

England Centre for Practice Development



The Cassandra Project: Recognising the Multidimensional Complexity of Community Nursing for Workforce Development

Final Report: 17th April 2015

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Funded by Health Education Kent, Surrey and Sussex

ISBN 978-1-909067-45-5

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Acknowledgements

The project team would like to thank the following people for their time, enthusiasm and contributions to this project and its report:

- The Project Steering Group (named in Table 1 below)
- Anna Humphreys, Administrator, England Centre for Practice Development
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List of Abbreviations

A&E	Accident and Emergency
ADL	Activities of Daily Living
AMHP	Approved Medical Health Practitioner
ASD	Autism Spectrum Disorder
BMI	Body Mass Index
BP	Blood Pressure
CAB	Citizens Advice Bureau
CBT	Cognitive Behavioural Therapy
CQC	Care Quality Commission
CfWI	Centre for Workforce Intelligence
CMHT	Community Mental Health Team
CRHT	Crisis Resolution and Home Treatment
DCN	District Community Nurse
DoH	Department of Health
DN	District Nurse
DWP	Department for Work and Pensions
ECG	Echocardiogram
FOI	Freedom of Information
GP	General Practitioner
HV	Health Visitor
HSCIS	Health and Social Care Information Centre
HEE	Health Education England
HEKSS	Health Education Kent, Surrey and Sussex
HMG	Her Majesty's Government
HR&OD	Human Resources and Organisational Development
IAPT	Improved Access to Psychological Therapies
IM	Intramuscular
IMHA	Independent Mental Health Advocacy
IT	Information Technology
IV	Intravenous
KMPT	Kent and Medway NHS and Social Care Partnership Trust
KSS	Kent, Surrey and Sussex
LETB	Local Education Training Board
LMR	Labour Market Review
MDT	Multidisciplinary Team
MH	Mental Health

MHPIG	Mental Health Policy Implementation Guide
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
OT	Occupational Therapist
PALS	Patient Advise and Liaison Services
PCP	Productive Community Programme
QNI	Queen's Nursing Institute
QIPP	Quality, Innovation, Production and Prevention
RCN	Royal College of Nursing
Rx	Prescription
SALT	Speech and Language Therapist
SC	Subcutaneous
SNCT	Safer Nursing Care Tool
SQL	Structured Query Language
SSM	Soft Systems Methodology
TDA	Trust Development Authority
UK	United Kingdom
USA	United States of America
WP&D	Workforce Planning and Development
WPPB	Workforce Planning Programme Board
YOT	Youth Offending Team

Executive Summary

Introduction

This study addresses the concerns expressed by NHS managers and commissioners in England that current measures of measuring workload and output in the community context are not robust enough to capture the complexity of care differences in rural and urban populations. Most existing workload activity tools are demand or supply driven, designed for hospital settings, and not transferable to the community context and only capture linear diary data such as time and motion. New ICT based models need to be developed to provide standardised means of determining which patients are 'complex,' in order to plan their consequent care pathways. Tools should capture both quantitative and qualitative data related to unseen care .e.g. writing reports, travel time, discussion of care referrals. Currently many district and community nursing teams have heavy caseloads, poor/inappropriate referrals, and an inability to state when capacity has been reached. The fact that a quarter of teams do refuse referrals is also a cause for concern (QNI 2014b). Even if this only happens occasionally, the implication is that a large number of patients (on a national scale) are not receiving the right care from the right nurse with the right skills in their own homes. Further evidence published this month by the RCN indicates that there is a large void developing in the existing district and community nursing workforce thanks to abolition of training programmes over the past decade, greater numbers of nurses retiring, downgrading of professional bandings and nurses leaving through stress and burnout due to unrealistic caseloads. There is therefore an urgent need to provide robust workforce planning and development tools and frameworks to support a systematic approach to developing the current and future workforce that is not bas

Project objectives

Building on a pilot study funded by Kent and Medway NHSE in 2013 the objectives of the second phase of the project were to:

1. Adapt the Cassandra Matrix workload activity tool specifically for the community nursing context with front line practitioners involved in Phase 1 and move from a paper based version to a web based platform.
2. Pilot the Cassandra workload activity tool across 6 community health care organisations across Kent, Surrey and Sussex with district nurses, general and specialist community nurses (bands 5-7).
3. Undertake a utility evaluation of the tool with participating organisations to provide proof of concept.
4. Aggregate the data sets to identify patterns that might impact on caseload management including identification of care left undone.
5. Work specifically with practitioners in Kent and Medway NHS and Social Care Partnership Trust (KMPT), to develop the conceptual framework for a new workload analysis tool for the capture of workload activity in the community context across integrated Mental Health teams.
6. Undertake further development of the Shared Purpose Framework through broader regional consultation developing levels of application within the framework for registered to expert practitioners so that the knowledge, skills, competencies and leadership

behaviours required to deliver person centred compassionate, safe and effective evidence informed care are articulated further.

This report is divided into 4 main sections:

- Section 1: Cassandra Project Pilot
- Section 2: Development of a Mental Health Workload Activity Tool – The Sophia Project
- Section 3: Development of the Shared Purpose Career Competence Framework for District and Community Nurses
- Section 4: Recommendations, Conclusions and Next Steps

Literature Review

Since the publication of the 2013 pilot study there have been a number of reports calling for effective and innovative workforce planning and development to embrace the vision of the Five Year Forwards Review to support transformation of services from hospital to community care close to or in the home. Despite the shift from hospital to community care, the RCN Frontline First : The Fragile Frontline report issued this month (2015) indicates that in the past decade there has been a dramatic fall in District Nursing (DN) numbers in England from 13,000 to 7,500, 45 per cent of whom are over the age of 45 and approaching retirement age. At the same time there has been a massive growth in the population with people living longer with more complex multiple health conditions (RCN 2015, QNI 2014b). The size and skill mix of community staffing levels have been determined historically based on custom around patient caseload, and the Queens Nursing Institute (QNI 2014b) report poor understanding of district and community nursing (DCN) roles. There is a lack of national consensus around definitions used to describe DCN activities, starting with the service (what is being done, how frequently it involves contact with clients) and the population served (and its density), further compounded by variation in how ‘caseloads’ are defined. Caseloads include a large number of older people, with complex multi-morbidities, polypharmacy and a myriad of psychosocial needs-higher levels of dependency require increasing levels of nursing time. The workload of the DCN service is inconsistently distributed, some teams are overworked and others underworked. This means that it is not possible to respond to variations in workload by redistributing nursing time to where it is most needed, increasing the risk of delivering a poor quality inefficient service. The QNI, RCN and NHS England call for a strategic approach to developing computer based national capacity and demand tools to measure and reflect the complexity of community nursing workload and output, maximising the potential of the existing workforce to enable planned growth.

Methodology

This study takes a critical realist approach to mixed methods research, triangulating quantitative and qualitative data collection strategies in order to understand the real world of practice and the multidimensional complexity of district and community nursing in different locality populations across England. It is an appropriate approach to understand real world challenges associated with care delivery because it recognises the role of both agency and structural factors in influencing human behaviour. The realist approach combines three social science principles: causal explanations are achievable; social reality is mainly an interpretative reality of social actors; and social actors evaluate their social reality (Delanty 1997). The theory of emancipatory Practice Development (ePD) remains integral to the

research design because the intent of ePD is to increase effectiveness in patient-centered care through enabling healthcare teams to transform the culture and context of care (Garbett and McCormack, 2002). The strategies used are aimed at promoting the empowerment of nursing staff, utilizing staff knowledge and expertise to identify the need for change, encouraging reflection on and in practice, and supporting staff to challenge themselves and each other. Our 2 phases of pilot work to date has demonstrated that using the Cassandra Tool to capture workload activity data has raised practitioner awareness of the spread of their workload and the contribution they make to delivering high quality person centered safe and effective care for clients. It has also empowered practitioners to raise concerns about safe staffing with managers as well as enabling them to focus on personal development planning and career development.

Methods

Multiple methods of data collection included:

- Administering the Cassandra Matrix ®workload activity tool in 6 community nursing organisations in Kent Surrey and Sussex over a four month period with a sample of band 5-8 district and community nurses integrated with a pre- and post-test utility evaluation online survey tool.
- Development of a Mental Health Workload Conceptual model called Sophia with Kent and Medway Partnership Trust.
- Further development of the Shared Purpose framework (Phase 1 output) into a Community Nursing Career Competence Framework.

Findings and Conclusions

- The findings demonstrates evidence that the Cassandra tool, whilst it does not allow for generalisations or inferences to be made about the pattern of work undertaken by community practitioners in the region, it does demonstrate proof of concept that the community nursing workload activity tool provides a robust mechanism for collecting complex multidimensional workload activity data that represents an accurate picture of what care is being delivered, to whom, in a range of settings for different bands of practitioners.
- The Sophia tool development workshops have enabled a partnership approach to developing a conceptual model of community mental health nursing and indicate that there is a high demand for community mental health services which is stretching practitioner caseloads and leading to a proportion of care left undone.
- There is considerable interest nationally at present in the development of a career competence framework for a range of health professionals working in primary care but in particular for district nurses, community and practice nurses. Completing the development of a career competence framework draft tool opens up real opportunities to test and adapt the tool regionally with community and district nurses which would offer greater clarity of role types, knowledge skills and competence of the regional workforce and we would advocate a pilot.

The development of modular tools to demonstrate connected processes and a triangulated approach based on professional judgement and peer benchmarking would enable

comparisons to be made which would engage staff to see the benefits of using such tools. Any tools selected for this purpose should be able to demonstrate a sound evidence based, and reliability and validity. We have found that enabling practitioners to capture their workload activity raises awareness of their role and contribution to patient care in the community and primary care setting and our feedback from users indicates the potential to use this opportunity to develop the leadership skills of the community workforce through the Career Competence Framework and associated training and professional development opportunities using the workplace as the focal point of learning to enhance inquiry, innovation and improvement skills.

Recommendations

The project identifies a series of key recommendations for stakeholders at regional level.

For Clinical Commissioning Groups:

- Encourage CCGs to consider supporting adoption and spread of Cassandra to provide big data that shows complexity of community nursing and broader care challenges for workforce planning in KSS so that the future workforce is fit for future purpose (Section 1. 3.1.4 Limitations of the project & Section 1. 5. Discussion). This kind of systematic workforce data would help CCGs to develop contracts around areas that require more investment e.g. continence assessment, falls prevention, advanced care planning for end of life etc. (Section 1).
- Encourage CCGs to consider commissioning and supporting rotational posts across community and acute settings to develop seamless integrated care along the patient pathway (Section 1).
- Participants felt strongly that CCGs should be encouraged to help organisations across the region to use Cassandra to look at staffing levels and skill mix. It could be used to look at the contribution of specialist nursing services in the community as well as community and district nurses (Section 1 & 3).

For HEKSS:

- Practitioners and leaders of community services felt strongly that Cassandra and modelling should be mandated as a key component of quality and safety in Kent, Surrey and Sussex (Section 1).
- Invest in adoption and spread of Cassandra to enable the project team to collect big data associated with workload activity (Section 1).
- Consider funding the pilot of the Sophia mental health workload activity tool for community services from the 2015-2016 budget in KMPT for a period of one year (Section 2).
- Support pilot and evaluation of the career competence framework in Kent, Surrey and Sussex (Section 3).
- Invest in commissioning whole systems leadership programmes that prepare community and district nurses for their future roles (Section 3).
- Arrange a KSS event to look at the innovations currently taking place in primary care to promote sharing of best practice in relation to workforce planning and development (Section 1 & 3).

For Local HEIs:

- Support the development and evaluation of robust workforce development tools that provide systematic evidence for future community services and the workforce fit for purpose to deliver the Five Year Forwards view (Section 1).
- Support the development of innovative curriculum to create future strategic transformational leaders in community and primary care to meet the shortfall in district and community nursing posts through retirement of an ageing workforce (Section 1 & 3).
- Diversify career choice options for undergraduate prequalifying students to fast track into new community and district nursing roles (Section 1).

1. Introduction

This study addresses the need for validated tools to measure nursing activity and workload in a community context. Most existing tools are demand or supply driven, designed for hospital settings, and not transferable to the community context. This research is needed now because NHS Managers and Commissioners in England have identified that current measures of measuring workload and output in the community context are not robust enough to capture the complexity of care differences in rural and urban populations, and NHS England has called for new ICT based models to be developed to provide standardised means of determining which patients are 'complex,' in order to plan their consequent care pathways. Tools should capture both quantitative and qualitative data related to unseen care .e.g. writing reports, travel time, discussion of care referrals. Currently many teams have heavy caseloads, poor/inappropriate referrals, and an inability to state when capacity has been reached. The fact that a quarter of teams do refuse referrals is also a cause for concern (QNI 2014b). Even if this only happens occasionally, the implication is that a large number of patients (on a national scale) are not receiving the right care from the right nurse with the right skills in their own homes.

The report presents 3 interrelated project outcomes and key deliverables:

- (i) A pilot and utility evaluation of the Cassandra Matrix® workload activity tool (Leary 2011) which has been adapted with community nurses and tested in community organisations in Kent, Surrey and Sussex. Cassandra offers an opportunity to capture the multidimensional complexity of community nursing care and a potential mechanism for modelling optimum caseloads to underpin decisions about safe staffing levels for future workforce planning and development;
- (ii) A new workload activity model to capture the complexity of workload in the community context for mental health professionals – the Sophia tool and,
- (ii) A career competence framework for community and district nurses band 5-8 for future piloting at regional and national level.

This project builds on the work completed in 2013 commissioned by NHS England Kent and Medway Local Area Team to find a workload activity tool suitable for capturing the complexity of community nursing workload to provide evidence that may be useful as a future workforce development and planning tool to determine skill mix in redesigning community health services (Figure 1). The original project report can be found at: <http://www.canterbury.ac.uk/health-and-wellbeing/england-centre-for-practice-development/recent-publications-and-reports.aspx>.

The original research questions were:

1. How do we solve the current workforce in community nursing creatively to promote sustainable transformational change?
2. What does the community nursing workforce of the future look like?

The first phase of the research was published this month in a peer reviewed national journal and has been presented at the QNI Digital Technology event in London in February 2015 (Jackson et al 2015 (Appendix 1).

1.1 Project Aims and Objectives

The second phase of the research commissioned by HEKSS between April 2014 and March 2015 aimed to:

7. Adapt the Cassandra Matrix workload activity tool specifically for the community nursing context with front line practitioners involved in Phase 1 and move from a paper based version to a web based platform.
8. Pilot the Cassandra workload activity tool across 6 community health care organisations across Kent, Surrey and Sussex with district nurses, general and specialist community nurses (bands 5-7).
9. Undertake a utility evaluation of the tool with participating organisations to provide proof of concept.
10. Aggregate the data sets to identify patterns that might impact on caseload management including identification of care left undone.
11. Work specifically with practitioners in Kent and Medway NHS and Social Care Partnership Trust (KMPT), to develop the conceptual framework for a new workload analysis tool for the capture of workload activity in the community context across integrated Mental Health teams.
12. Undertake further development of the Shared Purpose Framework through broader regional consultation developing levels of application within the framework for registered to expert practitioners so that the knowledge, skills, competencies and leadership behaviours required to deliver person centred compassionate, safe and effective evidence informed care are articulated further.

Although request for additional funding to cover the cost of the development of the Mental Health activity tool was made to HEKSS no additional funding was provided. The report therefore provides value added to the Programme Board for consideration of funding future testing of a new workload activity tool for integrated Mental Health community services in the funding year 2015-2016.

This report is divided into 4 main sections:

- Section 1: Cassandra Project Pilot
- Section 2: Development of a Mental Health Workload Activity Tool – The Sophia Project
- Section 3: Development of the Shared Purpose Career Competence Framework for District and Community Nurses
- Section 4: Recommendations, Conclusions and Next Steps

Figure 1: Shared Purpose Framework for Delivering a First Class Community Nursing Service across Kent and Medway

Enablers	Attributes	Consequences
<p>Individual</p> <ul style="list-style-type: none"> ➤ Motivated, courageous, committed staff ➤ Values compassionate person centred, safe and effective care, life-long learning and development ➤ Role clarity <p>Organisational Culture and Leadership</p> <ul style="list-style-type: none"> ➤ Commitment to enabling leadership development, collaborative working and public/community engagement ➤ Positive organisational culture that embraces shared values, creativity and innovation ➤ A clear vision and organisational objectives <p>Workforce</p> <ul style="list-style-type: none"> ➤ Appropriate skill mix and staffing levels linked to investment in workforce planning and development¹ ➤ Outcome competence framework for community nursing ➤ Dashboard and tools to demonstrate community nursing contribution and effectiveness ➤ Commissioning and funding of services, workforce and education ➤ Learning and development strategy with integrated peer review, supervision and appraisal systems <p>Organisational Systems</p> <ul style="list-style-type: none"> ➤ Comprehensive range of integrated care pathways that enables a person centred and evidence informed approach ➤ Systems for effective interdisciplinary communication, decision making information sharing and governance ➤ Systems for monitoring, benchmarking and evaluating patient experience, quality, safety, clinical outcomes, and public health ➤ Unified Telehealth and IT infrastructure 	<p>Person Centred Compassionate Care (PCCC)</p> <ol style="list-style-type: none"> i. Developing person centred compassionate, caring relationships and partnerships that build trust between service users and stakeholders ii. Implementing a personal plan of care delivered close to home and evaluating this against agreed objectives iii. Evaluating and acting on patient experience and monitoring outcomes <p>Safe and Effective Care</p> <ol style="list-style-type: none"> 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 ii. Interdisciplinary working and effective evidence informed decision making to provide integrated care and services across patient pathways <p>Establishing an effective workplace culture</p> <ol style="list-style-type: none"> i. Enabling leadership and values based decision making ii. Participating in reflective inquiry, collaborative learning, supervision and peer review iii. Interdisciplinary engagement in innovation and service development with service users 	<p>Service Users</p> <ul style="list-style-type: none"> ➤ Positive patient, family, carer experience ➤ Positive outcomes and quality of life reflecting personal objectives ➤ Maintenance of choice in relation to self-management, independence and recovery ➤ Preferred place of care or death achieved <p>Staff-Individual/Team Effectiveness</p> <ul style="list-style-type: none"> ➤ Increased staff satisfaction, recruitment and retention ➤ Opportunities for career and leadership development ➤ Demonstrating the contribution of community nursing to person centred safe and effective care <p>Organisation</p> <ul style="list-style-type: none"> ➤ Appropriate escalation and referrals to services and other agencies ➤ Admission avoidance ➤ Reduced length of stay and appropriate discharge ➤ Reduction in numbers of people requiring residential care ➤ Reduced harm (harm free care) ➤ Achievement of regulator standards and organisational objectives ➤ Achievement of public health outcomes ➤ Redistribution and more effective use of resources ➤ Stakeholder partnerships evaluated positively ➤ Recognised as providing a first class service

¹ Including administrative support for front line staff

Section 1: The Cassandra Project - Making the Complexity of Community Nursing Visible

2. Literature Review

Since the publication of the 2013 pilot study there have been a number of reports calling for effective and innovative workforce planning and development to embrace the vision of the Five Year Forwards Review to support transformation of services from hospital to community care close to or in the home.

The categories of literature and information found are detailed below in Table 2.

Table 2: Literature Review Search Results

Category	Number
Reports	9
Trust Reports	7
Peer reviewed journal articles	32

Despite the shift from hospital to community care, the RCN Frontline First: The Fragile Frontline report issued this month (2015) indicates that in the past decade there has been a dramatic fall in District Nursing (DN) numbers in England from 13,000 to 7,500, 45 per cent of whom are over the age of 45 and approaching retirement age. At the same time there has been a massive growth in the population with people living longer with more complex multiple health conditions (RCN 2015; QNI 2014b). The size and skill mix of community staffing levels have been determined historically based on custom around patient caseload, and the Queens Nursing Institute (QNI 2014b) report poor understanding of district and community nursing (DCN) roles. There is a lack of national consensus around definitions used to describe DCN activities, starting with the service (what is being done, how frequently it involves contact with clients) and the population served (and its density), further compounded by variation in how 'caseloads' are defined. Caseloads include a large number of older people with complex multi-morbidities, polypharmacy and a myriad of psychosocial needs-higher levels of dependency require increasing levels of nursing time. The workload of the DCN service is inconsistently distributed, some teams are overworked and others underworked. This means that it is not possible to respond to variations in workload by redistributing nursing time to where it is most needed, increasing the risk of delivering a poor quality inefficient service. The QNI, RCN and NHS England call for a strategic approach to developing computer based national capacity and demand tools to measure and reflect the complexity of community nursing workload and output, maximising the potential of the existing workforce to enable planned growth.

This work is now vital to ensure that there are enough nurses with the right skills in the right places at the right time in order to deliver high quality person-centred safe care for people close to or in their own home. Since the Francis Inquiry, significant progress has been made in acute hospitals in relation to staffing levels, with numbers increasing rapidly from 2013. However, from May 2010 to December 2014 the general community nursing workforce was down by over 3,300 nurses; 2,000 of whom are district nurses providing specialist care for elderly patients with complex multiple health conditions, a 28 per cent decrease to an integral part of the community workforce across England (figure 2). This means that an already over-stretched workforce is being forced to carry out even more work, with serious implications for patient care and staff welfare.

Figure 2: The number of FTE community workforce and acute workforce from May 2010 to December 2014



Source: (HSCIC, 2014)

Note: Total community workforce includes community services, community learning disabilities, community psychiatry and school nursing. Total acute workforce includes acute, elderly and general, paediatric nursing, maternity services, other psychiatry, other learning disabilities and neonatal nursing.

This issue is further compounded by cuts to the number of more experienced, and expensive, senior nursing posts disproportionately as compared to other bands; with a reduction of 1,545 band 7 and 1,317 band 8 nurses. Although numbers have increased slightly the NHS has 2,800 fewer senior nurses than it did in April 2010. This loss of knowledge and experience is a cause for concern because we need nurse leaders to champion the nursing contribution and to help shape new integrated community models of care. There are also concerns about regional variations in workforce numbers. For example in the East of England a BBC investigation reported a loss of more than 903 full time community nurses since 2010, more than twice the national average rate. The figures indicate the biggest drop has been among specialist district nurses who deal with more complex cases and prescribe medication. Since 2010 the numbers have fallen by 66% from

751 to 255 in this region alone. The fall in staffing levels has led to bigger and more complex caseloads with some community nurses visiting 25 patients during a shift.

High quality integrated community care helps people live independently in the community, raise quality of life and improve service effectiveness (NHS 2014). However, England is too diverse for a 'one size fits all' care model to apply across all community settings. The complexity of care increases as the population ages and managing long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget and time to manage. At the same time many people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

Community nursing services are diverse varying from region to region depending on the geographical location and population mix. A defining principle in contrast to hospital nursing is that community nurses supplement the self-care of the person. Care may be delivered in people's homes, health centres, clinics, care homes or hospital settings for example ranging from short term health promotion (post-surgery advice) to managing long term multiple conditions and support of the dying. Nurses are employed by NHS hospital trusts, mental health trusts, for profit and not for profit community social enterprises (Drennan 2014) and services are organized into teams with a mix of registered nurses and health care assistants, led by an experienced senior nurse, who may have a specialist practitioner qualification (QNI 2014b; RCN 2013; Drennan 2014). Teams may have a patient 'caseload' derived from a geographical location or from one or more general practitioners patient lists. There is a great deal of local variation in the commissioning of these services in terms of hours of provision, the boundary lines between these services and that offered by practice nurses employed within the general practice and the provision of other specialist services such as hospice at home teams (QNI 2014b, RCN 2013, Drennan 2014). Further variation is caused by factors such as providing services to rural and remote communities and levels of investment in mobile working solutions. We therefore need a flexible and balanced approach to workforce planning and commissioning of services that meets the changing needs of patients as well as their personal preferences.

Appropriate team size and mix are essential to these outcomes (Bosma & Higgins 2002, Department of Health (DoH) 2002; Hodder 1995; Richards et al. 2000; Hyde 2001). It is vitally important to have accurate data that can underpin decisions around commissioning skill mix and services so that the duration of each individual care episode provides the highest quality of interaction for both the practitioner and the client at home. In some parts of the country community nurses report spending 15 minutes per visit with a client and in others, 20 minutes. It is not difficult to determine anecdotally the potential impact on the quality of care and what care may be left undone or missed due to lack of time. If the level and mix of staffing is not well matched to what is needed, it is not just the volume of care that is affected, but the quality of each and every nursing action or interaction could be impacted by excessive workloads, the net effect being increased stress, sickness and low staff morale, as well as a higher rates of staff leaving the profession (QNI 2014b; RCN 2010). The RCN (2015) calls for NHS leaders to implement workforce planning that matches the needs of patients and an end to boom and bust workforce planning in order to grow the nursing workforce, and ensure it can keep up with demand with a sustainable and long-term plan.

However, flawed workforce planning methods and overwhelming data are barriers to workforce development and have led to inefficient and ineffective policy and practice, which in turn may lead to inappropriately staffed care delivery teams and sub-optimal expensive care delivery models (Hurst and Patterson 2014). A lack of consistent systematic approaches to patient allocation locally and nationally, negates potential for comparison across the service in terms of practice, impact, efficiency and effectiveness (Thomas et al, 2006). Many workload activity tools are paper based, with wide variation in staff engagement and in the quality and consistency of data inputted (Kane 2008). Current methods based on i. Professional judgement, ii. Population and health needs, iii. Caseload, iv Dependency acuity, portray services in terms of supply and demand, representing nursing as a linear series of tasks that are deterministic in nature (Hurst and Kirby 2014; Jackson et al 2014; Leary 2011). These assumptions have led to nursing work being simplified and captured as activity analysis e.g. (i) time and motion studies (ii) work on averages e.g. Safer Nursing Care work (iii) diary based making assumptions about what people are doing e.g. Case Allocate. Such methods do not capture complex work well (De Leon 1993; Raiborn 2004). Measuring workload based on counting patient contacts alone does not clearly demonstrate the full workload of nurses (QNI 2014b) – the bulk of work is “unseen”. New computerised solutions do not yet offer the ability to capture data about the amount of care left undone.

2.1 Key Policy Reports

The key national reports informing this review, in Table 3 below, are summarised to outline the main messages coming from them, moving from 2013 to the most recent in 2015.

Table 3: Summary of Key Reports

Reports 2013-2015 in chronological order	Report key points
<p>The Royal College of Nursing (RCN)</p> <p><i>Safe staffing levels – a national imperative (The UK nursing labour market review (LMR)) (2013)</i></p>	<ul style="list-style-type: none"> • This is a national report raising awareness of declining nursing levels and the negative impact on staffing more generally across the UK due to ongoing cost saving initiatives focusing on staffing levels. • The biggest decline and lack of growth in nursing levels is within the community sector due to forecast increases in retirements. • Proposed solutions include re-skilling and re-deploying existing nursing staff, as well as commissioning and recruiting more community nurses.
<p>National Quality Board Publication</p> <p><i>How to ensure the right people, with the right skills, are in the right place at the right time (2013)</i></p>	<ul style="list-style-type: none"> • This is an acute sector focused, calling for greater transparency around staffing levels and recommending expectations in relation to staffing. • The report recommends further work is carried out by key stakeholders (CQC, NICENHS TDA) to develop guidance for roles across the health economy.
<p>Centre for Workforce Intelligence</p> <p><i>Future Nursing Workforce Projections: Starting the Discussion (2013)</i></p>	<ul style="list-style-type: none"> • This national report continues the CfWI work on nursing workforce planning based predictions of future supply and demand requirements, informed by: <ul style="list-style-type: none"> ➤ Planned commissioning and attrition rates ➤ Retirement and net emigration ➤ Rates of activity and productivity ➤ Skill mix ➤ Financial forecasts • There is recognition that simple supply and demand understandings of workforce planning are not useful on their own and that organisational culture, and specifically a culture of compassion in care, is an important element for consideration.

Reports 2013-2015 in chronological order	Report key points
	<ul style="list-style-type: none"> Local analysis reflects familiar knowledge around challenges of meeting demands from ageing populations and increasing nurse retirements.
<p>Health Education England (HEE)</p> <p><i>Framework 15: Health Education England strategic framework 2014-2019 (2014)</i></p>	<ul style="list-style-type: none"> Recognising the workforce as the key drivers and enablers for change and transformation <i>Framework 15</i> identifies the lack of investment on people, due to a lack of ring-fenced budget, as prohibiting shifts towards better and sustainable positive cultures of care.
<p>Queens's Nursing Institute (QNI)</p> <p><i>District Nursing Review - Developing a National District Nursing Workforce Planning Framework (2014a)</i></p>	<ul style="list-style-type: none"> This is a review of district nursing workforce planning tools, identifying that many are developed and used only locally, and that they tend to focus on operational activities. Enthusiasm exists for tools that can inform better decision making and that are more accessible. There is recognition that tools need to be system compatible and flexible enough to be aligned to local contexts. Work continues by QNI to develop a workforce planning tool specifically for district nursing.

Reports 2013-2015 in chronological order	Report key points
<p>Health Education England (HEE)</p> <p>Raising the Bar, Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants (2015)</p>	<ul style="list-style-type: none"> • This report addresses the education and training of nurses and care assistants, suggesting ways in which they can be fit for purpose and sustainable for 10-15 years to come. • It recognises the key challenges for community service demands with rising co-morbidities and long term conditions and an ageing and growing population. • Building on the <i>NHS Five Year Forward View</i> that recommended, in particular for the community sector: <ul style="list-style-type: none"> ➤ Less divide between the acute and community care sectors ➤ Greater investment in primary care, including community nurses ➤ New care delivery models that focus on development of integrated out-of-hospital care by a multi-speciality community provider • The review asks questions around commissioning and funding, suggesting current resources are misdirected, and that inadequate data may be misinforming decisions at the cost of educational attrition rates and opportunities for integrated/co-trained health professionals. • The review calls for sustainable investment in the current and future workforces under eight themes to drive forward change: <ul style="list-style-type: none"> ➤ Theme 1. Enhancing patient voice in Education and training ➤ Theme 2. Valuing care assistants ➤ Theme 3. Widening access ➤ Theme 4. Assuring flexibility in the system ➤ Theme 5. Assuring high quality learning in pre-reg ➤ Theme 6. Assuring sustainable ongoing learning post-registration ➤ Theme 7. Sustainable research and innovation ➤ Theme 8. Assuring high quality funding and commissioning

It is difficult to see the advantage of further developments in workforce planning and development based upon singular health professional specialisms and current data and modelling tools when there are well-evidenced calls for sustainable transformational change that cannot be achieved without acknowledgement of the complex factors involved. A combination of lack of growth in the district and community nursing population over the last decade, and insufficient numbers of nurses having been trained for the future community workforce, have worked alongside an imbalance of demand and supply planning models that have led to negative impacts on the delivery of quality services in the community. These factors are compounded by a lack of workforce planning and ring fenced budgets for service transformation, leaving services chronically underdeveloped. Historical methods of calculating workforce modelling are no longer sustainable, and new tools and methods are needed to provide robust evidence for effective workforce planning.

2.2 Significant NHS Trust Reports

Table 4 outlines reports on community nursing and workforce planning and development from Somerset Partnership NHS Foundation Trust (2013), Kent and Medway NHS and Social Care Partnership Trust (2014), Northamptonshire Healthcare NHS Foundation Trust (2014), NHS Ayrshire and Arran (2013), NHS Greater Glasgow and Clyde (2013), and NHS Lanarkshire (2013). . The breakdown of trust reports overwhelmingly reflect considerable moves within Scotland towards much greater workforce planning capabilities than those that currently exist in England.

Table 4: Breakdown of Trust Reports

Organisation	Strategy & drivers	Profile	Priorities	Tools utilised
<p>Somerset Partnership NHS Foundation Trust – Managing the Nursing Resource – Part 1 – Review of Community Hospital Inpatient Establishment (2013)</p>	<p>Links to Strategic Objectives:</p> <ul style="list-style-type: none"> To remain the provider of choice for community health To continue to improve the quality of care and safety of services and to further improve the experience of patient, carers and families in contact with the service To realise the benefits for patients and staff of the acquisition of Somerset Community Health To value , support and empower all staff and volunteers to do their best through education, training and personal development so as to deliver high services in response to the needs of their patients, carers and families To promote innovation and service redesign based on best practice and working with partner organisations. Maximising efficiency and effective care in response to the financial challenges 	<p>Typical:</p> <ul style="list-style-type: none"> Change in patient dependency and mix Across the 13 community hospitals the difference in skill mix, and establishment numbers, has led to differing levels of care, quality of care, and patient safety outcomes <p>Consideration of factors like effective rostering, management of recruitment, resignations and sickness levels and identification of individuals for succession into more senior posts</p>	<p>Workforce transformation:</p> <ul style="list-style-type: none"> Review existing establishment Calculate minimum staffing levels in light of ‘Guidance for Safer Staffing Levels’ by the RCN and ‘Safer Staffing for Older People’s Wards’ Patient Safety Environment and Site Specific issues Hospital at Night Financial impact 	<ul style="list-style-type: none"> The RCN Safer Staffing Guidance documentation and the Trusts ‘Compassion in Practice’ vision and strategy for nursing and care staff to ensure that quality care and treatment is delivered

Organisation	Strategy & drivers	Profile	Priorities	Tools utilised
<p><i>Kent and Medway NHS and Social Care Partnership Trust – Enhancing Quality through Safer Staffing (2014)</i></p>	<p>Principle Objectives:</p> <ul style="list-style-type: none"> • To become an exemplary employer, enabling staff to reach their full potential • To enhance the quality and safety of the services by maintain or exceeding required standards <p>Risk identified: Patient safety would be compromised due to poor staffing levels</p>	<p>Objectives:</p> <ul style="list-style-type: none"> • Focus on safer staffing in particular with wad based staff. • Consideration of the environment, skills and competencies of the staff, and availability of all staff groups <p>To discuss the following in light of the above:</p> <ul style="list-style-type: none"> • Acute Services and Crisis Home Team • OPMHN & Specialist Service Line; community recovery service line and Forensic service line • Escalation policy • Recruitment and retention 	<p>Recommendations:</p> <ul style="list-style-type: none"> • Board to agree on safer staffing methodology and staffing identified • Note the progress of CRSL • Updates to Community Teams Older Adults, Eating Disorder and Emerald Ward • Agree the completion and outcomes of the Forensic benchmarking <p>Cost implications on the completion of the above work</p>	<ul style="list-style-type: none"> • The working of the Trust Safer Staffing Group • Hurst Tool 'judgement approach' • Caseload Analysis Tool (currently under development) • Professional judgement and dependency model

Organisation	Strategy & drivers	Profile	Priorities	Tools utilised
<p>Northamptonshire Healthcare NHS Foundation Trust – Interim Director of Nursing & Quality report – Delivering and monitoring Safer Staffing (2014)</p>	<p>Purpose</p> <ul style="list-style-type: none"> To fulfil the requirements of the National Quality Framework expectations. NHFT and commissioners are ensuring the delivering and monitoring of safer staffing To ensure that NHFT has sufficient nursing and care staff capacity and capabilities to deliver high quality safe services 	<p>Delivering and Monitoring Safer Staffing</p> <ul style="list-style-type: none"> Accountability and responsibility Evidenced-based decision making Supporting and fostering a professional environment Openness and transparency Planning for the future workforce requirements Clinical workforce strategy The role of the commissioners 	<p>Recommendations</p> <ul style="list-style-type: none"> Clear indication of the model that delivers and monitors safer staffing across NHFT Responsibility of the Trust Board and when they will review the information Indicates the work already commenced for each of the expectations Rolling programme of work informed by the NICE guidelines on evidence tools to support nursing development establishments To roll out e-rostering. 	<ul style="list-style-type: none"> National Quality Framework (2013) – ‘How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability’ Nurse sensitive indicators – allied to acuity and dependency Six Steps methodology to Integrated Workforce Planning The 6 C’s of Nursing
<p>NHS Ayrshire & Arran Workforce Plan 2013/2014 (2013)</p>	<ul style="list-style-type: none"> To move towards proactive workforce planning which will enable comprehensive visioning of the future workforce in terms of size and skill mix, ensuring this is congruent with the service and financial plans of the organisation <p>Four drivers:</p> <ol style="list-style-type: none"> Finance People Service Quality <p>Underpinned by culture and values</p>	<p>Capital profile (Building for Better Care):</p> <ul style="list-style-type: none"> New A&E New assessment unit <p>Non-capital:</p> <p>Predicted population reduction of 1% by 2030 and a further 2% by 2035</p> <p>Typical:</p> <ul style="list-style-type: none"> Aging workforce Aging population Increasing prevalence of complex long-term conditions, co-morbidities, and dementia 	<ol style="list-style-type: none"> Reduce bank/agency staff costs Delivery of high-quality, safe, and effective person-centred care <ul style="list-style-type: none"> To be delivered through the Workforce Planning Programme Board (WPPB) that facilitates both implementation and advancement of: Workforce planning tools and techniques Workforce information and intelligence Working with partners Learning and Development Efficiency and productivity Staff health and wellbeing 	<ul style="list-style-type: none"> NHS Scotland facilitated (through WPPB) implementation of workforce planning tools across Scotland There are 12 tools, covering 95% community, mental health, theatres, emergency departments, neonatal, maternity specialist nurses and children’s services. Each tool has three elements addressing the acuity and patient dependency within the speciality measures and professional judgement. The latter includes skill mix considerations. The workforce tools are valuable in their own right and include local standards, environment staffing, absence, age profile and turnover etc.

