission avoidance</td>
</tr>
<tr>
<td>➢ Systems for effective interdisciplinary communication, decision making information sharing and governance</td>
<td></td>
<td>➢ Reduced length of stay and appropriate discharge</td>
</tr>
<tr>
<td>➢ Systems for monitoring, benchmarking and evaluating patient experience, quality, safety, clinical outcomes, and public health</td>
<td></td>
<td>➢ Reduction in numbers of people requiring residential care</td>
</tr>
<tr>
<td>➢ Unified Telehealth and IT infrastructure</td>
<td></td>
<td>➢ Reduced harm (harm free care)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Achievement of regulator standards and organisational objectives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Achievement of public health outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Redistribution and more effective use of resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Stakeholder partnerships evaluated positively</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Recognised as providing a first class service</td>
</tr>
</tbody>
</table>

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8 Including administrative support for front line staff
### Shared Purpose Framework’s Positive Consequences linked to potential Indicators and Measures for Effectiveness of Community Nursing

<table>
<thead>
<tr>
<th>Consequences</th>
<th>Potential Indicators/Measures of Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Users</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Positive patient, family, carer experience</td>
<td>➢ Patient and service user experience</td>
</tr>
<tr>
<td>➢ Positive outcomes and quality of life reflecting personal objectives</td>
<td>➢ Emotional touch points</td>
</tr>
<tr>
<td>➢ Maintenance of choice in relation to self-management, independence and recovery</td>
<td>➢ KPI % of patient complaints and compliments</td>
</tr>
<tr>
<td>➢ Preferred place of care or death achieved</td>
<td>➢ KPI % of patients who feel involved in developing their care plan</td>
</tr>
<tr>
<td>➢ Quality of Life indicators</td>
<td>➢ KPI % of patients supported to die at place of choice</td>
</tr>
<tr>
<td><strong>Staff-Individual/Team Effectiveness</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Increased staff satisfaction, recruitment and retention</td>
<td>➢ Analysis of 360 degree feedback</td>
</tr>
<tr>
<td>➢ Opportunities for career and leadership development</td>
<td>➢ Peer review and supervision</td>
</tr>
<tr>
<td>➢ Demonstrating the contribution of community nursing to person centred, safe and effective care</td>
<td>➢ Portfolio of workplace evidence reflective of shared purpose framework</td>
</tr>
<tr>
<td>➢ Analysis of appraisal objectives and achievements, reflective review and annual nursing team reports</td>
<td>➢ Number of team awards local, regional, national</td>
</tr>
<tr>
<td>➢ KPI % of staff completing staff experience survey</td>
<td>➢ KPI % of staff referral to OH</td>
</tr>
<tr>
<td>➢ KPI % of staff sickness and absence rates (short and long term)</td>
<td>➢ Nursing care hours per patient day</td>
</tr>
<tr>
<td>➢ Skill Mix ratios</td>
<td>➢ Staff well being</td>
</tr>
<tr>
<td>➢ KPI % of patients supported to stay in normal place of residence</td>
<td>➢ KPI % of patients with an MDT care plan</td>
</tr>
<tr>
<td>➢ Hospital admission and re-admission rate</td>
<td>➢ National or local audit against NICE guidelines for patient pathway and standards</td>
</tr>
<tr>
<td>➢ KPI % of known caseload patients admitted to hospital and discharged with zero length of stay</td>
<td>➢ Benchmarking for services against national standards and pathways</td>
</tr>
<tr>
<td><strong>Organisation</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Appropriate escalation and referrals to services and other agencies</td>
<td>➢ Incidence reporting of harm or “Never” events</td>
</tr>
<tr>
<td>➢ Admission avoidance</td>
<td>➢ CQUINs and clinical indicators- e.g. falls with injury, pressure sores, harms</td>
</tr>
<tr>
<td>➢ Reduced length of stay and appropriate discharge</td>
<td>➢ Public health outcome measures</td>
</tr>
<tr>
<td>➢ Reduction in numbers of people requiring residential care</td>
<td>➢</td>
</tr>
<tr>
<td>➢ Reduced harm (harm free care)</td>
<td>➢</td>
</tr>
<tr>
<td>➢ Achievement of regulator standards and organisational objectives</td>
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</tr>
<tr>
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<td>➢</td>
</tr>
<tr>
<td>➢ Redistribution and more effective use of resources</td>
<td>➢</td>
</tr>
<tr>
<td>➢ Stakeholder partnerships evaluated positively</td>
<td>➢</td>
</tr>
<tr>
<td>➢ Recognised as providing a first class service</td>
<td>➢</td>
</tr>
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Data Results and Analysis

Cassandra data results and analysis

From the 26 self-selected participants (community nurses across employment bands 5-7) 24 returned ten days of complete data providing a 92% response rate.

In line with the Cassandra Matrix tool’s (Leary 2011) intended design all the data gathering was input into Excel using the sum function to give the ratio of interventions carried out by the context within which they happened, with totals for the contexts and the interventions for the ten day data collection period also being displayed. Total columns were not included when charts of the data were created as the visual effect of doing so is aesthetically problematic.

From the input data individual charts were produced for each participant showing their overall intervention totals by the context in which they were carrying them out. Two further charts were produced for each individual participant illustrating their activity totals by both context and by intervention.

The individual charts are an opportunity to view a visual representation of what individual practitioner are doing by showing the ratio of activities carried out contextualised by also showing the environment in which the activities occurs. The intention is to raise awareness of not only of what community nurses are doing, but also of what settings they are doing it in. Whilst the individual charts are not included in the overall project report, in order to provide anonymity, each project participant can request access to their individual data, and if they choose to do so, it will allow them to see the contributions they make and elicit insight into their own profile. Charts were also extracted that showed the intervention totals for each practitioner alongside those from other practitioners employed in the same organisation (Charts A, B, and C). One organisation had a large number of participants totalling 19, with the other two organisations having 2 and 3 participants respectively. The charts allow for an understanding of individual contributions to organisations, with a sense of overall organisational impact based on those individual efforts, towards an overarching profile of the organisation’s community nursing.

The employment band of practitioners was not always clear from the data return, but where it was charts were produced that showed a comparison of total interventions across bands 5-7 (Charts B and D). Information about bands was available from the organisation with 3 participants, although the organisation with 19 participants only returned information about 11 practitioners’ bandings, and so the chart produced for this organisation shows a comparison between the bands based on equal numbers of individuals from each band, and with those individuals being selected for being typically representative.

The organisational charts (Charts A, B, and C) provide an opportunity to see the profile for a whole set of employees’ activity, and for some inferences to be made from
observation of an organisation’s profile. The charts that show the comparison between activities and ratios relating to employment bands (Charts B and D) are also useful for making inferences on an organisational level.

For a general picture of community nursing across the organisations a chart was extracted that showed the consolidated interventions for the whole cohort of participants according to the context in which the care took place (Chart E). The consolidated data chart provides an overview of community nursing within the 3 organisations, and offers an opportunity to understand where the concentration of activity is both in terms of interventions and in terms of context.

Data set 17 was identified as an outlier as the data which had been gathered was significantly greater in value than any other set of data. Because of this participant 17’s data was not used in the band comparison for the organisation with the largest number of participants as it did not look typical. However, the data was not excluded from any other chart as it is not possible to dismiss the data as an inaccurate depiction of the practitioner’s activity.

The consolidated data chart (Chart E) illustrates a wide range of activities engaged in confirming a diversity of community nursing work. There are however, key areas of activity that constitute high and more significant ratios. The chart shows that generally speaking community nurses are involved in significantly more procedural and holistic assessment work over and above anything else, followed by care planning and evaluation, and caseload management; and from there symptom control and advise, promoting self-management, reassessment of needs, handovers, and administration. The largest spike in the data identifies that a significant amount of travelling is done, with the majority of that travel being scheduled as opposed to unscheduled.

The data also indicates that practitioners engage less, although still significantly, in the following: Providing health education, risk assessments and reviews, hospital avoidance, coordinating care, clinical risk assessments, and the chasing of referrals and results. The data also shows engagement in the following activities, although these constitute a less significant part of the overall work: Rescue work, carer support, dealing with distress, anxiety management, anxiety rescue, social assessment, safeguarding the vulnerable, mediation of relationships, social advice, psychological assessments, advocacy, communicating significant news, and joint assessments.

This picture of significant clinical and decision making activities juxtaposed, to a lesser degree, with interpersonal relationship skills only offers an interpretation of the general picture of community nursing within the context of the 3 organisations. The charts which show individual organisational profiles (Charts A, B, and C) offer more insight, and it is possible to identify that the ratio of engagement in interventions is context dependent as can
be seen with participants 23 and 24 in Chart C who work in a mental health context, in which it is likely they would be utilising interpersonal relationships skills more often than procedural or clinical skills. What can be noted is that generally speaking practitioners are required to draw on a broad spectrum of skills, but the emphasis upon which those skills are put into action may differ according to working environment.

The Vision and Purpose Statement and Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent and Medway has integrated within it the highly significant activity of care management and evaluation, and of the significant interventions of risk assessment, and admission avoidance.

Chart E shows that the vast majority of activity takes place in the domiciliary settings, and although there is evidence of some telephone and clinical activity, the minority of activity occurs within a multi-professional context. The aspect of overwhelming domiciliary care is incorporated within the Vision and Purpose Statement and Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent and Medway. Drilling down into the data and producing a visual representation, comparison can be made across the practitioners to show how often they work within a multi-professional context (Chart F). It is possible to see that those working within a mental health context are undertaking the vast majority of the multi-professional context work (participants 23 and 24), although participants 8 and 9, who work within another organisation, also engage significantly within this context, but this is not typical activity for their organisation. Because the different organisations returned data from vastly varying numbers of participants it is not possible to say definitively whether a particular organisation over another engages more in multi-professional working, but what does become apparent is that only a minority of practitioners, in general, are involved in noteworthy amounts of multi-professional context activity, and that it is possible this may be setting dependant. Multidisciplinary and partnership working are important components of the Vision and Purpose Statement and Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent and Medway, and the data indicates that there is compelling evidence for improvement within this key area.

The charts that illustrate comparison across the employment bands of 5-7 were only possible for 2 of the 3 participating organisations, as mentioned before. From this data though it is visible is that all the bands are involved in activities across the spectrum of interventions, although we see within one organisation (Chart B) that the band 6 practitioners engage in a higher proportion of work involving interpersonal relationships skills, and that the band 7 practitioners in an even higher proportion, with the band 5 practitioners only doing a very small amount of this type of activity. This is likely to be expected given the probable differences in experience and skill sets across the bands. The band 7 practitioners also engage in significantly higher amounts of caseload management and other administration
tasks, which could be commensurate with a role that likely has management responsibilities. However, the band 7 practitioners also carry out all the other range of activities that the band 5 and 6 practitioners are doing.

