



**UNIVERSITY OF
STIRLING**

SCHOOL OF
NURSING, MIDWIFERY
AND HEALTH

Community Nurse Workforce Planning Project

**Dr Annetta Smith¹
Mrs Helen Morrison²
Dr Mike Walsh³**

**School of Nursing Midwifery and Health¹
NHS Highland²
Institute for People Centred Healthcare Management³**

University of Stirling

&

NHS Highland

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Contact details for further information:

Dr Annetta Smith

School of Nursing, Midwifery and Health
University of Stirling
Highland Campus
Inverness
IV2 3JH

Tel: +44(0)1463255649

email: annetta.smith@tir.ac.uk

Helen Morrison

Associate Director (NMAHP Workforce Planning and Development)
NHS Highland
John Dewar Building
Inverness Retail & Business Park
Highlander Way
Inverness

IV2 7GE

Tel: 01463 704630

email: helen.morrison1@nhs.net

Dr Mike Walsh

Institute for People Centred Healthcare Management
University of Stirling Management School
FK9 4LA

Tel 00 44 (0) 1786 467322

Email m.p.walsh@stir.ac.uk

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Summary

Community Nurse Workforce Planning Project

The purpose of this project was to explore the potential for developing a flexible and innovative approach to community workforce planning that took account of the synergies between community health needs and the expertise and skill sets of community nurses. Workshops were held with community nurses in three localities within NHS Highland in 2010 and at the beginning of 2011. Information that emerged from the workshops provided a picture of the responsibilities and activities that community nurses are engaged in, as well as some of the challenges of delivering a service across the diverse localities in NHS Highland.

In May 2011 a wider stakeholder workshop was held, facilitated by one of the NMSH CHP general managers. The workshop considered the findings of the project to date, and proposed some changes. These changes were incorporated into the final report.

1. Project Background

1.1 Introduction

The purpose of this project was to explore the potential for developing a flexible and innovative approach to community workforce planning that took account of the synergies between community health needs and the expertise and skill sets of community nurses. Current health policy and developments in community nursing roles are providing an impetus for innovative and flexible workforce developments. Within NHS Scotland and NHS Highland communities, nurses are practising in a rapidly evolving service that includes working challenges to enable shifts in the balance of care. The *Better Health, Better Care, Action Plan*,¹ highlights care priorities such as personalised care, long term condition management, and a move towards more local delivery of care in communities to support strategies for shifting the balance of care. Similarly the NHS Scotland Quality Strategy² emphasises the need for patients to get support to help them manage their own condition closer to home and more quickly. As outlined in *Better Health, Better Care: Planning tomorrow's Workforce Today*³ NHS Boards are therefore required to ensure future workforce planning is based upon the delivery of services focused on patient need. NHS boards have been asked to move towards more dynamic workforce planning, which includes more effective horizon scanning, intelligence on projected patient needs, and patient dependency profiles to develop a clear view of future patient needs and the required model of care⁴. The emphasis on workforce planning should further ensure that service delivery reflects the specific needs of the populations within each area to provide better-planned and delivered services for patients³.

There is no single model currently used to assist workforce planning for community nurses that supports the synergy for delivery of services promoted by current policy. The majority of 'tools' available rely on case load profiling or activity analysis, or both these approaches, with the exception of one tool developed by the Scottish Government Health Department which compares the community nursing workforce by whole time equivalents (WTEs) across CHPs with similar populations (benchmarking approach). NHS Highland (NHSH) proposed a community nursing

¹ (Scottish Government 2007) Better Health Better Care Action Plan
<http://www.scotland.gov.uk/Publications/2007/12/11103453/9>

² (Scottish Government (2010) NHSScotland Quality Strategy
<http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality>

³ Scottish Government (2007) Better Health, Better Care: Planning Tomorrow's Workforce Today
<http://www.scotland.gov.uk/Publications/2007/12/13102832/0>

⁴ (Scottish Government (2009) A force for improvement. The workforce response to Better Health Better Care
<http://www.scotland.gov.uk/Publications/2009/01/20121026/0>

workforce model that combines these approaches, incorporates knowledge and skills requirements and workforce skill-mix, based on local nursing health and social needs. To support the development and testing of the model the University of Stirling agreed to work with community nurses on the project.

In respect of the project detailed in this report a number of issues arose quite early on that influenced the course and focus of the project. A fundamental requirement to workforce planning is not only a clear vision of the requirement of the workforce including what it is required to deliver (the aims), but also what activity, capacity, knowledge and skills are required to deliver the aims. Early in this project it emerged that while the overarching aims of NHSH were comprehensive and understandable, the organisations' requirements of the Community Nursing Services were less clear. This lack of clarity was compounded by the variety of service models across the localities, different interpretations by community nursing teams and individuals, and the availability of other services. Additionally, at the end of 2010 Highland Council and NHS Highland agreed in principle to commit to explore a pathway to integration of health and social care services, which in principle will progress the opportunity to develop lead agencies for children's services and adult services with the proposal that the NHS should lead on adult care and the Council on children's services.