Organisation	Strategy & drivers	Profile	Priorities	Tools utilised
<p>NHS Greater Glasgow and Clyde</p> <p>NHS Greater Glasgow and Clyde Workforce Plan 2013/14 (2013)</p>	<ul style="list-style-type: none"> • Culture: Improve the way we work together • Our Leaders: All our managers should also be effective leaders • Patients: We want to deliver a consistent and effective focus on listening to patients, making changes to improve their experience and responding better to vulnerable people • Workforce: Our aim is to develop a workforce which feels positive about being part of the Division • Resources: Targets areas of less efficiency and effectiveness and areas where we can improve quality and reduce cost <p>Underpinning the narrative is the National Quality Strategy which highlights the six dimensions of quality – safe, effective, person centred, timely, efficient and suitable</p>	<ul style="list-style-type: none"> • High levels of deprivation • Life expectancy low • Chronic disease increase expected • Population increase by 2.4% in next 10 years <p>Aging local population</p>	<ul style="list-style-type: none"> • Tackling health inequalities • Reducing emergency admissions • Accessible healthcare provided as locally as possible • Integration between primary and secondary possible • Efficient healthcare making best use of resources • Safe and sustainable healthcare • Affordable healthcare provided within the funding available • Adaptable, achieving change over time <p>Local recruitment</p>	<p>NHS Scotland six steps Methodology: is a workforce model which enables us to take a coherent view of the workforce across all job families and staff groups. The Community Nurse Workload tool is being implemented.</p> <p>The 6 Step Methodology to Integrated Workforce Planning (Skills for Health, 2008) contains workforce planning checklists at each step of the process and sign-posts to other data and information sources that will be of particular help in ensuring that workforce plans are evidence based.</p> <p>The Community Nursing Workload Tool is currently being developed to capture the workload of Community Nurses such as</p> <ul style="list-style-type: none"> • District Nurses • Health Visiting • School Nursing <p>The purpose of this new tool is to inform decision-making on staffing and workforce needs using a workload evidence base</p>

Organisation	Strategy & drivers	Profile	Priorities	Tools utilised
<p>NHS Lanarkshire NHS Lanarkshire Workforce Plan 2013/14 (2013)</p>	<ul style="list-style-type: none"> • To reduce health inequalities and improve health and healthy life expectancy • Integrated health and social care working to support people to live independently at home • Hospital day case treatment to be the norm, avoiding admissions where possible • To improve palliative care and supported end of life services 	<ul style="list-style-type: none"> • Aging workforce • Aging population (66% increase in over 75 years by 2031) • Increasing incidence of dementia • Birth rate 3% higher than rest of Scotland • Life expectancy 1 year less than rest of Scotland • High levels of the 'big killer' diseases of cancer, coronary heart disease and stroke 	<ul style="list-style-type: none"> • Deliver financial stability in a difficult fiscal environment • Re-training and re-deployment of staff in nursing, administrative, and support services roles to support service changes to provide enhanced community care. • Local recruitment • Recruitment, training, retention of flexible and skilled workforce • Education and training • Workforce planning capability 	<ul style="list-style-type: none"> • Development of a 2020 workforce vision • The Six Steps Methodology to Integrated Workforce Planning (Skills for Health, 2008)

There is some differentiation in the local population and workforce population profiles between England and Scotland -some areas in Scotland have greater health inequalities, but do not have aging workforces. Broadly, however, it can be observed that these policies and strategies are looking to achieve very similar objectives and that they have highly comparable priorities. They all look to provide integrated safe and effective care, through a culture of person-centeredness that is attentive to both service user and staff. It must be noted that whilst delivery of such care is the priority there is also a strong need for delivery to be affordable, and so there is tension between an acknowledged future increase in demand for service (CfWI 2013) and the investment required to deliver on that demand, and to deliver whilst also achieving cultural change and transformation. The 6 Step Methodology to Integrated Workforce Planning (Skills for Health 2008), and other explicitly identified tools, have been adopted throughout Scotland through the Workforce Planning Programme Board (WPPB). These tools, and specifically The 6 Step Methodology, provide planners and decision makers with an evidence base that acts as a foundation for informing their judgements and conclusions. NHS Lanarkshire supplements The 6 Step Methodology with a 2020 Workforce Vision (NHS Lanarkshire Workforce Plan 2013/14 2013) that demonstrates commitment to planning and decision making incorporating underpinning values, principles, and strategic priorities.

2.3 Missed Care/Work Left Undone

There is broad agreement within the literature that the work nurses do is complex and that increases in workload demand results in a significant amount of work left undone, with negative consequences for patient outcomes. However, although there is consensus that patient outcomes are being affected research to date has focused on the acute hospital setting only.

Kalisch et al. (2009:1510) define missed care as 'required patient care that is omitted (either in part or in whole) or delayed' in response to 'multiple demands and inadequate resources'. A literature search conducted June 2011– April 2013 identified a number of reasons why nursing care is missed. These included cost containment, nursing staff skill mix as well as rationalisation of employing registered nurses (Unruh 2003). The advent of staff to patient ratios has contributed to a poor relationship between the ideals of quality nursing care and the practical realities of every day clinical practice (Person et al. 2004) suggesting that patient outcomes are adversely affected by low staffing levels (Aiken et al. 2002, Needleman et al. 2002, Duffield et al. 2011). Recent studies also suggest that nursing care adequacy is influenced by the time in which that care is to be delivered, especially the effects of the nurses' work shifts. Current research indicates as nurses' work intensifies, they have less time to care for individual patients. In 2008, Schubert et al. 2008, reported results of a multi-hospital, international project studying the association between implicit rationing of nursing care and patient outcomes. They found that implicit rationing of nursing care was a significant predictor of six negative patient outcomes studied. Kalisch and Williams (2009) found that aspects of nursing care were most likely to be missed when nursing communication is impaired; material resources such as equipment and medications are unavailable or when acuity of patients increases or staffing decreases.

A study by Blackman et al (2015) identify eight variables as having direct predictor effects as to why nursing care is being missed, and includes shift type, nursing resource allocation,

health professional communication, workload intensity, workload predictability, the nurses' satisfaction with their current job and their intention to remain working.

Currently there is only anecdotal evidence that high caseloads in the community setting with heavy clinical and non-clinical administration is leading to episodes of missed care (Jackson et al 2014, Phase 1 report). The Cassandra Matrix workload activity tool has been designed to capture episodes of missed care so that an economic cost analysis may be applied in the future to indicate key areas that require resourcing and workforce planning to underpin new models of care delivery. The Chief Investigator on this project is currently working with the Office of Public Management to scope an appropriate treasury backed economic costing model for this purpose.

2.4 Enablers and Barriers to Workforce Planning

The workforce is both a key enabler and a driver of change in health, and must be integral to all future planning and investment decisions if the opportunities to improve care are to be realised. If we maintain current approaches to investment and training, we will perpetuate current models of care.

Developing a whole systems approach to workforce planning requires recognition of system enablers such as (i) local organisational values, beliefs, and principles that underpin service delivery and organisational culture, as well as (ii) reflecting national contexts around the principles of delivering compassionate, safe, and effective care, and that (iii) also integrate consideration of locally contextualised data around staff profile, skill mix, and supply and demand.

There is consensus, and a better developed understanding, that singular linear approaches and understanding to workforce planning and development are less beneficial; such consensus of opinion has enabled a move towards developing policies and strategies imbued with comprehensive and inclusive appreciations of the complexities of workforce planning.

There is still a lack of published tangible workforce planning tools and models for transforming primary and community services, and those that can enable a whole systems approach are absent or remain undisclosed and hidden within discrete organisations. The exception is in Scotland where a set of 12 workforce planning tools have been mandatorily implemented, resulting in some evidence of good evaluation. NHS Ayrshire and Arran (2013) state of the application of these tools,

'The outputs of adopting this approach has led to an increase in staffing numbers and enriched skill mix within older peoples services with a net result of improved flexibility and responsiveness to increased demand or absence and in turn reducing supplementary staffing costs' NHS Ayrshire and Arran (2013:24).

However, there has only recently been used and further evaluation could be beneficial in determining a broader evidence base of effectiveness.

2.5 Conclusions

Ultimately, due to the lack of research and literature in the area of health workforce planning and development, and in community nursing more generally (Curson et al 2010), there are

real opportunities to lead on research and development, with the possibility of effective tools, models and conceptual frameworks providing exemplars for best practice locally, nationally and internationally. Equally, the challenge is to develop visionary methodologies, methods and tools by designing them to allow for a filtering of context and a responsiveness to wider sociocultural, socioeconomic and socio-political subjectivities (Hurst 2006; Reid et al 2008; Holloway et al 2009; Kelly et al 2009; Curson et al 2010; Masnick and McDonnell 2010; Parsons 2010; Fraher and Jones 2011; Haycock-Stuart and Kean 2011; Leach and Segal 2011; Buchan and Secombe 2012; Chilton 2012; Farmer et al 2012; Tomblin Murphy et al 2012; Centre for Workforce Intelligence 2013).

3. Project Design, Methodology and Methods

This section of the report sets out the rationale for the methodological approach chosen on which to base the project design and selection of methods.

3.1 Methodology

The purpose of this phase of the project was to undertake a formative implementation and process evaluation of the Cassandra Matrix[®] workload activity tool (Leary 2011) for the community nursing context. Formative evaluations strengthen or improve the tool being evaluated -- they help form it by examining the delivery of the tool, the quality of its implementation, and the assessment of the organizational context, personnel, procedures, inputs, processes and outputs. Implementation evaluation monitors the fidelity of the tool delivery, whilst process evaluation investigates the process of delivering the tool, including alternative delivery procedures.

3.1.1 Phase 2 Project Aims and Objectives

The project aimed to:

1. Adapt the Cassandra Matrix[®] workload activity tool specifically for the community nursing context with front line practitioners involved in Phase 1 and move from a paper based version to a web based platform.
2. Pilot the Cassandra workload activity tool across 6 community health care organisations across Kent, Surrey and Sussex with district nurses, general and specialist community nurses (bands 5-7).
3. Undertake a utility evaluation of the tool with participating organisations to provide proof of concept as a model to predict and plan for optimum community nursing caseload activity within a whole system.
4. Aggregate the data sets to identify patterns that might impact on caseload management including identification of care left undone.

3.1.2 Ethical Approval for the Study

Ethical approval was provided by Canterbury Christ Church University Research Ethics and Governance Committee on 3rd March 2014 (Appendix 2). As no vulnerable groups were to be participating in the project no further ethical review was required under the terms of the University procedures. Anonymity for community nurse participants was clarified in a participant information sheet 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 personalised Cassandra Matrix work profile data for their own records and interest and to determine whether they wished to receive a full copy of the report. Individual participant data was not readily identifiable in the organisational analysis provided for each community organisation in the data analysis charts provided. It was made clear to employers of the participant organisations that individual community nurses' Cassandra activity profiles were confidential to the participants to avoid individuals being readily identifiable.

3.1.3 Project Steering Group

The steering group from Phase 1 (Table 1) of the project was expanded to include nursing director members from community organisations across Kent Surrey and Sussex, CCGs, NHS England and HEE. The Terms of Reference for the Project Steering Group are provided in Appendix 3. Terms of Reference were revisited to ensure they were fit for

purpose for the Phase 2 project and a schedule of meetings were established for the duration of the project through face to face and teleconference so that regular dialogue feedback and review was facilitated. Online consultation of documents for review was facilitated through the use of a Huddle virtual conference space which provides opportunity to review, edit and comment upon work in progress. Steering group members were also invited to participate in stakeholder workshops to adapt the tool for the community nursing context.

3.1.4 Limitations of the Project

The project team acknowledge the following limitations:

1. Gaining consistent membership of the project steering group was challenging in the first 5 months of the project as news of the work spread regionally and nationally we found that more people wanted to participate in the steering group so it was difficult to establish continuity of commitment at the start.
2. Winter hospital pressures along with the usually busy period for flu vaccinations had an impact on the organisations that had agreed to participate as self-selected pilot sites. This impacted in terms of sample size by participating organisations. We had aimed for a minimum sample of 50 community and district nurses working between bands 5-7 in each organisation which would have given us a pilot sample of 200 practitioners. In reality we achieved a sample of 80. However the purpose of the research was to demonstrate that the community version of the tool had proof of concept rather than collecting big data sets at this stage and our findings have achieved that (Section 1, number 4).
3. The project timescale was adjusted with permission from HEKSS to accommodate the winter pressures so that the timespan for data collection was lengthened. Despite this strategy and repeated meetings and reminders we did not discover that 2 organisations had not participated at all until the data collection period had closed. The limitation for the project was that these organisations did not achieve the opportunity to collect data that would have been useful to them in their workforce planning. We have however invited them to participate in the next phase of bigger data collection should the project be successful in gaining NIHR funding this summer (Section 4, number 7.8-7.9).
4. One participating organisation experienced IT access issues which seriously impacted on the readiness of staff to participate and was identified as the main factor in the sample size. The research team were made aware of the issues which we were able to resolve with the web support team at MSN who had helped us to design the web platform. However the utility evaluation indicated that the organisation could see the value in adopting the tool as a means of capturing robust evidence to inform workforce planning for the future.

3.2. Research Methods

3.2.1 The Cassandra Matrix ®tool

The Cassandra Matrix ®workload activity tool was originally designed as a paper-based tool to capture what nurses do (interventions), where their actions occur (contexts), who the work is done for (patients or carers), and what nurses do not have time to do (work left undone) (Leary 2011). The tool's robustness is derived from the fact that it is based on 50 million hours of activity analysis. Some 65 000 interventions have been captured to provide detailed

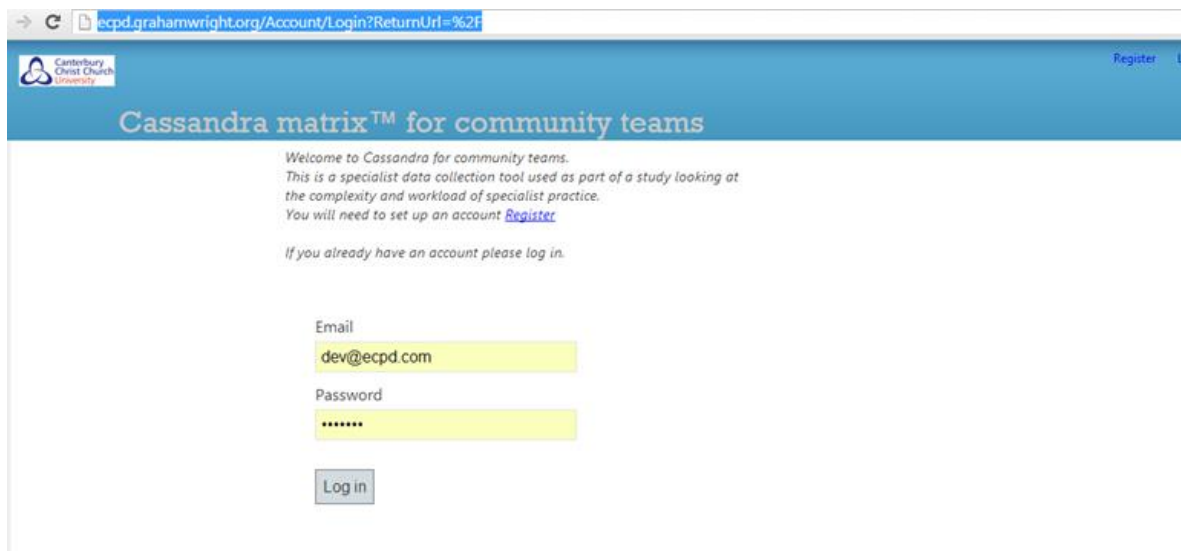
information about specialist nurse contributions in the field of oncology over a 9-year period (Leary et al 2014; Leary et al 2008). We reported on the pilot of the paper based version of the tool in Phase 1 with 3 community health care organisations in Kent and Medway in 2013.

In Phase 2, we worked with community nurses through a series of stakeholder workshops to review the findings and adapt the tool specifically for the community nursing context. An electronic version of the tool was created designed to be used in 'real time' as practitioners carry out their daily work using computers, phones or tablets to input their activity. The interventions are grouped into six main types:

1. Case management
2. Clinical admin
3. Non-clinical admin
4. Physical
5. Psychological
6. Social

Using a web platform the tool (*figure 3*) consisted of a series of easy to use screens that enabled practitioners to enter their workload activity data and a guide to using the tool was developed for all stakeholder organisations (Appendix 4).

Figure 3: Cassandra Web Opening Pages for Registration



Each pilot site (table 5) was asked to nominate a champion who the research team then trained to ensure that good guidance was available in each organisation using the tool to problem solve issues that may have arisen during the pilot.

Table 5: Participating Pilot Sites

	Organisation	Data Evidence
1	First Community Care Surrey	Collected data
2	Kent and Medway Partnership Trust	Collected data
3	Kent Community Health Trust	Collected data
4	Medway Community Healthcare	Collected data
5	East Sussex Health Care NHS Trust (ESHT)	Invited confirmed and then did not collect data
6	Central Surrey Health Services	Invited confirmed and then did not collect data
7	Virgin Care	Invited confirmed and then did not collect data
8	Sussex Community Trust	Declined to participate
9	Sussex Partnership Trust	Declined to participate
10	Surrey and Borders	Declined to participate

3.2.2 Utility Evaluation Survey

A Bristol Online Survey (BOS) (BOS 2015) was launched to provide an opportunity for participants to capture their evaluation in a pre-test/post-test design format using the same strategy as the Phase 1 study. Using the Claims, Concerns and Issues framework derived from fourth-generation evaluation (Lincoln and Guba 1985), the survey asked what positive statements participants would like to make about using the tool, what concerns they had and what questions they would like to be addressed. This information was taken with a simple cognitive mapping tool asking participants to make a judgment regarding how effective they were at measuring what they did both pre- and post-pilot. This enabled comparison before and after the workload activity data collection.

The response rate to the online survey was low despite several reminders being provided to pilot organisations. This was attributed by the pilot organisations to the winter pressures and

resultant nursing workloads which impacted on decisions about what constituted a priority. To improve the opportunity to gain feedback about utility, we provided a series of stakeholder workshops that enabled us to apply the key questions in a face to face context.

4. Findings

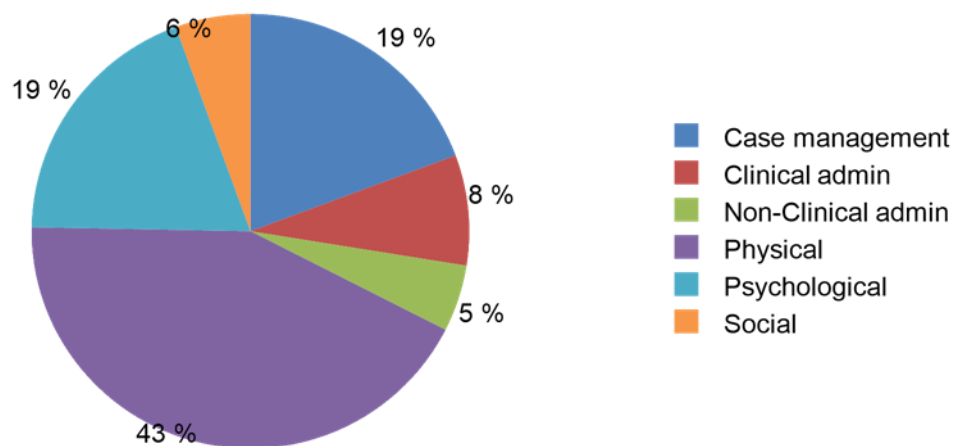
4.1 The Data Results

This summary of the findings demonstrates evidence that the Cassandra tool can show what care is being delivered (intervention), where it is being delivered (context), who it is being delivered to, and what nurses are not finding time to do in their patient contact time. The data presented in the body of the report here represents the cumulative sample of all participating community and district nurses across the pilot sites.

When the data was collected the interventions undertaken were categorised into 6 main areas (Figure 4):

1. Case management
2. Clinical admin
3. Non-clinical admin
4. Physical
5. Psychological
6. Social

Figure 4: Intervention by Type

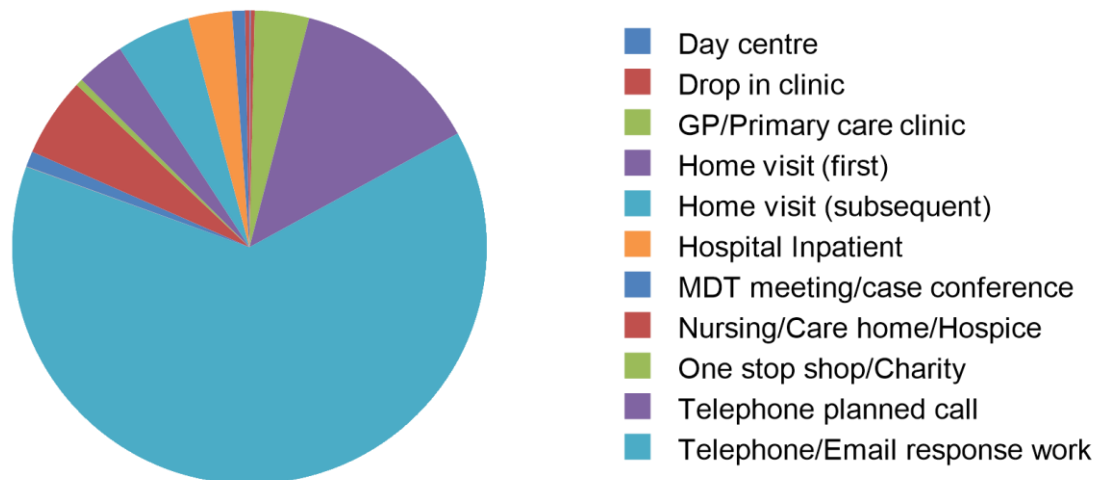


The locations (Figure 5) in which interventions took place ranged across:

1. Day centre,
2. Drop in clinic
3. GP/primary care clinic
4. Home visit (first)
5. Home visit (subsequent)
6. Hospital inpatient
7. MDT meeting/case conference
8. Nursing/care home/hospice
9. One stop shop/Charity
10. Telephone planned call
11. Telephone/email response work

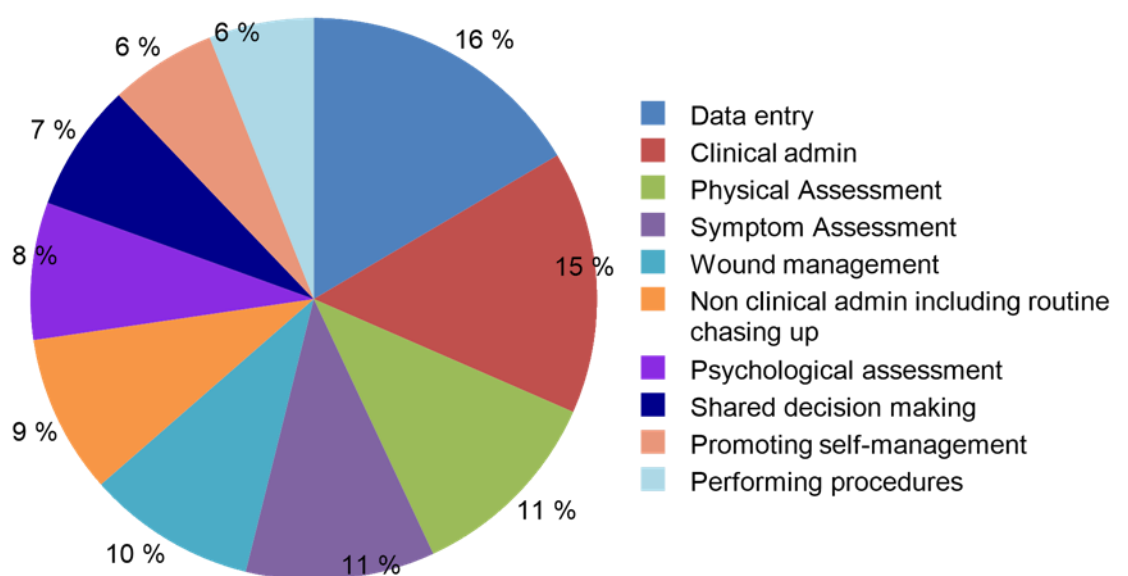
Figure 5: Intervention by Location

(For legibility % have been removed – calculations are derived from data on pp. 96-97)



For the most part care was delivered, which constitutes 76% of the time, in the home, with a remaining 24% of care delivered in a range of other much less often visited locations (Figure 5 above) . A complete breakdown of the specific interventions by category can be viewed in Appendix 5.

Figure 6: Top 10 Interventions Undertaken

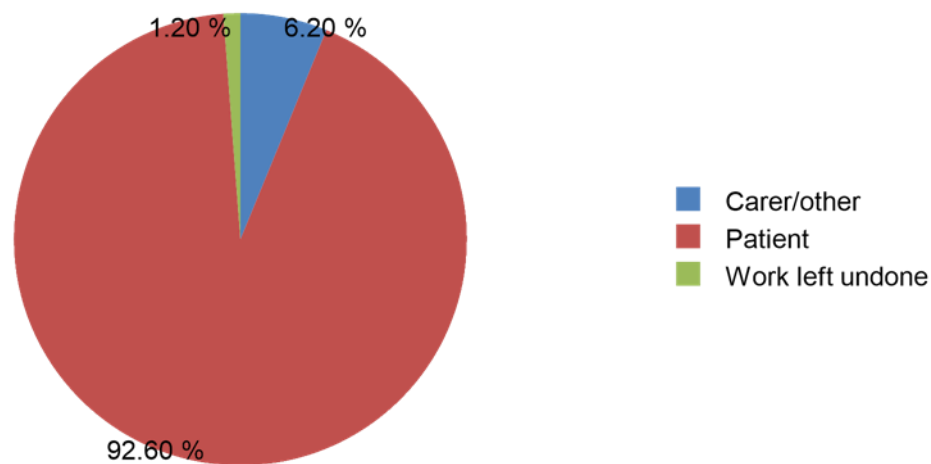


43% of interventions are related to physical health (Figure 6 above), followed by 19% relating to psychological health and an equal amount related to case management. 8% relates to clinical admin and 5 % to non-clinical admin, with 6% of interventions associated with social types of care. Interestingly, the top ten interventions overall across all participating pilot sites shows that there are 4 distinct groupings of activity. Clinical and non-clinical administration and data entry were most frequently performed activities, followed by

physical assessment, symptom assessment and wound management, performing procedures and administering medications. A fourth grouping of the most prevalent workload activity relates to psychological interventions such as psychological assessment, shared decision making and anxiety management. The least recorded interventions were identified as continence management, falls prevention and advanced care planning.

The findings show 11,000 points of data with 7,629 interventions collected in 58 regularly used categories. Overall, interventions are more likely to relate to direct patient care (92.60%) as opposed to a carer (6.2%). Only 1.2% of the data was identified as care left undone or 112 examples as shown in figure 7 below.

Figure 7: Direct/Indirect Care Provided by Person



Work left undone data (Appendix 5) was identified as 1.20% of total work. The data shows, that despite delivery of a high percentage of physical care seen in the combined, patient and carer data, there is physical (37%) and psychological (15%) care left undone that amounts to 52% of the total work left undone. Case management work makes up 29% of the total work left undone. Participants identified that 14% of clinical and 17% of non-clinical administration is left undone (clinical and non-clinical). Most of where the work is left undone is within the home (35%) - which reflects the dominance of most care being delivered in the home - or in drop in clinics (27%) and telephone/email responses not done (21%). 13% of work left undone relates to work in GP/primary care clinics. Interestingly, prescribing/supplying products makes up 10% and continence assessment makes up 7% of the top ten interventions for work left undone.

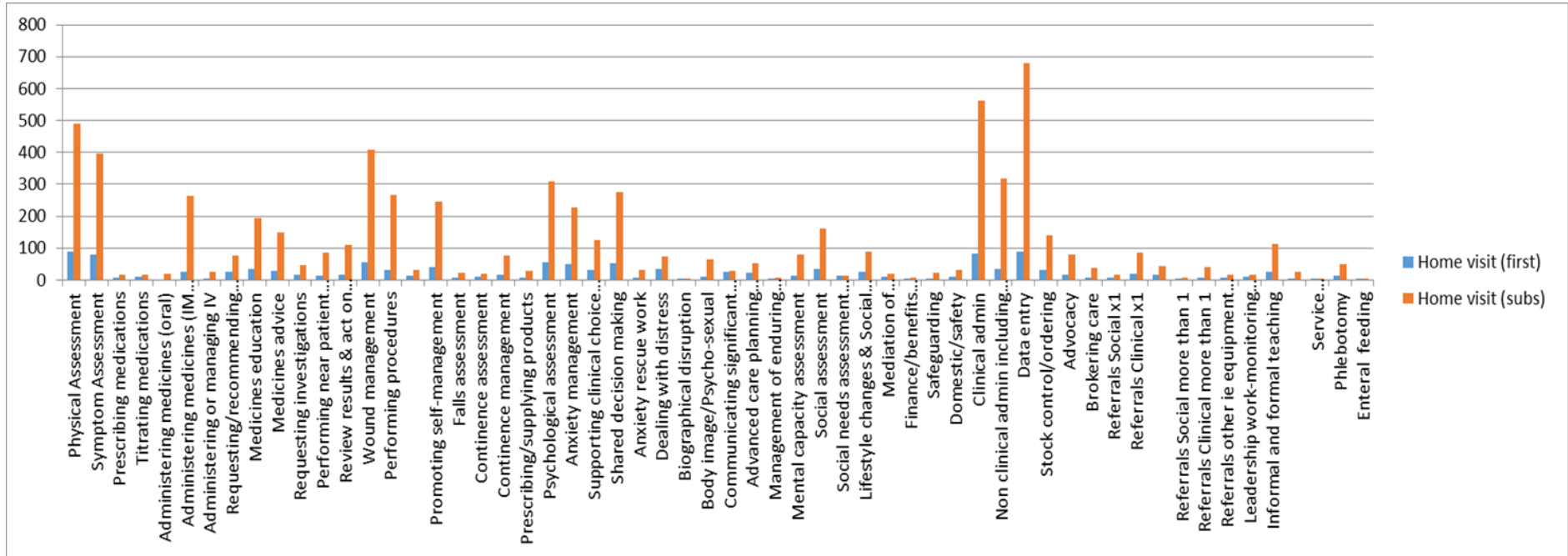
Data on care for patients (Appendix 5) follows a similar pattern to the combined data with physical interventions coming top (44%), followed by psychological interventions (19%) and case management at 19%. The similarity in data also translates across to the locations where care is delivered, which is 80% within the home, and again with the remaining 20% being delivered in other fair less often frequented locations. The top ten interventions for patient care demonstrated in figure 8 below, are reflective of the combined data with data entry and clinical admin more likely to be engaged in than physical and symptom assessment and wound management.

For the data relating to care delivered to carers/others (Appendix 5) there is a difference. Whilst physical care is given, the percentage is lower, at 33%, than for patients, whilst psychological care is higher, at 24% than for patients. Again case management figures significantly at 22%. In terms of where the care is delivered, again there is difference from the data relating to patient care. Most care takes place within the home, at 45%, but a significant amount is done whilst travelling or in a car, at 27%. The remaining 28% of care for carers/others, like for patients, also takes place in a number of other locations, although this is slightly higher in proportion to care for patients taking place in locations other than the home. The top ten interventions delivered to carers/others looks not dissimilar to that for patients and the combined data. Again, administration (clinical and non-clinical) is more likely to be undertaken (31% with data entry at 10%) than psychological assessment (11%) or shared decision making (11%).

This data is not inconsistent with other research into work left undone or missed. In 2012 the RCN established a correlation between lack of time and work left undone. Nurses reported having left work undone, or having done work inadequately, recurrently in key care areas, and in particular those most often associated with co-morbidities and frailty, and the care of older adults. For example, 45% reported compromises in falls prevention care, and 33% similarly for assistance with using the toilet or managing incontinence. Ball et al's (2013) study of English hospitals found that advanced care planning, reported as compromised (not updated or developed) 47% of the time, was amongst the most frequently reported work left undone or missed because of lack of time. Studies on missed care and care left undone have, to date, reflected what happens in acute hospital environments and so no current picture of the extent, and the consequences, of missed care and care left undone in the community sector exists.