The band comparison data (Chart D) from the organisation that collected the larger amount of data sets provides a somewhat, although not completely, similar picture. Again the band 6 and band 7 practitioners are involved in the full range of activities, with band 5 practitioners engaged more significantly in procedural work, care planning, and travelling. It is not possible to identify, or infer, the management activity of the band 7 practitioners within this particular organisation, but the Cassandra Matrix tool (Leary 2011) is not designed to capture this information; and because of that, and the fact that these observations on band comparison are based on a small amounts of data, it is not possible to make any robust observations about band comparison activity other than to say that the Cassandra Matrix tool (Leary 2011) itself requires amendment if elucidation around role responsibilities is required. Potentially however, what can be inferred is that there may be an implication for ensuring proactive Band 7 leadership development; and leadership enablement and development are features of the Vision and Purpose Statement and consequently the Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent and Medway.

In summary, the data and subsequent charts provide a picture of community nursing that is quite likely to be what may be expected to a large degree. And this is noteworthy in that it means the Cassandra Matrix tool (2011) is able to actually provide that visual profiling and representation that is currently known, but not palpably known and evidenced. The Pre and Post Cassandra Pilot Evaluation indicated that the invisibility of community nursing’s contribution was of concern to practitioners, and that a main hope for the project was that the community nursing effort would be, easily captured, clearly demonstrated, and demonstrated for positive and beneficial worth and not as a measure or indicator of practitioners’ capabilities or proficiency. The Cassandra Matrix tool (Leary 2011) has proved to be an easy tool to engage with and use, and in this sense has enabled practitioners to be participates in the workforce planning and development of community nursing; and the engagement and enablement of staff is strong component of the Vision and Purpose Statement and Shared Purpose Framework for Delivering a First Class Community Nursing Service Across Kent and Medway.

It is important to remain cognizant of the fact that all three of the pilot sites involved in gathering data for this project is representative of particular socio-economic areas of Kent and Medway and that it is possible edification of this is evident within the data. However, this edification cannot be tested because data from differing demographics is not available for comparison. Also, the project is a pilot venture and so the data set, whilst valuable and
enlightening, remains relatively small. Undertaking further data collection from a larger number of practitioners and from areas with more divergent demographics than the pilot sites could yet prove to be significant in terms of either confirming that there is a general expression of the contribution of community nursing, or in illustrating that there are significantly different expressions of community nursing contributions that are dependent on wider socio-economic or socio-cultural determinants. The literature review identified the value of a greater understanding of the wider determinants of health to workforce planning and development (Parsons 2010; Farmer et al 2012).

In conclusion, use of the Cassandra Matrix tool (Leary 2011) compromises a way of confirming and a bringing to attention what may already be known, and a starting point for undertaking data collection that can evidence what practitioners are doing, but also identify, and therefore bring to prominence, gaps in data collection that, if acted upon, might provide for more understandings and critical insights into what is rapidly becoming the forefront of care provision.

BOS survey results
The BOS response rate was 21.6% and the results were cross referenced with the already populated the Vision and Purpose Statement and the Shared Purpose Framework to ensure that the addition ideas, comments, and contributions were already present or were incorporated. The BOS results for questions 5-9, which elicited information about ways and means of measuring effectiveness, enabled the development of indicators and measures that could be used to demonstrate the effectiveness of the Shared Purpose Framework’s Consequences.
Claims, Concerns & Issues - Pre and Post Pilot Evaluation Summary

1. Introduction

Twenty four Community nurses across two community organisations in Kent and Medway piloted an adapted Cassandra Matrix Tool. A tool termed ‘Claims, Concerns & Issues’ drawn from the Stakeholder Evaluation Approach developed by Guba & Lincoln (1989) has been used to evaluate participants’ experience of using the Cassandra pilot together with a simple cognitive mapping tool asking participants to make a judgement about how effective they were at measuring what they did both pre and post pilot.

Of the 24 nurses participating, 15 Community nurses completed the pre-evaluation and 14 completed the post evaluation. The summary below highlights the main themes emerging and identifies key recommendations.

2. How effective do you believe you are at currently measuring what you do?

In response to this question, the ratio of –ve responses to positive responses changed between the pre evaluation and the post evaluation with a –ve:+ve ration of 10:4 in the pre evaluation to 6:8 in the post evaluation. Therefore it appears that using the tool impacted positively, with more participants believing they were more effective in measuring what they do, however this may be due to having their awareness raised rather than due to the tool itself.

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</tr>
</thead>
<tbody>
<tr>
<td>Pre Pilot</td>
<td>n=15</td>
<td>1</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Post Pilot</td>
<td>n=14</td>
<td>1</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

Participants were asked to justify their position they selected, both before and after the pilot. This data resulted is detailed in Appendix 1 but summarised below using **bold italics**. Prior to the Pilot, the justification for answering the questions identified are summarised across a number of themes:

- **I do not currently measure what I do**
- **I am able to prioritise what I do/we manage caseload but it doesn't necessarily add up**
- **We currently collect some data about contacts, but there are limitations**
- **I wish there was an effective way of measuring what I actually do everyday**
- **I measure my own effectiveness in relation to feedback received.** The following quote illustrates this theme:

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9 One person identified they were in the middle between ‘+’ and ‘-’
’I wish there was an effective way of measuring what I actually do everyday – I wish there was a camera on my shoulder sometimes to show just what I have to try and fit in my working day’ (selected ‘-’ on scale).

- **I measure my own effectiveness in relation to feedback received** illustrated by the following quote:
  
  Although not audited, personally I measure my effectiveness from patient and GP feedback and the positive outcomes I achieve. This is reflected in responses from patient questionnaire (selected ‘+’ on scale).

Following the pilot, justifications were informed by an **increased awareness need to measure & how much we do** illustrated by the following quote:

’I have been made more aware that I do not measure what I do on a regular basis. Using the tool has made me feel better about the quality and quantity of work I do in my role on a daily basis’ (selected ‘-’).

Other themes supporting justification for position on scoring scale included:

- **online recording is improving measurement but doesn’t reflect everything i do**
- **no real way of measuring**
- **measure my own effectiveness by patient response and outcomes**
- **main priority is time management & prioritisation** – the following quote illustrates this:
  
  ‘main priority is time management and prioritising of importance. At times this can be difficult due to the number of visits or shortness of staff. Which in turn makes it difficult to measure what I do’ (selected ‘+’ on the scale).

- **will measure more if benefits community nursing** illustrated as follows;
  
  ‘I would only make more of an effort to measure what I do if I felt that there would be an underlying benefit to community nursing as a whole’ (selected ‘+’ on scoring scale).

### 3. Claims

In response to the question what positive statements would participants like to make about the Cassandra tool before and then after using the pilot, a number of similar themes emerged across pre and post data. The themes derived from the data are detailed in Appendix 1 but are highlighted below in **bold and italics**.

The tool was considered by quite a few to be easy to complete in both pre and post pilot data. Before the Cassandra tool in the pilot it was considered as positive, hopeful & helpful in highlighting what we do. After the pilot this view was further endorsed and broadened - it clearly highlights what we do each day as well as the scope & impact of the role.
The Cassandra tool was viewed as helping to **assist in assessing workload, managing cross-overs & providing administrative support** pre-pilot. Post-pilot it was recognised by some to **have potential to provide evidence of what I do as well as inform staffing levels & admin support. Demonstrating variety & complexity of specialist nurses**, a theme pre-pilot was reflected post pilot in **Identifies the skills & knowledge I use daily**.

**Whilst one person felt Cassandra quantifies what you do,** after the pilot there was broader recognition that it **could identify volume of tasks and also effectiveness of what is done daily.** In the pre-pilot it was recognised that **there is a need for feedback and opportunities for to review** and also that the Cassandra tool might help with **improving team work.** In the post pilot this was further reflected in its potential to **enable more understanding of job and who does what in the MDT.**

For one person the post evaluation endorsed: **the many times I make a difference to patient care.**

### 4. Concerns & Issues

Concerns about the Cassandra tool pre and post the pilot are identified and themes in Appendix 1, as are the issues raised. Issues are key questions any reasonable person would be asking. The findings from the analysis are presented below as a narrative with key themes identified in **bold italics.**

#### 4.1. Relevance

A main concern and issue pre pilot was the relevance of the tool to Community Nursing as reflected in the questions:

- **Will it reflect community nursing & workload appropriately?**
- **How does it relate to my work/capture its worth?**
- **Why is not more generic?**

This relevance and appropriateness was questioned in relation to perceiving it was **mainly aimed at a specialist focus** and in the post pilot the themes:

- **Is it relevant for our role?**
- **Not all activities included/it doesn’t cover all the aspects of my work?**
- **Is it the most appropriate tool – could it be more generic?**

On the other hand, a post pilot themes was **could it be used to highlight the role/what the nurse does for the patient?**

#### 4.2. Using the Tool
The biggest concern with using the tool before the pilot was providing accurate information and activity times. Questions about accuracy of the data still remained in some participants’ view, but less so, post implementation. The question Does everyone have a common understanding about terms and how to interpret work? was linked to the accuracy issue and post pilot the format for capturing information was a theme. There was uncertainty and confusion/lack of information about the tool from some participants pre-pilot with a concern about the time spent on each activity even though the Cassandra matrix does not measure the length of time taken in activities but the ratio of the activities in relation to each other.

4.3 Benefits
Issues raised were associated with asking the questions pre-pilot around How will it improve things?/What are the benefits? and then in the post pilot data How will this benefit my work & patients?

4.4. Concern for Jobs
Concerns consistent in both pre and post-pilot data were concern about jobs and whether the tool would be used to down grade people. This concern was linked to completing the Cassandra matrix and whether there was a risk of influencing the input to make it look different.

4.5 What happens to the results of the pilot?
This question was asked pre-pilot and endorsed post –pilot by questions such as Will feedback be provided & what will be done with the data?

4.6. More time and paperwork
A small number of responses were raised as concerns in the pre-pilot about the time taken to complete the matrix, more paperwork and less time for patients.

4.7. Knew nothing about pilot & why is it necessary
Pre-pilot minority concerns and issues included knowing nothing about the pilot and questioning why it was necessary.

5. Conclusion and Recommendations from Participant Feedback Pre and Post Cassandra Pilot
1. HOW community nurses demonstrate the effectiveness and visibility of what they do is an issue. There currently appears to be no tools that demonstrate this which is why
piloting Cassandra for this purpose was important. As a tool it has some potential. The use of Cassandra has increased the participants’ awareness of the need to demonstrate the contribution they make as well as their confidence about how they may go about this.

2. There was confusion about what Cassandra does and doesn’t do as a tool and what it would be used for. This led to identifying activities such as management, audit and other activities expected of team leaders being flagged up as missing from the tool. However these aspects/activities fall outside the tool’s focus, (although acknowledged as constituting part of their professional role). The tool focuses on the daily interventions of community nurses in relation to patients directly. The sheets for capturing the data (excel) were evaluated as simple and easy to use. Better guiding materials need to be developed to prepare community nurses for subsequent use.

3. There was concern about the relevance of Cassandra to community nursing but this seemed to be linked to whether community nursing was understood from a generalist or specialist perspective and a lack of clarity about their role as members of the Multidisciplinary Team (MDT).