The project leads agreed that further development and testing of the proposed workforce planning model could not proceed until the core accountabilities, responsibilities and activities required of Community Nursing Services could be clarified. The project diverted its attention to seek to elicit the core and non-core activity required of Community Nurses, which utilised their knowledge skills and capacity most efficiently and effectively.

Taking consideration of the current context, the project progressed with a slightly altered focus that provided community nurses with the opportunity to collaboratively work through some of the initial stages of the workforce planning model with particular focus on current and future community nurse roles, responsibilities, and community health needs. Information emerging from this collaborative process can then inform and contribute to the development of community nurse workforce plans.

It is anticipated that outcomes from this project can contribute to the evidence base that informs practice development. This need for evidence in relation to workforce planning has been reiterated in health policy recommendations (Scottish Government 2007, 2009).

1.2 Aims

To identify the factors that influence workforce planning and that assist community nurses to engage in workforce planning that reflects community health needs and informs workforce development. The project was planned in two phases as identified. This report reports on the completed phase 1.

Phase 1

- **To establish levels of community nursing knowledge, and understanding of the relationships between community health needs and the capacity, knowledge and skills practitioners require to support these needs**
- **To map current community nurses' knowledge and skills against those required to support current and future health needs**

Phase 2

- To develop workforce transition plans that reflect community health needs and articulate relevant nursing roles
- To prepare and evaluate workforce transition plans that reflect community health needs and articulate relevant nursing roles
- To develop criteria for, and collate examples of, good practice in community nursing workload assessment and workforce planning

1.3 Methods

The project was undertaken using qualitative methods to obtain information that met the aim and the objectives of the project. An action research approach using soft systems methodology (SSM)⁵ facilitated examination of practice followed by suggestions of systems or solutions which can start to address emerging models of community nursing care. The crucial stage of SSM in this project was to identify core and non core skills required by community nurses to reflect community health and nursing needs and to compare the evolving model of workforce planning and development to actual practice. Differences that emerged were then used as a basis for further development that included consideration of how the relevant systems work, how they might work, and what the implications for workforce practice and development might be. The final stage of SSM normally comprises action where practitioners can test out the changes they identified (this component was not addressed in this phase of the project). Appendix 1 connects the project objectives to relevant SSM stages and inquiry methods. Four workshops were run to elicit the information required.

The workshops were essentially developmental and iterative, moving from problem identification to solution focused actions. The seven core elements of nursing in the community were used as a conceptual framework to structure the workshops and allowed nurses to systematically explore roles, functions and activity within community nursing teams⁶. The core elements clarify the intended knowledge, skills and approaches of nursing roles in the community. Importantly for this project, the

⁵ Checkland P. and Scholes J (1999) Soft Systems Methodology in Action John Wiley and Sons Ltd

⁶ Scottish Government (2007) Visible, Accessible, and integrated Care Report Of The Review Of Nursing In The Community In Scotland <http://www.scotland.gov.uk/Publications/2007/07/16091605/13>

community nurses were already familiar with the core elements and could use them as points of reference to describe the scope and capacity of their roles. A critical underpinning theme for all four workshops emphasised the importance of workforce planning and the need to ensure that service delivery reflected the specific needs of the populations within the local areas that were represented by community nursing teams. There was explicit recognition that the planning focus reflected the needs of service users and community health needs rather than the care providers. Appendix 2 connects the workshops aims, core elements, the key questions and sub questions that were addressed in each of the workshops. Additionally, this project was characterised by an approach to workforce planning that emphasised iterative engagement by community nurses with the issues that were identified, and ensured rigorous examination and debate around these issues to achieve a level of consensus and understanding about the information that would inform workforce planning cycles.

1.4 Participants

Nurse participants included nurses working in the community, the majority were District Nurses, Health Visitors or School Nurses, but one team included the team administrative assistant and another a practice nurse, some of the participants had also undergone transition education to Community Health Nurse roles. Participants represented 3 different locality areas within NHS Highland. Two of the areas identified were pilot sites for the Review of Nursing in the Community, the other area did not participate in the review.

Details of participant numbers and localities are provided in Appendix 3

1.5 Data collection and Analysis

Community nurses were invited to attend a series of workshops facilitated by members of the project team over a 3 month period. A fourth workshop was held three months after the analysis of all workshop data. Although there was some variation in attendance between the workshops, all workshops did mainly have consistent membership that helped to facilitate a coherent approach to the project. Workshop 1 and 3 comprised full day workshops and were facilitated face to face in each of the three localities. Video Conference (VC) was used to run workshop 2. The conference helped to mitigate problems related to the geographical spread of participants, it maximised participation opportunities, and importantly brought community nursing teams from the 3 locality areas together in a forum that collectively allowed them to interrogate the consequences of the issues that had been identified. Workshop 4 was conducted by VC in January 2011 and served as a member check through informant feedback and helped with the accuracy and validity of information. Finally, a small group met prior to the completion of the report to help verify that information reflected some of the detail that emerged from the workshops.

Workshop one was an initial mapping exercise that established levels of practitioners' knowledge and understanding of the relationships between community health needs and the capacity, knowledge and skills practitioners require to support these needs. Workshop participants were facilitated in an application of Soft Systems Methodology (SSM) to produce "rich pictures" of their work systems, and map this against knowledge and skills required to support current and future workforce needs. This mapping took a broad view of need (community health needs) and workforce.