We had hoped to collect a bigger data set from the pilot organisations in order to start to mine the data for patterns that would underpin work on optimum caseload modelling. However the data set was not big enough to be able to do this work. The current dataset does not allow for generalisations or inferences to be made about the pattern of work undertaken by community practitioners in the region but it does demonstrate proof of concept that the community nursing workload activity tool provides a robust mechanism for collecting complex multidimensional workload activity data that represents an accurate picture of what care is being delivered, to whom, in a range of settings for different bands of practitioners. With big enough data sets for different bands of community and district nurses it will be possible to capture spread of activity across locality delivery teams within organisations to determine whether the workforce modelling and planning processes accurately meet supply and demand for future service delivery. The tool can be used in rural and urban geographical locations in order to capture different supply and demand needs which will vary across the country and according to population needs.

Figure 8: Spread of Interventions



4.2 Results from the Evaluation of Using Cassandra

Using a Claims Concerns and Issues Framework (Guba and Lincoln 1989) evaluation of Cassandra highlighted the feedback from participants in table 6:

Table 6: Utility Evaluation of the Cassandra Matrix ®workload activity tool

Claims	Concerns	Issues
<p>It is a good tool to use because it provides nurses with the systematic evidence needs to raise awareness of the impact that nurses are having at the front line as well as providing data that evidences skill mix and workforce development issues.</p> <p>We had really enthusiastic motivated nurses who could see how they could use the tool to support their workload planning and how it could contribute to developing the community nursing service, workforce and profession.</p> <p>It helped to raise awareness and the profile of the community nursing profession.</p> <p>It shows what we are actually doing.</p> <p>Staff have been really excited about using the tool and its potential to show their organisations the workload that they currently have.</p> <p>Staff were really motivated to use the tool once they could see how easy it was to use.</p> <p>For staff it acknowledges the complexity of what they are doing and the time spent on case out of hours over and above their contracted hours as well as showing how much work is done in transit in their car- so it validates what they are doing.</p> <p>Organisationally it had the benefit of encouraging people to engage with IT and digital technology and had the added bonus of staff turning on their Galaxy devices.</p> <p>It also highlighted the issues associated with Wi-Fi</p>	<p>In one organisation the system went down which created a lot of stress and anxiety and many nurses who were keen to use the tool then lost interest as they were too busy to accommodate it later in their schedule.</p> <p>In the same organisation the web platform issues and patchy Wi-Fi reduced the number of staff who finally engaged in the pilot.</p> <p>Some data had to be inputted at home for staff within this same organisation.</p> <p>Given the number of episodes of care left undone being reported a participant did question whether staff are being really honest about what they are not getting time to do.</p> <p>Having a champion and cascade of helpers in each organisation would support ongoing use and keep momentum going to use the tool.</p> <p>Future guidance to go with the tool needs to clearly identify what benefits there are the for the individual practitioner and what they are going to get out of it for a quick win and the materials needs to be slicker for busy staff who only have time to read key messages.</p>	<p>Could the tool be further reviewed to look at whether clinical admin can be separated into caseload (overall) and that of individual patient so that the distinction is clearer?</p> <p>Does the tool provide clear enough indication of time taken to complete non clinical admin?</p> <p>Could the tool be used to demonstrate the contribution of health visitors to child and family health in the community?</p> <p>Could the tool be used to demonstrate the contribution of Practice Nurses to the delivery of care in GP practices?</p> <p>Is it possible to provide a filter that shows locality data within an organisation?</p>

Claims	Concerns	Issues
<p>accessibility and Wi-Fi blackspots things like issues with Vodafone and systems which we would not have known about so as a consequence we have been able to identify issues ahead of time and pave the way for the electronic patient record system being implemented shortly.</p> <p>Staff felt really empowered.</p> <p>The evidence produced is compelling and hard to ignore.</p> <p>It is critical that the complexity of our work is evidenced and the tool does that.</p>		

5. Discussion

We can report with confidence that the model is robust and is capable of collecting and collating big data sets that will show the spread and complexity of community nursing activity across different band levels within organisations.

There now exists the national appetite and widespread support from NHS England, the Queen’s Nursing Institute and the Royal College of Nursing to scale the use of a community nursing workload activity model across a number of implementation sites in England in 2015. This will enable activity data to continue to be gathered using a grounded approach until saturation is achieved. Following this, the data will be mined for patterns in order to develop a representative optimum caseload model ready for testing. This has not previously been achieved in the community context.

It is hoped that this will enable a representative ‘whole system’ to be built that injects realism into practice, accurately reflecting the management of complex work instead of trying to measure the component parts in isolation. Developing an understanding of the interrelationships between care interventions, context and multiple users is an iterative process that involves working with large data to look for patterns that will enable the development of a representative model that reflects activity in all its dimensions in order to calculate optimum caseload accurately. By mining data and modelling the relationship that is assumed to exist, it may be possible to build more accurate data capture tools that provide increased insight into the relationship between complex nursing care and patient safety factors (and subsequent cost effectiveness). It is hoped that this will allow predictive modelling in future. Furthermore, the approach will help to identify how much work is planned and how much is unplanned. This is an important aspect to explore in detail since it enables the analysis of reactive versus proactive workforce activity and to balance the supply-and-demand-driven model currently pervading workforce planning. It is also an important factor in estimating the cost of care, or the cost of care left undone.

Section 2: Initial construction of the Sophia model with KMPT NHS Trust

The Complexity of Community Mental Health Practice

Prepared by Professor Alison Leary, Chair Healthcare and Workforce Modelling London
South Bank University

Thanks go to Andrew Dickers of KMPT, staff who took part in the workshops, Carrie Jackson, Anne Martin, Toni Wright, Kim Manley, Anna Humphreys and staff at the England Centre for Practice Development.

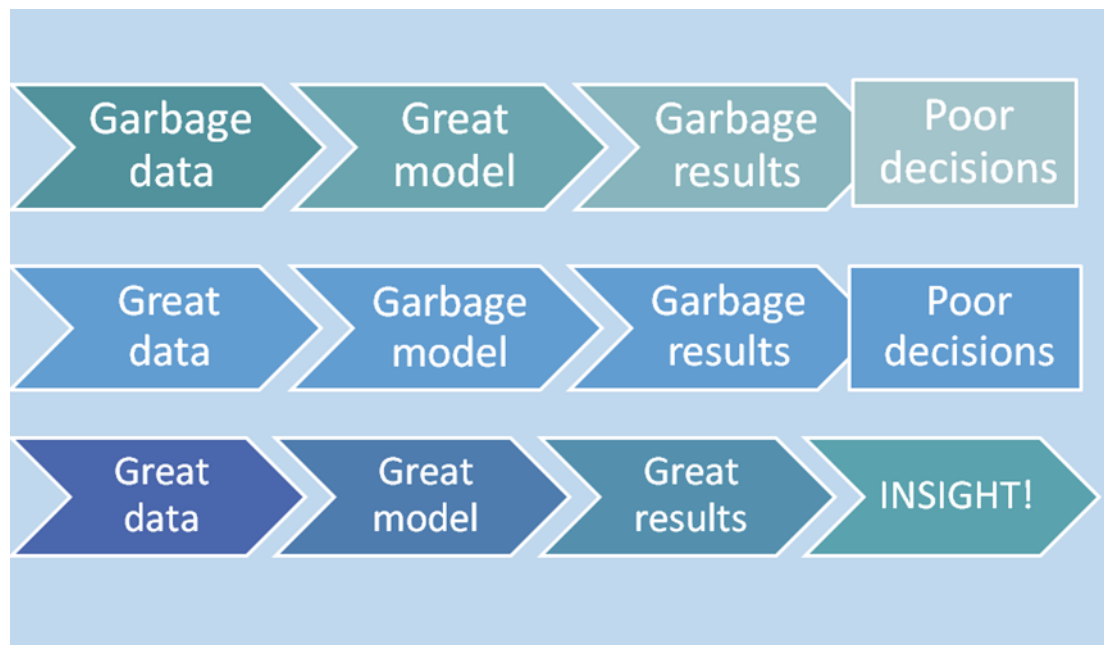
6. Introduction

This project arose from the desire of Mental Health Community Teams working in the Kent and Medway NHS and Social Care Partnership Trust (KMPT) to understand and model the complexity of their work in order to calculate optimum caseloads. KMPT is a large and complex organisation that crosses several geographical boundaries in Kent, Surrey and Sussex. It was an integral member of the Phase 1 community project and was keen to find a mechanism for capturing robust workforce evidence needed to plan future mental health services. KMPT's teams comprise a variety of different practitioners working at different levels in different settings such as older people's mental health, acute services and services for people with learning disabilities.

In 2014, ECPD worked with the Trust over a series of 3 stakeholder workshops to design and develop the conceptual framework for the model, named 'Sophia'. Whilst the Trust is currently using Hurst's AUKUH tool (2005) to capture workforce data to underpin safe staffing decisions for inpatient mental health wards, the Hurst tool does not provide the design infrastructure for the community context.

In order to build a representative model and subsequent stochastic² caseload calculations it is important to understand the "real world" situation. Models that do not reflect the real world or its complexity are likely to fail in terms of explanative model building and subsequent predictive modelling (Witten & Frank 2005). If data capture or modelling is not reflective of the real world there is a risk of a "garbage in garbage out" scenario occurring (Figure 9).

Figure 9: Why it's Important to Understand the Real World before Capturing Data



² 'Stochastic modeling concerns the use of probability to model real-world situations in which uncertainty is present.... Use of a stochastic model reflects only a pragmatic decision on the part of the modeler that such a model represents the best currently available description of the phenomenon under consideration, given the data that is available and the universe of models known to the modeler'. Peter Glynn <http://web.stanford.edu/class/cme308/OldWebsite/notes/ProbReview.pdf> (accessed 14 4 15)

6.1 Background

Community-based mental health and social care refers to any care or support service users receive to help them manage a mental health problem whilst they are living in the community (Mind 2014a). In the UK there has been a move towards greater provision of a range of integrated community-based mental health services since the 1990s, although according to a review held by the Cochrane Library (Malone et al 2009) the effectiveness of this move is questionable. The development of community-based mental health services runs parallel with the historical reduction in hospital beds, often referred to as the period of deinstitutionalisation within mental health (Burns 2007). Community Mental Health Teams (CMHTs) originated in the UK as part of this process and is now 'one of the most common and long-established forms of delivering comprehensive mental health care' (Burns, 2007:325). CMHTs are mainly responsible for the assessment and care of service users with complex mental health problems, who require a greater input than that offered by general practices or general social work services. Referrals to CMHTs are usually from GPs, social services and hospital medical staff (mainly from A&E) (Burns 2007).

Chronic underspending across mental health services have recently hit the headlines, with 67% of CCGs spending less than 10% of their budget on mental health services (Mind 2014b). There is wide reporting and recognition that there has been underinvestment in mental health services and that a rebalancing of funding within the health service is required to address what is a major cause of disability in the UK (Foley 2013), and an increasing demand for services (RCN 2010). The Five Year Forward View (NHS 2014) proposes that any increased investment in mental health services needs to provide for equity across child and adults services by 2020. Advocate groups, such as Mind (2014b), have called for financial parity with non-mental health care provision.

Staffing CMHT's remains a challenge. From a workforce planning point of view the complexity of the work done by CMHTs is not well researched. Whilst, there is no one agreed definition of complexity, complex systems in the natural world consist of units interacting at different levels – sub-systems which are composed of even more intricate subsystems (Fuchs 2013). Nursing was recognised as a complex activity in the 1960's by authors such as Hall (1964) and later by scholars (Ebright et al 2003). The assumption that nursing is linear has no underpinning evidence. Despite this most computer informatics systems appear to consider nursing as a linear activity-a series of tasks that happen sequentially rather than a set of inter-relational activities. Almost none of the commercial data capture systems reflect the inter-relational nature or complexity of mental health nursing work e.g. System One, RiO.

Overall caseload for a CMHT is dependent on catchment area, local morbidity, available resources and traditional health care set up (Burns 2007). The size of the team and caseloads is important to its efficient running, as it has been identified as being difficult to function with small staffing numbers and as such inadequate skill provision (Burns 2007). Tucker et al (2013) outlines CMHTs capacity is to be stretched by an increase in older adults suffering from dementia and the associated strategies that will promote the implementation of care for those service users' and their carers, enabling them to be supported in their homes and other community settings. One way of coping with this increase in service demand is the extension of service provision, as Burns (2007) identified that in recent years CMHTs have tended to extend their operational hours, offering services over longer days

(i.e. 8am-7pm) and some limited services over the weekends. Teams also tend to have common characteristics across older adults and children and adolescent services, with most teams inclined towards more informal less authoritarian internal working relationships that foster role overlap and continuity of care, not only within their own teams but across the acute community settings.

The intended initial purpose of the project was to model the complex work of multiprofessional mental health practitioners with different levels of expertise and experience in the community setting across Kent in order to calculate optimum caseloads. This requires high volumes of detailed and multidimensional activity data.

Currently workforce data related to case management is recorded and collated on a daily basis by staff using RiO Clinical Information System. RiO provides an electronic patient record (EPR) used by the Trust to support Mental Health & Learning Disabilities services. RiO is a linear data collection tool that focuses on time and motion data in order to calculate caseloads. At KMPT practitioners felt that the fidelity of this data capture did not reflect the complexity of care delivered or the real world situation.

In order to model the work of mental health professionals it is important to develop a data ontology, a concept used in computing science, to model and reflect real world situations which are complex and interrelated rather than simple and linear and which then can be linked to the current knowledge base.

Philosophically, ontology is a branch of metaphysics concerned with the nature of existence and classifying interrelationships. Within data knowledge and engineering the word ontology is applied in a slightly different way. Ontology in the context of computer science, knowledge representation and reasoning means;

'a model of a domain of interest described in a logical language.' (Davies 2010, p198)

Ontologies have moved beyond the domains of library science, philosophy, and knowledge representation to realms of data science and knowledge engineering and range from simple taxonomies to more complex structures (McGuinness 2003). The purpose of developing the data ontology is to develop a common framework of knowledge with an agreed common understanding allowing the collection of inter-relational data. A lightweight ontology is more associative and can be useful in the early stage of ontology construction to provide the broad landscape for understanding an entity. This allows the development of a structured framework of knowledge for the purpose of capturing information which can be used and understood by different groups such as users, developers and those who might access or use the data such as decision makers. A data ontology also makes the capture of complex information possible - the risk of many systems in nursing is that data captured does not reflect the complexity of practice or makes false assumptions. Data ontology makes assumptions and knowledge explicit (Corcho et al 2001).

Many informatics systems do not capture the inter-relational nature of complex work within data ontology-they are primarily taxonomies of lists of activities rather than knowledge frameworks. This means that drawing data from informatics systems can underestimate the work done and are not reliable for modelling nursing workload demand

A system which employs a more accurate model of the user's world, one that is realistic, will in general be more meaningful to that user and will be better able to accommodate change (Davies 2010) thus the aim of this project was to build an ontology that would better represent the real world of CMHTs.

6.2 Purpose

The purpose of this project was to collaboratively build with KMPT, a data ontology that conceptualizes the complexity of community mental health nursing, ready to be piloted as a workload activity tool for workforce modelling and optimum caseload calculations.

6.3 Assumptions & activities

As this project was time limited a number of assumptions underpin the work informed by the literature, previous work in specialist communities and checked with project participants. These were:

- The participants are experts in what they do and understand their own "real world" situation
- The work that practitioners do is likely to be complex and not a linear series of tasks
- There is an element of case management at different levels of complexity i.e. from peer support workers to case managing advanced practice nurses. This work is congruent with other long term conditions management
- Caseload does not equal workload

6.4 Methodology and Methods

Soft systems methodology (SSM) (Checkland 1998) is the approach selected to achieve the project's purpose because it is consistent with multiple views, different perspectives and assumptions, different stakeholders and complexity. It sets out to build a model for understanding the real world and ideas for improvement. SSM inquiry has seven stages (Checkland 1998). Some of the stages address the "real" world, and some address a conceptual world.

1. Entering the problem situation
2. Expressing the problem situation
3. Formulating root definitions of relevant systems
4. Building Conceptual Models of Human Activity Systems
5. Comparing the models with the real world
6. Defining changes that are desirable and feasible
7. Taking action to improve the real world situation

For the purpose of this project the focus of activity was on stages 1-4 to develop an iterative model through three workshops with mental health community staff from KMPT. The first two workshops were intended to elicit the reality of "real world" activity from a group of community mental health workers and the third workshop focused on ratifying the emerging dataset and identifying any gaps that required further clarification and detail. The first workshop took place in July 2014, the second in September 2014, the ratification workshop in February 2015 and consisted of practitioners of different grades, service area and roles, which are outlined in Tables 6 and 7 below.

Table 7: KMPT Workshop Participants' Roles and Service Areas

Staff Roles Represented	Services Represented
<ul style="list-style-type: none"> • Administration Managers • Care Coordinators • Directors of Nursing, Governance and Quality • Nurses (Community Psychiatric and Learning Disabilities) • Occupational Therapists • Peer Support Workers • Service Managers • Team Leaders 	<ul style="list-style-type: none"> • Community Recovery Service • Crisis Resolution Home Treatment • Early Intervention Psychosis Service • Learning Disabilities • Liaison Psychiatric Service • Older People's Community Mental Health Service

Table 8: KMPT Workshop Attendees

Workshop Number	Workshop Attendees
1	28
2	15
3	8

We endeavoured to maintain a core group of staff that consistently provided critique and review across the three workshops to promote continuity and member checking the audit trail. The groups were facilitated in a number of activities based on Checkland's approach (1998) using the key domains of the Cassandra Matrix ®tool as a framework to explore the key categories of workload activity. The process was iterative over a number of months, so that as findings emerged they were checked with workshop participants through an online newsletter and survey as well as commentary on working documents, to question real world fidelity. The findings were then used to build a real world taxonomy and lightweight data ontology (Davies 2010) which is the precursor for detailed data collection.

Conceptualized categories were described from the workshop activities undertaken in workshop 1 and 2 to form higher-level abstract knowledge to express the concept of a knowledge domain (Noy and McGuinness 2001) – in this instance mental health nursing in the community. The elements of the domain include concept, attributes, relation, and instance (Yu and Hsu 2011). Ontological construction uses the following methods: relational analysis, clustering, and formal concept analysis. The relational analysis discovers and clusters the relations of keywords (Yu and Hsu 2011). This analysis was therefore intended to enable the development of a lightweight ontology.

Ethical approval was provided by Canterbury Christ Church University Research Ethics and Governance Committee on 3rd March 2014 (Appendix 2). As no vulnerable groups were to be participating in the project no further ethical review was required under the terms of the University procedures.

7. Findings

7.1 The emerging model, example taxonomy and work left undone

Participation in the group work was high and elicited many items from which to build the ontology. In parallel to the project a competition with KMPT colleagues was used as a strategy to identify a name for the conceptual model and this also served to maintain a high degree of engagement with practitioners who had attended the workshops and contributed to the development of the conceptual model. Sophia, Goddess of Wisdom was the selected name for the future workload activity tool.

The findings are presented under three sections:

- The emerging conceptual model and its key components
- Constructing a data ontology using an example for the concept of crisis
- Identifying work left undone

7.2 Emerging conceptual model and key components

The emerging conceptual model encompassed the key components:

- Contexts and brokering networks
- Key domains:
 - Physical domain
 - Social domain
 - Psychological domain
 - Non-clinical administrative domain
 - Clinical administrative work/case management domain

7.2.1 Contexts and brokering networks

Participants easily identified the varied contexts in which they worked and also the brokering networks used to access care. Contexts were clarified and clustered and are shown in Figure 12, and brokering networks in Figure 13. Context is defined for this purpose as the conditions and circumstances that are relevant to community mental health practice. Brokering networks create relationships among groups of people with shared concerns and objectives in order to promote mutual understanding and facilitate the exchange of knowledge across social boundaries as well as developing new capacity to work together to find, create, share, and use relevant knowledge. This is particularly important and challenging at the same time for KMPT given the size and geographical spread of its practitioner population and services.

Figure 10: Contexts in which Practitioners Work

<ul style="list-style-type: none"> • Best interest meetings • Car • Care home • Carer work/home • Church/cultural centre • Community facilities • Community Mental Health Team hubs • Council offices • Court • Day centre • Drug & alcohol services • Duty system • Educational establishment • Emails • Fax • Forensic units 	<ul style="list-style-type: none"> • GP • Home follow up • Home new • Hospital • Learning disability services • MDT meetings • Phone • Police station • Prison • Professional only meetings • Public places • Rehab providers • Social services premises • Street • Text • Triage • Voluntary organisations
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Figure 11: The Brokering Network-Those Accessed to Provide Care for Clients of the Service or Their Families.

This version includes local agencies.

A&E/Emergency care	Family planning	Probation
Admiral nurses	Fire Service/smoke detectors	Rehab
Ambulance service	Forensic team	Rethink
Art Therapist	Funders for care provision	School counsellor
ASD service	Geriatricians	Sensory loss team
Asylum team	GP	Sexual health
CAB	Housing Associations	Shelter
Care managers	IAPT	Social Services
Care/nursing homes	IMHA	Solicitors
Charities i.e. Mind	Intermediate care	Talking therapies
Church/spiritual centres	Interpreter	Vocational advisors
Complementary therapy	Mobile services	Women's refuge
Continence services	Mother infant MH	YOT
Council	Neurologists	Young Healthy Minds
Courts	Ophthalmologist/audiologist	
Cultural centres	Other are CMHT	
District nurse	Other clients	
Driving assessor	Pain management	
Dual sensory unit	PALS	
DWP	Paula Carr Trust	
Eating disorders service	Physiotherapist/OT/SALT	
Families	Police	

7.1.2 Key domains of care

Five domains of care were identified and itemised. The first three domains reflect the interventions provided under the focus of physical, social and psychological domains. The remaining two domains capture non clinical administrative activities those that could be undertaken by an administrative worker and those associated with clinical case management work that need to be undertaken by a clinician. The content of these domains are outlined in the following figures;

- Physical domain (Figure 12)
- Social domain (Figure 13)
- Psychological domain (Figure 14)
- Non-clinical administrative domain (Figure 15)
- Clinical administrative work/case management domain (Figure 16)

Figure 12: The Physical Domain

<ul style="list-style-type: none"> • Administration of medicines • Advocacy • Assessment • BMI • BP • Contraception/starting a family • ECG • Exercise • Falls assessments • Healthy eating • Medication reviews • Medicines self-management 	<ul style="list-style-type: none"> • Meeting information needs of diagnosis • Nutritional assessment • Requesting imaging • requesting/interpreting bloods • Rescue work GP Rx • Rescue work/medicines • Sexual health • Sleep hygiene • Smoking cessation • Waterlow scores • Weight management
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Figure 13: The Social Domain

<ul style="list-style-type: none"> • ADL assessment • Advocacy • Carers assessment • Counselling on driving restrictions • Dealing with police/courts • Employer liaison • Financial paying for medicines • Financial/benefits/work • Funeral planning/will • Housing 	<ul style="list-style-type: none"> • Inclusion activities • Organize food supply • Personal budget management • References • Rescue/financial exploitation • Safeguarding (children) • Safeguarding (vulnerable adults) • Social history & assessment • Social inclusion • Tribunal assessments/reports
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Figure 14: The Psychological Domain

<ul style="list-style-type: none"> • Advanced directives • Advocacy • Anger management • Anxiety management • Art therapy • Assessment • Buddying • Care planning • CBT • Coping strategies • Crisis planning • Dealing with distress • Family therapy • Grief counselling • IMHA • Working with strengths 	<ul style="list-style-type: none"> • Instilling hope • Living in the moment/pacing • Living well with dementia • Medicines concordance • Mindfulness • Personal boundaries • Problem solving • Recovery tools • Relapse prevention • Rescue work/medicines • Risk taking • Screening scores • Solution focussed therapy • Suicide prevention • Trauma management • Ventilate feelings
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Figure 15: The Non-clinical Administration Domain

<p>This is defined as work that could be done by an administrative worker.</p>	
<ul style="list-style-type: none"> • Absence and sickness reports • Booking clinics • Booking rooms/space • Business information • Chasing other • Chasing test results • Chasing up old notes • Diary management • Email • Filing • IT issues • Lone working • Missed appointments/rebooking • Ordering/Supplies • Organising agency cover 	<ul style="list-style-type: none"> • Organising training/eLearning • Parking permits • Place • Request for FOI • Risk registries data entry • Rostering • Routine data entry • Stationary management • Students paperwork • Travel claims/expenses • Typing action plans • Typing incident reports • Typing reports/letters • Typing risk assessments • Updating shared drive

Figure 16: The Clinical Administrative Work/Case Management Domain

This is work that requires a clinician to undertake.

- Action plans
- Audits (clinical)
- Business information
- Clinical forms
- Data entry (clinical)
- Drug funding
- Emails
- Inspections
- Logs
- Referrals
- Students reports etc.
- Writing care plans
- Writing reports
- Writing/dictating letters

7.3 Constructing a data ontology for the concept of crisis

An ontology is a way of capturing knowledge in a framework that draws together key inter-relationships, it enables knowledge to become visible. Ontologies are made up of two main components; classes and relationships. The lists, referred to as taxonomies and identified in figures 13-18, were used as the basis of further exploration by workshop participants so as to identify key relationships in building a data ontology that reflected real world community mental health practice.

Table 9 provides an example of the taxonomy for the concept of “Crisis” Care showing the inter-relational nature and interwoven domains of care, that care is complex and not a series of tasks. Firstly it is important to gain consensus on what the concept means and what tasks /interventions/activities are involved (Step 1). Using the seven pillars of care domains of workload activity identified by KMPT staff it is important to then classify which pillar care domains the activity belongs to (Step 2) and then what actions and interventions are required (Step 3).

Table 9: Case Example of Taxonomy for Concept of Crisis

Step 1:

Case Example of Taxonomy for Concept of Crisis
Crisis: what does it mean?
<ul style="list-style-type: none"> • An unexpected event that requires more resources and specific skills • Any situation that arises, which is not planned: start, peak of crisis, end of crisis • Incident happening related to risk (increased) • Urgent action (safeguarding; statutory work) • Different depending on the service user • Changes dependent on individual worker and how they might perceive a crisis – this can be based on experience
Exactly what do you do?
<ul style="list-style-type: none"> • Try to minimise risk/likelihood of risk: • Urgent visit • Cancel other appointments/arrange cover/reschedule appointments • Arrange OPA/speak to consultant • Assess mental state, emerging risks, environmental factors • Safeguard the person(s) • Crisis plan/provide crisis card/review care plan, medication • Speak to colleagues/seniors/AMHP/CRHT team • Supervision • IR1 (incident report) – SUI reporting (serious untoward incident) • Clearly document crisis • Contact other agencies – police, college, GP etc. • Look at relapse planning • Physical: Rearrange diary, telephone to rearrange, prioritise, discuss with team to help identify most appropriate person to help, select and manage the environment (home visits: is it safe or call police AMHP/first aid)

Step 2:



Psychological:	Social:	Admin:	Care manage:	Physical:	Admin:	Psychological distress:
<p>Reflect and make sense, formulate a plan, formulate a clinical picture to convey to team, emotional support for family, reassure (impact knowledge, honesty, clinical knowledge), supervise and debrief.</p>	<p>Communication with family and carers, reassurance to family, safeguard children, vulnerable people, pets.</p>	<p>Record on RIO (database) in the right place, telephone/fax, rearrange diary, sharing information.</p>	<p>Assessment skills (regarding crisis, need risk, treatable by self or refer on) – Previous history and outcome, look at ways to self-manage, take control, management, plan based on what interventions are needed such as positive risk taking and letting the patient stay in control.</p> <p>Options – Home treatment, admission to hospital (section or informal).</p> <p>Crisis broken into different interventions: Social: Housing, benefits, debt management, relationships,</p>	<p>Self-neglect, poor diet, underweight/overweight, side effects of medication, pregnancy, drug/alcohol use, erratic concordance with medication – GP follow up, hospital admission, drugs and alcohol (do they have an addiction), drugs interactions (could there be reactions with other meds), medication, physical health (e.g. UTI, blood pressure, infections). Check if physical illness could be changing their behaviour (past history, overdoes and could this affect their physicality), Self-harm wounds cleaning and inspection re free</p>	<p>Time management, poor I.T. systems, system bureaucracy, poor environment, documentation (has it been adjusted), phone calls, care plan adjustments, change in clustering, diary changes, referrals (do they need urgent referral).</p>	<p>(carer/staff/client), self-harm, suicidal ideation, impact on relationships, disassociation (recovery plans, support, engagement), serious self-harm (dressings, monitoring to reduce/stop possible infections), domestic issues (safeguarding), client involvement.</p>

			<p>isolation, disengaging, police, schools, university, college, courts, drugs, housing (direct payments, do they live in a safe environment), domestic abuse, injury, family dynamics (relationships), financial (bills, food, concerns), police involvement (have they been arrested), work (struggles, job loss, bullying at work).</p> <p>Clinical/care management: Lack of insight, No Drs within team, difficulty in getting medial reviews with Drs, GP follow up.</p>	<p>from infection, pregnancy (hormones).</p>		
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Step 3:



Action/Interventions

- Urgent appointment
- Medical review
- Other health professionals
- Assess the situation; do you need others (police, ambulance, team, housing, financial)
- Does it need to be escalated (management involvement)
- Do they need a mental health assessment? – diary – prioritise = change things about. Move clients, liaise within team if cover needed
- Reasons for crisis interventions: diagnosed illness, family dynamics, serious incident (violence, death), dynamic factors (drugs, alcohol), medications (too much/not taken), sudden changes (death, breakdown of placement)
- Reasons for crisis in the team: team crisis (not enough staff/work hours to manage/referrals increase)

7.4 Work left undone

In order to model the demand on time it is also necessary to identify the work that is left undone. The range perceived as left undone by workshop participants included all the items listed in Figure 17.

Figure 17: Work that is Left Undone

- | | |
|--|---|
| <ul style="list-style-type: none">• Professional development• Complete tasks/interventions/care to satisfaction• Regular lunch/ breaks• Clinical Supervision• CPA (MDT) holistic• Quality assurance• Respond to emails• Time to reflect• Research• Portfolio (Revalidation)• Mandatory Training Vs (E learning) quiz | <ul style="list-style-type: none">• Professional learning/ development• Support groups for clients• Putting learning into practice (knowledge translation)• Annual leave• Partnership working with other support services• Facilitating others• Emotional support• Caring for self• Valuing others• Mental health days• Admin |
|--|---|

8. Discussion

The workshops have enabled a partnership approach to developing a conceptual model of community mental health nursing within KMPT and indicate that there is a high demand for community mental health services which is stretching practitioner caseloads and leading to a proportion of care left undone. Staff report to be spending a considerable amount of time inputting data to the RiO management system which increases their administration workload and reduces the contact time available to spend with patients.

Given the scale and complexity of the organisation at KMPT, future modelling around the demand for care services needs to be undertaken to explore population needs and related workload demands and the proportion of work being left undone in more depth. There does appear to be a large amount of case management work which the current informatics system RiO does not appear to be capturing. This is because RiO is a linear system that looks at the time it takes to complete an intervention. It does not capture the complexity of care by looking at context, who is involved in the care and what care is being left undone or missed. Developing the data ontology and collecting such data will help to more accurately model the real world situation. This would result in a workload activity tool that can be piloted across the organisation to capture the multidimensional complexity of care and the workload of different bands of staff across locality teams. This data would provide a rich picture of activity across the organisation to provide evidence for robust workforce planning and development of services. The tool would be able to provide evidence of where care is taking place, whether there are gaps in workforce or overlaps in activity and most importantly what care is being missed and needs to be addressed by workforce solutions.

Section 3

Development of the Shared Purpose Career Competence Framework for District and Community Nurses

9. Introduction

In Phase 1 of the project we reported on the development of a shared vision for delivery of community nursing services and a Shared Purpose Framework for Kent and Medway which identified the enablers, attributes and outcomes for delivering “**First class compassionate, safe and effective care closer to home enabling people to make choices, self-manage and maintain control over their quality of life**” (Jackson et al 2015). Purpose is the ultimate ‘why’ of the practice and/or service we provide:

‘Shared purpose results when a group of individuals aligns their belief systems or values with a common challenge, vision or goal’ (Finney 2013:5).

The importance of having a shared purpose has recently been recognised by the NHS in its shared purpose model (NHS 2013). *‘Purpose taps into people’s need for meaningful work; to be part of something bigger than ourselves. It encapsulates people’s cognitive, emotional and spiritual commitment to a cause... purpose becomes shared when we find commonalities between our values, beliefs and aspirations’ (Finney 2013:6).* A shared purpose is therefore a powerful strategy for unifying diverse stakeholder groups in collaborative enterprise, enabling everyone to work creatively together in the same direction, embracing agreed goals (Figure 1).

9.1 Aim

The aim of the second phase of the project was to:

- Undertake further development of the Shared Purpose Framework through broader regional consultation developing levels of application within the framework for registered to expert practitioners so that the knowledge, skills, competencies and leadership behaviours required to deliver person centred compassionate, safe and effective evidence informed care are articulated further.

9.2 Methodology

This phase of the research used emancipatory Practice Development (ePD) as the guiding methodology. Practice development is a complex intervention that integrates the systematic development of practice with empowerment of practitioners and cultural change that sustains specific outcomes (Manley et al 2014). Practice Development as a methodology achieves a shared purpose and outcomes (Manley et al 2011) through:

- Using the principles of collaboration, inclusion and participation (CIP principles), which develop ownership for change and direction as well as self-empowerment
- Agreeing values and beliefs about what is to be achieved, as well as, ways of working (including creativity), which provides a frame of reference that enables self-direction, mutual challenge and support for agreed values and behaviours.
- Involving all in decision-making, which accords value to those involved and enables engagement, joint responsibility and multiple perspectives and differences to be recognised and acknowledged.
- Embedding shared values and beliefs and related patterns of behaviour into workplace culture through social systems that reduce dependence on single/specific individuals.

9.3 Methods

Eight regional workshops across Kent, Surrey and Sussex were held in June and July 2014 (Appendix 6) in order to further develop the shared vision and shared purpose framework developed in Phase 1 (2013) into a career competence framework for band 5-8 community and district nurses. With permission from East Kent Hospitals University Foundation NHS Trust, the study used the EKHUFT Shared Purpose Framework as a guiding template to adapt for the community context. An advance organiser was sent to each workshop participant identifying the expectations of the workshop (Appendix 7). The workshop enabled focused group work around the competences required for each of the four purposes across bandings. Data was captured from each workshop and then integrated into the framework after each workshop. That way each group were able to act as a member checking group for the next as the framework developed to ensure it represented their role experiences and expectations at each banding.

9.4 Limitations

Despite the offering of 8 workshops and widespread awareness raising activities of this opportunity through the steering group members and their organisations, uptake was low and several dates were cancelled. The draft framework was sent out to each participating organisation twice through the steering group between July and October 2014 inviting critique, and feedback. Two organisations provided feedback that enabled the framework to be further refined. In February 2015, with the extension of the project timeline, we offered a further three regional workshops to consider the next steps to testing the shared competence career framework for community and district nurses.