4. No other clinical interventions were highlighted as missing from Cassandra, only the aspects that Cassandra didn’t intend to capture (management, audit, and policy).

5. The benefit of the tool is that it makes visible the contribution of community nurses and enables peer review and benchmarking.

6. The tool itself is not intended as a measure but instead provides a ratio of activities that can be used for benchmarking and peer review.

7. The data gathered from the Cassandra phase of the project will be fed back to the pilot site organisations to share with participants at the end of the project.

Recommendations

1. To adapt the Cassandra tool for the Mental Health context and pilot more broadly with a larger sample of mental health practitioners.

2. To develop guidance materials to prepare Cassandra for subsequent use.

3. To pilot the Cassandra tool in organisations covering a different socio-economic mix e.g. more affluent communities, to complement the findings from this pilot with its high incidence of social deprivation to see if there is any difference in activity and workload.
Recommendations and Next Steps

Introduction

This report provides a summary of recommendations for the project steering group with full project report and outcomes being delivered on Friday 6th December 2013.

The purpose of this four month commissioned project was to:

1. Scope what models are already in existence in relation to effective nursing workforce development and planning tools in the community setting.

2. Review the literature for evidence of patient related outcomes from a registered/unregistered nursing workforce.

3. Align this to similar work undertaken elsewhere e.g. EKHUFT shared purpose framework—nursing workforce skills, knowledge, competences to deliver person centred safe and effective evidence informed care.

4. Consider developing a shared purpose framework for piloting as a potential community nursing workforce development tool.

5. Undertake a specialist community nursing review using the Cassandra Matrix to capture the specialist nursing contribution in the delivery of person centred safe and effective evidence informed care in two pilot sites.

6. Produce a project report that makes recommendations for future community nursing workforce shared purpose framework to support the commissioning process and development of leadership potential that impacts on education commissioning.

The Commissioners posed the following questions:

• What models/tools/frameworks are already in existence and what are their strengths and limitations? Where are the gaps?

• What would a community nursing workforce look like to deliver this model?

• How can existing frameworks/models/tools be used as a benchmark for effective workforce development planning for nursing services?

• How can a benchmark tool be used by commissioners to lobby for nursing skill mix, delivering value for money, effectiveness, and economic benefits for patient outcomes?

Project Activities:

Data was gathered from a programme of collaborative activities with stakeholders:
1. A Stakeholder Consultation Workshop which resulted in a draft Shared Purpose Framework, Vision and Purpose statement.

2. Pilot of the Cassandra Matrix tool across three organisations in Kent and Medway over a 10 day period with a sample of community nursing services.

3. Individual practitioner self-assessment pre- and post- pilot of the impact of the Cassandra Matrix tool on their own awareness of the contribution they make as a community nurse to delivery of the service.

4. Stakeholder survey to further develop and strengthen the Shared Purpose Framework and Vision and Purpose statement.

At each phase of the project data has been used to check that the enablers, attributes and consequences of delivering a First Class Community Nursing Service across Kent and Medway are robust and representative of all stakeholder contributions and values.

Feedback from the Pilot of the Cassandra Matrix Tool

A full analysis of this phase of the project will be reported on 6\textsuperscript{th} December in the main report. In summary, the overarching purpose of Cassandra was to:

- Capture specialist community nursing contribution to make it visible.
- Enable the roles to be compared in terms of like for like.
- Determine whether the tool is useful for this purpose in the absence of any other tool to capture what nurses are doing in practice with patients.

Project Outputs:

For this phase of reporting the project team have presented the main project outcomes: the Vision and Purpose Statement, Shared Purpose Framework encompassing the 6Cs and suggested Indicators/Measures for informing the demonstration of effectiveness of community nursing services across Kent and Medway. The full project report will provide detailed analysis of all phases of the project as an audit trail.

- Output 1: Vision and Purpose Statement
- Output 2: Shared Purpose Framework
- Output 3: Suggested indicators/measures to demonstrate the impact of a First Class Community Nursing Service across Kent and Medway mapped to the Shared Purpose Framework
- Output 4: Cassandra Community Nursing Activity Analysis
- Output 5: Practitioner evaluation of the Cassandra Community Nursing Activity Analysis
Recommendations:
The recommendations are themed as follows:

Shared Purpose Framework
1. To consult more broadly on the vision and the framework with all key stakeholders including patients and carers.
2. For each organisation to engage their teams in embedding in practice the vision, values and framework through their HR and workforce strategies to complement what a leadership programme might offer.
3. To identify which tangible enabling factors identified in the shared purpose framework are present or absent across the three organisations involved in the pilot in Kent and Medway so as to develop an action plan for their development e.g. competence framework across NHS career framework levels.
4. To develop a dashboard of indicators of effectiveness for community nursing from the existing Shared Purpose framework, to therefore enable front line teams to gauge progress against improving and sustaining core purposes and values and services.
5. To develop case examples of best practice across Kent and Medway to illustrate the shared purpose framework in action as well as to celebrate community nursing.
6. To hold a regional launch of the vision and framework organised and hosted collaboratively with the England Centre of Practice Development.
7. To embed greater patient and public engagement at every level of practice when implementing the framework, shared vision and purpose.

Establishing an Effective Workplace Culture
8. To develop a Kent and Medway wide accredited community nursing leadership programme to develop and embed the attributes of the framework within workplace teams and cultures.
9. To pilot a dashboard approach informed by the Indicators/measures as part of a Leadership programme which enables practitioners to be exposed to a range of tools to develop transformational leadership skills and embed the framework and vision within organisations across Kent and Medway.
10. To influence the development of future HEI curricula to create the workforce knowledge, skills and competencies required for the delivery of innovative services in the future informed by the vision and shared purpose framework.

Further Development of the Cassandra Tool
11. To modify and adapt Cassandra as a tool for capturing workforce data on a larger scale (part of next stage bid).
12. To adapt the Cassandra tool for the Mental Health context and pilot more broadly with a larger sample of mental health practitioners.
13. To develop guidance materials to prepare Cassandra for subsequent use.
14. To pilot the Cassandra tool in organisations covering a different socio-economic mix e.g. more affluent communities, to complement the findings from this pilot with its high incidence of social deprivation to see if there is any difference in activity and workload.
15. To develop a competence framework integrating Cassandra interventions, performance indicators, knowledge and know-how for community nursing across NHS career framework levels in Kent and Medway.

Identifying other Appropriate Tools and Approaches

16. To develop an approach for identifying skills gaps in the workforce across the patient pathway.
17. To identify senior practitioner/team leader expertise and professional judgement around workforce planning and skill mix and triangulate with other tools to support professional judgement\(^\text{10}\) that ECPD could integrate with the next stage project bid.
18. To develop a competence framework integrating performance indicators, knowledge and know-how for community nursing across NHS framework career levels Kent and Medway.

\(^{10}\) Professional judgment in relation to questions such as Do you have enough staff and staff with the right competences? What is the most important strategy when you don’t have enough staff? Where are the pinch points? What times are more staff required?
Reference list


Appendix 1 - Community Nursing Workshop Outcomes and Audit Trails

Outcomes of the Community Nursing Workshop
Hosted by the England Centre for Practice Development
Held at Hall Place, Canterbury
Friday 27th September 2013
10.30am-4.30pm

1. Overview of workshop
The workshop’s purpose was intended to develop and populate a framework for community nursing services across Kent and Medway within the context of current strategy, commissioning and provision that is inclusive and integrated.

Values clarification exercise (after Manley 1992) undertaken in mixed groups of 4

1. I/we believe the **ultimate purpose** of community nursing is...
2. I/we believe this purpose is **achieved by**.....
3. I/we believe the **enablers and inhibitors** to this purpose are ....
4. I/we believe **effective community nursing** would be **recognised by** the following activities happening...
5. I/we believe the **indicators** of effective community nursing are
6. I/we believe the **outcomes** of community nursing are...
7. **Other** values and beliefs I/we hold about community nursing are....

Appendix 1 outlines the processes used to address the following activities:

- Develop a shared purpose for community nursing across Kent and Medway using values clarification
- *Develop a draft vision/statement of purpose*
- Develop draft implementation framework for community nursing
- Explore the Shared Purpose Framework from EKUHT

Discuss the potential of the Cassandra Matrix

AUDIT TRAIL 1

Summary of Workshop Processes

Activity 1 Developing a shared purpose for community nursing across Kent and Medway using values clarification

Activity 2: Collaborative Theming and presentation of themes

Activity 3: Working with the themes

*Group 1: Purpose: Develop a draft vision/statement of purpose*
Using: themes emerging from values clarification statement 1 and considering 2.

Output: Draft vision/statement of purpose for community nursing across Kent and Medway

Group 2: Purpose: To categorise the enablers at different levels (individual to organisation)
Using: themes emerging from values clarification statement 2, 3, relevant others and reversing inhibitors to make them enablers.
Output: Each category and sub category is written on a separate post-it

Group 3: Purpose: Synthesise 4-8 attributes of effective community nursing. These are high level action verbs that reflect what would be experienced as effective community nursing in practice.
Using: themes emerging from values clarification statement 4, possibly 2, and relevant other areas
Output: Each attribute to be written on a separate post-it

Group 4: Purpose: Classify the consequences/outcomes of effective community nursing at different levels and align with available/potential indicators
Using: themes emerging from values clarification statements 1, 5, 6 and other relevant themes
Output: Each category and sub category to be written on a separate post-it

Activity 4: Populating draft framework for community nursing
Activity 5: Introduction to the Shared Purpose Framework developed at East Kent Hospitals University Foundation trust
Activity 6: Potential relevance of Shared Purpose framework for community nursing in Kent and Medway using Claims, Concerns, Issues tool?

Group work part 1: Claims, concerns and issues exercise about the framework in relation to potential for use/application to community nursing

Group 1: Purpose 1: Person centred care (pp1-11)
Group 2: Purpose 2: Safe care (pp12-19)
Group 3: Purpose 3: Effective Care (pp20-36)
Group work part 2: Theming claims, concerns, issues. Using themes to revisit draft framework for community nursing and make recommendations for embellishments/changes.

Activity 7: Groups present themes and recommended embellishments/changes to framework

Activity 8: The Cassandra Matrix (Leary 2011) – a tool that makes specialist nursing’s contributions visible!

Consider the following questions
- Which interventions in the Cassandra Matrix apply to community nursing?
- Which interventions do not apply to community nursing?
- Which interventions could be added to better reflect community nursing?
- What impact does your discussions have for informing the community nursing framework

Activity 9: Headlines from the Literature Review

Activity 10: Action Plan, Next steps

Activity 11: Evaluation of Workshop and close

Audit Trail 2

Outcomes of Workshop Activities

The themes arising from activities 1-3 (Appendix 1) using the values clarification exercise and collaborative theming have generated first draft data around the ultimate purpose of community nursing and how this purpose can be achieved, as well as how it would be recognised and enabled

1.1. Purpose and how the purpose is achieved
The ultimate purpose of community nursing is to work collaboratively in providing safe and effective holistic nursing care to people in or near their home; enabling people to make choices, self manage and maintain control over their quality of life.