Data collection throughout was guided by the use of broad based, critical questions that encourage participants to undertake an exploration of the problem and potential solution. For example, *how do outcomes from community health needs assessment influence activity, priorities, skill-mix and practice?* Data from each set of workshops was collated and preliminary analysis carried out. This analysis was returned to workshop participants for verification prior to the next set of workshops.

2. Findings

The findings clarify the key issues that impact on workforce planning for community nurses and are presented in a way that reflects their priorities for care delivery and understanding of health care needs in the communities where they work.

The project identified:

- The context of care and influence of that context on community nursing activity
- Policy drivers most relevant to Community Nursing
- Priority client groups
- Service design challenges and potential solutions
- Priority accountabilities, responsibilities and activity

2.1 Context of care and influence on community nursing activity

The activities of Community nursing teams and of individuals within the teams are influenced by a range of variables that impact on the context of care delivery. Those identified through the workshops have been themed as follows:

- health and nursing needs of the population
- sensitivity of service design and delivery to meet the needs of urban, rural, remote communities
- service design and patient pathways
- resources within the nursing team and partner teams/organisations
- practice standards
- national and local policy
- professional and organisational accountability and responsibility

A brief description of each is given below

Health and nursing needs of the population

The overall health and social needs of the resident and temporary population, taken from epidemiological and social data.

Service design and patient pathways and sensitivity to urban, rural, remote and island communities

The health, social and education services available to the local population. This includes, how they interface with each other; the pathways across and between the services, including public and third sector; those services that can be directly accessed by the public; and those services that require referral from another professional/organisation.

Resources within the nursing team and related teams/organisations

The human and financial resource available to people requiring health and/or social services, some of which are temporary.

Practice standards

The organisational and professional standards that govern the services available and the evidence base that supports them.

National and local policy

The legislation, health and social policy and NHS strategic framework and operational policies.

Accountability and responsibility

Accountability is the extent of authority given to the team by NHS and NMC to provide the service and for the standards of practice they provide. Responsibility is the elements that contribute to the accountability.

Collectively, the context of care was identified as influencing nurses' accountability, responsibility and activity, to varying degrees across community nursing teams. Changes to one, or more, variable, can have a significant impact on a team, requiring them to review their priorities, activities, knowledge and skills.

2.2 Key policy Drivers

In order to progress the aims of the project, a clear picture of the scope of responsibilities and activity of Community Nursing Teams was required. In the workshops the teams prioritised activity by looking at the key drivers, priority client groups and the responsibilities and associated activity relevant to the expertise of community nursing teams. The policy drivers identified were commonly referred to in the workshops as being particularly relevant when considering where community nursing should focus activity:

- Person-centred care
- Safe care
- Quality
- Effective care
- Efficiency
- Self-care
- Health protection
- Health prevention
- Reducing long-term conditions
- Reducing the impact of long-term conditions
- Reablement
- Preventing hospital admissions
- Integrated approach to discharge planning
- Anticipatory care
- Reducing hospital lengths of stay
- Palliative and end of life care
- Getting it right for every child (GIRFEC)/ Hall IV
- NHS Community Nursing Practice Standards
- Inter-disciplinary and inter-agency working

2.3 Priority Client Groups

Five overarching client groups were identified that mainly represented the core group that were supported by community nursing services:

1. Adults and children who are unable to attend surgeries, clinics and other facilities for nursing assessments, care and treatments because of health status, complex cognitive or social compromise
2. All children and their families in line with GIRFEC universal services

3. Children and families with additional health needs. In some cases this will include social and educational needs
4. Children and families requiring integrated services
5. Local population – health protection, promotion and improvement

Within these broad groups the following were prioritised:

- Housebound/immobile
- People receiving palliative and end of life care
- Children and adults identified as at risk of abuse
- Children and families with complex health needs (which may include social and/or educational needs)
- Families requiring additional support with parenting skills
- Families and people with chaotic life-styles where they also fall into one or more of the above categories.

While there were some differences in the groups identified, these differences were in fact fairly minimal, and where differences emerged they normally were because of contextual reasons. For example, it was noted that some services were appropriate for a particular team because that team included Practice Nursing within its services, whereas the others were funded to provide Public Health and District Nursing Services only.

2.4 Accountability, responsibility and activity

The workshops incorporated discussions on accountability and responsibility when considering the activity of community nursing teams. The need to be explicit about these emerged, because of the interdependent nature of Community Nursing with other services. It became clear that while activities may be provided by a range of colleagues within and outwith the nursing team and/or NHH, accountability and/or responsibilities for some activities, as well as standards of care, could lie with a different team or organisation. The core and non-core activity of community nursing teams refer to accountability, responsibility and technical activity incorporating practice, management, leadership and education, and includes direct and in-direct patient care and supporting activity.

For the purpose of this project, core and non-core activity is defined as:

Core activity: All community nursing teams should provide all these activities because they are identified as having the required knowledge and skills and are the most effective and efficient resource to do so.