9.5 Findings

The framework, the Shared Purpose Career Competence Framework for Community and District Nurses, (Figure 18) has been structured around the NHS Career Framework and is based on the 'outcomes' approach to competence, favoured by Skills for Health and the NHS Knowledge and Skills Framework (Department of Health 2004). This approach makes clear the actions expected in the workplace, informed by the knowledge, skills, knowhow as well as the behaviours required. Key contextual drivers are also identified. Both the Knowledge and Skills Framework dimensions and organisational effectiveness criteria have been mapped to the framework adapted from EKHUFT.

The Shared Purpose Career and Competence Framework for community nurses identifies four key purposes (see Figure 18).

Figure 18: The Shared Purpose Career & Competence Framework for Community Nurses key purposes

Purpose 1	Purpose 2	Purpose 3	Purpose 4
Provides and assures first class (Holistic person and family centred care) compassionate care close to home evaluating and researching the service user's/stakeholder's experience	Provides and assures safe care close to home monitoring and evaluating safe practice	Provides effective care close to home at the individual, service and organisational level using evidence based approaches and resources appropriate to achieving optimal patient outcomes	Contributes to establishing an effective workplace culture that sustains first class safe and effective care close to home through relationships, teamwork, leadership, active learning, development, improvement and innovation

The four purposes of the shared purpose framework are easy to remember and make explicit what is expected of staff at every level of the NHS Career ladder. It integrates performance indicators, knowledge and know how, attitudes and behaviour and contextual factors. Each purpose is linked to quality and also embraces the 6Cs (Care, Compassion, Communication, Courage, Commitment and Competence) arising from the UK's national nursing and midwifery strategy (Department of Health 2012). At this point it is acknowledged that the framework needs further testing and we would advocate that practitioners at band 5-8 are able to use the framework through self-assessment to determine its validity and reliability. The advantage is that it has the potential to be embedded in job descriptions, annual appraisal, personal development planning and as a framework to underpin leadership development programmes for the community and district nursing workforce.

Figure 19: the Shared Purpose Career & Competence Framework for Community and District Nurses

Shared Purpose Framework Job Descriptors Continuum (Adapted with permission from East Kent Hospitals University NHS Foundation Trust Shared Purpose Framework)						
Band	5	6	7	7	8a	8b
Career level	Registered Practitioner	Senior Registered Practitioner	Advanced Level Practitioner			Consultant Practitioner
Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
1. Provides and assures first class (Holistic person and family centred care) compassionate care close to home evaluating and researching the service user's/stakeholder's experience						
Overarching competence (horizontal) & Sub-theme (vertical)	Provide and co-ordinate first class compassionate care close to home to individuals, groups of patients, service users and carers	Provide and assure first class compassionate care close to home to individuals, groups of patients, service users and carers across the team.	Provide and assure first class compassionate care, evaluating the service user's experience across the service/locality.	Provide and assure first class compassionate care, evaluating the service user's experience across the patient pathway / service.	Provide and assure first class compassionate care and evaluate the service users' experience across the service/locality.	Provide and assure first class compassionate care, evaluate and research the service users experience across the patient pathway, service, organisation and health economy.
Providing person-centred compassionate care	<ol style="list-style-type: none"> 1. Role model person-centred compassionate care. 2. Document patients' / service user's care preferences in a personal plan of care with agreed goals, care and treatment plans and ongoing evaluation to enable continuity of care and shared decision-making. 3. Provide up to date information to enable patients and service users to make informed decisions. 4. Signpost, promote and facilitate self-care, self-recovery and wellbeing. 	<ol style="list-style-type: none"> 1. Facilitate and implement a philosophy of person-centred, compassionate care that places the patient /service user at the heart of care. 2. Enable others to develop a shared understanding of person-centeredness and provide feedback to team members in relation to person-centred behaviours. 3. Work with complex and challenging situations, identifying supportive strategies for self and team using person-centred leadership approaches. 4. Encourage celebration of person-centred practice and open challenge of unacceptable care practices. 	<ol style="list-style-type: none"> 1. Be a visible person-centred, compassionate leader, accessible to the team and working alongside, patients and service users to assure consistency of person-centred care across the team. 2. Develop and implement a common vision for person-centred care and staff expectations, activities and behaviours required to achieve this vision. 3. Monitor standards of person-centred care providing regular and systematic feedback on how care is experienced by patients and service users and implementing learning. 4. Create a culture which encourages celebration of person-centred practice and open challenge of unacceptable care practices. 	<ol style="list-style-type: none"> 1. Provide person-centred and compassionate care to patients and service users through total care packages and episodes of care across community settings. 2. Provide flexible and accessible support and advice services to enable personalised care, address health instability/ crisis or new health care needs to improve the patient/service users' experience and enable resources to be used effectively. 3. Facilitate service users to detect and self-manage early symptoms of deterioration following discharge and long term side effects and symptoms of disease and to grow their own expertise. 4. Provide psychological, social, practical and financial advice and support in a timely manner to patients and carers. 5. Facilitate and chair local support group and implements buddy systems for patients and service users. 	<ol style="list-style-type: none"> 1. Maintain a visible presence across locality to enable accessibility to staff and service users. 2. Foster peer support, sharing, learning and review about person-centred practice across the service. 3. Role model high support and high challenge through giving and receiving feedback about person-centred care and experiences. 4. Implement and monitor person-centred, compassionate care across the service and the achievement of related action plans. 5. Role model involvement and engagement of participation of patients, service users and staff in planning, organising and evaluating person-centred care services. 6. Facilitate local public, patient involvement and engagement. 	<ol style="list-style-type: none"> 1. Provide organisational and strategic leadership in person-centred, compassionate care, articulating the concept and vision and what this means to all members of the interdisciplinary team. 2. Set and implement organisational standards that reflect person centeredness to guide organisational and health economy expectations. 3. Implement systems that ensure that the service user's voice is heard in all key activities across the organisation, including organisational board. 4. Develop, implement and evaluate strategies to foster involvement and engagement with patient /service user action groups to guide organisational learning and service development.
Courageously Speaking up for and listening to patients	<ol style="list-style-type: none"> 1. Act as an advocate to ensure the voice, needs and views of the service user are heard in a meaningful way, recognising and protecting vulnerable adults and children. 2. Enable the service user to participate in interdisciplinary team meetings to ensure their voice is heard. 	<p>Inform and lead decision making in interdisciplinary working relationships to ensure service user involvement, and care decisions are based on both service user/carer choices and best evidence.</p>	<ol style="list-style-type: none"> 1. Act as an advocate for human rights and information to support informed choice. 2. Implement and monitor services to support service users' human rights. 	<ol style="list-style-type: none"> 1. Uphold human rights in all situations. 2. Promote the role of advocacy through implementing professional and organisational standards. 	<ol style="list-style-type: none"> 1. Implement systems that ensure that the service user's voice is heard in all key activities across the organisation, including at senior management level. 2. Create an open environment which is receptive to challenges from staff on behalf of their service users and carers, support and empower staff with meeting their needs. 	<ol style="list-style-type: none"> 1. Role model the maintenance of service user advocacy in all situations. 2. Build alliances across the organisation and health economy to ensure that services and practices meet service user/carer needs.

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Band	5	6	7	7	8a	8b
Career level	Registered Practitioner	Senior Registered Practitioner	Advanced Level Practitioner			Consultant Practitioner
Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
Inviting and using service user feedback	1. Encourage open and honest feedback formally and informally from service users and carers. 2. Contribute to evaluating the achievement of person-centred and compassionate care.	1. Evaluate the achievement of person-centred care across the team/pathway using monitoring and reporting systems. 2. Provide timely feedback to the community team on standards of care provided to and experienced by service users.	1. Actively engage with patients, service users and staff to evaluate the achievement of person-centred care across the service using monitoring and reporting systems. 2. Provide timely feedback to the community team on standards of care provided to and experienced by patients and service users.	1. Actively engage with service users and staff to evaluate the achievement of person-centred care across the pathway using monitoring and reporting systems. 2. Provide timely feedback to the community team on standards of care provided to and experienced by service users. 3. Implement and evaluate systems for enabling full participation of service users in planning, organising and evaluating care services.	1. Develop and implement action plans arising from service user feedback. 2. Develop, implement and evaluate strategies to foster engagement with service user action groups for guiding service development.	1. Implement formal systems for collecting and reviewing staff and service user feedback across service/organisation working with service teams to make sense of feedback, identify and implement actions. 2. Facilitate local public and patients' involvement and engagement in evaluating and researching services. 3. Lead a programme of research and evaluation around the service users' experience.
Working in a person-centred way with others	Role model person-centred and committed ways of working with all members of the interdisciplinary team.	1. Establish a person-centred culture that values commitment from all members of the interdisciplinary health care team. 2. Manage workload activities and commitments without compromising the health and well-being of self and others.	Establish and monitor a culture for maintaining staff wellbeing, motivation, commitment and job satisfaction across the interdisciplinary team/pathway.	Lead the development of a person-centred culture and ways of working across the patient pathway that values the contribution of all.	Implement and monitor systems for maintaining staff wellbeing, motivation, commitment and job satisfaction across the service, reporting to the senior management team.	1. Implement systems that recognise and celebrate staff achievements in the provision of person-centred care and commitment. 2. Develop community leaders who enable a person-centred culture, commitment and empowerment.
2. Provides and assures safe care close to home monitoring and evaluating safe practice						
	Provide safe care to individuals, groups of patients, service users and carers and perform risk assessments to evaluate and act on risks according to local and national safety standards.	Provide and assure safe care to individuals, groups of patients, service users and carers according to local and national safety standards across teams.	Provide and assure safe care to individuals, groups of patients, service users and carers according to local and national safety standards, evaluating this across the team/ service.	Provide and assure safe care to individuals, groups of patients, service users and carers according to local and national safety standards, evaluating this across the patient pathway/ service.	Provide and assure safe care to individuals, groups of patients, service users and carers according to local and national safety standards and evaluating these across the service/locality.	Provide and assure safe care to individuals, groups of patients, service users and carers and according to local and national safety standards and evaluating and researching patient safety across the patient pathway/service /organisation and health economy.
Providing safe care	1. Develop a plan of care that reduces and mitigates risks to patients. 2. Escalate risks to ensure immediate safeguards, enabling further action to minimise risks. 3. Maintain a safe environment for patients, service users and staff according to local and national policy for infection control, manual handling and patient safety. 4. Alert others to the impact of staffing, skill mix and patient dependency on care provision and act to optimise this.	1. Work with team to maintain safe practice working to optimise resources, equipment and staffing. 2. Implement and evaluate a programme of patient safety across team.	1. Work with team leaders/ managers to maintain safe practice across teams, ensuring adequate resources, equipment and staffing. 2. Implement and evaluate a programme of patient safety across teams. 3. Set, achieve, evaluate and sustain safety objectives across teams.	1. Work with interdisciplinary team and pathway to maintain safe practice across the patient pathway/service, ensuring adequate resources, equipment and staffing. 2. Implement and evaluate a programme of patient safety across pathways. 3. Set, achieve, evaluate and sustain safety objectives across patient pathways.	1. Lead on patient safety across service, using a systematic approach to reviewing and evaluating safety, including clinical audit, benchmarking, incident analysis and case reviews around patient safety facilitating effective action planning across locality/service. 2. Flag and action risks around deficiencies in resources, equipment / staff across the service.	1. Role model the maintenance of patient safety and safe environments across the organisation. 2. Ensure that clinical governance, safety and risk frameworks and their requirements are understood and implemented throughout the organisation/health economy. 3. Lead on establishing organisational standards and policies.
Embedding the Safety Culture	Role model best practice in patient safety, challenge practice, and raise concerns using incident reporting system when patient and staff safety are compromised.	Contribute to establishing a team culture that encourages the celebration of best practice in patient safety, implement learning from incidents, and challenge and intervene when patient and staff safety are compromised.	Establish a culture that encourages the celebration of best practice in patient safety, implement learning from incidents, and challenge and act when patient and staff safety are compromised across teams.	Establish a culture that encourages the celebration of best practice in patient safety, implement learning from incidents, and challenge and act when patient and staff safety are compromised across the patient pathway/service.	1. Establish a culture across the service that systematically addresses and decreases the likelihood of errors occurring. 2. Nurture a fair/minimal blame approach that facilitates learning from patient safety incidents. 3. Support managers and team leaders with the development and effectiveness of their supervisory role.	1. Establish a culture across the organisation that enables best practice in patient safety to be achieved and celebrated. 2. Provide organisational and strategic leadership around patient safety and the achievement and celebration of best practice across the health economy.

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Band	5	6	7	7	8a	8b
Career level	Registered Practitioner	Senior Registered Practitioner	Advanced Level Practitioner			Consultant Practitioner
Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
Reviewing and improving safety practice	Contribute to delivery of effective improvement action planning as a result of root cause analysis (RCAs), audit, complaints and risk assessments.	<ol style="list-style-type: none"> 1. Lead development of team patient safety action plans and their implementation. 2. Participate in systematic approaches to reviewing and evaluating safety including audit, benchmarking, incident analysis and case reviews. 3. Support and implement patient safety improvements systems across the team through peer supervision and review. 	<ol style="list-style-type: none"> 1. Facilitate implementation of national standards and best practice evidence across the service in relation to patient safety. 2. Analyse incident themes and trends - reporting through the Governance structure as appropriate. 3. Lead on the delivery of improvement action plans as a result of incidents / RCA's, audit, complaints, risk assessments. 4. Support and follow-up adverse incident reporting to bring about change across teams. 	<ol style="list-style-type: none"> 1. Facilitate implementation of national standards and best practice evidence across the service in relation to patient safety. 2. Analyse incident themes and trends - reporting through the Governance structure as appropriate. 3. Lead on the delivery of improvement action plans as a result of incidents / RCA's, audit, complaints, risk assessments. 4. Support and follow-up adverse incident reporting to bring about change across the patient pathway/service. 	<ol style="list-style-type: none"> 1. Lead, maintain and review professional standards, policies, guidelines and procedures to underpin safety across the service. 2. Lead patient safety and adverse incident investigations and working groups. 3. Provide accurate and timely feedback on safety reviews to all staff and regular reports in collaboration with relevant departments relating to safety activities. 4. Demonstrate contribution to reductions in adverse events across the service/locality. 	<ol style="list-style-type: none"> 1. Integrate national priorities for safety into organisational practices, drawing on standards and best practice evidence to guide. 2. Participate in and engage organisational boards with external safety bodies to ensure that all learning and improvement plans resulting from audits and inspections are implemented across the organisation. 3. Participate with organisational boards in monitoring organisational performance using key performance indicators. 4. Contribute and lead the development of performance indicators relevant to the provision of safe care across the health economy.
3. Provides effective care close to home at the individual, service and organisational level using evidence based approaches and resources appropriate to achieving optimal patient outcomes						
	Provide evidenced based care to individuals, groups of patients, service users and carers and continually review and develop own effectiveness and contribute to ongoing service improvement.	Provide and assure evidence based care to individuals, groups of patients, service users and carers and continually review and develop own and service effectiveness and contribute to ongoing service improvement.	Provide and assure evidence based care to individuals, groups of patients, service users and carers, continually review and develop own and service effectiveness, and contribute to ongoing service improvement and research.	Provide and assure evidence based care to individuals, groups of patients, service users and carers, continually review and develop own, service and pathway effectiveness, and contribute to ongoing service improvement and research.	Provide and assure evidence based care to individuals, groups of patients, service users and carers, and continually review and develop own and service effectiveness and contribute to research.	Provide and assure evidence based care to individuals, groups of patients, service users and carers, continually review and develop own, service and organisational effectiveness; lead service improvement and actively contribute to the body of knowledge through research.
Providing effective integrated care to individual service users and groups of stakeholders	<ol style="list-style-type: none"> 1. Assess, plan, deliver, co-ordinate and document evidenced based care to individual service users based on national and local policies, standards, guidelines and best practice, documenting care decisions as an accountable practitioner, whether care is delivered by self or others. 2. Focus on the desired health outcomes for service users consistent with current professional knowledge and patient choices. 3. Enable and encourage patients'/service users towards self-sufficiency. 4. Enable others to recognise and monitor deterioration in health using early warning tools and organisational protocols to minimise delays to appropriate treatment. 5. Use information technology to enable health care data collection, analysis and interpretation and effective care documentation for individual service users. 6. Draw on the strengths of the whole integrated health care team when planning, delivering, co-ordinating and evaluating complex health care needs and outcomes, 	<ol style="list-style-type: none"> 1. Assure the assessment, planning and documentation of evidence based care to individual patients and service users based on national and local policies, standards, guidelines and best practice. 2. Prioritise problems and decisions in complex situations to ensure the best possible outcome for patients and service users, explaining factors that influence decision-making. 3. Undertake or enable others to follow-up patient screening/specialist assessment and refer appropriately 4. Provide culturally sensitive patient and carer information about condition, local and national information, support groups and charities. 5. Provide telephone advice and support to non-complex patients, service users and staff. 6. Role model and assure processes for recognising and acting on the deteriorating patient using early warning tools and organisational protocols to recovery and discharge. 	<ol style="list-style-type: none"> 1. Role model and articulate expertise in the assessment, planning and documentation of evidence based care to individual patients and service users based on national and local policies, standards, guidelines and best practice. 2. Take responsibility for making difficult and complex decisions using all the available evidence to support decisions that ensures the best possible outcome for patients and service users, enabling others to appreciate the factors. 3. Provide a strong presence and visibility in community health settings through supervisory role and providing feedback to ensure standards are maintained. 4. Collaborate with others to design, implement, manage and evaluate patient services and pathways to achieve patient outcomes and improve continuity across the patient journey using human and financial resources effectively. 	<ol style="list-style-type: none"> 1. Deliver integrated total care packages and complete episodes to individual patients/service users across specific patient pathways based on holistic assessment, national guidelines, specialist competences, and best practice, documenting this care as an accountable practitioner. 2. Documenting case management, assess, diagnose, plan, implement and evaluate specific treatments and interventions 3. Act as a prescriber within local and national policy to a) increase the timeliness of patient care and service responsiveness, b) administer own treatment regimes, monitoring effectiveness 4. Provide flexible advice for new patients with undifferentiated and differentiated diagnosis and patients with complex and challenging needs/new symptoms to initiate 	<ol style="list-style-type: none"> 1. Provide a strong presence and visibility across integrated community health care areas so as to: be accessible to patients and staff; give and receive feedback on experiences and standards; and provide expert advice and guidance 2. Review decision making processes across the service to ensure that decisions are made at the appropriate level, based on best evidence, local and national guidelines, and within governance frameworks. 3. Lead, develop, implement and review service standards, policies, guidelines, procedures and service improvement. 4. Co-lead and collaborate with interdisciplinary team relevant service accreditation activities. 	<ol style="list-style-type: none"> 1. Provide a strong presence, leadership and access to expertise across community health care areas with a 50% contribution to direct care. 2. Review decision making processes across the organisation to ensure that decisions are made at the appropriate level, based on best evidence, local and national guidelines, and within governance frameworks, enabling others to identify the consequences and implications of decisions to foster informed integrated care decision-making and strategic action. 3. Provide organisation- wide expertise and strategic direction and guidance for achieving excellence in practice. 4. Contribute to national guideline development groups and steering groups across the health economy to promote integrated first class care. 5. Lead and contribute to national and international forums, steering groups, policy development and strategy for specialism, ensuring organisation benefits from leading edge developments, creating strategic network alliances to

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Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
	recognising the diverse and unique contribution of each member.			<p>treatment and treatment changes in different settings to reduce risk and promote admission avoidance.</p> <p>5. Receive referrals to enable quicker intervention to reduce risk and promote admission avoidance, liaising with GP and other members of the integrated health care team regarding implementing treatment options, or refers, as appropriate.</p> <p>6. Provide advice and consultation support flexibly to health care professionals for complex decision making across service, facilitating resolution and taking responsibility for difficult decisions using all the available evidence.</p> <p>7. Design, implement, manage and evaluate patient pathway, working with patients, informed consent to improve patient outcomes, continuity and effectiveness of care across the patient's journey, collaborating with others locally and regionally.</p> <p>8. Streamline care between primary and secondary providers to enable care closer to patients' home; improved access; reduced admissions and effective use of resources.</p>		<p>optimise organisational access to resources and information.</p> <p>6. Provide expertise, at a national and international level through learning and development opportunities, invited key note conferences, consultancy and university honorary appointments that brings kudos and income to the organisation.</p>

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Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
Maintaining own effectiveness and enabling others to be effective	<p>1. Maintain own effectiveness through critical review of decisions made by self and others, ensuring knowledge and skills are up to date and learning is actioned.</p> <p>2. Continually develop own and others' effectiveness through formal and informal learning approaches that use the workplace as the main resource for learning and include critical structured reflection, peer support & review, and engaging others in giving and receiving feedback.</p> <p>3. Enable and supervise support workers and students to deliver planned and effective care consistent with patient's/service user preferences, local and national standards.</p>	<p>1. Maintain effectiveness by keeping up to date with best practice for specific patient pathways, systems and models of care through participating in local specialist forums, uses and grows networks for expanding knowledge and information sources.</p> <p>2. Enable and support others to work together to implement and review relevant evidence implement local and national guidelines, standards, and best practice across team and pathway 3. Facilitate peer review and support using a variety of approaches both formally and informally linked to the giving and receiving of feedback.</p> <p>4. Facilitate staff to solve their own problems providing support, challenge and a safe learning environment.</p> <p>5. Provide learning and development opportunities based on best practice and the future needs of the service within the team.</p>	<p>1. Keep up to date with best practice for specific patient pathways through national specialist forums, journals and networking</p> <p>2. Contribute to developing, implementing and evaluating local/organisational policies and guidelines.</p> <p>3. Implement systems for reviewing and managing non-routine and complex decisions, i.e. around the deteriorating patient to reduce hospital admissions/readmissions.</p> <p>4. Lead and model peer support and review using formal and informal approaches</p> <p>5. Facilitate role development of others to improve service provision, support career progression and succession planning.</p> <p>6. Work with others to obtain feedback on and review own service and patient outcomes</p> <p>7. Contribute to building and maintaining a culture of effectiveness and excellence across teams.</p>	<p>1. Keep up to date with best practice for specific patient pathways through national specialist forums, journals and networking.</p> <p>2. Contribute to local/organisational policies and guidelines where national guidelines do not exist.</p> <p>3. Implement systems for reviewing and managing non-routine and complex decisions, i.e. case reviews, etc.</p> <p>4. Lead and model peer support and review using formal and informal approaches across the service.</p> <p>5. Facilitate role development of others to improve service provision, support career progression and succession planning.</p> <p>6. Actively support the supervisory role of ward managers and team leaders.</p> <p>7. Contribute to building and maintaining a culture of effectiveness and excellence across the service.</p>	<p>1. Establish peer review and support systems across the service for the purpose of maintaining consistent professional standards, reviewing dashboard data and actions and developing a culture of giving and receiving feedback.</p> <p>2. Provide expertise and advice to different members of the interdisciplinary team across the service.</p> <p>3. Lead workforce development across the service to improve capacity and capability of clinical practice and clinical leadership across the service/locality.</p>	<p>1. Lead the implementation of peer review and support systems across the organisation for the purpose of maintaining consistent professional standards, reviewing dashboard data, patient outcomes and experience, and developing a culture of giving and receiving feedback and critical review.</p> <p>2. Provide expertise and advice to different members of the interdisciplinary team across the organisation and to inform strategic decision-making and strategy.</p> <p>3. Lead, develop, implement and review service and organisational standards, policies, guidelines, procedures and service improvement across locality/health economy.</p>

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Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
Evaluating and researching effectiveness	<ol style="list-style-type: none"> 1. Evaluate individual service user experiences and outcome/self-care goals using agreed measures/indicators. 2. Contribute to monitoring and reviewing dashboards and ensuring availability of accurate, valid, timely and relevant information to support integrated decision making within the team. 3. Contribute to monitoring and evaluating standards of care provided by community team using a range of different tools and measures. 4. Contribute to monitoring and reviewing dashboards to ensure availability of accurate, valid, timely and relevant information to support integrated decision making within the team. 5. Participate in reviewing the patient journey to reduce duplication maximise flow and provide holistic service to patients and service users. 6. Participate in team and service reviews, benchmarking and national audits. 7. Participate in service improvement and share good practice within the team. 8. Contribute to building a research and evaluation culture within the team. 	<ol style="list-style-type: none"> 1. Participate in the clinical evaluation of patient outcomes/self-care goals using agreed measures/indicators to evaluate impact of interventions and service. 2. Monitor and evaluate standards of care provided by clinical team using a range of different tools and measures. 3. Facilitate collaborative review, analysis and interpretation of dashboards with ward team to ensure; availability of accurate, valid, timely and relevant information to support decision making across the service; and action planning. 4. Participate in reviewing the patient journey to reduce duplication, maximise flow and provide holistic service to patients and service users. 5. Lead and participate in clinical audit activities, benchmarking, incident analysis and case reviews of team or pathway facilitating effective action planning. 6. Participate in service improvement and share good practice across the team. 7. Contribute to developing a research and evaluation culture across the team. 	<ol style="list-style-type: none"> 1. Lead the monitoring and review of dashboard information to ensure availability of accurate, valid, timely and relevant information to support integrated decision making across the service, facilitate data analysis and interpretation and implement action plans as a result of reviews and audits. 2. Participate in reviewing the patient journey to reduce duplication, maximise flow and provide holistic service to patients and service users. 3. Implement and evaluate systems for enabling full participation of staff in partnership with patients and service users in decision-making and planning, organising and evaluating care services and outcomes. 4. Actively engage in reviewing research evidence, implementing relevant findings and contribute to generating new knowledge for and from practice. 5. Contribute to developing a research, inquiry and evaluation culture across the service through active involvement in evaluation, scholarly inquiry and research locally. 	<ol style="list-style-type: none"> 1. Regularly review the patient journey to reduce duplication, maximise flow and provide holistic service to patients and service users. 2. Implement and evaluate systems for enabling full participation of staff in partnership with patients and service users in decision-making and planning, organising and evaluating care services and outcomes. 3. Enable availability of accurate, valid, timely and relevant information to support decision making across the service, facilitate and implement data analysis and interpretation, and action planning in reviews, audits and annual reports. 4. Actively engage in reviewing research evidence, implementing relevant findings and contribute to generating new knowledge for and from practice. 5. Contribute to developing a research, inquiry and evaluation culture across the service through active involvement in evaluation, scholarly inquiry and research locally. 	<ol style="list-style-type: none"> 1. Lead reviews, evaluations, and critical reflections on decisions made about patient/service user care, enable learning across the service. 2. Regularly review the patient journey to reduce duplication, maximise flow and provide a holistic service to patients and service users close to home. 3. Demonstrate contribution to improvements in patient outcomes. 4. Lead on service improvement and implementation in relation to patient and service user feedback and service review. 5. Ensure availability of accurate, valid, timely and relevant information to support organisational integrated decision-making and objectives, and analyse and interpret data to inform action plans, their implementation and evaluation. 	<ol style="list-style-type: none"> 1. Facilitate uptake and impact of R&D activity to inform practice across the organisation and local health economy using knowledge transfer and mobilisation strategies. 2. Lead an integrated interdisciplinary programme of R&D in relation to generating new knowledge and understanding. 3. Lead with other consultant practitioners on facilitating a culture across the organisation and local health economy that values, research, evaluation and scholarly inquiry, and grows capability and capacity. 4. Support and supervise others using different R&D approaches and methods to address corporate objectives around the specialism. 5. Act as a peer reviewer of R&D projects nationally. 6. Contribute to policy development locally, regionally and nationally.
4. Contributes to establishing an effective workplace culture that sustains first class safe and effective care close to home through relationships, teamwork, leadership, active learning, development, improvement and innovation						
	Contribute to establishing an effective team culture that sustains first class compassionate, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation.	Establish an effective team culture that sustains first class compassionate safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation.	Establish an effective workplace culture across teams that sustains first class compassionate, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation.	Establish an effective workplace culture across teams and patient pathway that sustain first class compassionate safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation.	Establish an effective workplace culture across the service/locality that sustains first class compassionate safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation.	Establish an effective workplace culture across the service, organisation and health economy that sustains first class compassionate, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation.
Being self-aware and developing effective relationships	<ol style="list-style-type: none"> 1. Sense, understand and respond appropriately to own and others' emotions with an appreciation of the consequences of ones' own actions for others. 2. Develop effective collegial relationships with team members and appreciate the consequences of own actions for others. 3. Model openness and honesty and encourage this in others. 4. Take responsibility for maintaining own wellbeing and monitoring the wellbeing of others. 	<ol style="list-style-type: none"> 1. Role model relationships that are respectful and maintain dignity of others based on self-awareness and emotional intelligence 2. Build relationships based on the giving and receiving of feedback, high support and high challenge. 3. Act to support, sustain and monitor the wellbeing of others within the team. 	<ol style="list-style-type: none"> 1. Role model effective interdisciplinary relationships and the giving and receiving of feedback based on own self-awareness and emotional intelligence. 2. Establish and monitor a culture that enables staff wellbeing across teams. 	<ol style="list-style-type: none"> 1. Role model effective interdisciplinary relationships and the giving and receiving of feedback based on own self-awareness and emotional intelligence. 2. Establish and monitor a culture that enables staff wellbeing of all staff across service/locality. 	<ol style="list-style-type: none"> 1. Build strong and collaborative relationships with both internal and external stakeholders to achieve service goals and objectives based on a foundation of self-awareness and emotional intelligence. 2. Establish and monitor a culture that enables and supports staff wellbeing across the service/organisation. 	<ol style="list-style-type: none"> 1. Build strong and collaborative relationships with both internal and external stakeholders to achieve organisational goals and objectives based on a foundation of self-awareness and emotional intelligence. 2. Establish and evaluate a culture that enables and supports staff wellbeing across the organisation and local health economy.

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Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
Working as an effective team	<ol style="list-style-type: none"> 1. Contribute as a team member being clear of own role and the role of others. 2. Draw on the strengths of the whole care team recognising the diverse and unique contribution of each member. 3. Contribute actively to interdisciplinary team working and decision-making. 	<ol style="list-style-type: none"> 1 Role model interdisciplinary team working at every opportunity, ensuring the skills and capabilities of team members are optimised to provide excellence in care. 2. Build relationships with the interdisciplinary team and others across the service being clear about own role and facilitating role clarity and expectations of others. 3. Value diversity within the team, the contribution of various skills and personalities of each member equitably, and developing their potential. 4. Help team members become competent and confident in understanding and contributing to the team's vision and objectives enabling them to contribute. 	<ol style="list-style-type: none"> 1. Role model collaborative working, acknowledging and celebrating the contributions of others in leading or contributing to team effectiveness. 2. Lead and contribute to a number of different inter-disciplinary teams across service. 3. Build and maintain team effectiveness, team stability and motivation. 4. Challenge and stimulates team members to bring in innovation, nurturing creativity across teams. 	<ol style="list-style-type: none"> 1. Lead and contribute to a number of different inter-disciplinary teams across service. 2. Set team related objectives to ensure that a team working approach is the priority. 3. Role model collaborative project working, acknowledging and celebrating the contributions of others in leading or contributing to team effectiveness. 4. Challenge and stimulate team members to bring in innovation, nurturing creativity in team members. 5. Use teambuilding strategies to build and maintain team effectiveness, team stability and motivation across the service/locality. 	<ol style="list-style-type: none"> 1. Role model interdisciplinary team working at clinical and service levels. 2. Create a culture of team working across the service, embedding team working in the service, identifying and celebrating effective teams. 3. Use all opportunities to increase the level and quality of team working, enabling teams to explore alternatives, be creative and supporting them through learning from these experiences. 4. Review and evaluate team effectiveness, supporting teams with increasing effectiveness and investigating where teamwork has failed ensuring service learning. 	<ol style="list-style-type: none"> 1. Facilitate a culture of team working, embedding team working in service and organisational systems that identify and celebrate effective teams. 2. Evaluate and research team effectiveness supporting teams with increasing effectiveness where required across the organisation and local health economy.
Leading person-centred, compassionate, safe and effective care	<ol style="list-style-type: none"> 1. Recognise own role as a potential leader and the impact of leadership on the experiences of patients and staff. 2. Participate in developing and implementing a shared team vision, and achieving mutually shared values, beliefs, goals and objectives. 3. Recognise when there may be contradictions between values and beliefs articulated and behaviour in self and others and act to minimise this. 4. Acknowledge and celebrates the achievements of self and others. 	<ol style="list-style-type: none"> 1. Develop own leadership potential and encourage, model and inspire personal behaviour that reflects the team's shared vision and common values around person-centred, compassionate, safe and effective care. 2. Contribute to developing and implementing a shared vision/philosophy across team and translate this for others into expected patterns of behaviours to ensure safe, effective, person-centred and compassionate care by all staff. 3. Inspire, influence, and develop others by providing both high support and high challenge to team members and colleagues, displaying courage when tackling difficult issues and challenging behaviours. 4. Create a safe psychological and social, as well as, physical, environment so team members can work effectively and achieve team objectives. 5. Identify opportunities to recognise and celebrate success within the team. 	<ol style="list-style-type: none"> 1. Model effective clinical leadership and encourage and inspire others in their clinical leadership development. 2. Inspire personal behaviour that reflects the team's shared vision and common values around person-centred, compassionate, safe and effective care. 3. Develop and implement a shared vision/philosophy across team and translate this for others into expected patterns of behaviours to ensure safe, effective, person-centred and compassionate care by all staff. 4. Inspire, influence, and develop others in challenging situations by providing both high support and high challenge to team members and colleagues, displaying courage when tackling difficult issues and challenging behaviours. 5. Facilitate a safe psychological and social, as well as, physical, environment so team members can work effectively and achieve team objectives. 6. Build in regular opportunities to recognise and celebrate success. 	<ol style="list-style-type: none"> 1. Model effective clinical leadership and encourage and inspire others in their clinical leadership development. 2. Inspire personal behaviour that reflects the team's shared vision and common values around person-centred, compassionate, safe and effective care. 3. Develop and implement a shared vision/philosophy across team and translate this for others into expected patterns of behaviours to ensure safe, effective, person-centred and compassionate care by all staff. 4. Inspire, influence, and develop others in challenging situations by providing both high support and high challenge to team members and colleagues, displaying courage when tackling difficult issues and challenging behaviours. 5. Facilitate a safe psychological and social, as well as, physical, environment so team members can work effectively and achieve team objectives. 6. Build in regular opportunities to recognise and celebrate success. 	<ol style="list-style-type: none"> 1. Role model high quality leadership behaviours and shared values translating this for others into expected patterns of behaviours to ensure safe, effective and person-centred and compassionate care by all staff. 2. Endorse the importance of implementing a shared vision and common values across the service to achieve excellence in person-centred care. 3. Facilitate a culture of effectiveness and excellence across the service which is open and receptive to challenges from staff on behalf of their patients and supports and empowers staff with meeting the needs of patients and service users. 4. Support others in their clinical leadership development through mentorship and coaching, giving and receiving of feedback, high support and high challenge enabling clinical leaders to develop their supervisory role through both words and actions. 	<ol style="list-style-type: none"> 1. Role model high quality clinical, strategic and academic leadership behaviours and shared values translating these for others into expected patterns of behaviours to ensure safe, effective, person-centred and compassionate care by all staff. 2. Endorse the importance, at all levels, of implementing a shared vision and common values across the service to achieve excellence in person-centred care, raising awareness of the role of clinical leadership and its impact. 3. Facilitate a culture of effectiveness and excellence across the organisation which is open and receptive to challenges from staff on behalf of their patients and supports and empowers staff with meeting the needs of patients and service users. 4. Support others in their clinical leadership development through programmes that increase capability and capacity of leaders, mentorship and coaching, giving and receiving of feedback. 5. Influence and lead R&D that increases understanding and knowledge about how to develop leaders and cultures of effectiveness in health care practice through scholarly practice inquiry, research and evaluation.