This purpose is achieved through:
- Effective risk assessment and care planning
- Integrated care pathways
- MDT effective team working through collaboration
- Good communication and information sharing
- Right skill mix and numbers
- Technology
- Education
- Effective commissioning
- Right culture and values
- Leadership

Effective Community Nursing is recognised by:
- Positive clinical outcomes
Effective health promotion
Positive patient experience
Innovation/service development
Strong leadership
Effective integration
MDT working
Admission/readmissions reduction/avoidance
Effective communication across boundaries/agencies
Recruiting and retaining staff through staff satisfaction
Skilled competent staff
Effective risk management

The **indicators of effective community nursing** are:
- Reduced/appropriate admission
- Appropriate rate of discharge
- Reduced referral to social care
- Reduced spend
- Reduced harm
- Patient/carer satisfaction and experience
- Enabled and developed staff
- Staff satisfaction and attitudes

The **outcomes of effective community nursing** are:
- Appropriate admissions/admissions avoidance
- Measurable improved quality of life evidence (outcomes/rates)
- Patient self-management
- Compassionate caring partnerships
- Reduced GP complaints
- Harm free care
- Patient/family satisfaction, support and experience
- Preferred place of death/EoLC
- Improved access to specialist services
- Positive workforce/workplace cultures

2. Populating an Implementation Framework

The framework outlined below was generated from activity 4 outlined in Appendix 1
### 3.1 Group Feedback on the framework’s Enabling Factors outlined above:

**Individual Level**
- Integrate core value set
- Include CPD learning
- Need to ensure that resources are included at all levels
- Resources must be inclusive of people and carers

**Team Level**
- Include clinical leadership

**Organisational Level**
- Include strategic leadership
- Capture integrated communication across all levels
- Include Workforce planning

**Regional Level**
- Include workforce planning

**Societal Level**
- Include emphasis on prevention
- Public engagement

### 3.2 Groups Feedback on Attributes in the framework above

- Assessment needs to be added or made clearer

### 3.3 Groups Feedback on Outcomes in the framework above

- Include "control over their health AND quality of life"
- Recruitment and retention
- Indicators/outcomes of morbidity/mortality
- Integrated pathway of care is an outcome of collaboration

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**Notable Points**

- **Provision of safe and effective care in or close to home**
- **Positive staff patient experience**
- **Empowering the person to maintain independence and self manage**
- **People enabled to make choices and maintain control over their quality of life**
4. EKHUFT Shared Purpose Framework

4.1. Summary of Claims, Concerns and Issues (SPF) This resulted from activity 6 & 7 outlined in Appendix 1:

<table>
<thead>
<tr>
<th>Claims</th>
<th>Concerns</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could attach the framework to all job descriptions</td>
<td>Language (ward)</td>
<td>How would it be implemented in community nursing and communicated?</td>
</tr>
<tr>
<td>Good reference to contextual factors</td>
<td>Hospital focused</td>
<td>Should we be looking at underlying themes across different frameworks?</td>
</tr>
<tr>
<td>Clear indicators between staff bandings</td>
<td>The risks and risk assessments have relevance issues for community nursing e.g. lone working</td>
<td>Rectify SPF Band 8 for posts with a Technology focus</td>
</tr>
<tr>
<td>Refines attitudes and behaviours</td>
<td>Bit difficult to discriminate between levels- what are the key differences?</td>
<td>Limited reference to family and carers and external agencies</td>
</tr>
<tr>
<td>Core set of knowledge and skills enhanced at each level</td>
<td>There is no band 3</td>
<td>What do we mean by workplace- needs defining</td>
</tr>
<tr>
<td>Useful for appraisal and performance management</td>
<td>Should it be adopted or not?</td>
<td>How would it be positioned and rolled out</td>
</tr>
<tr>
<td>Brings it all together</td>
<td>Absence of mention of delegation within safety culture</td>
<td>How would you align the SPF values with own organisation</td>
</tr>
<tr>
<td>Potential link to teams and training</td>
<td>Role of band 2 practitioners in different organisations will vary</td>
<td>What training package is behind the SPF</td>
</tr>
<tr>
<td>Transparency for pay progression</td>
<td></td>
<td>How would you measure effectiveness of SPF?</td>
</tr>
</tbody>
</table>

4.2. Observations about the Share Purpose Framework developed in the workshop and EKHUFT framework

- People who lack capacity not captured
- Need to include reference to evidence based practice
- Need to consider health promotion
- Need to consider children’s nursing

5. The Cassandra Matrix for Community Nursing

Activity 8 outlined in Appendix 1 led to the following Feedback on relevance

Definitions needed
- What does “rescue” and “anxiety” mean?
- Tracking notes required
- As it currently stands it may not have relevance for some areas of community nursing

Needs to add:
- Interpreting results
- Communication/talking with other professionals and agencies
- Carer support
- Signposting and advice
• Risk Assessment
• Travelling time and unplanned travelling time
• Line management
• Medicines and diagnosis
• Health promotion and illness prevention
• Handover and case management

6. Next Steps, Recommendations, Actions

6.1. Next Steps
1. Adapt Cassandra Matrix
2. Agree pilot sites and recruit sample of community nurses to use tool over 10 consecutive working days
3. Agree pilot sample
4. Validate audit trail of workshop and framework

- Use the workshop activities and developments to assist in the understanding of services for both commissioners and providers
- Shared purpose framework for community nursing needs to be fit for purpose for the organisation, principles the same, owned by the organisation
- Needs to reflect community in all aspects and be simplified with clear measurements

7. Evaluation of workshop
Key words used to describe the experience of the workshop were Thoughtful, innovative, enlightening, collaborative, inspiring, confirming

The Haiku poem created from a synthesis of these experiences was:

Collaborative
Thoughtfully innovative
Enlightened, inspired

Audit Trail 3 of Workshop Activities from Group Work

A values clarification exercise was undertaken to develop a shared purpose for community nursing and this was then collaborative themed. This is outlined below to provide an audit trial

The ultimate purpose of community nursing is....

<table>
<thead>
<tr>
<th>Themes</th>
<th>Individual post-its</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of the whole person</td>
<td>• Holistic assessment in own environment</td>
</tr>
<tr>
<td></td>
<td>• Holistic care</td>
</tr>
<tr>
<td></td>
<td>• Provide holistic care</td>
</tr>
<tr>
<td></td>
<td>• Holistic care in the community setting</td>
</tr>
<tr>
<td></td>
<td>• Person centred</td>
</tr>
<tr>
<td></td>
<td>• Family centred</td>
</tr>
<tr>
<td>Provision of first class safe and effective</td>
<td>• First class nursing care near to the persons’ home</td>
</tr>
<tr>
<td>care close to or in the home</td>
<td>• Home</td>
</tr>
<tr>
<td></td>
<td>• Safe and effective</td>
</tr>
<tr>
<td></td>
<td>• Closer to home</td>
</tr>
</tbody>
</table>
Close to home

To work collaboratively with other agencies
- Integration
- Other agencies
- Collaboration

Empowering the person to maintain independence and self management
- Maximising independence
- Empowering people
- Promotion of health and well being
- Self management

Enabling people to make choices to maintain control over their quality of life
- Enabling patients to maintain control
- Patient choice
- Quality of life

Draft summary sentence of the ultimate purpose:
The ultimate purpose of community nursing is to work collaboratively in providing safe and effective holistic nursing care to people in or near their home; enabling people to make choices, self manage and maintain control over their quality of life.

This purpose can be achieved by.....

<table>
<thead>
<tr>
<th>Themes</th>
<th>Individual post-its</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective risk assessment and care planning</td>
<td>- Effective care planning</td>
</tr>
<tr>
<td></td>
<td>- Defined and measurable goals and outcomes</td>
</tr>
<tr>
<td></td>
<td>- Good assessment</td>
</tr>
<tr>
<td></td>
<td>- Risk assessment and response</td>
</tr>
<tr>
<td>Right skill mix and numbers</td>
<td>- Appropriately skilled staffing</td>
</tr>
<tr>
<td></td>
<td>- Skilled practitioners</td>
</tr>
<tr>
<td></td>
<td>- Right skills</td>
</tr>
<tr>
<td></td>
<td>- Knowing limitations</td>
</tr>
<tr>
<td></td>
<td>- Right skill mix</td>
</tr>
<tr>
<td></td>
<td>- Appropriate staffing levels</td>
</tr>
<tr>
<td></td>
<td>- Numbers of staff</td>
</tr>
<tr>
<td>Technology</td>
<td>- Technology</td>
</tr>
<tr>
<td>Education</td>
<td>- Education</td>
</tr>
<tr>
<td>Effective commissioning</td>
<td>- Effective commissioning- world class</td>
</tr>
<tr>
<td>Good communication and information sharing</td>
<td>- Communication</td>
</tr>
<tr>
<td></td>
<td>- Good communication</td>
</tr>
<tr>
<td></td>
<td>- Information sharing</td>
</tr>
<tr>
<td>MDT effective team working through collaboration</td>
<td>- Sharing skills</td>
</tr>
<tr>
<td></td>
<td>- Effective MDT team working</td>
</tr>
<tr>
<td></td>
<td>- Escalation to other disciplines</td>
</tr>
<tr>
<td></td>
<td>- Collaboration</td>
</tr>
<tr>
<td></td>
<td>- Dependent on effective multidisciplinary care</td>
</tr>
<tr>
<td></td>
<td>- Should not be only dictated by GPs- what community nurses do</td>
</tr>
<tr>
<td>Integrated care pathways</td>
<td>- Integration</td>
</tr>
<tr>
<td></td>
<td>- Integration of services</td>
</tr>
<tr>
<td></td>
<td>- Care pathways- individual, effective positive outcomes</td>
</tr>
<tr>
<td></td>
<td>- Effective cross boundary working</td>
</tr>
<tr>
<td>Right culture and values</td>
<td>- Right culture and values</td>
</tr>
<tr>
<td></td>
<td>- Approachable, responsive</td>
</tr>
<tr>
<td></td>
<td>- Value people not disease</td>
</tr>
<tr>
<td></td>
<td>- Care and compassion</td>
</tr>
</tbody>
</table>
- **6 Cs**

