NHS England

# Framework for commissioning community nursing

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# Framework for commissioning community nursing

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Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

NHS England's purpose is to create the culture and conditions for health and care services and staff to deliver the highest standard of care. To ensure that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations.

When this framework is implemented locally, commissioners and providers should pay due regard to the Public Sector Equality Duty (section 149 of the Equality Act 2010) and to the need to reduce inequalities between patients in access to health services and the outcomes achieved (Health and Social Care Act 2012). Service design should be appropriate and accessible to meet the needs of diverse communities.

Guidance for NHS commissioners on Equality and Health Inequalities legal duties can be accessed at
http://www.england.nhs.uk/ourwork/gov/equality-hub/legal-duties/

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# 1 Introduction

This framework has been developed as part of the Transforming Nursing for Community and Primary Care Programme (TNfCPC), the Senior Responsible Officer for the programme is Jane Cummings, Chief Nursing Officer England. The framework supports commissioning of community nursing in response to the Five Year Forward View. It focuses on community nursing whilst recognising that greater integration for health and social care will be needed to meet future needs.

Community nursing[1] refers to a diverse range of nurses and support workers who work in the community, including district nurses, intermediate care nurses, community matrons and hospital at home nurses. It does not specifically include general practice nurses, community mental health, learning disability or children's nurses although is transferable and all are central to integrated working.

The Five Year Forward View (1)[2] outlines the challenges faced by the health and social care system in response to an ageing population with increasingly complex and multifaceted health and wellbeing issues. Delivering the strategic vision of the Five Year Forward View requires a 'joined up' approach for effective commissioning and delivery of community nursing services.

***What is community nursing?***

*Community nursing encompasses a diverse range of nurses and support workers who work in the community. This framework focusses on community nurses providing care for the over 18's encompassing the district nursing service, community matrons, intermediate care and specialist nurses as examples.*

Subject experts and partner organisations (Appendix 1) have contributed to the development of this framework for commissioning community nursing within the current health and social care context. They have identified the key characteristics of a community nursing workforce and the main challenges for community nursing services. The framework is based on these challenges and in response to the emerging new care models, part of the Five Year Forward View. Formed of eight components the framework will support commissioners and providers to understand the inter-relationships between the components important to commissioning community nursing. These components encompass assessing need, planning services, commissioning the service and reviewing the impact through outcomes.

These components can also be adapted to the wider integrated health and social care system.

The framework provides an overview of community nursing workforce planning tools in advance of winter 2015. This is prior to the multi professional approach to the

[1] When "district nurse" is used it refers specifically to district nurses not community nurses in general.

2 The Five Year Forward View was collaboratively produced by NHS England, Health Education England, Public Health England, NHS Trust Development Agency (TDA), Monitor, and the Care Quality Commission.

development of guidance on safe staffing being undertaken by the Chief Nursing Officer and NHS Improvement.

Guidance from the Queens Nursing Institute (QNI) (2) and Health Education England (HEE). (3) should be read in conjunction with this framework to support community nursing commissioning.

The QNI have developed Voluntary education standards for district nurse education and practice (2) providing further insight into the knowledge base and competencies required of service leaders working in a community setting. The standards will support this work to enable greater consistency in expectations of district nurses.

HEE (3) will also publish an overarching education and career framework for district and general practice nursing service at the end of October 2015. This will provide clarity of roles and expected educational achievement for the NHS to follow. Both of these documents will complement this framework and set the career landscape for nurses which will guide community nursing workforce commissioning.

Commissioners and established community nursing providers should also use the framework to assess and develop current community nursing services

# 2 Purpose

The purpose of the framework is to provide:

- insight into community nursing, the challenges and opportunities to enable effective commissioning of community nursing
- a focus for assurance conversations with providers
- eight components guiding the assessment, planning, commissioning and impact of a community nursing service
- an overview of a range of workforce tools to assist planning in community nursing.