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Role descriptor	Registered Community Nurse	Senior Registered Community Nurse	Community Team Leader	Community Specialist	Community Matron/Service e Manager	Consultant Practitioner
Active learning for transforming care and practice	<p>1. Engage in opportunities to give and receive feedback, provide high support and high challenge.</p> <p>2. Question the practice of self and others to ensure best practice through a system of reflective practice.</p> <p>3. Participate in, and facilitate others, in continuous professional development, using formal and informal learning and development approaches that draw on the workplace as the main resource for learning.</p>	<p>1. Role model active learning, participating in peer support and review so as to learn from reviewing own practice and leadership.</p> <p>2. Use formal and informal opportunities for giving and receiving feedback in relation to agreed ways of working and role clarification, enabling team members to reflect on, evaluate, develop and learn from their practice, including the use of simulations and theory in practice.</p> <p>3. Enable others to use the workplace as the main resource for active learning, innovation and continuous quality improvement.</p> <p>4. Facilitate self and peer assessment using reflective appraisal and 360 degree feedback.</p> <p>5. Contribute to developing a learning culture, using the workplace as the main resource for learning.</p> <p>6. Enable others to participate in regular learning and development within the context of the inter-disciplinary team.</p>	<p>1. Use the workplace as the main resource for learning and developing practice, knowledge, skills, and competence in relation to the needs of different patient groups.</p> <p>2. Develop a learning culture where structured reflection and peer review leads to development, improvement and ongoing effectiveness.</p> <p>3. Develop and participate in training/learning opportunities that encourage team working in an inter-disciplinary environment.</p> <p>4. Identify and develop learning and development resources.</p> <p>5. Provide coaching, mentorship and facilitate peer review and support for achievement of specialist competences.</p> <p>6. Plan own career development and support others with their learning and development across teams.</p>	<p>1. Use the workplace as the main resource for learning and developing practice, knowledge, skills, and competence in relation to the needs of different patient groups.</p> <p>2. Develop a learning culture where structured reflection and peer review leads to development, improvement and ongoing effectiveness.</p> <p>3. Develop and participate in training/learning opportunities that encourage team working in an inter-disciplinary environment.</p> <p>4. Identify and develop learning and development resources.</p> <p>5. Provide coaching, mentorship and facilitate peer review and support for achievement of specialist competences.</p> <p>6. Plan own career development and support others with their learning and development across service/locality.</p>	<p>1. Role models reflection, peer review and support for ongoing learning and career planning.</p> <p>2. Facilitate a learning culture across the service with opportunities for shared learning and development.</p> <p>3. Participate in the evaluation of service learning and development and its impact on practice, staff wellbeing and patient outcomes and experience across service/locality.</p>	<p>1. Role models reflection, peer review and support for ongoing learning and career planning.</p> <p>2. Facilitate a learning culture across the organisation with opportunities for shared learning and development, growing capability and capacity in the facilitation of learning, development, improvement and inquiry in practice.</p> <p>3. Participate in the evaluation of organisational learning and development and demonstrate its impact on patient care, safety, knowledge translation staff wellbeing and satisfaction across the locality/health economy.</p>
Developing, improving & innovating	<p>1. Embrace positive change as a way of life, nurturing own and others' creativity.</p> <p>2. Participate in identifying areas for change and improvement.</p> <p>3. Contribute to continuous and systematic quality improvement and practice development in response to identified need, including care pathway development, new models of care, patient, service user and staff feedback enabling the participation of all within the team.</p>	<p>1. Identify areas for change and improvement.</p> <p>2. Contribute to continuous and systematic quality improvement and practice development in response to identified need, including care pathway development, new models of care, patient, service user and staff feedback.</p> <p>3. Facilitate and engage others through collaboration, inclusion and participation, to contribute to meeting corporate objectives, implementing and evaluating practice change, development and innovation, and sustaining change behaviours within the team.</p>	<p>1. Challenge and stimulate team members to bring in innovation, nurturing creativity in team members.</p> <p>2. Identify, implement and evaluate new interventions, initiatives and innovations that: improve access and continuity of care for patients and service users; speedier identification of issues; and reduce duplication of resources.</p> <p>3. Develop and evaluate new services proactively that improve the patient's experience and outcomes.</p> <p>4. Use evidence based approaches to achieve and embed widespread change and innovation</p> <p>5. Implement systems for enabling full participation of patients, service users and staff in planning, organising and evaluating care services across teams.</p>	<p>1. Challenge and stimulate team members to bring in innovation, nurturing creativity in team members.</p> <p>2. Identify, implement and evaluate new interventions, initiatives and innovations that: improve access and continuity of care for patients and service users; speedier identification of issues delaying discharge and recovery; and reduce duplication of resources.</p> <p>3. Develop and evaluate new services proactively that improve the patient's experience and outcomes.</p> <p>4. Use evidence based approaches to achieve and embed widespread change and innovation.</p> <p>5. Implement systems for enabling full participation of patients, service users and staff in planning, organising and evaluating care services across the service/locality.</p>	<p>1. Lead strategic development, improvement and innovation across specific organisational work streams that both inform and respond to organisational objectives.</p> <p>2. Use system drivers, engagement strategies, transparent measurement, improvement approaches, leadership, rigorous delivery and spread of innovation to achieve organisation -wide transformation of practice and services.</p> <p>3. Support staff in the development and implementation of innovative practice, new initiatives and interventions.</p>	<p>1. Develop and embed an integrated approach to practice, service and quality - improvement, development, scholarly inquiry and innovation across the organisation.</p> <p>2. Lead strategic development, improvement and innovation across specific organisational work streams that both inform and respond to organisational objectives.</p> <p>3. Use system drivers, engagement strategies, transparent measurement, improvement approaches, leadership, rigorous delivery and spread of innovation to achieve organisation -wide transformation of practice and services.</p> <p>4. Support staff with developing their capacity and capability in scholarly inquiry, development, improvement, implementation and evaluation of innovative practice, new initiatives and interventions.</p>

The utility evaluation of the Shared Purpose Career Competence Framework (Bands 5-8 adapted by permission of EKHUFT) from the February workshops and an online survey used a Claims Concerns and Issues tool (Guba and Lincoln 1989) to illuminate participants experiences and the consensus findings are reported here:

1. The SPF integrates the 6 Cs, KSFs and NHS Leadership Skills Framework. It has been extensively researched and developed by front line practitioners and published in the international literature and is a copyrighted document that can be developed with permission for the community nursing context (Manley et al 2014).
2. The SPF integrates personal qualities with actions required at each level to deliver on the four purposes associated with the vision for a first class community nursing services delivery in the region.
3. The most important thing across the bandings is that it offers a whole systems cross health economy approach.
4. It would be helpful to test the framework with a group of practitioners at each level inviting them to assess themselves against the framework
5. In different organisations the descriptors and responsibilities for bands vary therefore you cannot have a uniform descriptor e.g. in some organisations a band 7 is a Cluster Lead, a Matron or a Specialist nurse, in others a band 6 is a team leader and in other a band 8 may be Heads of Service or Consultant practitioner. It is best therefore to stick with the Agenda for Change banding rather than post title.
6. The concept is a good one and participants recommend that we undertake a further test by inviting different bands of practitioners to assess themselves against the tool e.g. band 5, 6, 7, 8 using survey monkey and in addition gather data that is about the band they occupy, the title of their post, how long they have occupied it and why.
7. It will be important to simplify the language for ease of use. When used as a tool you would have one band per page rather than in the columns across bands as they are currently represented. It could be simplified to use as Top Tips on plastic cards to be carried around with the practitioner and/or as an interactive infographic.
8. The SPF will be really useful for revalidation and accreditation.

9.6 Discussion

There is considerable interest nationally at present in the development of a career competence framework for a range of health professionals working in primary care but in particular for district nurses, community and practice nurses. Since completing this work as a draft tool we have contacted the Chief Executive of the QNI to inquire whether they would be willing to test the tool in their next phase of national work with stakeholder groups. There are real opportunities to test and adapt the tool regionally with community and district nurses which would offer greater clarity of role types, knowledge skills and competence of the regional workforce and we would advocate a pilot through 1. SCPHN students undertaking district nursing programmes, 2. Community and District Nurses undertaking Masters programmes, 3. The Kent and Medway Community of Practice for Health Visitors, and 4. The project steering group identifying organisations that would act as pilot test sites in 2015.

Section 4: Recommendations and Conclusions

10. Conclusions

The Phase 2 project has demonstrated that the Cassandra[®] workload activity tool has been successfully adapted for the community nursing context and is capable of capturing the complexity of workload activity and the nursing contribution to patient care.

It is abundantly clear that it is essential to define what we mean by “community nursing” as there are significantly different and varied roles in community and primary care delivery which vary from organisation to organisation and region to region.

It is imperative that we are able to capture the complexity of nursing caseloads in order to match staff with the right skills and competences to future proof for the Five Year Forwards Review and new models of care. The Cassandra workload activity tool does that. Capturing the complexity of community nursing workload is essential in informing NICE guidance on community nursing staffing for the future but we need to fully understand demand in order to develop better service delivery model solutions. Current tools use limited demand data and fall short of data ontology i.e. effectively combining data or information from multiple sources. Being able to move away from the historical approach to workforce planning in community nursing requires a considerable culture shift not only in terms of how we collect data but also how it is then used to inform practice, quality and workforce planning.

A priority is to be able to understand what we mean by planned and unplanned demand for workforce planning as well as understanding the needs of the service user, service and workforce. Patient acuity needs to be considered in patient population data. Currently the approach to caseload management varies across the country and there is little systematic evidence being used to balance supply and demand. It is important to recognise that there will be considerable variation in rural and urban geographies and therefore impact of caseload on individual practitioners and teams will vary. It is important that any workload planning tool is able to ensure links with primary care and social care and consider the whole integrated team and provides data in a format that staff can understand and use to drive improvement and provide trend data for CCGs.

Whilst national organisations are calling for a single workforce planning model for England, it is important to have more than one workload activity and workforce planning tool to map demand that reflect the diversity of services required. However individual tools need to meet the service requirements and be fit for purpose with validity measures built in to assure quality outcomes. There is currently a lack of evidence of the validity of some workforce planning tools and therefore future investment and work is need at national and regional level to identify what works best and for whom and in what circumstances. Commercially available tools enable good data collection but are tasked based and need to reflect more

about caseload management / work left undone as an underpinning framework. Additionally, organisations are reporting nationally that they are not able to run two different systems, one for data collection and another for clinical recording. Yet in order to provide the most informed decision making, there is not just one type of decision, e.g. nurses need to make decisions based on needs assessment, workload management and workforce planning. Tools therefore need to reflect service design, i.e. workload management and the number and complexity of staff (skill mix). The development of a modular tool to demonstrate connected processes and a triangulated approach based on professional judgement and peer benchmarking would enable comparisons to be made which would engage staff to see the benefits of using such tools.

At regional level, it is important that we are able to support relationships about decision making in relation to commissioning community services and developing the workforce based on the best evidence which balances the components of demand/need/modelling/workforce and outcomes. Any tool that is selected for this purpose should be able to demonstrate a sound evidence base, and reliability and validity. We have found that enabling practitioners to capture their workload activity raises awareness of their role and contribution to patient care in the community and primary care setting, and our feedback from users indicates the potential to use this opportunity to develop the leadership skills of the community workforce through the Career Competence Framework and associated training and professional development opportunities using the workplace as the focal point of learning to enhance inquiry, innovation and improvement skills. By doing so, it also enhances community and district nurses' understanding of what they need to regulate their practice (self-regulation) and at a national level, the QNI is now undertaking a piece of work around self-regulation that this work can inform.

10.1 Recommendations

The project identifies a series of key recommendations for stakeholders at regional level.

For Clinical Commissioning Groups:

- Encourage CCGs to consider supporting adoption and spread of Cassandra to provide big data that shows complexity of community nursing and broader care challenges for workforce planning in KSS so that the future workforce is fit for future purpose (Section 1.3.1.4 Limitations of the project & Section 1.5 Discussion). This kind of systematic workforce data would help CCGs to develop contracts around areas that require more investment, e.g. continence assessment, falls prevention, advanced care planning for end of life etc. (Section 1).
- Encourage CCGs to consider commissioning and supporting rotational posts across community and acute settings to develop seamless integrated care along the patient pathway (Section 1).
- Participants felt strongly that CCGs should be encouraged to help organisations across the region to use Cassandra to look at staffing levels and skill mix. It could be used to look at the contribution of specialist nursing services in the community as well as community and district nurses (Section 1 & 3).

For HEKSS:

- Practitioners and leaders of community services felt strongly that Cassandra and modelling should be mandated as a key component of quality and safety in Kent, Surrey and Sussex (Section 1).
- Invest in adoption and spread of Cassandra to enable the project team to collect big data associated with workload activity (Section 1).
- Consider funding the pilot of the Sophia mental health workload activity tool for community services from the 2015-2016 budget in KMPT for a period of one year (Section 2).
- Support pilot and evaluation of the career competence framework in Kent, Surrey and Sussex (Section 3).
- Invest in commissioning whole systems leadership programmes that prepare community and district nurses for their future roles (Section 3).
- Arrange a KSS event to look at the innovations currently taking place in primary care to promote sharing of best practice in relation to workforce planning and development (Section 1 & 3).

For Local HEIs:

- Support the development and evaluation of robust workforce development tools that provide systematic evidence for future community services and the workforce fit for purpose to deliver the Five Year Forwards view (Section 1).
- Support the development of innovative curriculum to create future strategic transformational leaders in community and primary care to meet the shortfall in district and community nursing posts through retirement of an ageing workforce (Section 1 & 3).
- Diversify career choice options for undergraduate prequalifying students to fast track into new community and district nursing roles (Section 1).

10.2 Next Steps for continuation of project work

The project team are currently participating in a national workforce development working group established by NHSE to explore best practice models for implementation across England. The Cassandra project findings have been presented at international and national conference and are being considered an example of best practice that should be further piloted in England. To this end we have submitted an application to the NIHR HS & DR commissioned call for workforce development tools and our application is currently under consideration. We have six implementation sites across the country ready to participate in this next phase of research which will enable us to capture the big data set we need to mine for data patterns in order to create an optimum caseload model.

We are seeking funding to pilot the Sophia tool with Kent and Medway Partnership Trust and other Mental Health Care providers in the region in 2015-2016 funding year. The initial next steps are to explore more of the work left undone, understand current caseload and workload including stratification of different types of caseload. Thereafter we plan to build an SQL database which allows multidimensional capture of this work, similar to what we have

done in the Cassandra programme with community and district nurses. This will allow high volume data capture from practitioners which can then be used to model optimum caseloads.

We anticipate that the QNI will be able to use the work undertaken on the Shared Purpose Career Competence Framework as part of their current developments and pilot with a larger sample to test application to practice and promote further refinement of the framework.

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12. Appendix

Appendix 1

CASELOAD AND WORKFORCE PLANNING

Making the complexity of community nursing visible: the Cassandra project

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There is a growing body of research evidence showing that staffing levels make a difference to patient experience and outcomes, quality of care and the efficiency of care delivery (Royal College of Nursing (RCN), 2010a; Francis, 2013; National Advisory Group on the Safety of Patients in England, 2013; National Institute for Health and Care Excellence (NICE), 2014). There are significant limitations to the current evidence on skill mix in the global health workforce, and there is a lack of specific literature on nursing workforce tools and models (Buchan and Seccombe, 2012), especially within the community context (Storey et al, 2009). Hurst (2006) predicts

that workforce planning and development will increase in complexity as the variables affecting it proliferate with the pace of services. The critical question is how to positively and progressively support, develop and transform the community nursing workforce in times of change to meet demand as populations overall increase in age, live longer, and as ever more complex comorbidities rise (Buchan and Seccombe, 2012; Smith and Jack, 2012; RCN, 2013, 2015). In addition, the political rhetoric and imperatives currently surrounding health-care provision are compelling workforce planning and development teams and commissioners to implement strategies that will deliver on effectiveness, safety and person-centredness (Francis, 2013).

ABSTRACT

The need to effectively promote safe staffing levels in community settings challenges commissioners and providers of services to find rigorous methods of capturing workforce evidence that can be systematically used to shape effective services and skill mix for the future. This article presents a brief review of current approaches and challenges to measuring community nursing workload activity in England. Specifically, it shows phase 1 pilot results using the Cassandra Matrix activity tool and review of ongoing developments and progress to demonstrate scalability for national implementation. As part of a much larger practice development project to develop community nursing, the pilot used mixed methods to collect 10 days of workload activity data from a self-selected sample of band 5–7 nurses working in general and specialist community nursing roles in three community organisations, and to evaluate their experiences of using the tool via an electronic survey. The findings indicate that the tool has significant potential for capturing the complexity and multiple dimensions of nursing work in community contexts, and phase 2 work has led to a community version of the tool being piloted on a larger scale across six community organisations.

KEY WORDS

- Community nursing • Safer staffing • Workload activity tools
- Complexity of care • Workforce modelling

Situating nursing

Nursing work itself is complex (Hall, 1964; Leary et al, 2008; Warren et al, 2012); however, when portrayed in terms of supply and demand, nursing work in the inpatient, specialist or community setting is often represented as a linear series of tasks that are deterministic in nature. These assumptions have led to nursing work being subjected to reductionist research methods using activity analysis that are quite simplistic (e.g. time and motion studies), but such methods do not capture complex work well (De Leon, 1993; Raiborn, 2004). In the research undertaken by Leary (2011) with specialist nurses in oncology settings, for example, a nursing act has eight dimensions, including intervention, context, time, emotional effort and other factors (Breast Cancer Care, 2008; Leary et al, 2008; RCN, 2010a; 2010b; Oliver and Leary, 2012). These aspects are rarely accounted for in any kind of time and motion or work-sampling study, particularly the application of vigilance in order to rescue patients from adverse consequences of disease or treatment (Oliver and Leary, 2012).

Scottish, Welsh and English contexts

The collection of meaningful data in the community nursing context is difficult to coordinate or even access, given that

community nursing occurs in many different contexts or locations and population demographics vary hugely across the country (Leary et al, 2008; Chilton, 2012). In Scotland, local and national workforce planning and the mechanisms used are more centrally coordinated. *Everyone Matters: 2020 Workforce Vision* (Scottish Government, 2013) sets out its priorities for creating an integrated workforce across care settings for the next 5 years. A centralised whole-systems approach to process mapping alongside measurement of demand, capacity, activity and backlog provides the evidence base for service improvement. There are four nationally agreed tools for workload measurement and planning in the following categories (Audit Scotland, 2007):

- ♦ Adult acute care
- ♦ Paediatrics and neonatal nursing
- ♦ Primary care
- ♦ Mental health and learning disabilities

In these areas, authorities are testing and piloting tools until they are fit for purpose and ready to be rolled out on a national basis. There are now seven tools in existence that take a triangulation approach, measuring activity, professional judgement and clinical quality indicators instead of measuring a single value (RCN, 2010a).

In Wales, health organisations submit annual workforce plans to the National Leadership and Innovation Agency for Healthcare (NLIAH) workforce development unit, which then feed into the education commissioning process. However, the quality of these plans appears to be very variable.

Models currently being piloted in England appear to be looking at the time taken to perform an intervention activity. Examples include:

- ♦ Time and motion studies based on capturing a linear series of tasks (<http://1.usa.gov/1A723GC>)
- ♦ Work on averages like the Safer Nursing Care work (<http://bit.ly/1LqZti8>)
- ♦ Diary-based examples making assumptions about what people are doing but which are not transferable because they are only sensitive to the diaries being monitored.

While it is important to develop a variety of tools to map workload activity and workforce requirements according to local health context needs, the limitation of these approaches is that they could underestimate and misrepresent the complexity and multiple dimensions of the community care episode, the time taken to provide it and the skill mix required to deliver it. It is important to acknowledge that there may not be one tool that will provide all the answers, but instead focus should be placed on testing tools for validity and reliability so that they reflect the multiple dimensions of care and are able to calculate the workload activity of the whole workforce to create a systematic evidence base to promote whole-systems working across the local health economy.

In 2013 and 2014, the England Centre for Practice Development piloted the Cassandra Matrix tool, a data collection tool originally designed for the specialist nursing community to help them articulate their activity to non-nurses (Leary, 2011). This article presents the initial findings of the phase 1 pilot study and highlights the benefits and

challenges of using a new approach to capturing workload activity as well as providing a snapshot of the story so far in terms of phase 2 and 3 work.

Current themes in workload planning and measurement

The current understanding of how to provide safe staffing levels in order to provide the right care in the right place at the right time has been identified by the RCN (2010b) in their *Safer Staffing Guideline* report. These recommendations are currently being addressed by NICE as well as the Centre for Workforce Intelligence and professional organisations and regulatory bodies. Workforce planning at a national level presents a number of challenges because, as the RCN (2010a) suggests:

- ♦ It has generally not been done well across the UK and has led to 'boom to bust' scenarios
- ♦ Changes in demand (increasing capacity, move to community) and changes in supply (ageing workforce), and the relationship between the two are not well reflected in workforce plans
- ♦ With the exception of Scotland, local and national workforce planning is not systematically integrated
- ♦ Effective workforce planning requires commitment to matching supply to demand (with an accurate assessment of both) and the authority to translate the results of the agreed approach into workforce plans.

Workload measurement tools may capture workload demands in order to plan staffing levels, but few give a clear idea of the mix of employees or skills needed to deliver safe, quality and effective patient care specifically in the community setting. The first fundamental issue is that there is a lack of national consensus around the definitions being used to describe nursing interventions and activities, starting with the service itself (what is being done and how frequently it involves contact with clients) and the population served (and its density) (RCN, 2010a). It is further compounded by variation in how 'caseloads' are defined; therefore, it is almost impossible to arrive at consistently defined data that allows averages to be produced and comparisons to be drawn because of population demographics and differences in skill mix across the country.

If the level and mix of staffing is not well matched to what is needed, it is not just the volume of care that is affected, but the quality of each and every nursing action or interaction could be affected by excessive workloads—the net effect being increased stress, sickness and low staff morale as well as a higher rates of staff leaving the profession (RCN, 2010a). From a community perspective it is vitally important to have accurate data to underpin decisions regarding commissioning skill mix and services so that the duration of each individual care episode provides the highest quality of interaction possible for both the practitioner and the client at home. In some parts of the country, directors of nursing are reporting variance in the contact time allocated by patients, but there is currently no systematic evidence to support a standardised approach. From anecdotal evidence it is not difficult to determine the potential impact on the quality of care and

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tasks that may be omitted or missed due to lack of time.

Levels of workforce planning

Workforce planning is undertaken at different levels (national, regional and local) and can be categorised into three main types of activity by level and purpose.

1. Workforce modelling

Workforce modelling uses current provision to predict future care needs to anticipate the demand for nursing staff. Also known as workforce flow, calculations are made on the basis of flow into and out of the labour market to predict the number of nurses needed to meet demand (a demand-driven model to inform workforce training plans).

2. Establishment setting

Establishment setting is a commonly used approach to determine or review the funded establishment of nursing posts required to deliver a specific service.

3. Daily planning/rostering

Daily planning or rostering is an approach used to match the staff deployed to variation in workload. It requires a regular review of patient mix (a predictor of associated workload) to ensure that supply meets demand for care anticipated. For example, the workload may be higher during flu vaccination season to meet the demands of the local population.

Ultimately, due to the lack of research and literature in the area of health workforce planning and development, and in community nursing more generally (Curson et al, 2010), there are real opportunities to lead on research and development, with the possibility of effective tools, models and conceptual frameworks providing exemplars for best practice locally, nationally and internationally. Equally, the challenge is to develop visionary methodologies, methods and tools by designing them to allow for a filtering of context and a responsiveness to wider sociocultural, socioeconomic and sociopolitical subjectivities (Hurst, 2006; Reid et al, 2008; Holloway et al, 2009; Kelly et al, 2009; Curson et al, 2010; Masnick and McDonnell, 2010; Parsons, 2010; Fraher and Jones, 2011; Haycock-Stuart and Kean, 2011; Leach and Segal, 2011; Buchan and Secombe, 2012; Chilton, 2012; Farmer et al, 2012; Tomblin Murphy et al, 2012; Centre for Workforce Intelligence, 2013).

The Cassandra Matrix tool

'Cassandra' was originally designed as a paper-based tool to capture what nurses do (interventions), where their actions occur (contexts), who the work is done for (patients or carers), and what the nurses do not have time to do (work left undone) (Leary, 2011). The tool's robustness is derived from the fact that it is based on 50 million hours of activity analysis. Some 65 000 interventions have been captured to provide detailed information about specialist nurse contributions in the field of oncology over a 9-year period. The research team had previously worked with the tool to measure the specialist nurse contribution in a large NHS acute trust that was undergoing a significant programme of workforce remodel-

ling. Based on the authors' experiences, the aim of the present project was to evaluate whether it could be piloted in the community nursing context.

The electronic version of Cassandra is designed to be used in 'real time' as practitioners carry out their daily work using computers, phones or tablets to input their activity. The interventions are grouped into four main types:

- ♦ Physical interventions
- ♦ Psychological interventions
- ♦ Social interventions
- ♦ Case management and administration

The tool will provide an accurate picture of how an individual practitioner spends most of their working time provided that a minimum of 70–100 hours of work are recorded. The electronic version of the tool generates individual reports (for a practitioner to judge their own workload) and annual appraisal negotiations. This information would also be useful for personal development planning and career progression. The organisational-level report demonstrates the spread and complexity of work across professional career bands as well as demonstrating what work has been left undone.

Methods

Purpose and objectives

The phase 1 pilot was commissioned by NHS England Kent and Medway local area team and North Kent clinical commissioning groups between September and December 2013 to determine the suitability and applicability of the Cassandra workload activity tool for the community nursing context. Project commissioners' critical questions guiding the study were:

- ♦ What tools 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 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?

A regional project steering group consisting of representatives from NHS England local area team, Health Education England, directors of nursing and quality in community nursing organisations and local NHS trusts was established to monitor and review project progress.

Testing

In order to test the validity of the tool for the community nursing context, a regional integrated mental health trust agreed to test it prior to the pilot with one of its community nursing teams to ensure that it appropriately described community nursing activities and interventions. A paper-based version of the tool was then piloted with three self-selected organisations working with a designated champion in each who recruited a sample of self-selected band 5–7 community

nurses willing to pilot the tool (*Appendix 1*). The total sample size for the pilot was 24 self-selected participants. Data were captured by each individual participant over a period of 10 working days. Using the paper-based tool, an activity was ticked every time it occurred against an inventory of pre-determined interventions. Each participant was responsible for completing daily record sheets and then adding up the total number of activities for each day. Once 10 days' data capture had been completed, the data sheets were returned to the research team and inputted into a Microsoft Excel spreadsheet. This provided an instant analysis of key activities, generating an individual report of workload activity as well as an organisational-level report of the spread of workload across the bands participating in the pilot.

A Bristol Online Survey (BOS) (BOS, 2013) was launched to provide an opportunity for participants to capture their evaluation in a pre-test/post-test design format. Using a claims, concerns and issues framework derived from fourth-generation evaluation (Lincoln and Guba, 1985), the survey asked what positive statements participants would like to make about using the tool, what concerns they had and what questions they would like to be addressed. This information was taken with a simple cognitive mapping tool asking participants to make a judgment regarding how effective they were at measuring what they did both pre- and post-pilot. This enabled comparison before and after the workload activity data collection.

Ethical approval for the study

Ethical approval for the study was provided by the University Ethics Committee. Anonymity for community nurse participants was clarified in a participant information sheet 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 personalised Cassandra Matrix work profile data for their own records and interest and to determine whether they wished to receive a full copy of the report. Individual participant data was not readily identifiable in the organisational analysis provided for each community organisation in the data analysis charts provided. It was made clear to employers of the participant organisations that individual community nurses' Cassandra activity profiles were confidential to the participants to avoid individuals being readily identifiable.

Results

Phase 1 pilot findings

Some 24 out of 26 participants returned 10 days of complete data, providing a 92% response rate. Individual reports were produced for each participant showing their overall intervention totals by the context in which they were carrying them out. The organisational charts provided 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. This enabled comparison between activities and ratios relating to employment bands at an organisational level. The pilot also generated a cross-organisational analysis report that showed the consolidated

interventions for the whole cohort of participants according to the context in which the care took place. This offered the opportunity to understand where the concentration of care activity lies, both in terms of interventions made and context. It also enabled the identification of some work overlap and repetition between band 5 and band 7 practitioners.

The data demonstrated that participating community nurses were involved in significantly more procedural and holistic assessment work over and above anything else, followed by (in order of significance): care planning and evaluation, caseload management, symptom control and advice, promoting self-management, reassessment of needs, handovers, and administration. The largest spike in the data identified that a significant amount of travelling was done in order to manage caseloads, with the majority of travel being scheduled as opposed to unscheduled. The majority of care activity took place in domiciliary settings, and although there was evidence of some telephone and clinical activity, the minority of activity occurred within a multi-professional context.

The data also indicated that practitioners engaged less (although still significantly) in providing health education, risk assessment and reviews, hospital avoidance, coordinating care, clinical risk assessment, and the chasing up of referrals and results. A less significant part of the overall work consisted of 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.

In summary, the data from this small pilot demonstrated that community nurses are required to draw on a broad spectrum of skills; however, the emphasis upon which of those skills is put into action differs according to the working environment.

User responses to the tool

The survey indicated overwhelmingly that participants felt that the tool would make visible the contribution of community nurses and is useful for both peer review and benchmarking care standards. One participant stated:

'It clearly highlights what we do each day as well as the scope and impact of my role'.

The pilot demonstrates that participants found the tool easy to engage with and use, and that it has:

'...potential to provide evidence of what I do, the skills and knowledge I use daily as well as inform staffing levels and admin support'.

The survey also identified for participants that managing time is a major concern that:

'...at times can be difficult due to the number of visits or shortness of staff. This in turn makes it difficult to measure what I do consistently'.

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Figure 1. Screenshot of the Cassandra Matrix tool at the beginning of the data entry process

Participants also identified the potential for the tool to be used to support integrated service delivery:

'It has the potential to promote more understanding of different roles and who does what in the multidisciplinary team.'

Discussion

The purpose of this initial phase 1 project was to test whether the Cassandra Matrix tool had the potential to be adapted for and used more extensively within community nursing organisations and settings. Therefore, our results and conclusions with a small sample size are not sufficiently generalisable to make broader recommendations regarding workforce design. However, they are useful in demonstrating that the tool is potentially valuable, that it is scalable and easy to use and that it promotes quick and easy comparative analysis of workforce activity for individuals, teams and organisations.

We can report with confidence that the tool clearly captured the full range of nursing activities across band 5–7 self-selected participants, verified by expert groups of community nurses. Furthermore, the tool demonstrated that band 5 practitioners were engaged more significantly in procedural work, care planning, and travelling. It was not possible given the small sample size to identify or infer the management activity of the band 7 practitioners. The phase 1 pilot demonstrated that the tool required some amendments in order to pick up additional community nursing interventions. A series of stakeholder workshops were established quickly to undertake consultation and consensus on what inclusions and additions needed to be made.

Future directions

Following a series of dissemination events at regional and national level, and further funding from Health Education England (Kent, Surrey and Sussex), the team is finalising a phase 2 pilot, testing an electronic community nursing version of the tool more widely with six community organisations across Kent, Surrey and Sussex to capture the workload activity of band 5–8 generalist and specialist community nurses on a larger scale (Figure 1). In addition, work is currently taking place with an integrated mental health and social care organisation to develop a mental health version of the tool for pilot in 2015 with a range of professional groups.

There now exists the national appetite and widespread support from NHS England, the Queen's Nursing Institute and the Royal College of Nursing to scale the use of Cassandra across a number of implementation sites in England in 2015. This will enable activity data to continue to be gathered using a grounded approach until saturation is achieved. Following this, the data will be mined for patterns in order to develop a representative optimum caseload simulation model ready for testing. This has not previously been achieved in the community context. It is hoped that this will enable a representative 'whole system' to be built that injects realism into practice, accurately reflecting the management of complex work instead of trying to measure the component parts in isolation. Developing an understanding of the interrelationships between care interventions, context and multiple users is an iterative process that involves working with large data to look for patterns that will enable the development of a representative model that reflects activity in all its dimensions in order to simulate the optimum caseload. By mining data and modelling the rela-

tionship that is assumed to exist, it may be possible to build more accurate data capture tools that provide increased insight into the relationship between complex nursing care and patient safety factors (and subsequent cost effectiveness). It is hoped that this will allow predictive modelling in future. Furthermore, the approach will help to identify how much work is planned and how much is unplanned. This is an important aspect to explore in detail since it enables the analysis of reactive versus proactive workforce activity and to balance the supply-and-demand-driven model currently pervading workforce planning. It is also an important factor in estimating the cost of care, or the cost of poor care.

Conclusion

Phase 1 and 2 testing has demonstrated that the community nursing version of the tool can quickly and accurately capture a representative picture of how community and district nurses spend their time. The electronic version of the tool has enabled more complex data to be collected that describes what people are doing and what breakdown of activity types is occurring within organisations and across NHS career grades within the workforce. Evidencing the complexity of community nursing enables practitioners, services, organisations and service users to reflect on its tangible value, and also to understand and appreciate that complexity alongside a fluid health economy in such a way that it is possible to plan future workforce development in a more comprehensive and inclusive way.

BJCN

Accepted for publication: 30 January 2015

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KEY POINTS

- Community nursing work is complex, multidimensional and varies across the country and by population mix
- Cassandra models a complex system and relies on understanding relationships as well as tasks that occupy time
- Workload activity data can be used to construct an optimum caseload model for community nursing and to identify workforce resourcing patterns
- In the future we will identify how much community nursing work is planned and unplanned and place an economic cost on care left undone



Appendix 1. Original adapted Cassandra Matrix tool

Daily record for practitioner 1					
	Domiciliary visit	Clinic visit	Telephone	Multi-professional meeting	Total
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 and review					
Reassessment of needs					
Psychological assessment					
Joint assessment					
Care planning and 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					
Carer support					
Advice (social)					
Advocacy					
Referral					
Chasing up results/referrals					
Travel (scheduled)					
Travel (unscheduled)					
Other administration work (non-clinical)					
Total					

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Appendix 2



3 March 2014

Ref: 14/H&SC/CL73

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

Dear Carrie

Confirmation of compliance for your study "*Developing a First Class Community Nursing Service in Kent, Surrey and Sussex.*"

I have received an Ethics Review Checklist for proportionate review of the above project to be carried out in collaboration 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/GovernanceAndEthics.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 research.