**Leadership**
- Nurses have overarching picture of a patient
- Role is key
- Provide leadership

---

**Effective Community Nursing is recognised by.........**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Individual Post Its</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive Clinical outcomes</strong></td>
<td>- Prompt assessments&lt;br&gt;- Prevent deterioration&lt;br&gt;- Positive outcomes&lt;br&gt;- Moving people towards recovery&lt;br&gt;- Patients achieving personal goals&lt;br&gt;- Patients receive end of life care in their preferred place&lt;br&gt;- Clinical outcomes</td>
</tr>
<tr>
<td><strong>Effective health promotion</strong></td>
<td>- Proactive not reactive nursing planning&lt;br&gt;- Proactive health promotion&lt;br&gt;- Effective care pathways for health promotion</td>
</tr>
<tr>
<td><strong>Positive patient experience</strong></td>
<td>- Patient focus on choice and quality of life&lt;br&gt;- Patient feedback&lt;br&gt;- GP feedback&lt;br&gt;- Quality of life&lt;br&gt;- Positive feedback&lt;br&gt;- Positive patient experience&lt;br&gt;- Good patient feedback&lt;br&gt;- Evaluating patient experience and outcomes</td>
</tr>
<tr>
<td><strong>Innovation/service development</strong></td>
<td>- Innovation and service development in place&lt;br&gt;- Contributing and engaging in innovation and service development</td>
</tr>
<tr>
<td><strong>Strong leadership</strong></td>
<td>- Strong leadership&lt;br&gt;- Recognising the role of the nurse as primary case holders&lt;br&gt;- Case manager and decision making</td>
</tr>
<tr>
<td><strong>Effective integration</strong></td>
<td>- Cannot be uniprofessional&lt;br&gt;- Support primary care&lt;br&gt;- Shift from hospital to community/home&lt;br&gt;- Integration&lt;br&gt;- Community engagement&lt;br&gt;- Improved integration and cross sector working&lt;br&gt;- Remove barriers to joint working&lt;br&gt;- Trust between organisations</td>
</tr>
<tr>
<td><strong>MDT working</strong></td>
<td>- Timely MDTs&lt;br&gt;- MDTs to work</td>
</tr>
<tr>
<td>Theme</td>
<td>Post its</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Admission/readmissions reduction/avoidance</td>
<td>• Working collaboratively</td>
</tr>
<tr>
<td></td>
<td>• Proactive “pulling” of patient management</td>
</tr>
<tr>
<td></td>
<td>• Reduced hospital admissions</td>
</tr>
<tr>
<td></td>
<td>• Reduction in secondary interventions</td>
</tr>
<tr>
<td>Effective communication across boundaries/agencies</td>
<td>• Effective communication</td>
</tr>
<tr>
<td></td>
<td>• Good liaison with all agencies</td>
</tr>
<tr>
<td></td>
<td>• Effective communication flows</td>
</tr>
<tr>
<td></td>
<td>• Open communication and information sharing with all key stakeholders</td>
</tr>
<tr>
<td>Recruiting and retaining staff through staff satisfaction</td>
<td>• Increasing staff recruitment and retention</td>
</tr>
<tr>
<td></td>
<td>• Improved staff satisfaction</td>
</tr>
<tr>
<td></td>
<td>• Reduction in staff sickness</td>
</tr>
<tr>
<td>Skilled competent staff</td>
<td>• Skills and competence to manage complexity</td>
</tr>
<tr>
<td>Effective risk management</td>
<td>• Areas of poor care would be escalated</td>
</tr>
<tr>
<td></td>
<td>• Managing risk to the individual, family and carers supported by lifelong learning</td>
</tr>
</tbody>
</table>

Effective community nursing is enabled/inhibited by (+ive/-ive).................

<table>
<thead>
<tr>
<th>Theme</th>
<th>Post its</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and pathways (+ive/-ive)</td>
<td>• Communication</td>
</tr>
<tr>
<td></td>
<td>• Continuity</td>
</tr>
<tr>
<td></td>
<td>• Pathway work</td>
</tr>
<tr>
<td></td>
<td>• Policies and procedures</td>
</tr>
<tr>
<td></td>
<td>• Shared documentation</td>
</tr>
<tr>
<td></td>
<td>• Personalised care</td>
</tr>
<tr>
<td>Technology (+ive/-ive)</td>
<td>• Information governance</td>
</tr>
<tr>
<td></td>
<td>• Shared information</td>
</tr>
<tr>
<td></td>
<td>• Technology</td>
</tr>
<tr>
<td></td>
<td>• No single IT system</td>
</tr>
<tr>
<td></td>
<td>• IT</td>
</tr>
<tr>
<td></td>
<td>• Telehealth</td>
</tr>
<tr>
<td></td>
<td>• Telemedicine</td>
</tr>
<tr>
<td>Resources (+ive/-ive)</td>
<td>• Funding</td>
</tr>
<tr>
<td></td>
<td>• Access to effective training and funding</td>
</tr>
<tr>
<td></td>
<td>• Finance efficiencies and constraints</td>
</tr>
<tr>
<td></td>
<td>• Resources</td>
</tr>
<tr>
<td></td>
<td>• Right number of staff in workforce</td>
</tr>
<tr>
<td></td>
<td>• Equipment</td>
</tr>
<tr>
<td></td>
<td>• Workload</td>
</tr>
<tr>
<td></td>
<td>• Using skills available to deliver nursing care collaboratively</td>
</tr>
<tr>
<td></td>
<td>• Knowing what the right number of staff is</td>
</tr>
</tbody>
</table>
## Decision led working (+ive/-ive)

- Risk averse/fear
- Others expectations
- Disjointed working between/across agencies
- Social care
- Disjointed working between professionals
- Criteria for effective decision making

## Education and training (+ive/-ive)

- Traditional values
- Supervision
- Quality skilled workforce
- Appropriate skill mix
- Skills and competence
- Clear career pathways valuing practice

## Culture (+ive/-ive)

- Clear vision and objectives
- Normalisation
- Low harm
- Low blame culture
- Motivated engaged staff
- Family
- Carers

## Leadership (+ive/-ive)

- Strong determine leadership
- Strong leadership

### The indicators of effective community nursing are:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Post its</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced/appropriate admission</td>
<td>Sharp clinical decision making</td>
</tr>
<tr>
<td></td>
<td>Reduced readmission to hospital</td>
</tr>
<tr>
<td></td>
<td>Reduced hospital admissions</td>
</tr>
<tr>
<td></td>
<td>Reduced inappropriate admissions</td>
</tr>
<tr>
<td></td>
<td>Reduced admissions</td>
</tr>
<tr>
<td>Appropriate rate of discharge</td>
<td>Reduced delay in discharge of inpatients</td>
</tr>
<tr>
<td></td>
<td>Reduced length of hospital stay</td>
</tr>
<tr>
<td></td>
<td>More rapid discharge</td>
</tr>
<tr>
<td></td>
<td>Appropriate discharge</td>
</tr>
<tr>
<td></td>
<td>Reduced length of stay</td>
</tr>
<tr>
<td>Reduced referral to social care</td>
<td>Reduced referral to social care/placements</td>
</tr>
<tr>
<td>Reduced spend</td>
<td>Reduced spend in health economy</td>
</tr>
<tr>
<td>Reduced harm</td>
<td>Reduced harm</td>
</tr>
<tr>
<td>Patient/carer satisfaction and experience</td>
<td>Carer satisfaction</td>
</tr>
<tr>
<td></td>
<td>Achieving personalised patient goals</td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>Enhanced patient experience</td>
</tr>
<tr>
<td>Enabled and developed staff</td>
<td>Enabling and developing care home staff</td>
</tr>
<tr>
<td>Themes</td>
<td>Post its</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Good career development opportunities</td>
<td></td>
</tr>
</tbody>
</table>
| Staff satisfaction and attitudes                     | • Job satisfaction
• Staff satisfaction
• Recruitment and retention |

The outcomes of effective community nursing are recognised by………………

<table>
<thead>
<tr>
<th>Themes</th>
<th>Post its</th>
</tr>
</thead>
</table>
| Appropriate admissions/admissions avoidance             | • Increased appropriateness and escalation of needs
• Reduced emergency admissions
• Reduced inappropriate admissions
• Reduced admissions
• Admissions avoidance                                   |
| Measurable improved quality of life evidence (outcomes/rates) | • Improved healing rates
• Clinical outcomes
• Improved outcomes
• Quality of life assessment improvements                 |
| Patient self management                                 | • Improved patient empowerment
• Patient self management                                        |
| Compassionate caring partnerships                       | • Compassionate caring partnerships                                      |
| Reduced GP appointments                                 | • Reduced GP appointments                                               |
| Harm free care                                          | • Harm free care
• Reduced risk of harm                                           |
| Patient/family satisfaction, support and experience     | • Provision of family support
• Patient satisfaction
• High satisfaction of family
• Positive patient and carer experiences
• Patient experience                                        |
| Preferred place of death/EoLC                           | • Preferred place of death
• End of life care at home
• Patient choice
• Responsive feedback on place of death                     |
| Improved access to specialist services                  | • Improved access to specialist services                                 |
| Positive workforce/workplace cultures                   | • Positive workplace cultures                                           |
## AUDIT TRAIL ANALYSIS

### Question 1 Claims

<table>
<thead>
<tr>
<th>PRE PILOT THEMES &amp; RESPONSES (each bullet is an individual response collated under a broader theme in CAPS)</th>
<th>POST PILOT THEMES &amp; RESPONSES (each bullet is an individual response collated under a broader theme in CAPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EASY TO COMPLETE</strong></td>
<td><strong>EASY TO COMPLETE</strong></td>
</tr>
<tr>
<td>• Easy to complete</td>
<td>• Easy to complete</td>
</tr>
<tr>
<td>• Tick box exercise – easy to do whilst seeing the patient</td>
<td>• Not too much effort to fill in</td>
</tr>
<tr>
<td>• Liked the terminology – practical and easy to use</td>
<td>• Quick and easy to understand and use</td>
</tr>
<tr>
<td>• Easy to use</td>
<td>• The layout is easy, it could be made simpler with more areas for jobs like flus, blood test, dressings</td>
</tr>
<tr>
<td></td>
<td>• It is easy to use</td>
</tr>
<tr>
<td><strong>POSITIVE, HOPEFUL &amp; HELPFUL IN HIGHLIGHTING WHAT WE DO</strong></td>
<td><strong>CLEARLY HIGHLIGHTS WHAT WE DO EACH DAY AS WELL AS THE SCOPE &amp; IMPACT OF THE ROLE</strong></td>
</tr>
<tr>
<td>• Positive step to justify our work</td>
<td>• Clearly shows where my time is spent</td>
</tr>
<tr>
<td>• I am excited about undertaking this piece of work I am hoping that it may highlight the extensive role which I and nurses undertake in our daily roles</td>
<td>• I found the matrix a really useful and effective way of highlighting what I do on a daily basis</td>
</tr>
<tr>
<td>• Will be helpful to my work</td>
<td>• Allowing to have insight of a breakdown of tasks completed each day</td>
</tr>
<tr>
<td>• Hoping it will highlight some of the work we carry out which is not captured</td>
<td>• Makes you appreciate how much is done each day... clarifies scope and impact of job!</td>
</tr>
<tr>
<td>• Highlights to immediate managers and commissioners the extent of work undertaken each day</td>
<td></td>
</tr>
<tr>
<td><strong>DEMONSTRATING VARIETY &amp; COMPLEXITY OF SPECIALIST NURSES?</strong></td>
<td><strong>IDENTIFIES THE SKILLS &amp; KNOWLEDGE I USE DAILY</strong></td>
</tr>
<tr>
<td>• It is attempting to demonstrate the variety and complexity of duties carried out by specialist nurses</td>
<td>• I was able to identify all the skills and knowledge that I use on a daily basis</td>
</tr>
<tr>
<td>• It appears to be very focused on specialist nurses and not the community nurse (RIGHT PLACE _more of a concern)</td>
<td></td>
</tr>
<tr>
<td><strong>ASSIST IN ASSESSING WORKLOAD, MANAGING CROSS-OVERS &amp; PROVIDING ADMINISTRATIVE SUPPORT</strong></td>
<td><strong>HAS POTENTIAL TO PROVIDE EVIDENCE OF WHAT I DO AS WELL INFORM STAFFING LEVELS &amp; ADMIN SUPPORT</strong></td>
</tr>
<tr>
<td>• Hopefully it will assist us in assessing our workload not just clinically but also administratively</td>
<td>• It highlighted how much more I do outside what may be deemed my norm as the standard role of the nurse</td>
</tr>
<tr>
<td>• It may highlight a need for increased admin support</td>
<td>• The matrix will prove positive if data is scrutinised and staffing levels improved as a result of the information collated</td>
</tr>
<tr>
<td>• Implementing a detailed structure of job role, reducing cross overs</td>
<td>• Providing evidence of daily workload achieved from 8 hr shift</td>
</tr>
</tbody>
</table>
**Positive to see an attempt at establishing additional work carried out that is not captured**