# 3 Current context

The current challenges facing the NHS which impact on community nursing services are well known. There is an ageing population with increased health needs, a growing need for nursing care at or closer to home, a focus on timely and appropriate discharge from hospital, a rise in people with increasingly complex levels of health and social care requirements.

Healthcare provision needs to respond to these challenges by improving productivity whilst reducing or stabilising healthcare costs; providing care closer to the person's home and reducing episodes of unplanned health care. There is a need to develop a cost effective and sustainable community nursing service whilst maintaining and improving high quality care.

The publication of the Five Year Forward View (1) aims to address the health and wellbeing gap, the care and quality gap and the funding and efficiency challenges in the context of rising demand and resources focussed on hospital care. Despite the intended transfer of care closer to or at home there has been only a "0.6% increase in the number of nurses working in the community over the past ten years." (1 p. 30)

Community nurses are essential to support the movement of care from hospitals to settings at or closer to people's homes. They currently deliver care in primary and community settings with hospital-based specialist services, social care and third sector partners, but this collaboration needs to be strengthened. There are many policies and initiatives to support this such as the development of new care models, the better care fund, prime ministers challenge fund, seven day working, avoiding delayed transfers of care and urgent and elective care networks. The concept of greater integration between primary care and community nursing as part of the new care models is well described in the recommendations of the Primary Care Workforce Commission (4). Greater integration aims to strengthen and streamline services to reduce fragmentation supporting people to live as well as possible, centred on the outcomes important to them.

This framework will support local commissioning of a person centred outcome based approach to community nursing; appropriately resourced; to deliver improved health outcomes and cost effectiveness. (5)

A key element of commissioning a community nursing service is to have an understanding of the workforce providing this. There are difficulties with recruitment, retention, and an aging community nursing workforce, alongside the issues of rising acuity, dependency and demand for care. Using a workforce tool can provide evidence of capacity and demand, productivity and cost effectiveness and support skill mix changes.

The next section describes the key characteristics of a modern community nursing workforce.

# 4 Key characteristics of community nursing

Community nursing has developed over the years, historically the perception of the district nursing service is that it cared for older people who were unable to leave their homes to seek health/nursing care, (6) however it is increasingly recognised that community nurses can and do provide much more than this.

*"The ultimate purpose of community nursing is to work collaboratively in providing safe and effective holistic nursing care to people in or near their home:, enabling people to make choices, self-manage and maintain control over their quality of life" (38 p. 80)*

Community nurses have a multitude of core skills and knowledge for assessing and providing care in the home environment; wound and leg ulcer care (assessment, diagnosis and management), intensive nursing care at the end of life, pain management, timely hospital discharge, rehabilitation, maximising independence and provision of support and advice to the individual, carer and family.

Community nurses have developed additional skills in response to the changing needs of the population they serve such as long term

condition management, identifying and supporting those with exacerbations of serious illnesses. It is important to recognise that care should be holistic, focussing on self-care, prevention, behaviour change and not task oriented.

The changing health and social care environment, requires improved integrated care services (4), to respond to this the community nursing workforce needs to be:

- resilient and adaptable, able to cope with unpredictable situations sometimes under less than optimal circumstances
- confident in lone working and making autonomous decisions, often without immediate or remote support
- skilled at proactive and anticipatory care, working with individuals and carer's to enable them to recognise acute or chronic changes in their condition or wellbeing, using advanced practice skills for assessment, diagnosis and prescribing
- skilled and effective at working in partnership in a multidisciplinary team
- able to work effectively with carers to support them in their role to meet person centered outcomes, for example in end of life care to be in the preferred place of choice wherever possible
- skilled in behaviour change or coaching strategies to support individuals to be empowered and confident in managing their conditions and wellbeing through secondary prevention
- able to conduct risk assessments and risk mitigation to ensure interventions can be delivered safely to people at home
- able to recognise where safeguarding or mental health is compromised and assess the individual's mental capacity to consent
- able to prevent unnecessary hospital admission and facilitate timely discharge
- confident in higher level communication skills such as appreciative enquiry that enable the use of effective communication skills to negotiate care plans and establish a co-productive relationship
- strongly focused on enabling individuals to take responsibility for their self-care
- effective users of technology, promoting its use with people in their care
- able to apply population level health and wellbeing initiatives, building strong relationships with third sector organisations
- able to use appropriate outcome measures to evidence the effective use of community nursing services
- skilled in the caseload management of a caseload, workload and resource utilisation
- confident in their individual professional development and in supervising colleagues and students
- able to manage change through flexibility, innovation and strategic leadership.