Yours sincerely

A handwritten signature in black ink that reads "Roger Bone".

Roger Bone
Research Governance Manager
Tel: +44 (0)1227 782940 ext 3272 (enter at prompt)
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Professor Rama Thirunamachandran, Vice Chancellor and Principal

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Appendix 3

**Developing a First Class Community Nursing Service Across Kent Surrey and Sussex
Health Education England Kent Surrey Sussex (HEKSS), Phase 2 Project May-
December 2014**

Terms of Reference for Project Steering Group

Project Summary:

This project builds on the outcomes and outputs for a stage 1 commissioned project funded by NHS England Kent and Medway Local Area Team to (i) develop a Shared Purpose Framework for the delivery of a First Class Community Nursing Service across Kent and Medway, and (ii) pilot the Cassandra Matrix Tool as a way of mapping community nursing activity to provide evidence that may be useful as a future workforce development and planning tool to determine future skill mix in redesigning community health services. The project underpins the development of person centred cultures of community nursing effectiveness to deliver safe and effective care to the right person, in the right place.

The next phase of this project will:

1. Further develop the shared purpose framework through broader regional consultation with community nurses, patients and carers and service users. This will include developing levels of application within the framework for registered to expert practitioners so that the knowledge, skills, competencies and leadership behaviours required to deliver person centred compassionate, safe and effective evidence informed care are articulated further.
2. Modify the Cassandra Matrix Tool for the community context based on feedback from stage 1, and undertake a more detailed activity analysis of community nurses (Adult, Child, Mental Health) across the region using the Cassandra Matrix Tool with a bigger sample of practitioners in Kent, Surrey and Sussex.
3. Develop an optimum caseload tool based on a deeper quantitative understanding of the work of nursing in KSS Community settings using data mining and pattern recognition techniques and develop virtual workload simulation case scenarios and model negative space.

The project is innovative because:

1. Currently there is no readily identifiable workload activity analysis or workforce development tool that helps community nursing to readily identify its contribution to providing care for people close to home. The tool has the potential to provide national workforce data desperately needed to help shape the services and the workforce of the future
2. A Shared Purpose Framework for community nursing in the region helps organisations to work with a common vision and purpose and focus clearly on the knowledge, skills, behaviours and competencies required of an effective community nursing workforce.
3. There are currently no readily identifiable indicators of effectiveness of the outcomes of community nursing
4. Developing practitioner self-awareness of the contribution they make to the delivery of person centred, compassionate, safe and effective care is vital in developing transformational leadership capacity and professional/organisational/workplace cultures.

Policy Context:

This project funded by the HEKSS Primary Care Board, fits with the Skills Development Strategy for Primary Care. The work stream is expected to expand to encompass community care to support the system change required to deliver care closer to home (HEKSS 2012). *“Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams. Leaders of health care provider organisations, managers, clinical leaders and Health Education England have a duty to provide the environment, resources and time to enable staff to acquire these skills”* (Berwick review into patient safety in the NHS in England, 2013).

The future community health care model requires a forward thinking community nursing service capable of delivering an integrated approach to care for people close to home. There are however a wide arrange of different types of community nursing roles (general, specialist, general specialist) providing support for Adults, Children and people living with Mental Health concerns. It is vitally important that we have a clear understanding of the unique contribution they make to delivering a first class community nursing service, delivering care to the right person in the right place. If community services are to transform to deliver care close to home, workload activity data sets and tools are vital to underpin the workforce planning for the future. This specific project links directly with:

- Compassion in Care action area 5 as part of developing evidence based tools for safe levels of community staffing.
- Culture change based on a values informed approach. The approach taken also is locally owned with the beginnings of qualitative measures of success and links to cultural change.
- DH Response to the Francis Report Recommendation 26 and the intention is that this research will inform NICE with an evidence base for community nursing and care.

This project also fits with the Education Outcomes Framework (EOF) development priorities as it enables:

- a. Healthcare practitioners to demonstrate impact of learning on improvements in quality of care and patient experience outcomes;
- b. Healthcare organisations to establish value for money and strengthen workforce development planning;
- c. A benchmark to guide development of pre-requisites, knowledge, skills and attitudes in relation to values and behaviours of community nurses to deliver person centred, compassionate, safe and effective care.
- d. Contribute to healthcare organisations’ dashboards to enable them to measure the impact of professional development on quality of care and patient outcomes linked to effectiveness indicators.
- e. Influence workforce planning and skills development strategies for healthcare organisations through using robust systematic mechanisms for measuring effectiveness.
- f. Create more accountable reporting for commissioning of education to impact on strands of work linked to the Skills Development Strategy and capacity building in the workforce.

Project Timeline

May-December 2014

The Role of the Steering Group

The role of the Steering Group is to advise on the development and co-ordination of Phase 2 of the Community Nursing Project and to act as a 'critical friend'.

Ways of Working

Based on CIP principles (collaboration, inclusion and participation) open dialogue and opportunity for critical review will be provided through a Huddle conference space, face to face meetings and teleconference, as well as regional stakeholder events and on line survey tools. Where a specific meeting has been called and there are insufficient numbers to effect decision making, the Chair will seek to consult absent members to achieve consensus to effect swift action.

The Board is co-chaired by the Project Director, Carrie Jackson, Director of the England Centre for Practice Development and another nominated lead from the region.

The Group will meet a minimum of four times (as many as 7 depending on availability) during the project not including stakeholder workshop events.

- Members of the Group will receive papers ahead of meetings and papers related to review of progress according to project milestones
- Agendas for meetings will be co-produced and meetings co-chaired.
- Minutes of the meeting will be kept by a designated note taker and agreed by all members of the Group who attended the meeting.
- Members may be contacted between meetings for advice should the need arise.
- From time to time individuals may be co-opted to provide specific advice and expertise as required.

Membership

- The Group will comprise project team members from the England Centre for Practice Development and self-nominated leaders across Kent, Surrey and Sussex. Group membership will last for the duration of the project ending December 2014.
- Members of the Group are expected to be involved in stakeholder consultation event(s) and in piloting tools where appropriate.

Responsibilities

- To promote swift and effective communication and consultation with relevant health care leaders across Kent, Surrey and Sussex networks
- To ensure that the project keeps to time and meets its intended targets.
- To support the further development of the shared purpose framework.
- To provide advice on issues that affects stakeholders and support strategies to promote stakeholder and service user engagement in regional events.
- To provide advice and guidance as appropriate to ECPD in developing and monitoring project tools and frameworks.
- To support successful pilot of frameworks and tools through effective sampling and engagement of key staff within organisations.
- To provide a mechanism via which requests for updates and/or attendance at meetings can be channelled.
- To provide a forum for discussion of progress.

- To implement the recommendations of the project strategically within own organisations.
- To promote the work at national and regional events and through networks.
- To help guide the development of recommendations for further work.

Appendix 4

An activity analysis tool for community nursing

A Guide to using the Cassandra Matrix™.

What is The Cassandra Matrix™?

Cassandra is a simple data collection tool that was originally designed for the specialist nursing community to help them articulate their activity to non-nurses. It is designed to help you show how you spend most of your working time. It is based on a much larger and more complex database of specialist nursing activity. We are hoping that we can develop a version for community nurses. That's where we need your help!

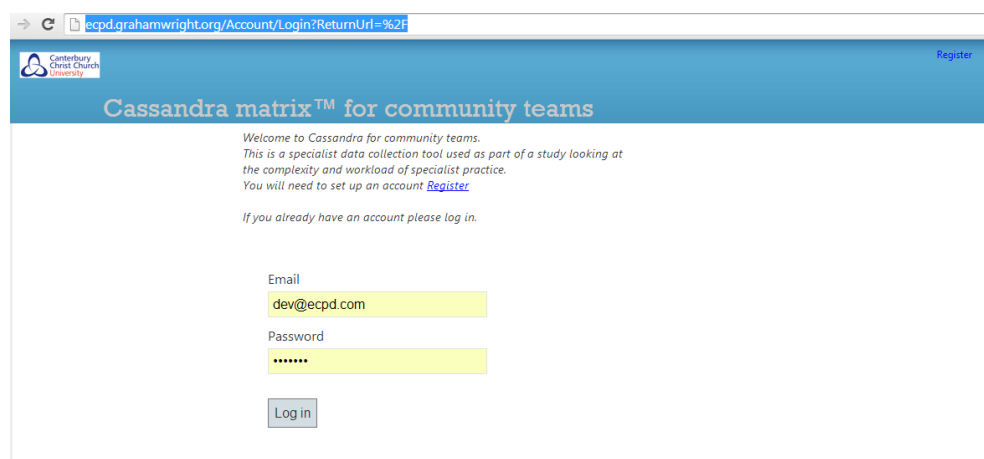
Cassandra gives you a representative picture of how you spend your time, without having to record much information. Cassandra doesn't record all your activity - just most of it. It also records the activity most associated with either income or savings if you work in an acute NHS Trust. Cassandra will represent your work accurately provided that you each record about 70-100 hours of work. This will give a picture of what you do most of the time. Despite what it might say in job descriptions most specialists nurses don't spend a lot of time doing research, formally teaching and in management. If you spend large chunks of time **teaching, researching or managing** subtract that time and record it separately.

Why an electronic version?

You might have tried Cassandra on paper before. We are taking that work a step further and collecting more complex data. We hope this will help us calculate optimum caseloads. We cant collect this data very easily on paper.

How to register for an account.

When you go to our test site <http://ecpd.grahamwright.org/Account/Login?ReturnUrl=%2F> (as this is a test site initial log on and registering might take a minute or so-but it should be fine once you are collecting data.) You will see a page like this. Click on "register"



The screenshot shows a web browser window with the URL <http://ecpd.grahamwright.org/Account/Login?ReturnUrl=%2F>. The page header includes the Centurion Christ Church University logo and a 'Register' link. The main heading is 'Cassandra matrix™ for community teams'. Below this, there is a welcome message: 'Welcome to Cassandra for community teams. This is a specialist data collection tool used as part of a study looking at the complexity and workload of specialist practice. You will need to set up an account [Register](#).' A note follows: 'If you already have an account please log in.' The login form contains an 'Email' field with the text 'dev@ecpd.com', a 'Password' field with six dots, and a 'Log in' button.

You will be taken to a page to register your account

Cassandra matrix™ for community teams

Register.

Create a new account.

Email

Password

Confirm password

Place of work

Job title

Band

Please select your band

Please select your band

Band 1

Band 2

Band 3

Band 4

Band 5

Band 6

Band 7

Band 8

Band 9

Please complete the form. We only use your email to set up the account so it is unique to you. We will not save it or use it to identify you at any time. Once you have completed the form press “register” then you are all set to start collecting data.

How to collect data.

This version of Cassandra is web based and so needs internet access (computer, phone or tablet). On the phone or tablet you will only be able to input data. You will need a computer to see your results.

To get a reasonable picture of your activity you will need to collect 70-100 hours of work. You can do this in days or hours over a number of weeks. We are hoping to collect this data over the month of September 2014. For example you could record a couple of weeks work or you could record half days, different days of the week etc. until 70 hours is reached.

70 hours is the minimum you can collect and it should be a representative spread of your work (for example, do not collect data only on Tuesdays unless you only work one day per week).

Cassandra captures what nurses do (interventions) and where they happen (contexts). In this version of Cassandra we are looking to collect information on who the work is done for (patients or carers) and if you wanted to do things but couldn't for. Each time you perform interventions simply tick the box according to what interventions you provided and where. For example symptom control in outpatients. At the end of the day, add up the scores and transfer them to your personal spreadsheet on the website.

If you have days dedicated to **research, management or formal teaching** (which are not recorded by Cassandra) then just leave these days out.

The spreadsheet for each individual nurse has some basic automatic analysis in it already, which you can see straightaway if you are using it on a computer.

How do I input my data?

The home page for data entry is this one. You will need to complete for each episode of

The screenshot shows a web browser window at the URL `ecpd.grahamwright.org/DataCollection`. The page header includes the Canterbury Christ Church University logo and the text "Cassandra matrix™ for community teams". Below the header, there is a "Home: Data Collection" link and a "Start" button. A progress indicator shows "0 of 5 Complete".

The main content area contains a list of steps on the left:

1. Start
2. Interventions, Physical
3. Interventions, Psychological
4. Interventions, Social
5. Case management & Admin

Below the list, there is a welcome message: "Welcome to Cassandra for community teams. This is a specialist data collection tool used as part of a study looking at the complexity and workload of specialist practice. You can download the instructions [Here](#). At the end of the day please tell us how much unpaid overtime you have worked."

The form fields include:

- Date: 22 August 2014
- Is this data entry for: Please select
- Where/how did this take place? Please select
- How many hours did you work today? Include any unpaid overtime or worked through lunch breaks: 0

A blue arrow points to the date field. A "Next" button is located at the bottom right.

care.

We collect data as episodes of care delivered by place or context. IE if you visit someone at home Cassandra will ask for the activity you have performed there for patients, carers and work you didn't have time to do.

After you have completed this click on "next" and you will move through the rest of the data entry for that episode of care. The next screen is physical care. This list has been developed from our work together so far. It is not definitive by any means and will be developed over time.

The screenshot shows the "Interventions, Physical" screen. The header includes the Canterbury Christ Church University logo and the text "Cassandra matrix™ for community teams". Below the header, there is a "Home: Data Collection" link and a "Start" button. A progress indicator shows "1 of 5 Complete".

The main content area contains a list of interventions on the left:

1. Start
2. Interventions, Physical
3. Interventions, Psychological
4. Interventions, Social
5. Case management & Admin

Below the list, there is a list of interventions:

- Symptom Assessment
- Prescribing medications
- Titrating medications
- Administering medicines (oral)
- Administering medicines (IM, SC)
- Administering or managing IV
- Requesting/recommending medical
- Medicines education
- Medicines advice
- Requesting investigations
- Performing neat patient testing
- Review results & act on findings
- Wound management
- Performing procedures
- Rescue work (physical/devices/dru
- Promoting self-management
- Falls assessment
- Continence assessment
- Continence management
- Prescribing/supplying products

A blue arrow points to the "Interventions, Physical" step in the list. A blue arrow points to the "Interventions, Physical" header. A blue arrow points to the "Next" button.

Annotations include:

- "Select if this episode of care is for a patient, a carer/other or its work you didn't have time to do" (pointing to the "Is this data entry for:" field)
- "Select where this happened" (pointing to the "Where/how did this take place?" field)
- "At the end of the day please put in how many ACTUAL hours you worked. This only needs to be done ONCE per day not each time" (pointing to the "How many hours did you work today?" field)
- "Press Ctrl and click to choose more than one intervention" (pointing to the intervention list)

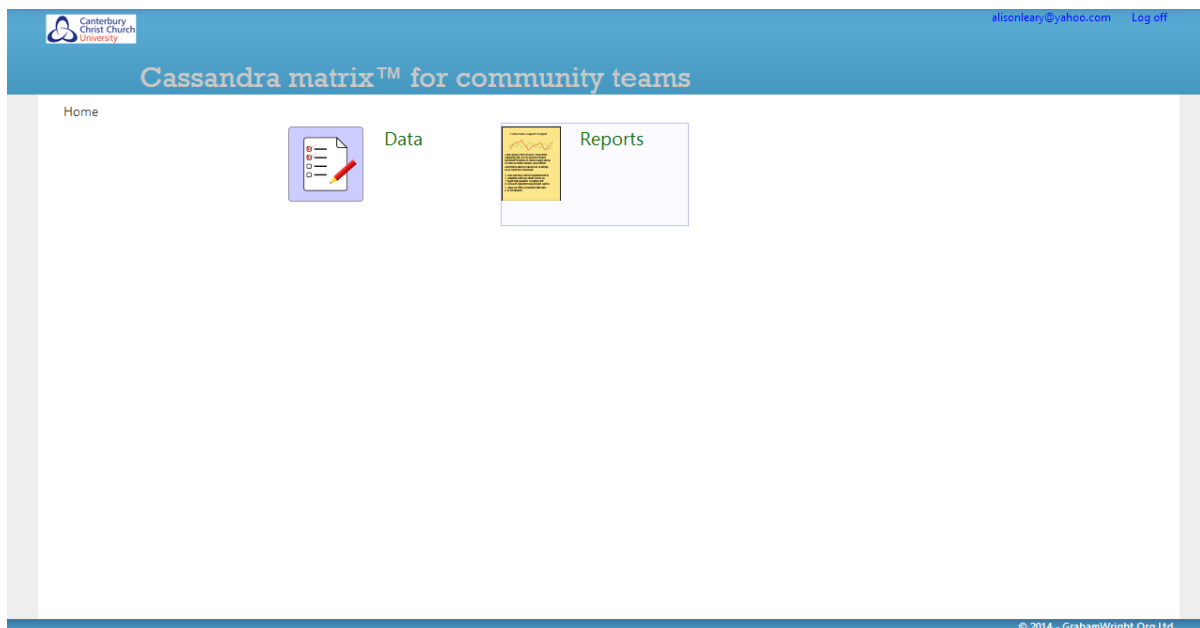
A "Previous" button is located at the bottom left, and a "Next" button is located at the bottom right.

You can choose as many or as few choices as you wish. By holding the “ctrl” button and using a mouse to click you can choose multiple items. Simply click again to unselect them. If you roll the cursor over the items they will give you an explanation. Continue through psychological, social and case management until you press “finish”. This will take you back to the start and you can add in another episode of care.

If it doesn't look like this it means you might not have JavaScript enabled-ask your IT department to do this for you.

How do I see my data?

Going to the “home” page will give you a screen like this:



When you have input the 70-100 hours' worth of data from your sheets simple press the report page.

You will see a number of pie charts and graphs that show you how you spend your time. You can choose to see how you spend “all” of your time or just the time you spend with patients, the time you spend with carers or if you have input it, the work you don't get time to do.

Frequently Asked Questions

What if I don't have access to the internet?

This version of Cassandra is designed to be used in “real time” ie as you go through your day. It can be used on computers, phones or tablets. If having access to the internet is a problem there is a paper version of Cassandra you can use which you can then use to input your data at a later stage. If you need this please let us know.

The contexts

The contexts are the most common places where you work– or where work arises from.

The ones listed in this version of Cassandra are

Home visit (first)

Home visit (subsequent)

Nursing/Care home/Hospice
Telephone/Email response work [Reacting to messages/issues](#)
Telephone planned call [Planned telephone calls](#)
GP/Primary care clinic
Hospital Inpatient
Hospital Outpatient
Travel/Car
Drop in clinic
MDT meeting/case conference
Virtual Clinic/ward round
Urgent Review [totally unplanned work in response to a request/crisis](#)
Support Group/Group Appointment
Day centre
One stop shop/Charity

We can add more if there are other settings where you regularly work and want to record. If you want to add an additional context, let us know.

There is no 'office' context. If you do something in the office, put it under the context where the activity arose from so for example if you do the activity in the office but it arose from a home visit then use home visit.

Who you did you do the activity for?

It would really help us understand more about the complexity of the work and the workload if you can tell us who you are completing an episode of care for. There are three choices

Patients The patients on your caseload

Carers/Others The people you care for who are not on your caseload

Work left undone The work you would have liked to have done but did not have the time or resources to do. For example you might complete a visit and choose 5 interventions from the other menus. However you might consider that you would have like to have also given more time to the patient, their carer or family but could not. Choose "work left undone" and then the interventions you would like to have done. This will really help us understand workload.

How do I know what items to choose?

Cassandra captures what nurses do (interventions) and where they happen (contexts) and who they happen to. You need choose each time you perform an intervention this means for most people that each patient or carer encounter will consist of several interventions.

The interventions are grouped into four main types in this version of Cassandra:

1. Physical interventions
2. Psychological interventions
3. Social interventions
- 4 Case management & Administration

Based on the bigger dataset we know that, when averaged out over many occurrences, each intervention type typically takes around the same amount of time. Therefore by analysing enough interventions, you can demonstrate how you divide your time over a typical year.

Here are some of the Interventions and explanations from the literature-if you would like to know more please contact us.

Physical

Physical Assessment This refers to physical assessments-be sure to think about the assessments you do

Symptom Assessment

Prescribing medications Writing a prescription

Titrating medications Adjusting medication based on an assessment

Administering medicines (oral)

Administering medicines (IM, SC)

Administering or managing IV includes disconnecting pumps, flushes

Requesting/recommending medications asking another professional to prescribe but you decided what was needed

Medicines education helping patients understand their medicines

Medicines advice sharing expertise with other professionals/teaching

Requesting investigations These can be anything such as labs, radiology etc

Performing neat patient testing

Review results & act on findings

Wound management includes assessment

Performing procedures

Rescue work (physical/devices/drugs/iatrogenic) Rescue work is where you prevent something harmful from happening for example you might detect an infection and act. "Rescue work" is based on Silber et al's (1992) work, which explored what would happen if a situation was not rescued. In this situation it refers to an intervention where a specialist nurse intervenes to prevent a situation deteriorating further perhaps leading to avoidable harm or to unscheduled care. The issue which resulted in the rescue work can be a deterioration of physical symptoms, a medicines issue or an iatrogenic problem (an adverse consequence resulting from a medical intervention) for example you might pick up the early signs of a chest infection or see something is incorrectly prescribed or not prescribed at all. Nurses use vigilance all the time to perform rescue work.

Promoting self-management This is enabling the patient to care for themselves ie education. These are the interventions you might use such as health promotion and education which lead to eventual self-management by patients and carers

Falls assessment

Continence assessment

Continence management

Prescribing/supplying products Continence or other products

Psychological

Psychological assessment refers to the assessments offered at NICE level 2. These are generally the interventions listed below such as active listening, helping to meaning-make or address issues of biographical disruption (loss of identity for example) this might also include a referral for more intensive interventions ie a psychologist or counsellor.

Anxiety management for most experienced nurses this is creating a safe space to explore fears and anxieties in relation to the illness or situation.

Supporting clinical choice and meeting information needs Assessing & meeting information needs using specialist knowledge of the group, exploring choices for example product choices or drug therapy

Shared decision making This is where you come to a joint decision after discussing options-not just giving information

Anxiety rescue work See 'rescue work' above. Anxiety rescue work might arise where a patient had been given mis-information or no information or rescue work as a result of the specialism is altered body image.

Dealing with distress The distress caused by the condition or its consequences
Biographical disruption This is where the patient has to make a significant shift in their identity ie a working adult-but now an adult with a stoma, cancer or other long term condition
Body image/Psycho-sexual
Communicating significant news
Advanced care planning conversations conversations about end of life care
Management of enduring mental health issues
Mental capacity assessment

Social

Social assessment An assessment of the patients social situation
Social Needs Assessment (formal)
Lifestyle changes & Social adaption Building a new life & negotiating change as person with a long term condition
Mediation of relationships/conflict resolution This is the process of adaption to often long term illness where the specialist nurse might negotiate or talk to relatives/significant others- could include supporting family carers in their response to their family member.
Finance/Benefits advice/housing
Safeguarding
Domestic/safety Domestic work done for patient safety ie changing a light bulb, shopping, pharmacy collection or other social

Administration, leadership & Case management

Clinical Admin Admin only a clinician can do ie requests. Referrals etc. e.g. dictating a letter to a GP, checking blood results in other admin work that a clinician has to do

Non clinical admin including routine chasing up Admin a lower band worker could e.g. booking an outpatient appointment, answering the phone and taking a message for someone else, typing letters, chasing routine results, preparing clinic notes-in other words admin work a lower band worker could do

Data entry Data entry (not including Cassandra)

Stock control/ordering

Advocacy

Brokering care Negotiation on behalf of patient with other professionals ie to get imaging done, reviews etc. **Advocacy/Brokering** is where you might negotiate or speak up for a patient. This might be in an MDT meeting if you are aware of patients thoughts on a particular area such as treatment choices. The brokering aspect is when you negotiate appropriate or faster care for example negotiating a CT scan or other clinical care such as a referral to a new consultant.

Referrals Social x1

Referrals Clinical x1

Referrals other ie equipment x1

Referrals Social more than 1

Referrals Clinical more than 1

Referrals other ie equipment more than 1

Leadership work-monitoring standards, vigilance & role modelling

Informal and formal teaching

Professional activity ie regular meetings/journal clubs/grand rounds etc

Service development/management

When thinking about **referrals** consider all referrals eg OT, physio, SALT, dietician, tissue viability, continence, orthotics/podiatry, any medical consultant including GP, health visitors/ other community nurses, nursing/care home, pain team, maternity services/midwife,

neurophysiology, audiology, ophthalmology, sexual dysfunction, psychologist, psychiatrist, CPN or for counselling / relationship counselling / talking therapies. Safeguarding, workplace/employer, educational are some examples.

Tips on completing.

- The more detail you can collect the better - for example if you are recording a clinical encounter you may do five or six things within it - make sure they are all recorded.
- Don't worry about whether each intervention takes a little time or a lot – that is all taken care of in the database which underpins Cassandra.
- Sometimes it will be difficult to know exactly which things to choose, but don't spend much time worrying about it – just use your best judgement. The following examples may help.

In 2013 Cassandra was used by some Multiple Sclerosis specialist nurses to look at their activity you might find these examples useful in terms of recording yours. These examples were put together for the GEMMS project by Amy Bowen and Geraldine Mynors.

Example

Miriam undertakes a home visit and finds the patient not coping well at home. His partner is overstretched and depressed, and it is clear that some respite care is needed. This is what she does, and what she chooses – all in the context 'home visit' & "telephone":

Tasks done on the call	Who for	Interventions chosen	Context
Assesses the patient's physical symptoms	Patient	Physical assessment Falls assessment	Home visit
Listens to the patient's anxiety about how difficult things are at home.	Patient	Psychological assessment Dealing with distress	Home visit
Also the carer's concerns	Carer/Other	Psychological assessment Dealing with distress	Home visit
Advises on some possible options for respite care	Patient	Social assessment Manages anxiety	Home visit
Back at the office, telephones a respite centre to see whether they would be able to take the patient for a few days	Patient	Referral (social) Brokering care	Telephone
Calls the patient's carer back to explain what is on offer and how the respite care would work, jointly makes a decision on how to proceed.	Carer	Supporting clinical choice and meeting information needs.	Telephone
Calls the care home back to confirm the arrangements	Patient	Admin - clinical	Telephone
Calls patient transport to arrange the transfer	Patient	Admin – non clinical	Telephone
Phones the patient's GP to explain what has happened and ask the GP to follow up	Patient	Admin – clinical Brokering Care	Telephone
Writes to the patient's GP to confirm the plan of action	Patient	Admin - clinical	Home visit (originated in home visit)

Problems?

If you are seeing lots of menus joined together it might mean JavaScript is not active on your computer-you need to ask your IT people to enable it.

If you have any problems please don't struggle-please call Alison or email her (details below).

Further reading

If you are interested in finding out more about the work which underpins Cassandra, the following are useful publications:

Nursing Standard, Leary: [Proving your worth](#)

ICN (2002). [Definition of Advanced Practice](#)

Meyer, G. & Lavin, M. [Vigilance \(2005\): The essence of nursing](#). Online Journal of Nursing 10(30).

Health Foundation [reviews of self-management](#), including [People Help Themselves](#)

Oliver S, Leary A (2012). [Return on Investment – Workload, value and complexity of the CNS](#). *British Journal of Nursing* 21(1): 32-37.

Any problems/issues/suggestions please contact Alison
alisonleary@yahoo.com 07721 412928 or the team at
Canterbury Christchurch University.

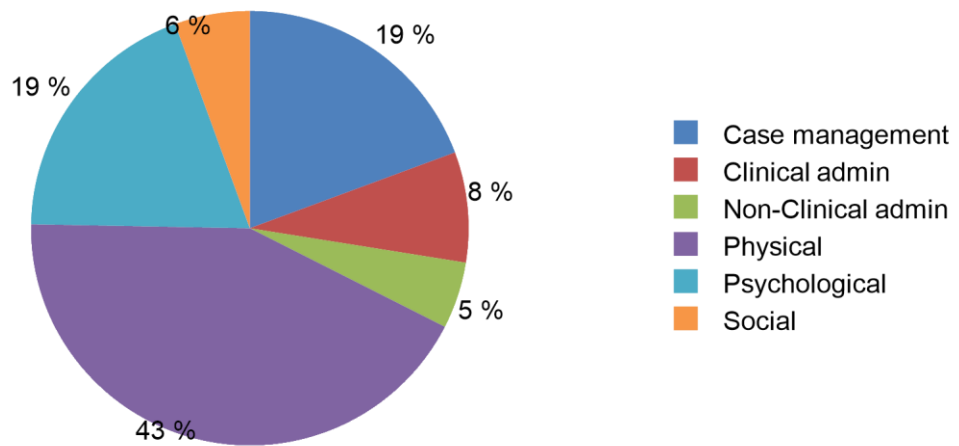
Thank you for participating!!

The Cassandra Matrix™ is a registered trade mark registered with the Trade Marks Registry, Intellectual Property Office of Great Britain and Northern Ireland Number 2627484 under Class 35 Electronic data storage and Class 42 Analysis of data (written and electronic) Scientific and technological services and research and design relating thereto: industrial analysis and research services, design and development of computer hardware and software, computer programming, computer consultancy services. The Cassandra Matrix TM and all variants remain the intellectual property of Alison Leary. Use is by agreement or licence. For the purposes of individual use by registered nurses in their own practice an agreement or licence is not required.

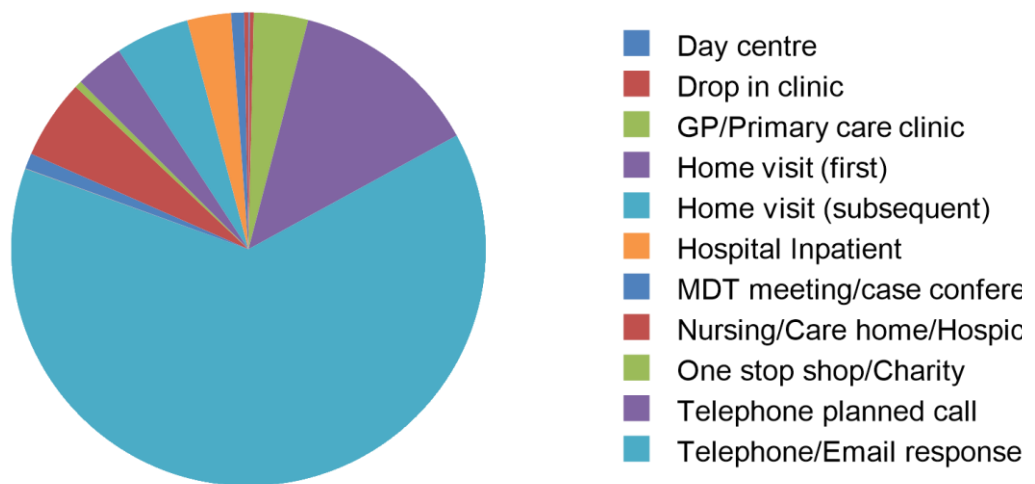
Appendix 5:
Cassandra All Data

Cassandra Report for all Data

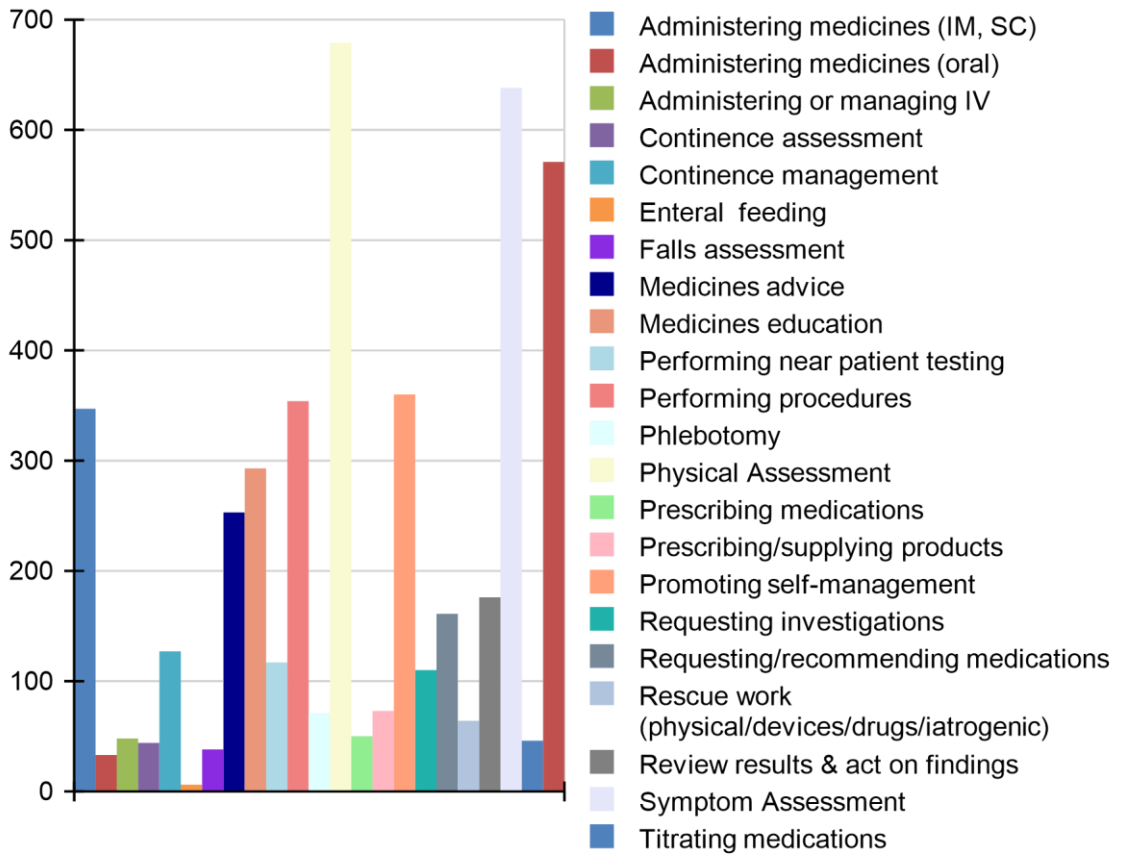
Intervention by Type



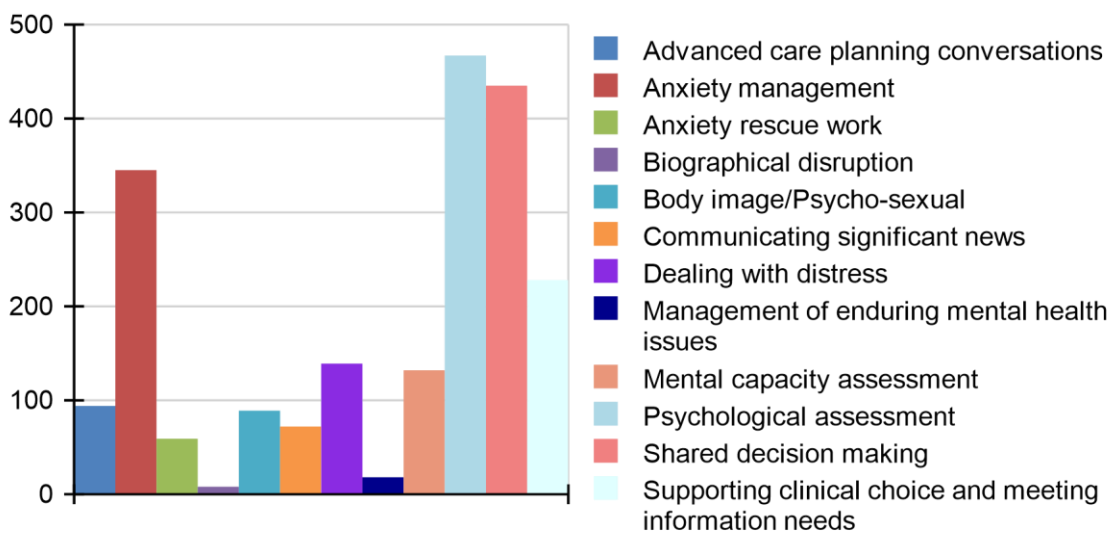
Intervention by Location - (For legibility % have been removed – calculations are derived from data on pp. 96-97)