**Has identified the need for more admin support in my role**

**QUANTIFIES WHAT YOU DO**
- Makes you quantify what you do … providing some surprisingly high results

**IDENTIFIES VOLUME OF TASKS AND ALSO EFFECTIVENESS OF WHAT IS DONE DAILY**
- It makes you think more carefully and breakdown every intervention I do for the patient
- Makes you reflect on role and how effective you are at fulfilling your role
- Totals identify volume of work carried out
- Makes you realise just how many tasks are completed in one day

**THERE IS A NEED FOR FEEDBACK/OPPORTUNITY TO REVIEW**
- I can see why there should be some kind of feedback on what/why we do what we do and how we try and manage our time and worth
- Provides an opportunity to review what we actually do in a day/shift

**ENABLES MORE UNDERSTANDING OF JOB & WHO DOES WHAT IN THE MDT**
- Gain more understanding of job role and who does what in the MDT

**IMPROVING TEAM WORK**
- Improving team work, we are all nurses, stop the phrase ‘them and us’

**THE MANY TIMES I MAKE A DIFFERENCE TO PATIENT CARE**
- When I look back on a days work I could see how many times I made a positive difference to patient care and experience

**Question 2 Concerns**

<table>
<thead>
<tr>
<th>PRE</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WILL IT REFLECT COMMUNITY NURSING &amp; WORKLOAD APPROPRIATELY?</strong></td>
<td><strong>NOT ALL ACTIVITIES INCLUDED/IT DOESNT COVER ALL THE ASPECTS OF MY WORK</strong></td>
</tr>
<tr>
<td>- Will it cover community nursing appropriately?</td>
<td>- Some activities undertaken cannot be classified such as professional development. Surprised that clinical administrative work not a category of its own such as completing audits! Letter writing, recording in patients notes</td>
</tr>
<tr>
<td>- Some days may seem quieter than others and this may suggest that less staff are needed</td>
<td>- Still does not reflect days work. No study days</td>
</tr>
<tr>
<td>- If it is a bit of a time and motion study, it will show truly the work we carry out</td>
<td>- Does not capture all elements of role. Needs to be geared more</td>
</tr>
<tr>
<td>- Very subjective and open to debate</td>
<td></td>
</tr>
<tr>
<td>PROVIDING ACCURATE TIMES &amp; INFO</td>
<td>ACCURACY</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Providing accurate times of patient contact from start to finish</td>
<td>• Each of those involved have interpreted boxes as something different so will not be accurate</td>
</tr>
<tr>
<td>• Gain information of work completed outside office hours i.e. working from home due to lack of time on shift</td>
<td>• Provide information for work completed out of hours (own time) due to high level of paperwork outstanding from the working day and will this give accurate results from the pilot</td>
</tr>
<tr>
<td>• The matrix does not involve time factors, just how many actions of a particular event.</td>
<td>• I was concerned about correctly recording the activities that I was doing through a day</td>
</tr>
<tr>
<td>• Difficulty being able to describe actions</td>
<td></td>
</tr>
<tr>
<td>• That I may not tick correct boxes and that it will be time consuming</td>
<td></td>
</tr>
<tr>
<td>• No timescale for visits</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FORMAT FOR CAPTURING INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Difficult to know where to put certain things</td>
</tr>
<tr>
<td>• Better explanation about how to use</td>
</tr>
<tr>
<td>• It's not clear where to put jobs and does not show the time each job takes, most visits are longer than can be shown by a tick box</td>
</tr>
<tr>
<td>• I found it quite hard to fit some of the roles into categories listed also feel people’s perception of the headings can be easily be perceived differently which may mean results will be inconsistent</td>
</tr>
<tr>
<td>MAINLY AIMED AT SPECIALIST</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>• Appears to lean towards Macmillan’s specialities and not all nurse specialists</td>
</tr>
<tr>
<td>• I am not a specialist nurse</td>
</tr>
<tr>
<td>• Mainly aimed at specialist nurses not sure it can apply to community nurses</td>
</tr>
<tr>
<td>• This has been developed to analyse the value of specialist nurses, not any grade</td>
</tr>
<tr>
<td>• Not the same as Alison Learys</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONFUSION/LACK OF INFORMATION ABOUT TOOL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• That maybe it is not clear enough to allocate all jobs to very easily</td>
<td></td>
</tr>
<tr>
<td>• No explanation of terms e.g clinical risk management</td>
<td></td>
</tr>
<tr>
<td>• What do colours mean?</td>
<td></td>
</tr>
<tr>
<td>• It was very confusing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONCERN JOBS AT RISK &amp; THIS INFLUENCES INPUT</th>
<th>CONCERN FOR JOB.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• People may be wary that their job may be at risk and therefore adjust the recording to make the role justifiable.</td>
<td>• In my role matrix possible shows that I complete specialist tasks that another nurse of a higher grade is being paid for</td>
</tr>
<tr>
<td>• They may enter more activity than is actually carried out</td>
<td></td>
</tr>
<tr>
<td>• I am concerned that I will be too conscious of fitting a particular activity to meet the areas covered in the Cassandra Matrix and think that it looks empty when completing a day’s work and perhaps try and do additional work to complete the matrix.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIME TO COMPLETE, MORE PAPERWORK, LESS TIME FOR PATIENTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Takes time to fill in – already overloaded with work</td>
<td></td>
</tr>
<tr>
<td>• More paperwork – less time to spend with patients</td>
<td></td>
</tr>
<tr>
<td>• It appears to be bit of a time and</td>
<td></td>
</tr>
</tbody>
</table>
motion study

**KNEW NOTHING ABOUT PILOT**
- I knew nothing about this until I received an email on 17/10/13 – only one of my colleagues knew about it as she was on annual leave

**NONE**
- None
- No real concerns as it is adaptable to most specialist areas, although you do have to think about admin and clinical data input and duplication

### Question 3 Issues

<table>
<thead>
<tr>
<th>PRE</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOW WILL IT IMPROVE/WHAT ARE THE BENEFITS</strong></td>
<td><strong>HOW WILL THIS BENEFIT MY WORK &amp; PATIENTS?</strong></td>
</tr>
<tr>
<td>- Has it proved to be beneficial in any particular area?</td>
<td>- How is this going to benefit my work and benefit the patient I see</td>
</tr>
<tr>
<td>- What benefits will it have?</td>
<td>- What benefit isn't to us - how will it help us</td>
</tr>
<tr>
<td>- Will this improve patient care?</td>
<td>- Will/can anything change as a result</td>
</tr>
<tr>
<td>- How will it impact/influence future practice</td>
<td></td>
</tr>
<tr>
<td>- What will be the outcome from the results</td>
<td></td>
</tr>
<tr>
<td>- Does the trust benefit from this pilot</td>
<td></td>
</tr>
<tr>
<td>- How it will benefit my work</td>
<td></td>
</tr>
<tr>
<td>- How it will benefit patients</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHAT HAPPENS WITH RESULTS?</th>
<th>WILL FEEDBACK BE PROVIDED &amp; WHAT WILL BE DONE WITH THIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What results will be taken from results of pilots</td>
<td>- Will we get feedback on what the results will be used for, is it going to benefit patient care</td>
</tr>
<tr>
<td>- Will the results be acted upon and by who?</td>
<td>- What will happen when evidence is collated</td>
</tr>
<tr>
<td></td>
<td>- Will feedback be given from results</td>
</tr>
<tr>
<td></td>
<td>- What purpose will the information gathered be put too. Will relevant managers be informed... Will my feedback be sent back to participants</td>
</tr>
<tr>
<td></td>
<td>- How the information will be utilised</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW DOES IT RELATE TO MY WORK/CAPTURE ITS WORTH</th>
<th>IS IT THE MOST APPROPRIATE TOOL – COULD IT BE MORE GENERIC?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does this relate to my work</td>
<td>- Is it the most appropriate tool to be using for a community based role. How will the results help in our role</td>
</tr>
<tr>
<td>- Non of the columns seem to include home visits( I am a community nurse – the matrix sheet seems to have been written for hospital/clinic)</td>
<td>- Why has this format of data gathering been chosen</td>
</tr>
<tr>
<td>- Is the matrix really a true reflection of a practitioner daily work</td>
<td>- Although easier to use, a generic overview would enhance the users</td>
</tr>
</tbody>
</table>
- Can it really capture the worth of a specialist nurse
- Does not cover all activities

**COULD IT BE USED TO HIGHLIGHT THE ROLE/WHAT NURSE DOES FOR PATIENT**
- Could it not be used with the trust to help highlight the importance of the role and how much we do. This has been carried out over a short period
- What a nurse actually does for the patient

**DOES EVERYONE HAVE A COMMON UNDERSTANDING ABOUT TERMS AND HOW INTERPRET WORK**
- How have staff interpreted the matrix and is there a common understanding of how to tick the correct box for the correct activity
- What do the colours mean?

**CONCERN ABOUT JOB**
- Am I going to be downgraded, as all the results will show is that an experienced nurse of a lower grade could carry out my role, thus saving money

**WHY NOT MORE GENERIC?**
- Why is it not more generic?

**WHY IS IT NECESSARY?**
- Why has this been introduced now when this was published over 2 yrs ago?
- Why does this matrix need to be carried out?