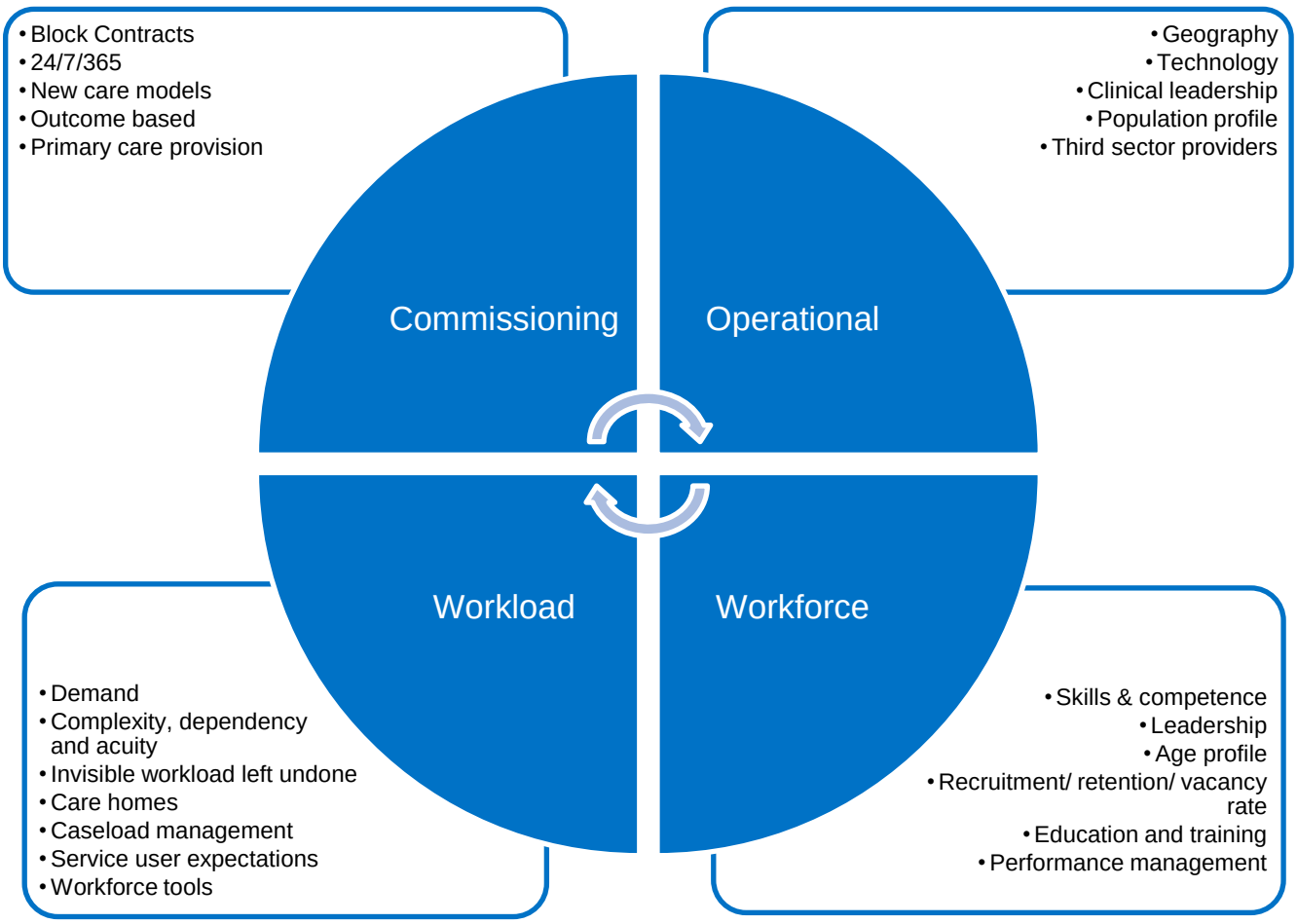
These attributes are recognised as key characteristics for district nurses and are described in other documents (2) (3), but are applicable to the wider community nursing workforce.