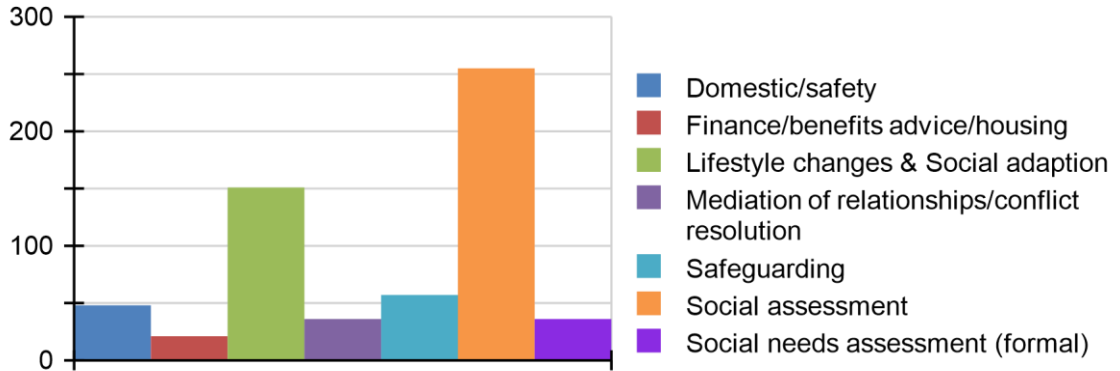
Physical Interventions



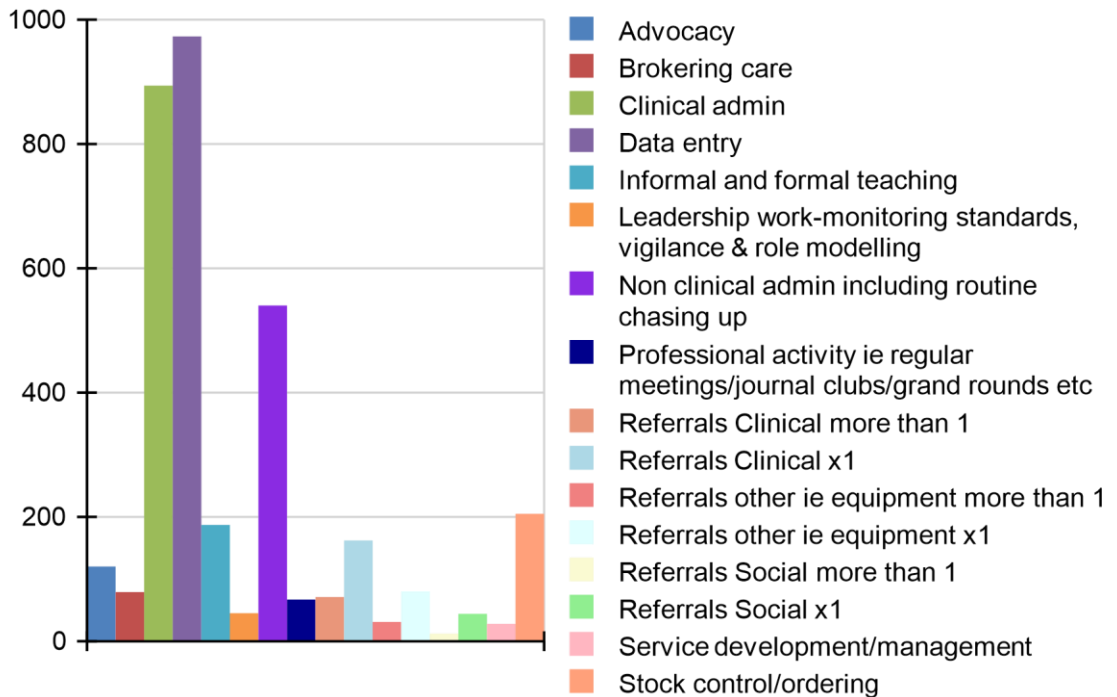
Psychological Interventions



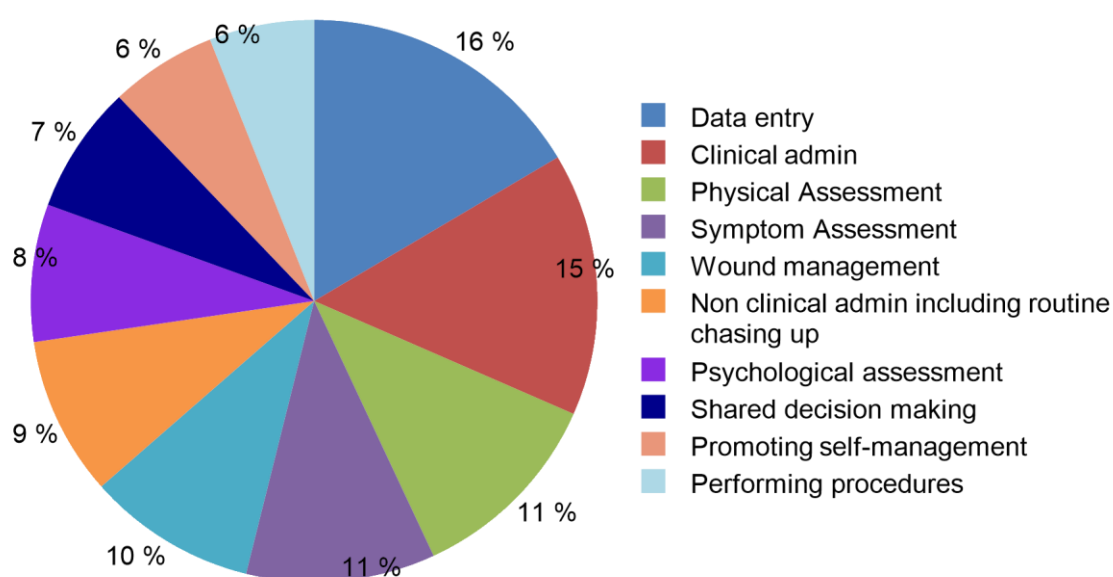
Social Interventions



Case Management & Administration



Top 10 Interventions

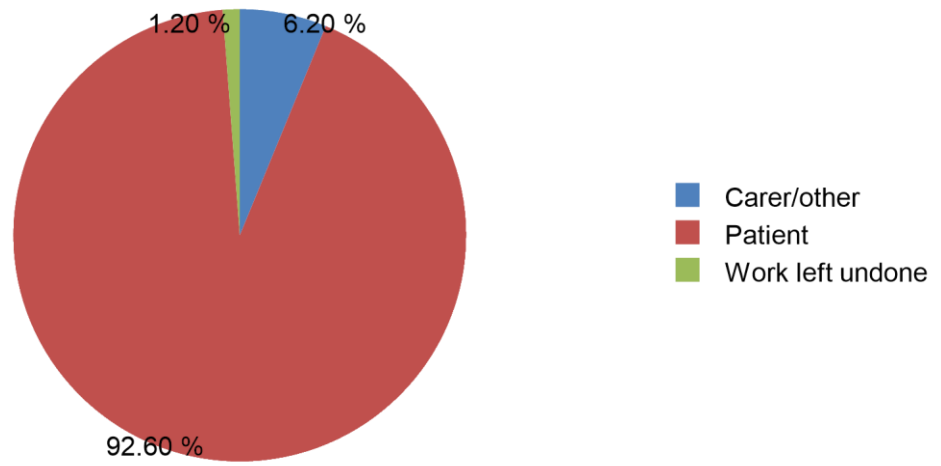


Intervention totals

Intervention	Total
Administering medicines (IM, SC)	347
Administering medicines (oral)	33
Administering or managing IV	48
Continence assessment	44
Continence management	127
Enteral feeding	6
Falls assessment	38
Medicines advice	253
Medicines education	293
Performing near patient testing	117
Performing procedures	354
Phlebotomy	71
Physical Assessment	679
Prescribing medications	50
Prescribing/supplying products	73

Promoting self-management	360
Requesting investigations	110
Requesting/recommending medications	161
Rescue work (physical/devices/drugs/iatrogenic)	64
Review results & act on findings	176
Symptom Assessment	638
Titrating medications	46
Wound management	571
Advanced care planning conversations	94
Anxiety management	345
Anxiety rescue work	59
Biographical disruption	8
Body image/Psycho-sexual	89
Communicating significant news	72
Dealing with distress	139
Management of enduring mental health issues	18
Mental capacity assessment	132
Psychological assessment	467
Shared decision making	435
Supporting clinical choice and meeting information needs	228
Domestic/safety	48
Finance/benefits advice/housing	21
Lifestyle changes & Social adaption	151
Mediation of relationships/conflict resolution	36
Safeguarding	57
Social assessment	255
Social needs assessment (formal)	36
Advocacy	120
Brokering care	79
Data entry	973
Informal and formal teaching	187
Leadership work-monitoring standards, vigilance & role modelling	45
Professional activity ie regular meetings/journal clubs/grand rounds etc	67
Referrals Clinical more than 1	71
Referrals Clinical x1	162
Referrals other ie equipment more than 1	31
Referrals other ie equipment x1	80
Referrals Social more than 1	12
Referrals Social x1	44
Service development/management	28
Stock control/ordering	205
Clinical admin	894
Non clinical admin including routine chasing up	540

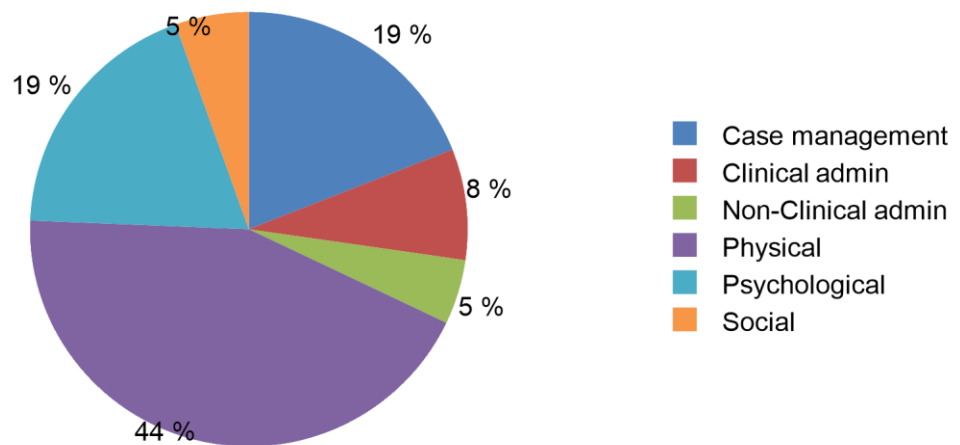
Intervention by Source



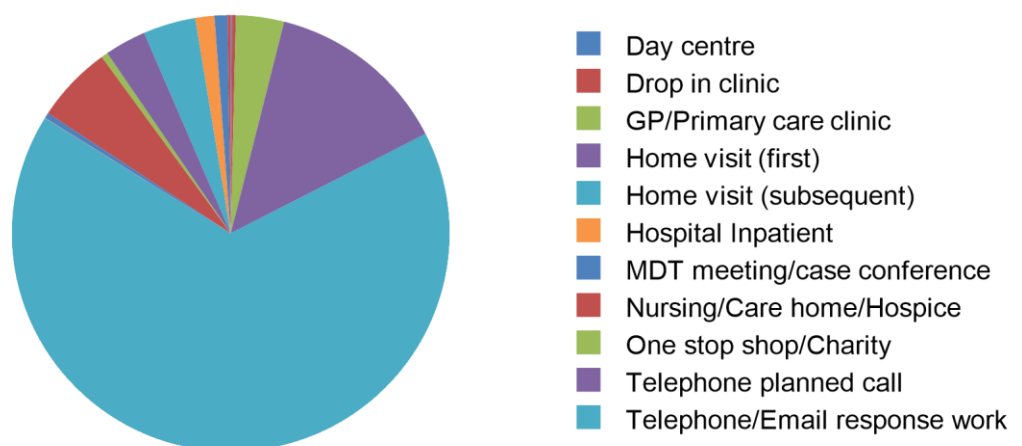
Cassandra Patient Data

Cassandra Patient Data

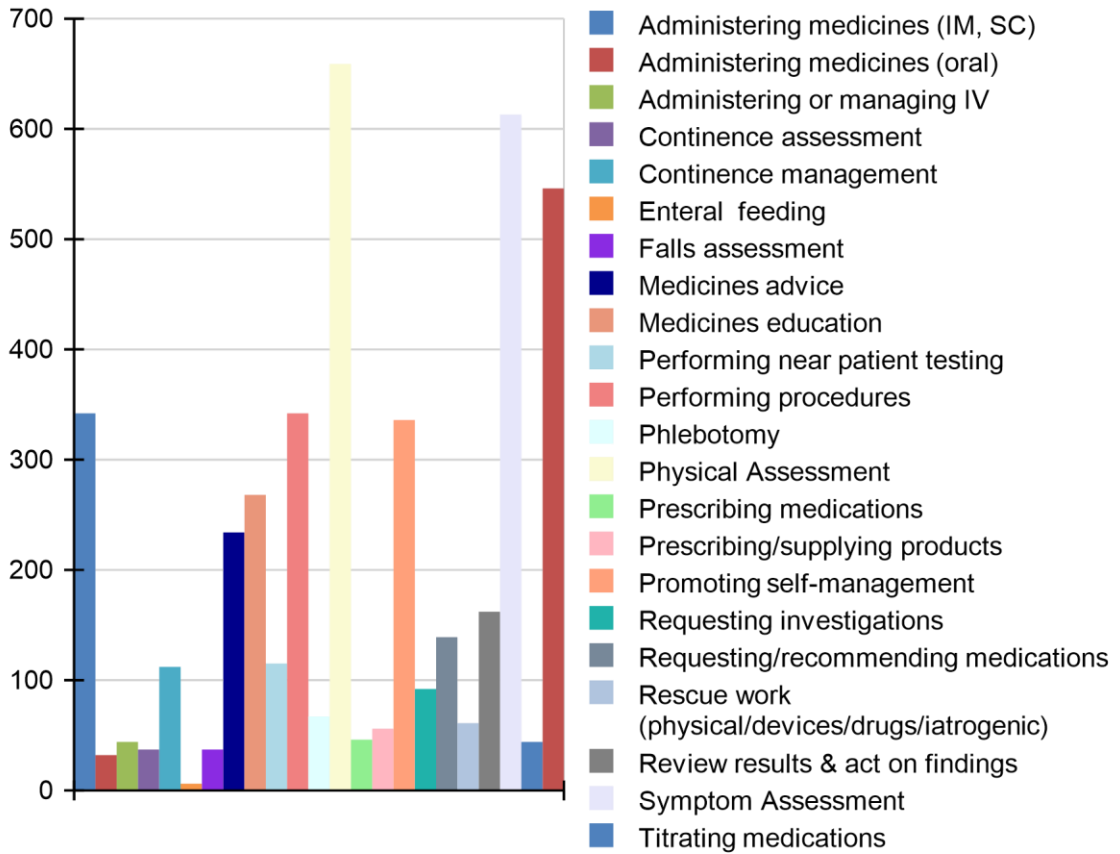
Intervention by Type



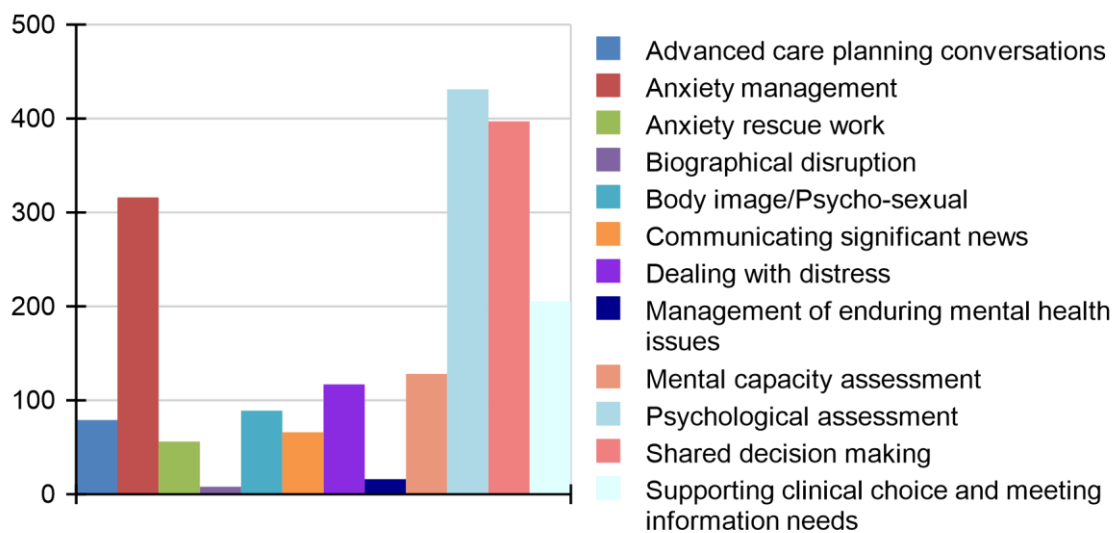
Intervention by Location - (For legibility % have been removed – calculations are derived from data on pp. 96-97)



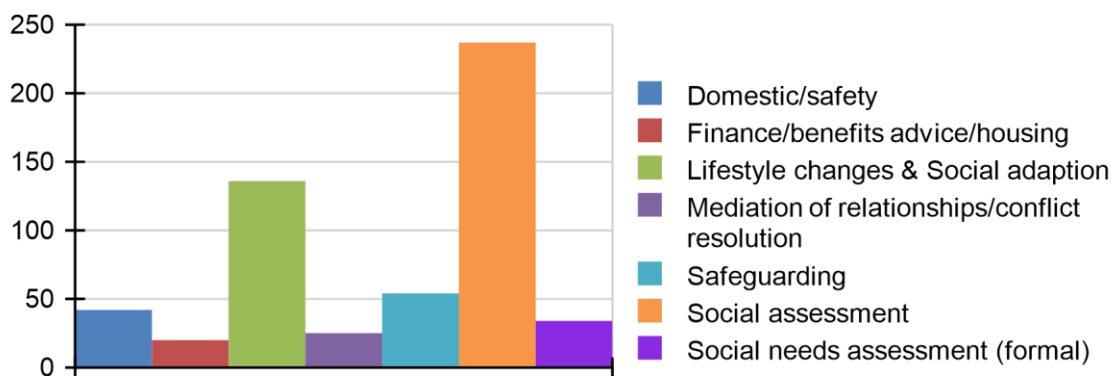
Physical Interventions



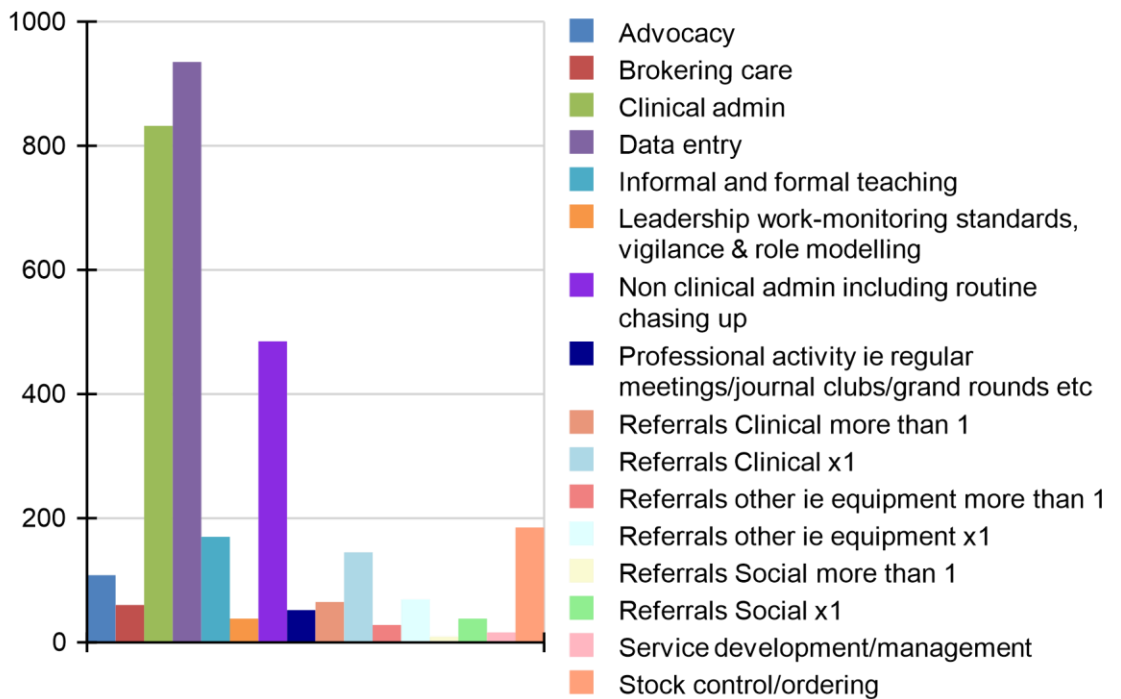
Psychological Interventions



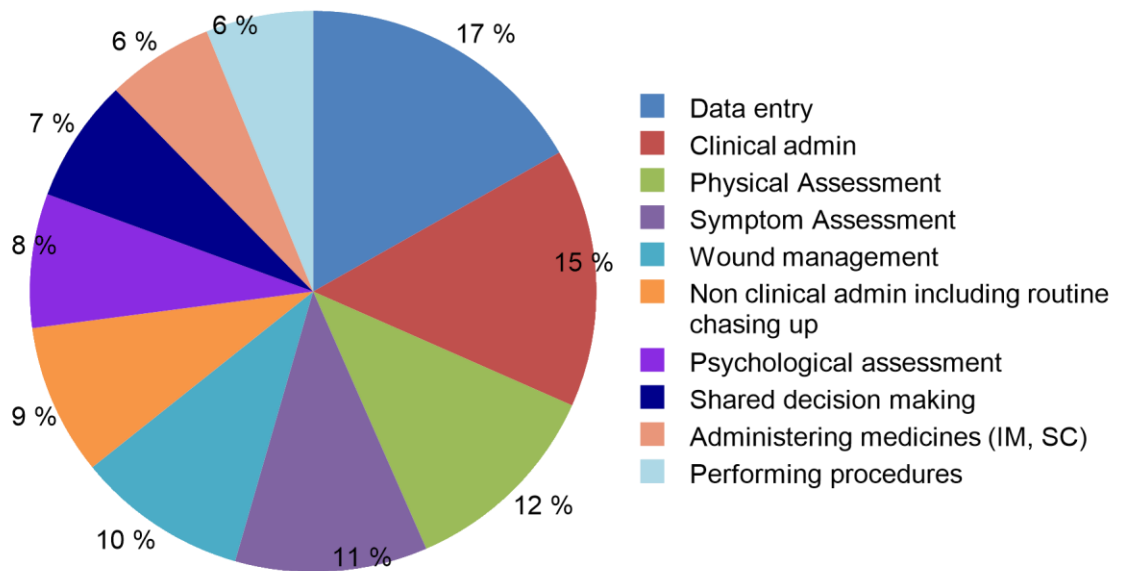
Social Interventions



Case Management & Administration



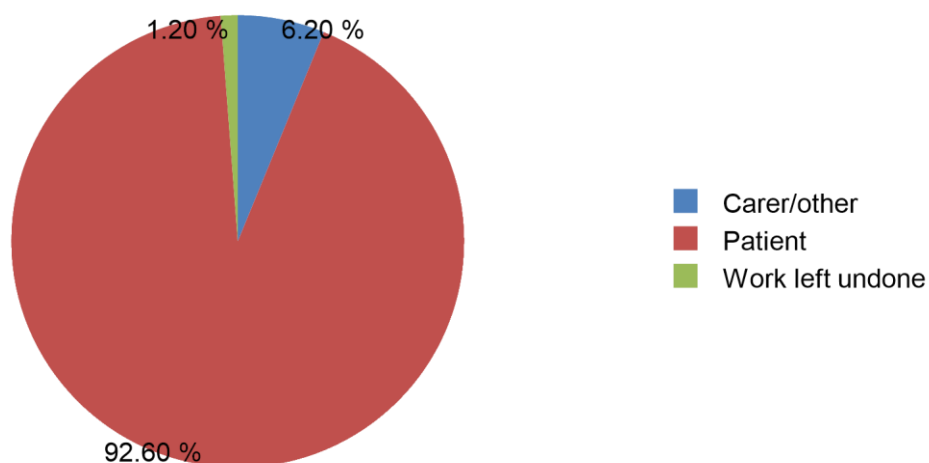
Top 10 Interventions



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Enteral feeding	6
Falls assessment	37
Medicines advice	234
Medicines education	268
Performing near patient testing	115
Performing procedures	342
Phlebotomy	67
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Rescue work (physical/devices/drugs/iatrogenic)	61
Review results & act on findings	162
Symptom Assessment	613
Titrating medications	44
Wound management	546
Advanced care planning conversations	79
Anxiety management	316
Anxiety rescue work	56
Biographical disruption	8
Body image/Psycho-sexual	89
Communicating significant news	66
Dealing with distress	117
Management of enduring mental health issues	16
Mental capacity assessment	128
Psychological assessment	431
Shared decision making	397
Supporting clinical choice and meeting information needs	205
Domestic/safety	42

Finance/benefits advice/housing	20
Lifestyle changes & Social adaption	136
Mediation of relationships/conflict resolution	25
Safeguarding	54
Social assessment	237
Social needs assessment (formal)	34
Advocacy	108
Brokering care	60
Data entry	935
Informal and formal teaching	170
Leadership work-monitoring standards, vigilance & role modelling	38
Professional activity ie regular meetings/journal clubs/grand rounds etc	52
Referrals Clinical more than 1	65
Referrals Clinical x1	145
Referrals other ie equipment more than 1	28
Referrals other ie equipment x1	69
Referrals Social more than 1	9
Referrals Social x1	38
Service development/management	16
Stock control/ordering	185
Clinical admin	832
Non clinical admin including routine chasing up	485

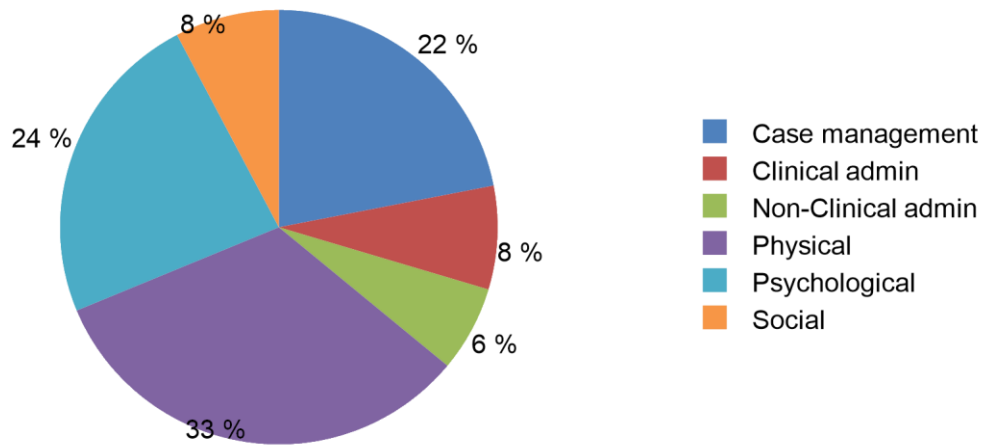
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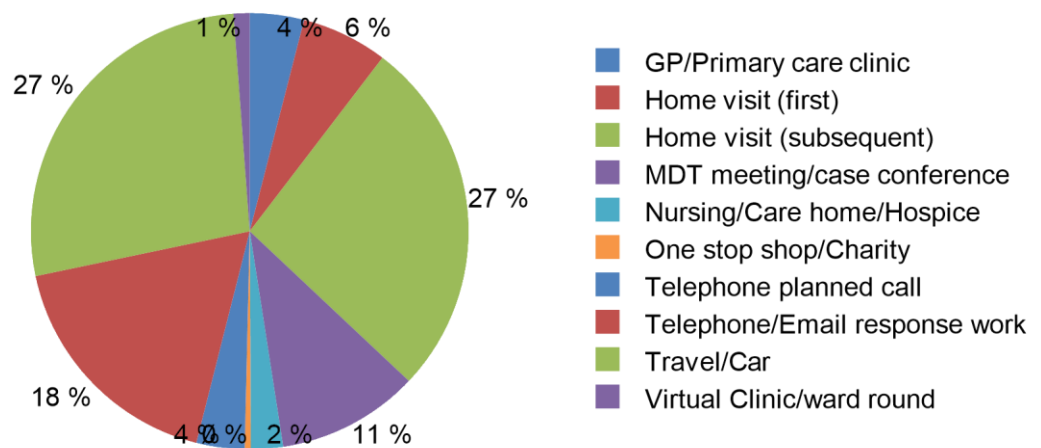
Cassandra Carer/Other Data