Non core activity: Consideration should be given to whether community nursing teams are the most efficient resource to deliver these activities because, there is limited evidence of health gain for individuals, alternative resources are, or may be, funded for the activity, or activity could be delivered in a more cost effective way by other services.

The tables in Appendix 4 summarise the core and non-core activities against an accountability, responsibility and activity framework, and includes suggestions for alternative service providers where relevant⁷.

The tables identify the accountability and responsibilities for care delivery with examples of the activity required for them to deliver on these. They are not exhaustive but are sufficiently detailed to provide a framework to progress workforce planning. Its purpose is to aid workforce planning and it is not intended to describe the detail or ethos behind clinical practice or service priorities, although the principles of person-centred care and self care were dominant throughout the workshops.

2.5 Service challenges and potential solutions

Suggestions on how service quality and efficiency could be improved for clients were identified although most, but not all, were seen to be outwith the influence of the individual teams. Although all of the service challenges identified did not apply to all the localities that participated in the project, these were the most common areas where service constraints existed. These constraints are summarised in Appendix 5. The important point to extract from this summary is that nurses proposed solutions and service enhancements for the service gaps they identified.

The tables in appendix 4 and 5 demonstrate the complex nature of Community Nursing and the reciprocal dependency it has on many other services, as well as the importance of motivation and ability of clients to comply with care plans. In conjunction with information previously detailed in this section the tables also provides a clearer picture of how the services contribute to the overall strategic priorities of the Board.

⁷ In discussions within the workshops and with professional leads, a number of ways to present the core and non-core activity were considered including: care aims, the prevention – curative – maintenance- palliative – terminal care continuum, service priorities and HEAT targets. The decision was made to present them against the client groups and supporting activities described above, as this most readily supports client-focused care, the development of care pathways and also reflects the way participants described activity.

3. Discussion and recommendations

The three localities produced over 1000 statements. From workshop 3 there are approximately 280 statements about improvements and 95 statements identifying clarifications needed to produce those improvements.

There is no simple thematic aggregation of these statements that remains satisfactorily representative of the statements made and in many ways they are best read as summarised in the previous sections. However there are some general propositions that emerge:

1. Community nurses in all three localities see themselves as a scarce skilled resource that is wasted sufficiently often to cause concern through use in place of either self care or care by others.
2. Community nurses are confident there are opportunities for improvement in the use of this scarce resource.
3. Community nurses see increased appropriate focus on self-care, carer-care and other agency-care as freeing up Community Nurse time to focus on patients with more complex needs and on supporting vulnerable individuals and families.
4. To achieve improvement in use of the scarce resource of community nurses improved coordination with all those involved in or affected by the care of patients who are or might be (correctly or otherwise) referred to the Community Nurse service.
5. This improvement requires the practical re-clarification or re-negotiation of the technical boundaries between health and non health care for all those individuals (including patients) and agencies (including social and third sector) providing care.
6. Coordination between the different professionals, agencies and service users requires the development of common values that underpin the decisions and choices of all those involved in caring – any gap between values will tend to increase the likelihood of inappropriate referral or care.
7. This may be best understood as the need for clarification of a Patient Community Nursing and Social Care Pathway that clarifies the criteria for entry to the pathway and exit from it and that is communicated to referring or complementary agencies, groups and individuals.
8. There is implied the need for recognition of a more general community and social care pathway involving primary, secondary, community, social, Third sector and Self care contributions, of which the community nurse contribution is a specific and discrete component in which uncertainties over boundaries with the activities, roles and responsibilities of other caring professionals and agencies are resolved or at least to be negotiated.

Despite the outcome of the Scottish Review of Community Nursing services calling for the integration of Public Health Nursing and District Nursing, service design has recently favoured a different emphasis for community nursing. Instead of Public Health Nursing priorities being focused on the population as a whole, there is a focus towards the health needs of children and their families, and District Nursing to focus on the nursing needs of adults who are unable to access services outside their own homes, with a particular emphasis on long-term conditions and care of the dying. The workshops identified that this focus has created a tension for community nursing services that needs to be addressed. The tensions are compounded by the expectations of clinical colleagues, managers, NHS and partner organisations. Together these have created a number of challenges that are summarised as service design challenges for Community Nursing Teams.

For the NHS to develop a workforce planning model for Community Nursing services, clarity on the core and non-core activities they require of this workforce is needed. Core and non-core activity for community Nursing Teams are proposed as a result of this project. Once NHS has agreed what should be included under each category, the development of a Community Nursing Workforce Planning Model can be progressed, one that is based on local health needs in line with local and national policy and takes into account the knowledge and skills of this workforce. The Core and Non-core activities identified may also support the development of patient pathways in NHS. Although some of the activities in the appendix are unambiguous, it is also noted some of the activities may be regarded as more aspirational and require further interrogation to clarify the precise level of intervention required to support them.

A number of service enhancements have been identified, along with examples of existing strategies that have proved effective for supporting community health needs and that have prevented exacerbations of conditions or prevented hospital admission.