# 5 Key factors affecting delivery of community nursing services

There are many factors that affect the efficient and effective delivery of community nursing services. These are highlighted in diagram one below, and embedded in the components of this framework in section six. The factors should be used as a basis for discussion in assurance conversations between commissioners and existing providers. These conversations will support the development and provision of the community nursing service and multi professional working.

The factors are categorised into commissioning, operational, workload and workforce factors.

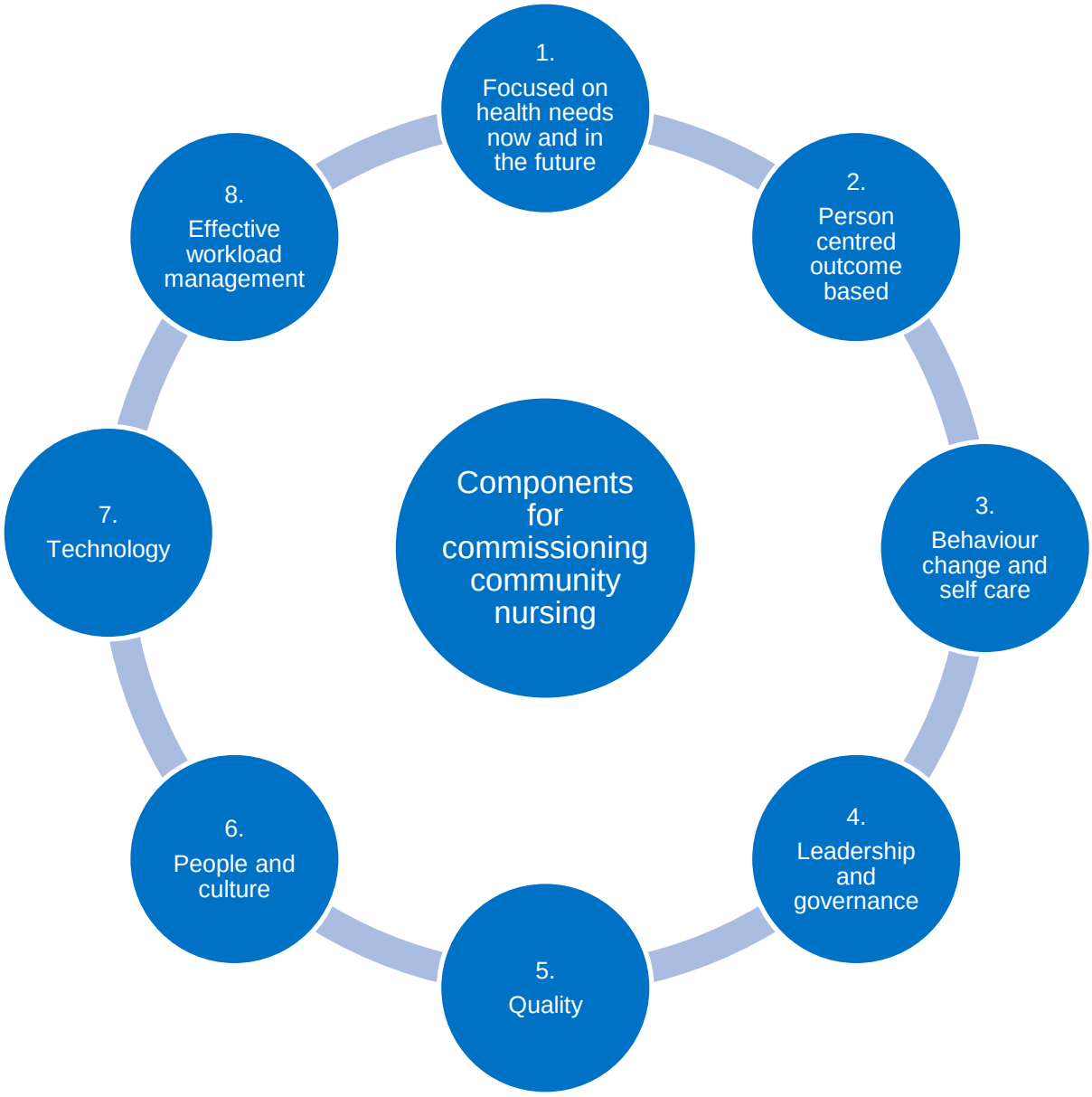
**Diagram 1 - Factors affecting community nursing services delivery**