**TIME SPENT ON EACH ACTIVITY**
- Does not indicate the amount of time being spent on each activity (but it would be impossible to calculate this

**Question 4 How effective do you believe you are at currently measuring what you do?**

<table>
<thead>
<tr>
<th></th>
<th>PRE</th>
<th>POST</th>
</tr>
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<tbody>
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<td></td>
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<td>-</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>n=16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 did not score
1 scored in between + and –

14

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I DO NOT CURRENTLY MEASURE WHAT I DO

- I do not believe I am very effective in documenting what I do. I feel that this is due to the changes within my role, being very busy
- Do not currently measure what I do in any quantifiable form

I AM ABLE TO PRIORITISE WHAT I DO/WE MANAGE CASELOAD BUT IT DOESN’T NECESSARILY ADD UP

- I feel I am able to prioritise workload to importance but this can be difficult at times due to increased level of work which can alternate each day
- I feel that we try to provide care and support and manage caseload and don’t necessarily ‘add up’ at end of shift we do
- During my working day I do my job to the best of my ability within that I do not consider what it is I’m doing to any degree of importance, just that it needs to be done

WE CURRENTLY COLLECT SOME DATA ABOUT CONTACTS, BUT THERE ARE LIMITATIONS

- The Comcare system we use is a very poor measure of what we do, it does not take into consideration the complexities and stresses we have to deal with, not just with clients and families but within the team. The diary entries we make are merely an aid as to who we are visiting
- We currently record contacts and referrals electronically. However admin/telephone calls/referrals are not recorded. Meetings are also not captured or study
- Although daily patient contacts are recorded on ‘Comcare’ this does not demonstrate the length of time spent on visits or the complexities. There is now no way to record time spent on non-clinical duties such as caseload management attending meetings etc
- At present we use various audits, surveys, Comcare to measure our

INCREASED AWARENESS NEED TO MEASURE & HOW MUCH WE DO

- I have been made more aware that I do not measure what I do on a regular basis. Using the tool has made me feel better about the quality and quantity of work I do in my role on a daily basis
- I feel from using this tool it has made me aware of what we do and how much. Just feel showing these times would help shown the role better as some visits can take one hour and travelling times

ONLINE RECORDING IS IMPROVING MEASUREMENT BUT DOESN’T REFLECT EVERYTHING I DO

- Measurement is better now with the online system, however a lot of our admin work we carry out may not be captured or documented clearly to give a true time in motion picture
- Still does not reflect meetings or study. Admin not clear
- This is not always reflected in my work as we do not measure all the interventions I do for my patients

NO REAL WAY OF MEASURING

- I still think that there is no real way of measuring effectiveness of what I do everyday, despite various audits, com care, continuum etc

MEASURE MY OWN EFFECTIVENESS BY PATIENT RESPONSE AND OUTCOMES

- I measure my own effectiveness by patient response and the outcomes I achieve

MAIN PRIORITY IS TIME MANAGEMENT & PRIORITISATION

- Main priority is time management and prioritising of importance. At times this can be difficult due to the number of visits or shortness of staff. Which in turn makes it difficult to measure what I do

WILL MEASURE MORE IF BENEFITS COMMUNITY NURSING

- I would only make more of an effort to measure what I do if I felt that there would be an underlying benefit to community nursing as a whole
work

I WISH THERE WAS AN EFFECTIVE WAY OF MEASURING WHAT I ACTUALLY DO EVERYDAY

- (-) I wish there was an effective, I wish there was a way of measuring what I actually do everyday – I wish there was a camera on my shoulder sometimes to show just what I have to try and fit in my working day

I MEASURE MY OWN EFFECTIVENESS IN RELATION TO FEEDBACK RECEIVED

- (+) Although not audited, personally I measure my effectiveness from patient and GP feedback and the positive outcomes I achieve. This is reflected in responses from patient questionnaire
Appendix 2 – Data Charts

Pilot site 1 activity chart (Chart A)
Holistic assessment
Symptom control advice
Symptom control referral
Symptom control management
Performing procedures
Hospital Avoidance intervention
Promoting self management
Providing Health Education
Providing Rescue work
Providing Vigilance admission
Risk assessment & review
Reassessment of needs
Psychological assessment
Joint assessment
Care planning & evaluation
Coordinating care
Caseload management
Handover
Safeguarding vulnerable
Clinical risk management
Anxiety management
Anxiety rescue work
Dealing with distress
Communicating significant news
Social assessment
Mediation of relationships
Advice (political)
Advocacy
Referral
Chasing up results/referrals
Travel (scheduled)
Travel (unscheduled)
Other administration work (non clinical)

Pilot site 3 activity chart (Chart C)

Number of interventions
Pilot site 1 Band comparison chart (Chart D)
Multi-professional working totals (Chart F)
## Appendix 3 – BOS Survey Results

### 1. What positive statements can you make about the Framework and the Vision and Purpose Statement?

- Breathe of fresh air to see a format that is easy to read and understand. Really clear on direction of travel.
- Concise

I think the Vision and Purpose Statement captures accurately the output from the workshop. It is comprehensive yet concise. The Framework is presented clearly and again reflects the content of the workshop.

It is clear and concise.

It is succinct and reflects the discussions that occurred.

This is clear and states the values expressed on the day. It is concise and easily understood.

### 2. What concerns do you have about the Framework and the Vision and Purpose Statement?

- I would not like to see the tome that was presented on the day as I do not feel it is usable. Also it needs to reflect both Medway and Kent
- In enablers ? good integrated IT
- May not be easy to understand for service users/patients clients due to some of the terms used. I am not clear what "check services" means in the last paragraph?
- The Vision and Purpose Statement should not contain acronyms (eg MDT). The footnote should also list the North Kent CCGs separately - as drafted it implies there is one single NK CCG - there are three separate organisations.
- Whilst safe care is mentioned I think that it needs to be followed through the rest of the purpose and statement. AS perceived as the other side of 'quality' to experience.
- Winning hearts and minds to make the transformational changes needed.

### 3. What changes would you make to the Framework and Vision and Purpose Statement?

- "check services" ? add good integrated IT
- Because I was part of the consultation group then I knew what to expect therefore it fits with what was discussed.

I would like the word at the first bullet point in the Vision changed from Developing to Enabling as I am sure many are already developed. Likewise removing Establishing from the second bullet. Under Attributes, 3rd bullet point: change objectives to outcomes. Under Attributes, 7th bullet, Changed provided to provision, reads better. Under Consequences, Individual, 6th bullet: change to Patient's preferred place of care or death achieved. Service, bullet 3 and 6 duplicates. Service, bullet11: Change to Redistribution and more effective use of resources

Links between compassionate cultures / reflective cultures and safety need to be made more explicit and clear. The change I would make is to add this in the recognised by.. part. I would also like to add this clearly in the framework in each categorise so that the evidence based links of culture and reflection to safety are explicit

See above for minor amendments to the statement. In the framework, the consequences
section needs some consideration to make sure that the language is right. In the Service/organisation section there is a "Reduced referral to social care" - that is not what we want to achieve - we want a reduction in the numbers of people going into residential care, but not a reduction in reablement/enablement packages from social care - these are the packages that will stop hospital admission and support people to stay living independently at home.

### 4. What questions would you like to ask about the Framework and the Vision and Purpose Statement?

**About the action plan and indicators that will measure success.**

I think there remains a question for me about the practicalities of implementing the framework - in terms of time to implement it and how it will be monitored in terms of impact on staff and on patients - what is the timescale for implementation? What KPIs will be used to monitor impact?

None currently

**Target audience/ Commissioners, providers, clients all of the above?**

### 5. What 3 indicators do you use to judge the individual effectiveness of community nurses?

- 360 feedback from patients and colleagues
- Positive clinical outcomes
- Consistent high standard of care delivered

Based on the National Voices Narrative statements - develop at least 1 KPI that measures positive patient experience in relation to empowerment and involvement - e.g. Number and % of patients who feel involved in developing their care plan. A KPI that measures overall satisfaction with service - again using the National Voices Narrative "I" statements as a guide. A KPI on quality of care - e.g. number and % of patients supported to die at place of choice - modelled against an agreed baseline (to show improved support to patients).

- Competence and knowledge, reflective practitioner with ability to put this into practice. Maintains someone's dignity whilst doing this.
- Comprehensive skills sets patient centred problem solver
- Patient satisfaction
- Student feedback
- Developing patient outcome measures
- Patient/carer/family feedback
- Process of care measures comparisons
- Benchmarking against peers used to evaluate

### 6. What 3 indicators do you use to judge the effectiveness of your service?

- Ability to ensure that correct skills match to patient needs. Professional experienced assessment on point of entry to service. Regular reassessment of need
- Clinical outcomes
- Patient satisfaction
- No harm

Feedback from patients and colleagues
- Positive clinical outcomes
- Consistent high standard of care and reflection on practice.
- Number and % of patients who have an MDT care plan (map and increase against an agreed trajectory)
- Number and % of known caseload patients admitted to hospital and discharged with zero length of stay (expected reduction - to be mapped against a trajectory and to be linked to the development of the integrated Discharge Teams operating across County - this will provide the data source)
- Number and % of patients supported to stay in normal place of residence - this needs to catch not necessarily a reduction in referrals to Social Care - more a reduction in admission to long term care - social care enablement packages should possibly increase to support admission avoidance (to hospital and
residential care) so we should not set KPIs that measure a reduction in referral to social care.

<table>
<thead>
<tr>
<th>Patient experience</th>
<th>Retention and sickness</th>
<th>Joint working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/carer/family feedback</td>
<td>Process of care measures</td>
<td>Benchmarking against other services used to evaluate</td>
</tr>
</tbody>
</table>

7. **What 3 indicators do you use to judge the effectiveness of your teams?**

- Effective Communication not just hand over but reflective discussion on appropriate/effective approaches and care. Good team management and matching skills and patient needs staff development
- Feedback from patients and colleagues Positive clinical outcomes Clear communication within the team.
- Innovation Cohesiveness Patient and staff experience
- KPI to measure stability of workforce and sickness absence rates. KPI to capture organisation's mobilisation of MDTs - so you can demonstrate attendance at and contribution to MDT process. KPI to measure staff morale
- Measure of stress in your staff The value that the team give of their patients; talking respectfully etc etc Commissioner feedback
- Patient focused support development and training team approach to problem solving

8. **What 3 indicators do you use to judge the effectiveness of community nursing?**

- Clinical outcomes patient satisfaction no harm
- Falls with Injury, Nursing Care Hours per Patient Day, Skill Mix
- Patient feedback staff survey clinical Indicators such as acquiring Pressure ulcer
- See above
- Services delivered to consistent high standard Service users happy with service Clear communication with all agencies involved
- We have a wide range of indicators, financial, HR, quality that are used

9. **What 3 indicators do you use to judge the effectiveness of community nursing services?**

- As above
- AS above clinical indicators will be pathway measures I think these need more work
- Clinical outcomes patient satisfaction no harm
- Cost effectively Patient outcome Stakeholder satisfaction
- see above
- We have a wide range of indicators, financial, HR, quality that are used

10. **What are your top 2 priorities in the framework for addressing first?**

- Appropriate means of gauging skill mix Identifying new service development and innovation
- Developing person centred compassionate, caring partnerships and relationships that build trust between service users and stakeholders Evaluating and acting on patient experience and the monitoring of outcomes.
- Implementing a personal plan of care and evaluating this against agreed objectives
Opportunities for career and leadership development

My priority for community nursing would be ensuring that there is investment in the workforce, if nursing teams are stretched and numbers are too low then the vision and framework will not be viable.