Appendix 1 Project Objectives

Objectives	Stages of SSM	Method
1. To establish levels of community nursing knowledge and understanding of the relationships between community health needs and the capacity, knowledge and skills practitioners required to support these needs.	<ul style="list-style-type: none"> • Problem is identified 	Facilitated Workshops (1 in each locality)
2. To map current community nurses knowledge and skills against those required to support current and future health needs.	<ul style="list-style-type: none"> • Relevant systems are identified 	Facilitated Workshops (1 in each locality)
3. To identify core areas of community health that that community nurses engage with to meet the health needs of the population	<ul style="list-style-type: none"> • Feasible and desirable changes are identified 	Facilitated Workshop (2) (1 joint workshop with all participants using videoconference technology)
4. To identify areas for development that can help to support processes for transition planning, including review of practice innovations.	<ul style="list-style-type: none"> • Feasible and desirable changes are interrogated. • Actions to improve situation are planned for implementation • Joint workshops to review and verify data and identify enhancement strategies. 	Facilitated Workshops (3& 4) Two further joint workshops to review data.

Appendix 2 Key aims of workshops

Workshop number	Aim of workshop	Core elements	Key questions related to core elements
Workshop 1	To explore the activities that impact on workforce planning	Current and future focus on core elements: a. Working directly with people b. Adopting public health approaches to protecting the public c. Co-ordinating services d. Supporting self –care e. Multidisciplinary team working f. Supporting anticipatory care g. Meeting health needs in communities	1. What are we doing now? <ul style="list-style-type: none"> • <i>Review of core and non core activity</i> 2. Where are we going to do in the future? <ul style="list-style-type: none"> • <i>Including risk assessment</i>
Workshop 2	To explore the implications of the information that has emerged from workshop 1 through a process of risk assessment	Risk assessment of core elements	1. What are the consequences of doing or not doing certain activities? Including: <ul style="list-style-type: none"> • Priorities of care • Gaps in care • Opportunities • Met and unmet needs 2. What knowledge and skills are required to support transition plans?
Workshop 3	To identify activities and strategies that will support implementation of transition plans		1. What is required to support the change in activity? <ul style="list-style-type: none"> • Identify spectrum of activity including activity that is: 1. key 2. additional 2. How will community nursing teams achieve the transition?
Workshop 4	To review and verify activity and risk data compiled.		

Appendix 3 Participant information

Workshop number	Locality	Number of participants
Workshop 1	Oban	14
	Thurso	10
	Tain	13
Workshop 2 Each locality participated in 3 way video-conference	Oban	14
	Thurso	3
	Tain	8
Workshop 3	Oban	9
	Thurso	6
	Tain	9
Workshop 4 Each locality participated in 3 way video-conference	Oban	9
	Thurso	4
	Tain	7

Appendix 4

Community Nursing Core and Non-Core Activity

CORE ACTIVITY - Adults and children with health needs who are unable to attend surgeries, clinics and other facilities (includes care homes where nursing care is not provided)

Accountability	Responsibility	Examples of Activity	Comments
Assessment of health, nursing and social needs of clients, and their carers, and development of initial client and carer care plans	<ul style="list-style-type: none"> Initial health and social assessment on referral Initial nursing interventions Ensure Lead professional is updated as appropriate 	<ul style="list-style-type: none"> Multi-disciplinary assessment Risk assessment Comprehensive nursing assessment Development of person-centred care plan Develop initial anticipatory care plan Delivery of immediate nursing care needs Prescribing Instigate appropriate self/carer-care support Refer to other teams/agencies for further assessment where required Record keeping Doppler Assessment 	<p>May include use of telehealth</p> <p>Includes specialist nursing care in care homes</p>
Provision and review of Nursing Care in line with care plans	<ul style="list-style-type: none"> Provision of direct and in-direct nursing care Review of nursing care needs Review of health and social care needs Promotion of self care and enablement Updating Lead Professional as/where appropriate 	<ul style="list-style-type: none"> Delivery of immediate nursing care needs including where required: <ol style="list-style-type: none"> IV therapies venepuncture Instigate appropriate self/carer-care support Refer to other teams/agencies for further assessment where required 	
Provision and review Nursing Care in line with care plan	<ul style="list-style-type: none"> Provision of direct and in-direct nursing care Review nursing care needs Review health and social care needs (if named professional) Promote self care Ensure Lead professional is updated as appropriate Contribute to case management meetings etc 		
Co-ordination of services, where identified as Lead Professional	<ul style="list-style-type: none"> Key contact for client/family Co-ordinate services, / Facilitate referrals between services Main contact for all professionals providing services Ensure care plans and anticipatory plans are reviewed and kept up-to-date 		

CORE ACTIVITY - Adults and children with health needs who are unable to attend surgeries, clinics and other facilities (includes care homes where nursing care is not provided)

Accountability	Responsibility	Examples of Activity	Comments
	<ul style="list-style-type: none"> • Arrange and manage case review meetings etc as required • Key community contact for discharge planning and coordination of services • Undertake and review emergency care plans 		

CORE ACTIVITY - Children and their families (11- 14 days to school entry)