# 6 The eight components for commissioning community nursing

There are eight components in this framework identified through consultation with community nursing experts. A number of key partner organisations contribute to the effective delivery of community nursing including, Local Education and Training Boards part of Health Education England, education providers and regulators. The framework however specifically identifies the responsibilities for commissioners and providers.
Each component covers the aims, rationale and delivery mechanisms with a focus for either provider (P), Commissioner (C) or both (C/P). The components can be applied to primary care and wider community services, all having a role in integrated care

**Diagram 2- Components for community nurse commissioning**



## Component 1: Focused on health needs - now and the future

### Aim

- Evidence based evaluation of population health needs and demographic challenges will be used to inform commissioning of community nursing.
- Use all available health economy data including provider data such as locality population, caseload and workforce information to inform planning.
- Create and sustain a nursing workforce that is prepared to deal with future healthcare and prevention challenges.

### Rationale

People requiring healthcare at home have diverse and complex needs, this is in part due to them living longer with multiple co-morbidities, including a rise in dementia diagnosis. Advancements in healthcare require the skills of the community nursing workforce to adapt over time.

| | **Delivery Mechanism** |
|---|---|
| C/P | Model individual and locality needs using population health management systems from a variety of sources, such as Joint Strategic Needs Assessement, Atlas of Care, Quality and Outcomes Framework and Primary care webtool (7). Compare this with information from provider caseload and workload data. |
| C/P | Share population data with communities and clinicians to develop a co-production solution for future healthcare needs. |
| C/P | Develop competencies of staff to ensure they are able to deliver nursing care mapped to the changing needs based on the population assessment and caseload analysis. |
| C/P | Commission education and training in line with findings of the health needs analysis to ensure a competent workforce. |
| P | Develop systems to assess for the potential presence of frailty with every contact with an older person (8). Consider use of the Frailty toolkit for General Practice (9) |
| C/P | Use Case finding and risk stratification (10) and Next steps for risk stratification in the NHS (11) to identify people with complex needs requiring case management and for identifying frailty. |
| C/P | Plan for carer's needs and carer's assessment. |
| C/P | Ensure the diverse needs of communities and inequalities for access and outcome is assessed and reduced. |

### Key

C= Commissioner
P=Provider

## Component 2: Person centred outcome based commissioning

### Aim

Community nursing is focused on meaningful person centred outcomes for individuals and carers, valuing impact, rather than individual contacts or tasks.

### Rationale

Traditional healthcare commissioning in the NHS has historically been based on block contracts and processes such as numbers of patient visits. The Kings Fund (12) highlighted that for community services this has been partially due to a lack of data and quality metrics. As a result, commissioning by block contracts has meant that providers have not been accurately rewarded for the work they have undertaken. Consequently, changing demand without a changing workforce, in some cases, has impacted on the effective delivery and quality of community services.