Skill mix and culture

Workforce levels - if the staffing establishment is not correct the framework cannot be implemented successfully. Training - the framework implementation must be supported by a robust training and development programme, set against a clear timescale.

11. Having attended the Community Nursing Workshop what would like to have changed about it?

| No change: |  | n/a | 3 |
| Change: |  | n/a | 3 |

11a. If you would have liked something different or changed please let us know what that is.

A challenge to the GP who felt he could do a better job if he managed the community teams! more GPs there

There did not appear to be enough representation from the community nursing workforce.

12. Would you be happy to participate in a follow up telephone interview to this survey?

| Agree: |  | 60.0% | 3 |
| Disagree: |  | 40.0% | 2 |
Appendix 4 – Community Nursing Workshop Flyer

The England Centre for Practice Development

Date  Friday 27th September 2013

Venue: Hpg13 Bolingbroke Room, Hall Place Campus, Canterbury Christ Church University

A WORKSHOP TO CREATE A COMMUNITY WORKFORCE DEVELOPMENT SHARED PURPOSE FRAMEWORK FOR COMMISSIONING AND PROVISION OF NURSING SERVICES

Introduction

This workshop is facilitated by the England Centre for Practice Development hosted by Canterbury Christ Church University in partnership with North Kent CCG and Kent and Medway Local Area Team. We will be delighted to welcome you to this creative workshop space.

Despite the urgent need to develop the community nursing workforce to deliver person centered, safe and effective, evidence informed compassionate care, there are no nationally significant workforce development frameworks currently in existence that can support providers and commissioners to identify the right skill mix for the future. In Kent however there is a growing body of work led by the England Centre for Practice Development in collaboration with commissioner and provider organisations that are capacity building in this area.

The workshop is part of a four phase project commissioned by our partners in North Kent and Kent and Medway. The purpose of this project is to:

1. Scope what models are already in existence in relation to effective workforce development models and workforce planning tools in the community setting (both community in-patient beds and community services).
2. Review the literature for evidence of patient related outcomes from a registered/unregistered nursing workforce.
3. Review similar work undertaken elsewhere e.g. EKUHT shared purpose frameworks nursing workforce skills, knowledge, competences to deliver person centred safe and effective evidence informed care.
4. Consider adapting a shared purpose framework for piloting as a potential community nursing workforce development tool.
5. Undertake a specialist community nursing review using the Cassandra Matrix to capture the specialist nursing contribution in the delivery of person centred safe and effective evidence informed care in two pilot sites.
6. Produce a project report that makes recommendations for future community nursing workforce shared purpose framework to support the commissioning and provision processes and development of leadership potential that impacts on education commissioning

The project must be complete by 30th November 2013.

Places on the workshop are offered to community nursing leaders, commissioners and specialist nurses with a vested interest in developing a community workforce planning tool that can be piloted in the locality, as well as members of the project steering group.
A WORKSHOP TO CREATE A COMMUNITY WORKFORCE DEVELOPMENT SHARED PURPOSE FRAMEWORK FOR COMMISSIONING AND PROVISION OF NURSING SERVICES

Carrie Jackson, Director England Centre for Practice Development Canterbury Christ Church University; Associate Professor University of Wollongong, New South Wales, Australia

Aims of the Workshop

- Develop a shared understanding of project purpose and anticipated outcomes
- Present an overview of the literature review findings and a conceptual framework
- To review a Shared Purpose framework tool developed by EKUFT and consider whether this approach would meet the requirements of community nursing roles
- Look at Cassandra Matrix interventions for relevance to community nursing and identify potential people to pilot the tool for 10 days
- Focus on current experience of staff skill mix to identify what is working, what are the concerns in practice, what questions are being asked. Develop an action plan.

Fees

This event is free of charge.

Cancellations will be accepted until three days prior to the workshop.

Timing of Workshop

1030-1600 hours, Hall Place Campus
Room: Hpg 13

Refreshments and Lunch will be provided

Booking your Place:

Provisional Facilitators

Dr Kim Manley CBE, Associate Director, Transformational Research and Practice Development, East Kent Hospitals NHS Foundation Trust, Co-Director England Centre for Practice Development & Visiting Professor Canterbury Christ Church University, Canterbury; Visiting Professor Surrey University
The England Centre for Practice Development

Date  Friday 27th September 2013
Venue: Hpg13 Bolingbroke Room, Hall Place Campus, Canterbury Christ Church University

A WORKSHOP TO CREATE A COMMUNITY WORKFORCE DEVELOPMENT SHARED PURPOSE FRAMEWORK FOR COMMISSIONING AND PROVISION OF NURSING SERVICES

Places are limited so please contact Carolyn Jackson
to book your place by Friday 20th September.
carolyn.jackson@canterbury.ac.uk

Getting to Hall Place
From Canterbury:
Hall Place is situated on the A2050, the main road out of Canterbury towards the A2 London bound.

From London:
Take the M2 coast bound
At junction seven take the A2 following signs for Canterbury and Dover
Take the fourth exit off the A2 (signposted for Canterbury). Hall Place is approximately one mile on the left.

Visitor Car Parking

All Visitors wishing to park on University premises must apply for a parking permit.

A visitor’s permit can be found at
http://www.canterbury.ac.uk/support/facilities-services/extranet/permit-for-visitor.asp
Appendix 5 – Ethics Consent Letter

30 September 2013

Ms Carolyn Jackson
Director
England Centre for Practice Development
Faculty of Health and Social Care

Dear Carrie,

Confirmation of compliance for your study “Community workforce development shared purpose framework for commissioning and provision of nursing services in Kent.”

I have received an Ethics Review Checklist for the above project to be carried out with Professor Kim Manley and Dr Toni Wright. Because you have answered “No” to all of the questions in Section B, and have submitted appropriate supporting documentation, no further ethical review will be required under the terms of this University’s Research Ethics and Governance Procedures.

In confirming compliance for your study, I must remind you that it is your responsibility to follow, as appropriate, the policies and procedures set out in the Research Governance Handbook (http://www.canterbury.ac.uk/research/governanceandethics/governanceande thics.aspx) and any relevant academic or professional guidelines. This includes providing, if appropriate, information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct of the study over its course should be notified to the Research Office, and may require a new application for ethics approval. You are also required to inform me once your research has been completed.

Wishing you every success with your study.

Yours sincerely,

Roger Bone
Research Governance Manager
Tel: +44 (0)1227 782940 ext 3272 (enter at prompt)
Email: roger.bone@canterbury.ac.uk

cc: Professor Kim Manley CBE
    Dr Toni Wright

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Appendix 6 – Participant Information Sheet

TITLE OF RESEARCH PROJECT
PARTICIPANT INFORMATION SHEET

A research study is being conducted at Canterbury Christ Church University (CCCU) by Carolyn Jackson, Director of the England Centre for Practice Development, Professor Kim Manley CBE and Dr Toni Wright Research Fellow.

Background
It is widely recognised that recent health care reforms have caused concern for the nursing workforce in the community setting (RCN, 2011). Better understanding is needed of the role of community nurses in delivering high quality patient outcomes, in order to inform improved service commissioning at a local level. Much literature and material that exists currently on workforce planning is descriptive in nature, and whilst that raises awareness of issues, and of a need for significant research and development in healthcare workforce planning, it goes little way in actually providing tangible solutions. The key question is how do commissioners determine the best skill mix of a workforce to deliver an increasingly complex health care model that meets the needs of an ageing population in Kent?

The purpose of this project is to:
1. Scope what models are already in existence in relation to effective workforce development models and workforce planning tools in the community setting (both community in-patient beds and community services).
2. Review the literature for evidence of patient related outcomes from a registered/unregistered nursing work force.
3. Align this to similar work undertaken elsewhere e.g. EKHUFT shared purpose framework-nursing workforce skills, knowledge, competences to deliver person centred safe and effective evidence informed care.
4. Adapt the EKHUFT shared purpose framework for piloting as a potential community nursing workforce development tool.
5. Undertake a specialist community nursing review using the Cassandra Matrix to capture the specialist nursing contribution in the delivery of person centred safe and effective evidence informed care in two pilot sites.
6. Produce a project report that makes recommendations for future community nursing workforce shared purpose framework to support the commissioning process and development of leadership potential that impacts on education commissioning.

What will you be required to do?
Participants in this study will be required to test out the shared purpose framework to see if it makes sense in relation to knowledge, skills and competencies required for different types of nurses in the community setting and using a workload analysis tool called the Cassandra Matrix, keep a record of the types of work activities and tasks undertaken over a 10 day period. This will enable the researchers to demonstrate the specialist contribution nurses make to delivering specialist care in the community. This data in turn will help workforce commissioners to make a case for why specialist nurses are needed in the workforce, how many are needed and the specialist contribution made to delivering person centred, compassionate, safe and effective evidence informed care.

To participate in this research you must:
- Be working in a specialist community nursing role in Kent
- Have at least 2 years post registration experience
- Have access to a computer and telephone

Procedures

You will be asked to:
Spend an hour of your time reading the shared purpose framework and making any recommendations for how it might be strengthened
Use the Cassandra workload assessment tool for a period of 10 days to keep a record of the types of activities you have been using in your nursing caseload
Spend up to an hour with the research team in a telephone interview to follow up on your thoughts and experiences.

Feedback

The final report summary will be sent to you at the end of the study in early December.

Confidentiality

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University’s own data protection requirements. Data can only be accessed by <state whom; this will normally be the same person(s) listed in the initial paragraph of this sheet>. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

Dissemination of results

The workforce development framework will be presented in project report format to the project commissioners and steering group and a paper will be published in a peer reviewed journal linked to community nursing, quality, and nursing management.

Deciding whether to participate
If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me. Should you decide to participate, you will be free to withdraw at any time without having to give a reason.

Any questions?

Please contact Carolyn Jackson, Project Lead, Director of the England Centre for Practice Development, Canterbury Christ Church University Tel 01227 782649 or Carolyn.jackson@canterbury.ac.uk
Appendix 7 – Participant Follow-up Letter

A Scoping Project to develop a Community Workforce Development Shared Purpose Framework for Commissioning of Nursing Services

Commisioned by Kent and Medway LAT and North Kent CCG¹

28th November 2013

Dear Colleague

You recently participated in a pilot of the Cassandra Matrix tool as part of a project to determine whether the tool is useful for the purpose of making visible the contribution of community nursing (what nurses are doing in practice with patients). Currently, nationally there is an absence of any specific tools that serve this purpose.

In the information we sent you we indicated that when the project reports on the 6th December we would be pleased to send you a copy of your individual 10 day workload analysis as well as sending you a copy of the final report once it is approved by the Steering Group. Individual analyses will NOT appear in the main report to protect the anonymity of individuals, so if you are interested in receiving a copy please would you contact Dr Toni Wright, Research Fellow at Toni.Wright@canterbury.ac.uk.

With thanks again for your contribution to the project.

Yours sincerely

Carolyn Jackson
Project Director
Director, England Centre for Practice Development
Faculty of Health and Social Care

¹ North Kent CCG- comprising Dartford, Gravesham, Swanley CCG, Medway CCG, Swale CCG.