Accountability	Responsibility	Examples of Activity	Comments
All children and their families in line with GIRFEC universal services			
<ul style="list-style-type: none"> • Assessment of health and wellbeing needs. • Identification of level of support to meet needs 	<ul style="list-style-type: none"> • Provision of, and Named Person for, universal services to children and families from 11 days to school entry • Leading, coordinating and delivering the Hall 4 universal core programme • Point of contact for child, parent, other professionals and members of the community • Maintenance of child's and health records – ensures core information is up to date • Planning, coordination, and delivery health and wellbeing interventions for children and families • Ensuring effective transfer of information about the child at points of transition to their new named professional or to school nurse at school entry 	<ul style="list-style-type: none"> • Full health and wellbeing assessments and reviews • Advice on immunisations • Family health assessments and development of family health plans • Parenting skills advice <ul style="list-style-type: none"> ○ Breast and infant feeding advice ○ Promote bonding and attachment ○ Advice on management of common childhood illnesses ○ Toileting • Maternal mental health screening • Health Promotion • Promote self-care • Advice on services to support health, social and education improvement • Contribution to, targeted, pre-natal services • Early identification of children and families who have needs related to health and wellbeing 	<ul style="list-style-type: none"> • The giving of immunisations to this age group would be non-core

CORE ACTIVITY - Children and their families (11- 14 days to school entry)			
Accountability	Responsibility	Examples of Activity	Comments
	<ul style="list-style-type: none"> • The delivery of early intervention as required • Act as a link between GP and preschool settings 		
Children with Additional Needs			
<p>Assessment and Provision of support to prevent escalation or deterioration to health and wellbeing</p> <p>Contribute to the development of the children's plan where social work is lead professional</p> <p>Provision of health related activities identified within the plan</p> <p>Provision universal services as appropriate</p>	<ul style="list-style-type: none"> • Where appropriate and agreed with multi-agency team, take role of Lead Professional for children with additional needs, not in the child protection system • Development and maintenance of interagency child's and health plans, through the application of my world triangle and assessment • Work closely with Integrated Service Officer to plan and participate in provision of identified early interventions activates for agreed period • Referral to other services where required • Coordinate care if additional health services are required • Plan and organise multi-disciplinary/multi-agency reviews as required • Ensure the lead professional is informed of changes to the child and/or families health and or other relevant circumstances timorously • Contribute to the identification and review of need • Submit reports and contribute to 	<ul style="list-style-type: none"> • Detailed Health and wellbeing care assessment and universal social and education assessment • Plan health and social interventions as appropriate e.g. intensive parenting skills support • Anticipatory care planning 	<p>Activities may be Provided, under the supervision of PHN by others services such as: family support workers.</p>

CORE ACTIVITY - Children and their families (11- 14 days to school entry)			
Accountability	Responsibility	Examples of Activity	Comments
	child protection plan meetings, core groups and other reviews as appropriate		

CORE ACTIVITY - Children and their families (children in school or receiving home education)			
Accountability	Responsibility	Examples of Activity	Comments
All children and their families in line with GIRFEC			
Provision universal services to children and families to school entry school aged children	<ul style="list-style-type: none"> • Arrange and Provision Health and Wellbeing reviews in partnership with pre-school establishment • Contribute to health promotion activities within the schools • Promote self care • Support educational establishment to support children with additional health needs • Provision of immunisation program 	<ul style="list-style-type: none"> • P1 and S1 Health reviews assessments and reviews • Immunisations • Assessment of physical and mental health needs • Provide an accessible, needs led service for young people and school age children who require additional support with mental and emotional health needs, • Attending Multi-disciplinary meetings 	
Children with Additional Needs			
Support educational establishments to support children with additional health needs Contribute to the development of the children's plan	<ul style="list-style-type: none"> • Support young people with emotional and mental health needs, and their families as identified in my world triangle and assessment plan • Ensure the lead professional is 	<ul style="list-style-type: none"> • Provide support to health and educational staff working with young people • Co-ordinate care provision with other members of the multidisciplinary /multiagency team 	<ul style="list-style-type: none"> • In partnership with CAMS teams

CORE ACTIVITY - Children and their families (children in school or receiving home education)			
Accountability	Responsibility	Examples of Activity	Comments
Provision health related activities identified within the plan Provision universal services as appropriate	informed of changes to the child and/or families health and or other relevant circumstances timorously <ul style="list-style-type: none"> • Contribute to the identification and review of need • Submit reports and contribute to reviews as appropriate 		

CORE ACTIVITY - Local population – health protection, promotion and improvement			
Accountability	Responsibility	Examples of Activity	Comments
Promote health behaviours within all one-to-one and family contacts Refer to specialist services as required		<ul style="list-style-type: none"> • Motivational interviewing • Alcohol brief interventions • Smoking cessation • Obesity • Safely in the home 	<ul style="list-style-type: none"> • Includes: 1.Brief intervention 2.Counter weight
Assess risks to vulnerable people at all face-to-face contacts		<ul style="list-style-type: none"> • Incorporate risk assessment in all assessments at all contacts 	<ul style="list-style-type: none"> • Includes: 1.Falls prevention 2.Child protections 3.Domestic violence 4.Moving and handling
Participate in team case finding activity		<ul style="list-style-type: none"> • Identify people at risk on case loads • Contribute to case finding activity with practices and social]work and other relevant agencies 	