Static funding levels, growing demand and unexplained variation in clinical care between providers has resulted in the need for services to be commissioned differently. Outcome based commissioning is increasingly seen as a way to reduce fragmentation and to reduce the barriers for integrated working across multiple health and social care providers. To add real value, the outcomes should focus on local needs and priorities addressing the prevention agenda, must be centred on what matters to the person, via personalised care and support planning (5).

The Kings Fund has described that whilst some commissioners have started to develop outcome based commissioning for community services, others remain less developed in their approach, focussing even more on activity. They suggest that community nursing needs to move away from task and contact based care to person centred outcome based care (12).

Providers need to be proactive at evidencing their impact using outcome measures. These may be based on, for example; patient care outcomes - dying in the preferred place of care; quality outcomes - experience of care; clinical performance outcomes - leg ulcer healing; workforce performance - sickness rates. Outcomes may be identified as part of a pathway demonstrating a staged approach to achieving patient centred outcomes (13).

One of the aims of the Five Year Forward is to promote further integration of services, via integrated teams that will respond to population need. These multidisciplinary professionals will work across organisational boundaries to deliver person centred outcomes. Effective working with GP practices is central to both community nurses and integrated teams.

The increase in dementia and anxiety in people with long term conditions also highlights the importance for teams to have mental health skills, the commissioning of this will need to be agreed. The new care models are developing different structures and teams and the impact of these different models will be useful in identifying and resolving challenges.

The Five Year Forward View also promotes people becoming more active participants in their care.

The current district nursing service is seen as flexible and clinicians frequently state that individuals are referred to the service as a 'catch all' if no other option is available (14). This may result in some individuals being in the service unnecessarily. Moving to outcome based commissioning would help to create whole system integration around the needs of the population rather than via rigid service boundaries.

| | **Delivery Mechanism** |
|---|---|
| C/P | Move from block contract commissioning and service which counts numbers of contacts, to person centred outcome based commissioning to streamline delivery of patient care. |
| C/P | Develop a shared vision between commissioners, providers and stakeholders to build an integrated care model which delivers person centred outcomes. |
| P | Provide a service flexing the delivery approach for person centred outcomes. |
| C | Develop standardised key performance indicators for outcome focused care which support integration and deliver improvement. Link these to workforce numbers and demand. |
| C | Identify outcome measures that could lead to service delivery change and ultimately person centred outcomes (13). |
| P | Capture and report evidence of performance outcomes based on the service users' experience, financial, operational and clinical measures using patient reported outcome measures (PROM's). |
| P | Have processes in place to support integration which reduce the transitions of care between services. |
| C/P | Support the development of governance and organisational models for decision making and mutual accountability. |
| P | Provide effective education and training to support culture and behaviour change in community nurses. |
| P | Support clinicians to work effectively with carers by responding to carers needs, helping them to stay healthy and to be appropriately supported with their caring responsibilities. Particularly in discharge care, end of life care and dementia. Utilise guidance such as Dementia revealed (15). |
| P | Embed personalised health budgets. |
| C/P | Obtain feedback from patient involvement forums, Friends and Family Test, staff survey, primary care information, staff turnover as a means of assessing outcomes. |
| C/P | Utilise the best practice guidance to support the implementation of personalised care Personalised Care and Support Planning Handbook (16). |
| P | Assess the effectiveness of care coordination and impact on individuals. |
| P | Utilise Multi-disciplinary team (MDT) working (17) supporting health and social care professionals to work across professional and organisational boundaries |

## Component 3: Behaviour change and self-care

### Aim

Community nurses work with people as full partners in care through personalised care and support planning, using behaviour change to help them recover from or manage ill health, stay well, or maintain independence.