Cassandra Carer/Other Data

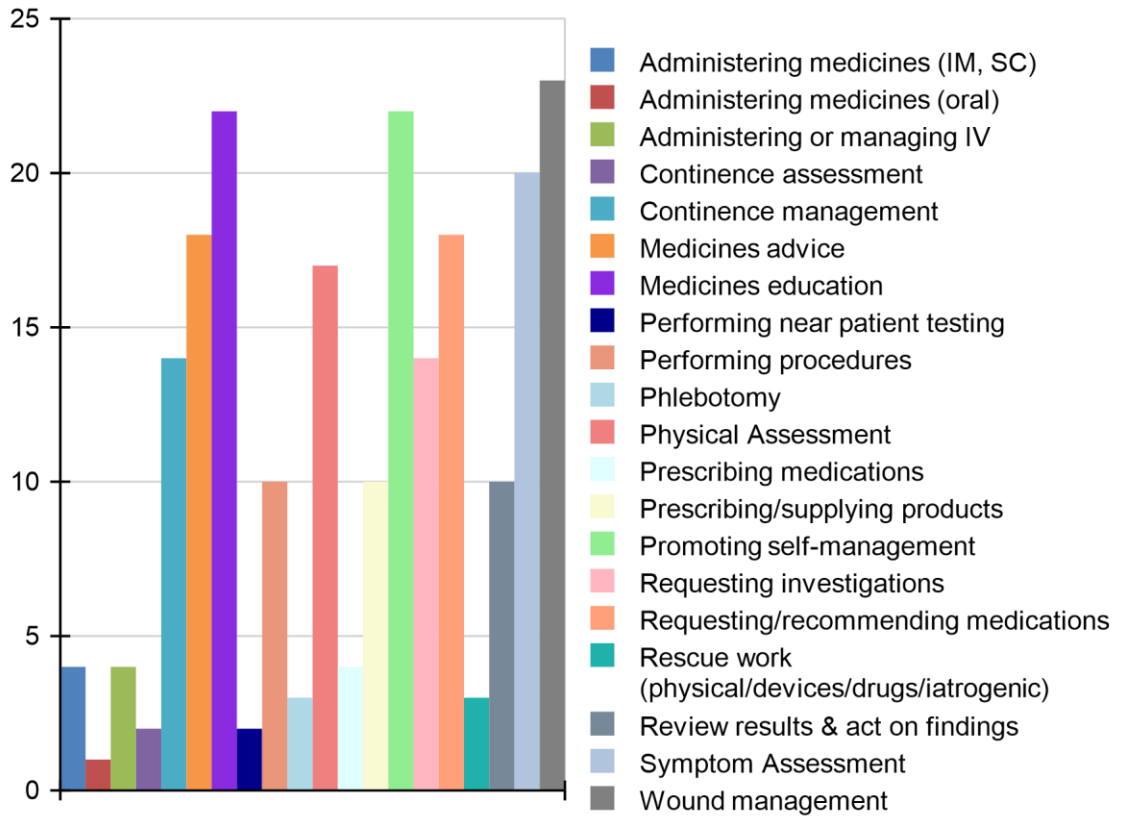
Intervention by Type



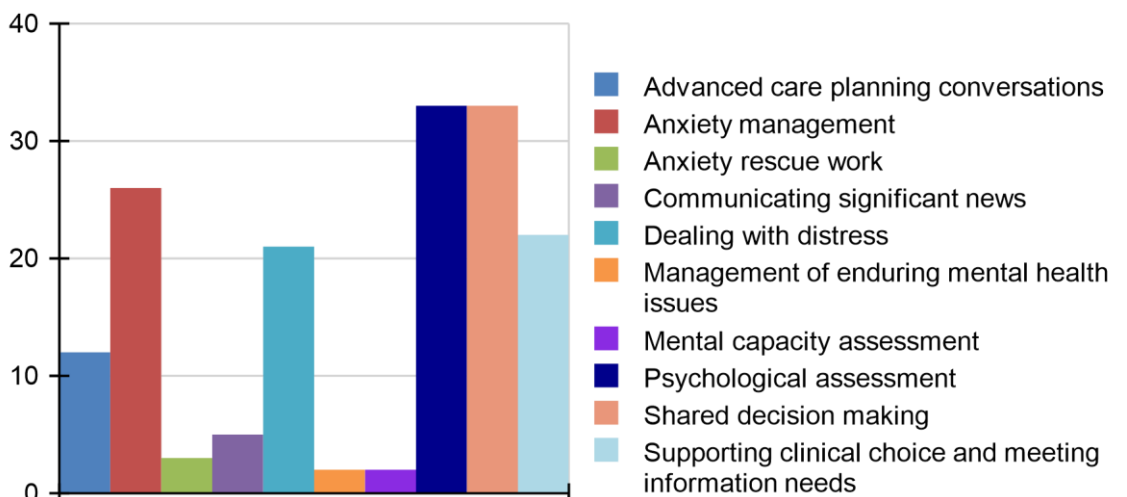
Intervention by Location



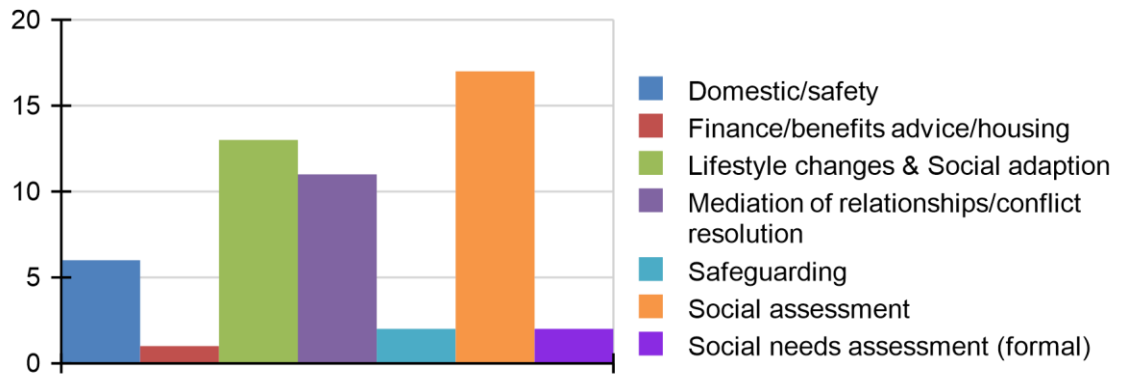
Physical Interventions



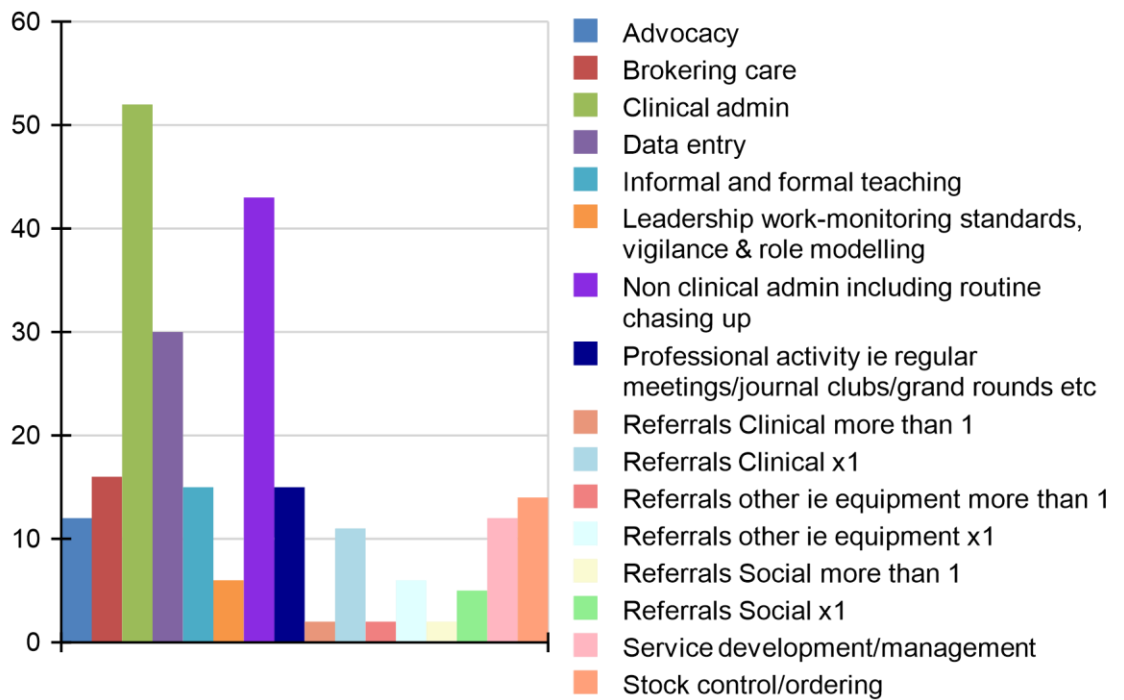
Psychological Interventions



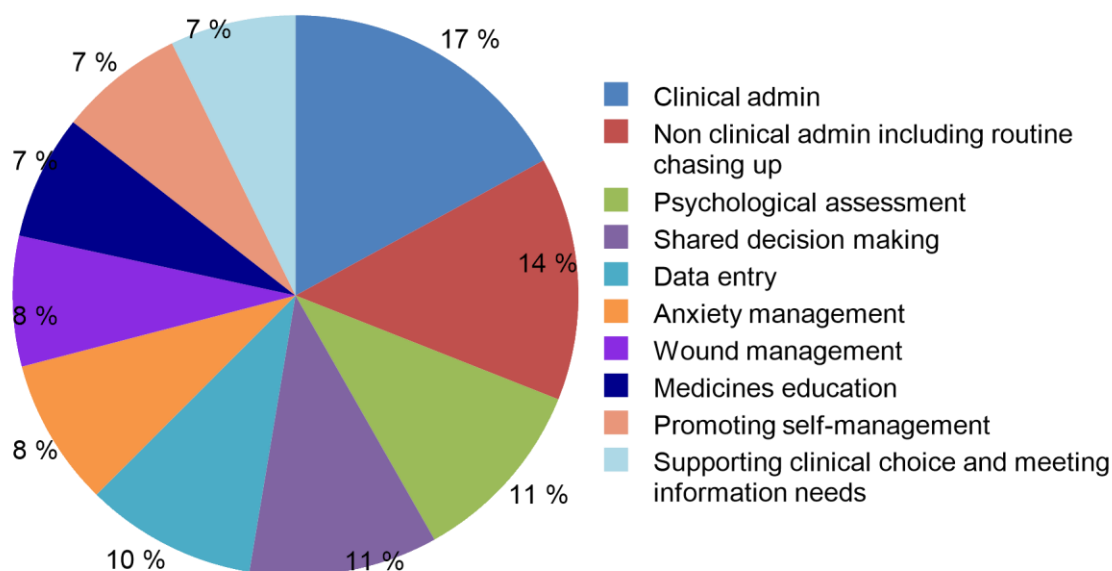
Social Interventions



Case Management & Administration



Top 10 Interventions

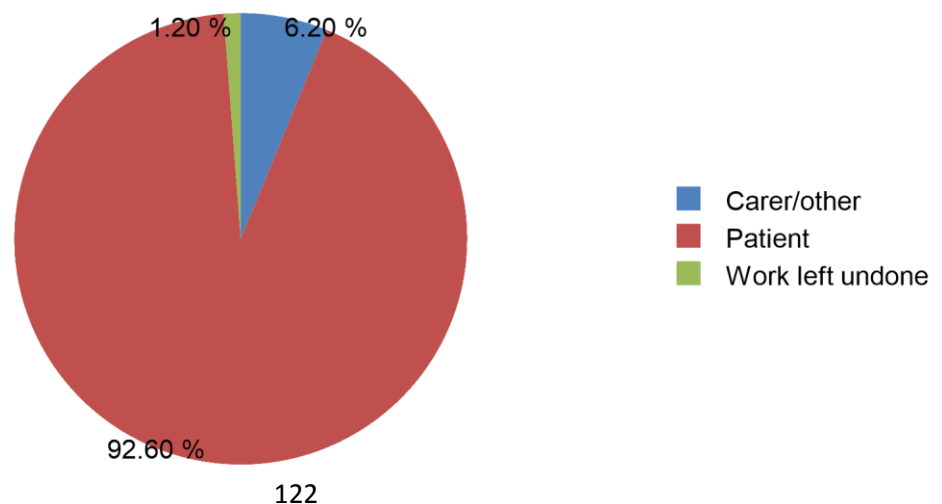


Intervention totals

Intervention	Total
Administering medicines (IM, SC)	4
Administering medicines (oral)	1
Administering or managing IV	4
Continence assessment	2
Continence management	14
Medicines advice	18
Medicines education	22
Performing near patient testing	2
Performing procedures	10
Phlebotomy	3
Physical Assessment	17
Prescribing medications	4
Prescribing/supplying products	10
Promoting self-management	22
Requesting investigations	14
Requesting/recommending medications	18
Rescue work (physical/devices/drugs/iatrogenic)	3
Review results & act on findings	10
Symptom Assessment	20
Wound management	23
Advanced care planning conversations	12
Anxiety management	26

Anxiety rescue work	3
Communicating significant news	5
Dealing with distress	21
Management of enduring mental health issues	2
Mental capacity assessment	2
Psychological assessment	33
Shared decision making	33
Supporting clinical choice and meeting information needs	22
Domestic/safety	6
Finance/benefits advice/housing	1
Lifestyle changes & Social adaption	13
Mediation of relationships/conflict resolution	11
Safeguarding	2
Social assessment	17
Social needs assessment (formal)	2
Advocacy	12
Brokering care	16
Data entry	30
Informal and formal teaching	15
Leadership work-monitoring standards, vigilance & role modelling	6
Professional activity ie regular meetings/journal clubs/grand rounds etc	15
Referrals Clinical more than 1	2
Referrals Clinical x1	11
Referrals other ie equipment more than 1	2
Referrals other ie equipment x1	6
Referrals Social more than 1	2
Referrals Social x1	5
Service development/management	12
Stock control/ordering	14
Clinical admin	52
Non clinical admin including routine chasing up	43

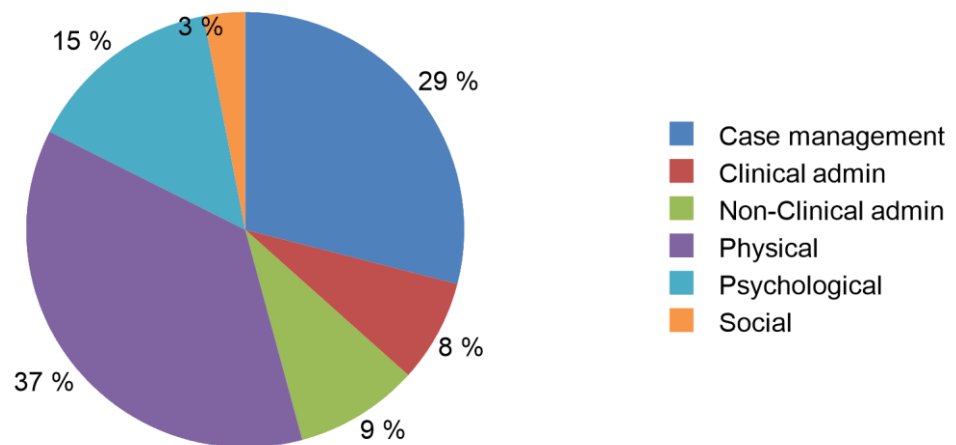
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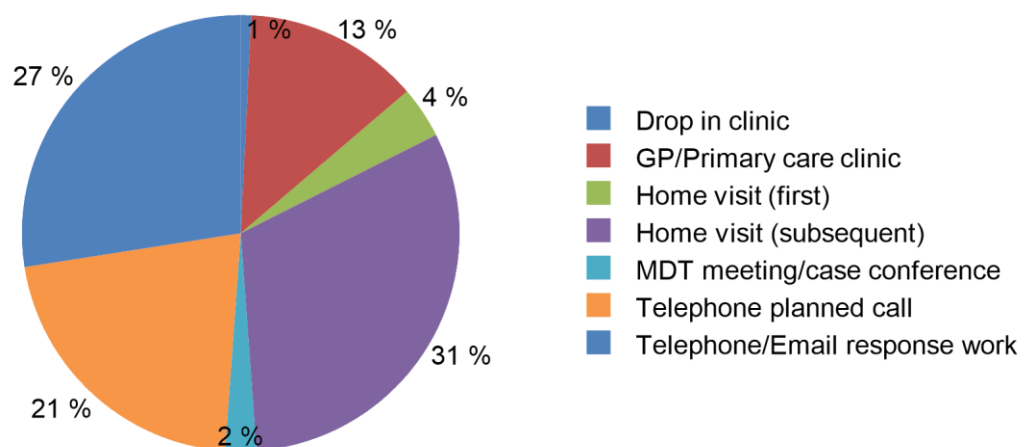
Cassandra Work Left Undone Data

Cassandra Work Left Undone Data

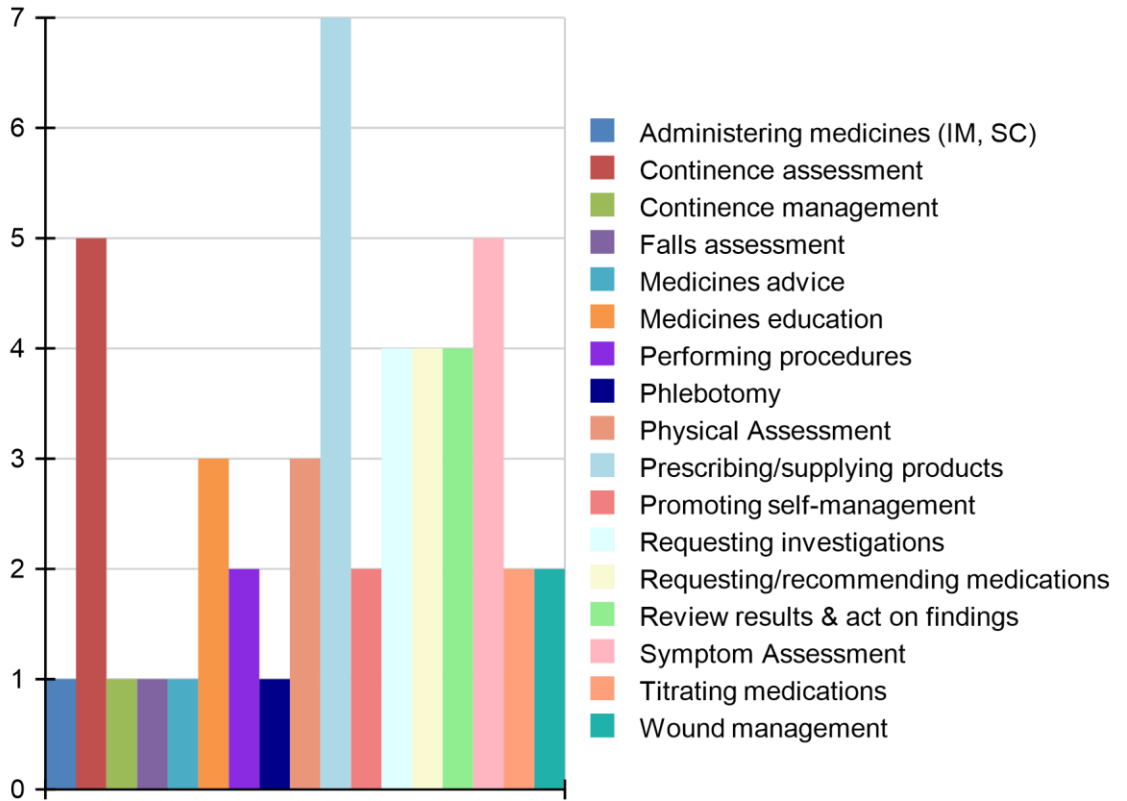
Intervention by Type



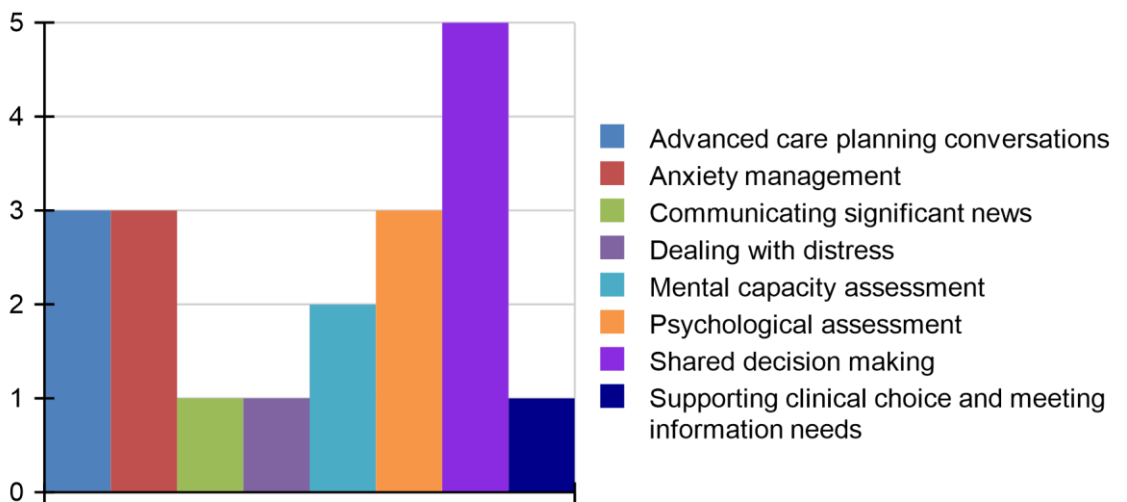
Intervention by Location



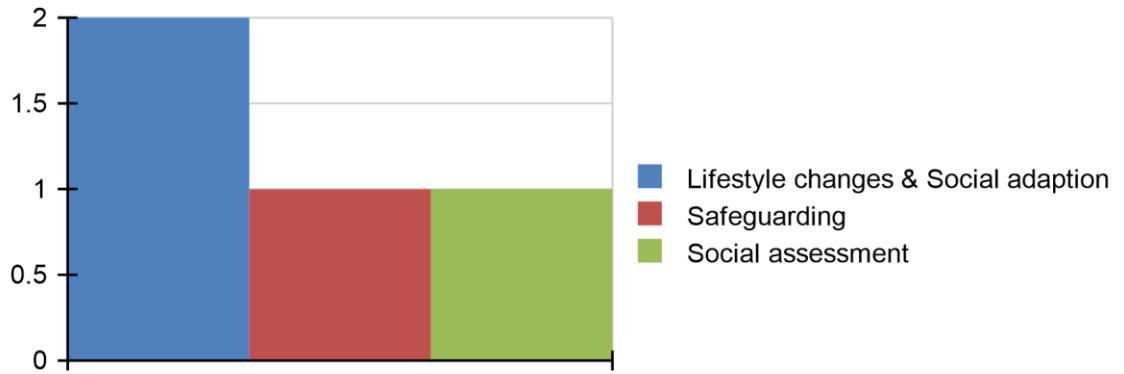
Physical Interventions



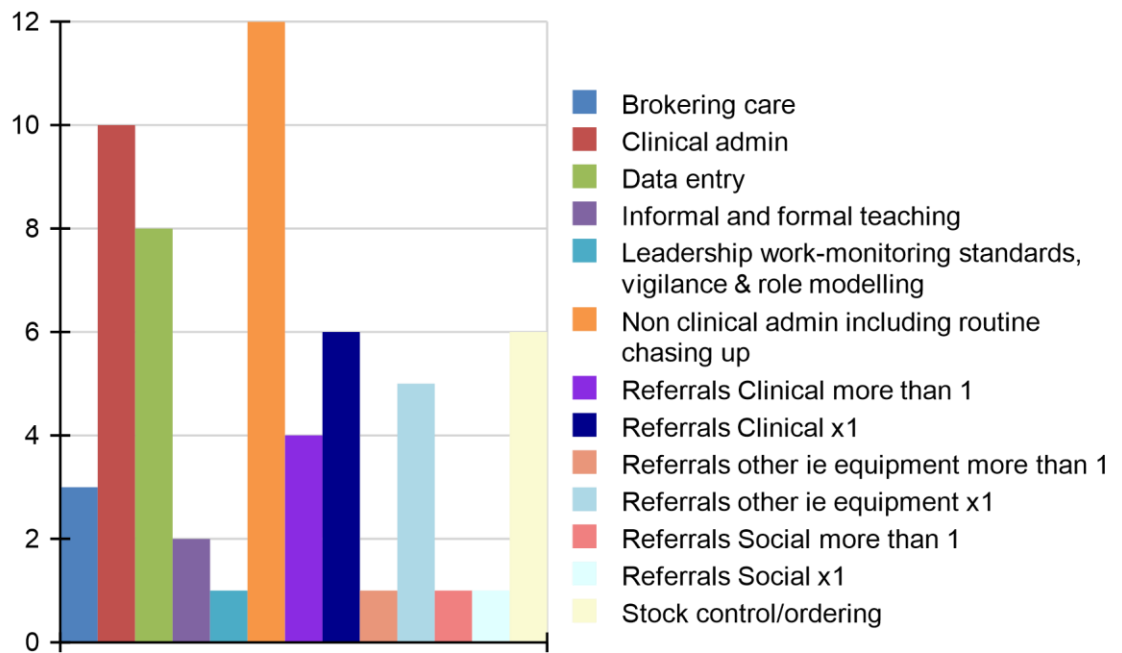
Psychological Interventions



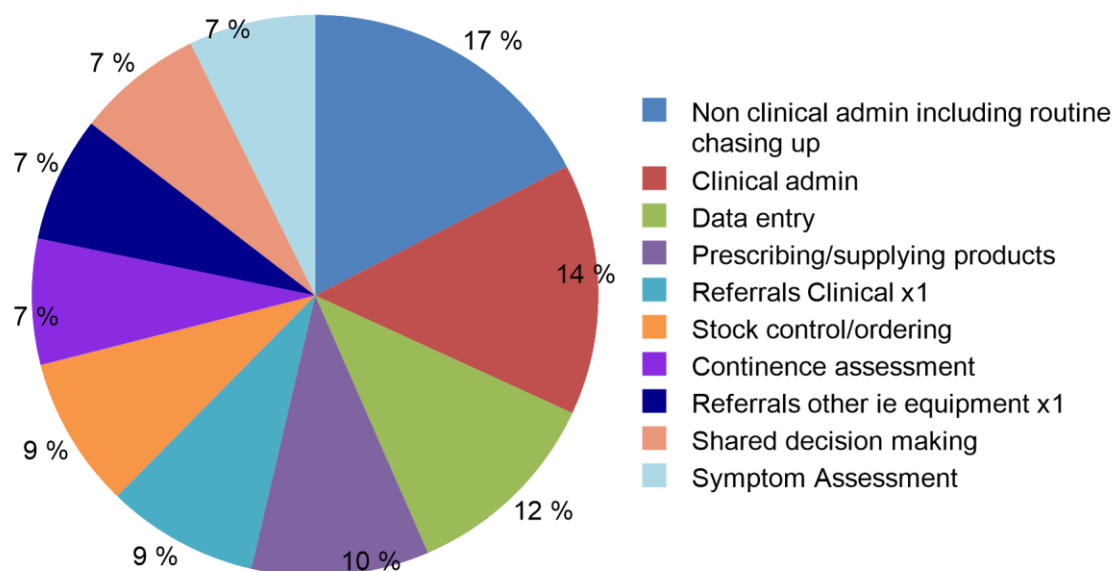
Social Interventions



Case Management & Administration



Top 10 Interventions

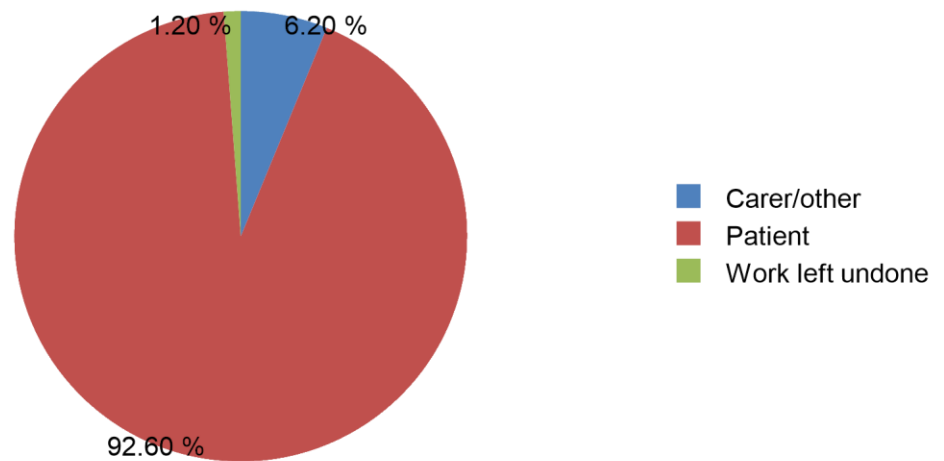


Intervention totals

Intervention	Total
Administering medicines (IM, SC)	1
Continenace assessment	5
Continenace management	1
Falls assessment	1
Medicines advice	1
Medicines education	3
Performing procedures	2
Phlebotomy	1
Physical Assessment	3
Prescribing/supplying products	7
Promoting self-management	2
Requesting investigations	4
Requesting/recommending medications	4
Review results & act on findings	4
Symptom Assessment	5
Titrating medications	2
Wound management	2
Advanced care planning conversations	3
Anxiety management	3
Communicating significant news	1
Dealing with distress	1
Mental capacity assessment	2

Psychological assessment	3
Shared decision making	5
Supporting clinical choice and meeting information needs	1
Lifestyle changes & Social adaption	2
Safeguarding	1
Social assessment	1
Brokering care	3
Data entry	8
Informal and formal teaching	2
Leadership work-monitoring standards, vigilance & role modelling	1
Referrals Clinical more than 1	4
Referrals Clinical x1	6
Referrals other ie equipment more than 1	1
Referrals other ie equipment x1	5
Referrals Social more than 1	1
Referrals Social x1	1
Stock control/ordering	6
Clinical admin	10
Non clinical admin including routine chasing up	12

Intervention by Source



Appendix 6



Faculty of Health and Social Care

The England Centre for Practice Development

A REGIONAL WORKSHOP TO REFINE THE SHARED PURPOSE FRAMEWORK FOR COMMISSIONING AND PROVISION OF A FIRST CLASS COMMUNITY NURSING SERVICE ACROSS KENT SURREY AND SUSSEX

Introduction

This workshop is facilitated by the England Centre for Practice Development hosted by Canterbury Christ Church University in partnership with Health Education England, Kent, Surrey and Sussex.



Shared Vision/Purpose

To provide first class compassionate, safe and effective care closer to home enabling people to make choices, self-manage and maintain control over their quality of life

This is your opportunity to shape the future direction of Community Nursing services in England by getting involved in a unique project that:

1. Has developed a clear vision statement and framework of attributes and outcomes for the delivery of person centered safe and effective care close to home for people in Kent, Surrey and Sussex. We need to refine this framework and include patients and

service user perspectives and front line nurse's experiences of how the framework may be implemented in practice.

2. Will help to inform the design of a workforce analysis tool that enables us to capture the broad range of general and specialist community nursing activities in a working day and use this data to model the investments needed in the future to support high quality care and a well resourced nursing service. This is really important and unique as currently in England there is no such tool that captures this kind of vital evidence for commissioners, policy makers, and heads of service. As NICE are being called upon by government to set these benchmarks we have an opportunity to influence the national picture.
3. Provides a unique opportunity to capture the activities you do as a frontline community generalist or specialist nurse working in Kent, Surrey and Sussex and have these recognised and celebrated both within your organisation and at a regional and national level.
4. Help to provide activity data that will enable us to map caseload management with simulated models around the resources needed for different patient care pathways across community settings.

The England Centre for Practice Development

A REGIONAL WORKSHOP TO REFINE THE SHARED PURPOSE
FRAMEWORK FOR COMMISSIONING AND PROVISION OF A FIRST
CLASS COMMUNITY NURSING SERVICE ACROSS KENT SURREY AND
SUSSEX

The project must be complete by 23rd December 2014.

There are 8 regional workshops and 1 specialist workshop for mental health practitioners being run on the following dates:

10th June - Medway

Workshop 1: 0930-1230 RWg15 Ground Floor,
Rowan Williams Court Building, Medway Campus
Workshop 2: 1330-1630 RWg15 Ground Floor,
Rowan Williams Court Building, Medway Campus

25th June - Crawley

Workshop 1: 0930-1230 Longley Room,
Crawley Library, Southgate Avenue, Crawley,
West Sussex RH10 6HG
Workshop 2: 1330-1630 Longley Room,
Crawley Library, Southgate Avenue, Crawley,
West Sussex RH10 6HG

27th June - Canterbury

Workshop 1: 0930-1230 HPg11
Malborough Room Ground Floor,
Hall Place Canterbury
Workshop 2: 1330-1630 HPg11
Malborough Room Ground Floor,
Hall Place Canterbury

9th July - Canterbury

Workshop 1: 0930-1230 Of27 First Floor,
Old Sessions House Main CCCU Campus, Canterbury
Workshop 2: 1330-1630 Of27 First Floor,
Old Sessions House Main CCCU Campus, Canterbury

11th July – Canterbury

For Mental Health Practitioners

Specific KMPT Day for developing Cassandra tools for
the Mental Health Setting

All day event: 0930-1630 Af33 First Floor,
Anselm Building Main CCCU Campus
Facilitated by Dr. Alison Leary

You only need to register to attend one workshop
Places on the workshop are offered to general and
specialist community nursing team leaders, and
community nurses working in Band 5-7 roles, heads
of service, service users, carers and patients, and
other practitioners with a vested interest in
developing a community workforce planning tool
that can be used in the locality.

The England Centre for Practice Development

A REGIONAL WORKSHOP TO REFINE THE SHARED PURPOSE
FRAMEWORK FOR COMMISSIONING AND PROVISION OF A FIRST
CLASS COMMUNITY NURSING SERVICE ACROSS KENT SURREY AND
SUSSEX

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

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

Dr Alison Leary, Independent Health Care Consultant
Visiting Reader England Centre for Practice
Development

Dr Toni Wright, Research Fellow

Tricia Leadbetter, Research Fellow

Anne Martin, Research Assistant

Fees

This event is free of charge.

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

Refreshments will be provided.

Booking your Place:

To book your place please contact

Anna Humphreys - Administrator for the England
Centre for Practice Development.

anna.humphreys@canterbury.ac.uk

<mailto:anna.humphreys@canterbury.ac.uk> your destination

Maps are provided with directions to venues as
attached.

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](http://www.canterbury.ac.uk/support/facilities-services/extranet/permit-for-visitor.asp)

Appendix 7

WORKSHOP TO REFINE THE SHARED PURPOSE FRAMEWORK FOR COMMISSIONING AND PROVISION OF A FIRST CLASS COMMUNITY NURSING SERVICE ACROSS KENT SURREY AND SUSSEX

Workshop Advance Organiser

In preparation for the workshop you are attending please have a look at the following documents:

1. The Shared Purpose Framework in the Executive Report for Phase 1 Community Project (attached)
2. The East Kent Hospitals University NHS Foundation Trust (EKHUFT) Shared Purpose Job Descriptors Continuum which is an example of how a shared purpose framework can be embedded across a whole organisation
3. The paper published in May in the International Practice Development Journal “*A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology.*”

Enabling the Community Nursing Shared Purpose Framework to Become a Reality

What are the Shared purposes?

- Providing holistic, compassionate person and family-centred care
- Safe and Effective Care Close to Home
- Effective workplace culture

Populating the framework is an activity we will be doing in the workshop but it would be helpful if you could look at the top level performance indicators for bands 5-7 nurses for each purpose.

What are Performance Indicators?

- Performance indicators are action orientated in terms of what practitioners can do in the workplace at the top level
- **What are the Shared Purposes? (see Table 7 below)**

Table 10: Shared Purpose Framework

(Manley et al 2014)

Providing holistic, compassionate person and family-centred care						
(Sub headings derived from EKHUFT' shared purpose framework)	Band 5 'Provide and co-ordinate .. to individuals and groups'	Band 6 'Provide and assure ... to individuals and groups across teams /patient pathways'	Band 7 generalist 'Provide and assure ..evaluating the patients experience across groups across teams /patient pathways'	Band 7 specialist 'Provide and assure .. evaluating the patients experience across teams /patient pathways'	Band 8 matron 'Provide and assure .. and evaluate the patients experiences across the service'	Band 8 consultant 'Provide and assure ... evaluate and research the patients experience across the service and organisation'
Provide holistic, compassionate, person & family centred care						
Invite and use patient and service user feedback						
Work in a person-centred way with others						

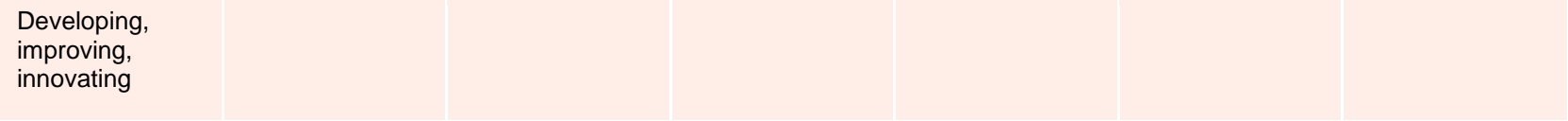
Safe and Effective Care Close to Home

(Sub headings derived from EKHUFT' shared purpose framework)	Band 5 'Provide safe and evidence-based care to patients and service users' and continually review and develop own effectiveness and contribute to on-going service improvement	Band 6 'Provide and assure safe and evidence-based care to patients and groups and continually review and develop own and service effectiveness and contribute to on-going service improvement	Band 7 generalist 'Provide and assure ... and continually review and develop own and service effectiveness and contribute to on-going service improvement and research	Band 7 specialist 'Provide and assure .. and continually review and develop own, service and pathway effectiveness and contribute to on-going service improvement and research	Band 8 matron 'Provide and assure .. and continually review and develop own and service effectiveness , lead service improvement and contribute to research	Band 8 consultant 'Provide and assure ... and continually review and develop own, service and organisational effectiveness , lead service improvement and actively contribute to the body of knowledge through research
Provide safe and effective care to individuals & groups						
Review and improve safety practice						
Maintain own effectiveness & enabling others to be effective						
Evaluate & research effectiveness						

Effective workplace culture

(Sub headings derived from EKHUFT' shared purpose framework)	Band 5 'Contribute to establishing an effective team culture that sustains person-centred, safe and effective x care through self-awareness, leadership, active learning, development, improvement and innovation'	Band 6 'Establish an effective workplace culture that sustains person-centred, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation'	Band 7 generalist 'Establish an effective workplace culture across teams and patient pathway that sustains person-centred, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation'	Band 7 specialist 'Establish an effective workplace culture across teams and patient pathway that sustains person-centred, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation'	Band 8 matron 'Establish an effective workplace culture across the service that sustains person-centred, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation'	Band 8 consultant 'Establish an effective workplace culture across the service and organisation that sustains person-centred, safe and effective care through self-awareness, leadership, active learning, development, improvement and innovation'
Being self-aware and develop effective relationships						
Work as an effective team						
Lead holistic, compassionate, person & family centred care						
Active learning for transforming care and practice						

Developing,
improving,
innovating



- What knowledge and know-how are required to achieve the performance indicators?
- What contextual factors need to be identified?