CORE ACTIVITY – Management, Leadership and Learning

Accountability	Responsibility	Examples of Activity	Comments
Ensure service needs are met	<ul style="list-style-type: none"> • Routinely review demand and ensure the demands are met to appropriate standards and efficiently • Review staffing establishments and skill mix with staff manager and accountants • Monitor quality against organisational and professional standards 	<ul style="list-style-type: none"> • Continually monitor and review caseloads • Continually prioritise demand and deployment of resources • Monitor, and address shortfalls in, record keeping 	<ul style="list-style-type: none"> • Incorporates <ul style="list-style-type: none"> ○ Annual record keeping audits
Manage, and support, staff in line with policies	<ul style="list-style-type: none"> • Ensure staff policies are appropriately applied • Ensure staff have access to appropriate clinical supervision • Ensure staff are practicing safely and competently • Ensure staff receive mandatory training as required 	<ul style="list-style-type: none"> • Staff reviews and implementation personal and direct reports, CPD plans in line with service needs and NHS policies • Absence management • Mandatory training records 	
Inform and manage budgets	<ul style="list-style-type: none"> • Identification of needs • Allocate resources efficiently and effectively 	<ul style="list-style-type: none"> • Regular review of budgets • Identify and seek mechanisms to address resource pressures 	
Inform and contribute to service redesign activities	<ul style="list-style-type: none"> • Highlight service design challenges • Share good practice 	<ul style="list-style-type: none"> • Attend and contribute to local team meetings etc • Contribute to LEAN and redesign programs 	
Provide student placements and mentorship	<ul style="list-style-type: none"> • Provide placements in line with agreements with HEIs • Ensure student placements meet quality standards • Ensure mentors receive appropriate education/training, and remain up-to-date 	<ul style="list-style-type: none"> • Agree student placements with HEIs • Review mentors' CPD requirements 	

NON- CORE ACTIVITY - Adults and children with health needs who are unable to attend surgeries, clinics and other facilities (includes care homes where nursing care is not provided)

Accountability	Responsibility	Examples of Activity	Comments
Provide home visits to undertake 'one-off' procedures at the request of other services	<ul style="list-style-type: none"> • Undertake procedures requested by e.g. GPs, inpatient services • Undertake full nursing and wellbeing assessment • Report back to referrer as appropriate and suggest plans to address any problems 	<ul style="list-style-type: none"> • Check dressings and wound healing • Venepuncture • Near Patient testing • Review health and wellbeing 	<ul style="list-style-type: none"> • Could the procedure be undertaken during direct contacts by General Practice personnel? • Could patients be educated to undertake these themselves by the referrer?
Provision of personal care	<ul style="list-style-type: none"> • Assess need, develop plan and provide required interventions • Undertake full nursing and wellbeing assessment • Provide immediate personal care requirements • Report back to lead/named professional as appropriate 	<ul style="list-style-type: none"> • Personal care • Nursing and wellbeing assessment 	<ul style="list-style-type: none"> • This is appropriate when the majority of time spent on provision requires nursing assessment and interventions, but when the balance of time and skills is predominantly personal care, the services provided by community nurses should be in line with core activity
Provide nurse-led clinics e.g. leg-ulcer clinics, ear-syringing, well person, LTC management	<ul style="list-style-type: none"> • Agree purpose, scope, frequency, referral protocols, and practice standards with partners and line managers • Provide services in line with agreed scope, frequency etc • Evaluate and review service, including adherence to referral protocols by referrers 	<ul style="list-style-type: none"> • Develop evidence based- service • Provide service efficiently and effectively • Set and monitor standards 	<ul style="list-style-type: none"> • There is need to ensure the Community Nursing Services are the most efficient and effective way to provide the service • Community nurses may provide specialist advice to other services e.g. tissue viability

NON- CORE ACTIVITY - Children and their families (pre-school and in school-aged)			
Accountability	Responsibility	Examples of Activity	Comments
Giving of routine childhood immunisations in the home and/or clinic – other than school Participate in mass immunisation programmes as required		<ul style="list-style-type: none"> • Planning and running clinics • Providing advice to parents/guidance • Administering immunisations • Managing immediate reactions 	
Provide additional HV Support to Children and families with additional health and social needs, pending assessment by service referred to	<ul style="list-style-type: none"> • Develop plans • Provide additional support as required • Inform agency referred to of any change in circumstances following referral • Keep manager (anyone else) informed of situation 	<ul style="list-style-type: none"> • Advanced support with parenting skills 	Sometimes this period may be for twelve months or more
Routine social assessment visits to families where children are on the 'at risk register'	<ul style="list-style-type: none"> • Undertake visits agreed in integrated children's plan • Inform Lead professional of the outcome of visits • Incorporate universal services as named person as appropriate 		This activity is undertaken on behalf of the Social Worker who will be the Lead Professional
Assist parents/guardians to fulfil parental responsibilities to attend clinics etc	For children with additional needs: <ul style="list-style-type: none"> • Provide support as agreed in Children's plan • Inform Lead professional of the outcome of visits • Incorporate universal services as named person as appropriate 		Only in exceptional circumstances undertaken where children not identified as requiring additional needs

NON- CORE ACTIVITY - Local population – health protection, promotion and improvement			
Accountability	Responsibility	Examples of Activity	Comments
Lead health promoting groups e.g. smoking cessation, weight management programmes	<ul style="list-style-type: none"> • Agree scope, frequency and target population with colleagues and line managers • Develop referral criteria, practice standards etc • Evaluate and review with colleagues and managers regularly 	<ul style="list-style-type: none"> • Smoking cessation • Obesity • Well women • Well men • Pre-natal classes 	<ul style="list-style-type: none"> • Examples are not exhaustive • the this was a core activity for PHNs/HVs but is not possible for most staff due to increased workload with pre-school children and GIRFEC
Lead Community development programs	<ul style="list-style-type: none"> • Identify need • Scope Project • Identify Community Assets • Develop strategic plan • Lead implementation • Undertake evaluation 		<ul style="list-style-type: none"> • In some cases community nurses lead the development, but had over delivery to of programmes to other agencies
Adults with complex needs health improvements	<ul style="list-style-type: none"> • Identify need • Scope Project • Identify Community Assets • Develop strategic plan • Lead implementation • Undertake evaluation 		

Appendix 5

Table 2 Service design challenges and potential solutions

Service provision challenges	Current Constraints	Proposed change for service enhancement	Models of good practice	Areas for further consideration	Benefits of service enhancement
1.Out of hours Service Out of hours provision is inconsistent across localities (Nb. Except for terminal care) Limited access to respite service provision	Limited nursing care after 5pm	More flexible community nursing service that includes shift systems till late evening	Tain: Augmented team provide care at home up until 24:00 hrs.	Requirement to clarify what the service requirements are, e.g. clarification of need until 20:00 – 22:00 hrs.	Service is more responsive and less reactive to health needs Service is more flexible
	Inability to have effective response to acute nursing situations, e.g. blocked urinary catheter				
	Limited social care for adults after 5pm Limited ability to respond to carer crisis, e.g. illness	More responsive service for social care after 17:00 hrs.	Tain: Shared facilities: 2 beds allocated in nursing home where care is nurse led and supported by care home that provide personal care	Risk that move from social care to private sector jeopardises shared service	Reduction in crisis admission to hospital
Out of hours terminal care	Response to need can be slow and inconsistent and service is not always available when needed. e.g. rapid deterioration	Response from the integrated care team and Marie Curie to support service delivery when patients' needs change			
Out of hours access to equipment	In some areas access to equipment, e.g. air mattress, commodes not always available when required				
2. Inter-agency and interdisciplinary working	Incompatible electronic record systems between	Realistic and practical solutions and the authority for authorisation of		Improve integration with	

arrangements are constrained by incompatible working systems	GP, hospitals and social work Lack of IT systems in and around community nursing Access to record systems affect continuity of patient care	frontline systems that will work Strategic approach to development of IT infrastructure for CN		GPs and their system to identify at risk patients.	
	Over-reliance on multiple photocopying that is resource and time intensive. Lack of confidence and proficiency with IT systems, e.g. typing skills	Move away from papers records as systems limitations permit		Patient held records will continue to be hand written	Time saving Interagency / Interdisciplinary work improved
3. Lack of mental health practitioners who are trained to address the needs of children and families	There is a need to respond to increasing needs for support in CAMHs	Proposed model of service delivery – 3 levels of service: 1. support from generalists 2. support form specialist practitioners 3. tertiary care Emphasis on multidisciplinary/ cross agency work, e.g. family support workers, guidance teachers	Generalist practitioners supported by specialists, model reduces dependency on one person Oban: Specialist practitioners support and help to develop other practitioners to provide services.	In areas where a specialist service is reliant on one person service model of delivery absence of that person can result in diminished service	Service is not withdrawn when specialist is not available
4. Inconsistent administrative support across community nursing teams		Administration to have common duties across localities: Setting up & managing records Removal of records Phone calls Ordering supplies Collating monthly statistics, e.g. sickness		Move towards using SMS messages instead of paper reminders for appointments System for ordering standard records from central locality in NHS	

5. Inappropriate referral to community nursing services post discharge	<p>Coherent approach to discharge planning and anticipatory care planning needs to be evident across all care settings including hospital care.</p> <p>Nurses used as a 'pop-in' service</p>	<p>Self-management to be encouraged as part of care delivery in hospital</p> <p>Re-enforce awareness of community nursing role with hospital staff</p>			
6. Inefficiencies with current systems for supporting continence management	<p>Inferior product quality</p> <p>Assessment processes are good but if nurse requires to refer onto incontinence service this causes delays and undermines nursing assessment skills.</p>	<p>Change to more effective product line. A higher quality product will reduce number of products used and improve patient outcomes.</p> <p>Consider introduction of voucher system and clients can access choice of product which at least covers cost of cheaper products</p>	<p>Emergency store of incontinence aids held in clinics and health services. Important for out of hours provision where patients' needs may change suddenly</p>	<p>Review service current approach to service provision and product use</p>	
7. Some child service posts in community are not protected	<p>Uncertainty around service provision. Withdrawal of services poses risks to vulnerable and intractable families</p>				<p>Key primary prevention role</p>