### Rationale

The integrated team is supported to assist with behaviour change, firstly to assess individual's knowledge, skill and confidence for managing their own health care using patient activation (18). Then secondly to adapt their intervention working with people to promote self-care and empowerment to make healthy behaviour changes (19) (20). People who are activated have better outcomes, improved test results across a number of conditions, engage in healthier behaviour and have fewer episodes of emergency care. Tailoring support for those least activated, leads to the greatest improvements. Moving to this approach may mean initial consultations with people take longer due to the holistic nature of the interaction. Over time the focus on education and empowerment will reduce the amount of healthcare intervention dependency on services, improve care delivery and patient outcomes.

Health coaching such as health trainers, expert patient programme and DESMOND all demonstrate the impact of behaviour change.

| | **Delivery Mechanism** |
|---|---|
| C/P | Utilise Framework for personalised care (21). Making every contact count (22) and NICE guidance on behaviour change. (19). |
| P | Ensure the integrated workforce is appropriately skilled in the delivery of behaviour change and promoting self-care. |
| C/P | Ensure behaviour change and assessing skill, knowledge and confidence is recognised as integral to practice and utilised as an outcome measure. |
| P | Use a patient reported measure on how well they have been involved in the decisions on their care. |
| C/P | Collate data on facilitating self-management as an outcome measure. |
| P | Establish if initial assessment appointments need to be longer in duration to facilitate a holistic assessment and plan of care. Work with people to identify and support behaviour change and self-care reducing longer term dependency on services. |
| C/P | Ensure the wider multidisciplinary workforce is fully engaged in the cultural change required with an approach to caring from a deficit to an asset based model of health and care. From viewing the 'patient' or individual as dependent, to self-caring and empowered building on their strengths. |
| C/P | Move from task based measures to person centred outcome measures. |
| P | Ensure a person centred approach where behaviour change may not be appropriate in people with conditions such as advanced dementia. Utilise Ambitions for palliative and end of life care (23) with people at the end of life. |
| P | Use a range of approaches to promote behaviour change and self-care such as building skills, knowledge and confidence of carers on the prevention of pressure ulcers as well as smoking and weight loss. |

## Component 4: Leadership and governance

### Aim

- Governance structures are appropriate and proportionate for effective delivery and shared decision-making.
- Managers, clinicians and nurse leaders in organisations will lead, promote and embed change across organisational boundaries that challenge traditional ways of working. They will model the culture of collaboration and integration to improve outcomes for people.
- Clinical and management processes support clarity of “core role” and “flexible roles” for the community nurse workforce to ensure effective person centred care.

### Rationale

Organisational and cultural change will be supported by excellent leadership to embed the changing models and service in practice. Leadership will address professional concerns and drive through transformational change. It is important leaders share examples of good practice and celebrate early successes.

| | **Delivery Mechanism** |
|---|---|
| C/P | Ensure leaders - both clinical and managerial- across community nursing understand and articulate the vision for outcome based commissioning and role model how this translates into clinical practice. |
| P | Ensure the appropriate capacity and capability at all levels to plan, manage and deliver care services to achieve the shared strategy and vision. |
| C/P | Develop clear processes to manage risks across providers. |
| P | Define expectations for clinicians in “core roles” and “flexible roles” facilitating empowerment and change to promote person centred care. Use guidance (2) (3) to support the change. |
| C/P | Allocation of resources is clear and transparent and regularly reviewed as flexible roles develop, ensuring systems are in place to monitor caseloads and workload to facilitate person centred outcomes. |
| C/P | Ensure there is an effective system for managing and evaluating clinical risk and safety across all pathways. |
| C/P | Ensure robust information governance arrangements are in place for information sharing in and across organisations. |
| C/P | Ensure project and change management systems and processes are in place to support the delivery of complex, whole system change to drive efficiencies and improve care. |
| C/P | Provide clearly defined service specifications for the service provided, facilitating person centred outcomes. |
| P | Ensure active clinical supervision systems are in place for effective caseload management. |
| P | Ensure performance management systems are in pace for effective workforce allocation. |
| P | Ensure community nurses have the knowledge and skills to provide effective basic and post-basic education/training in one-to-one contexts. |
| P | Support new care models where self-managed teams empower nurses to provide person centred outcomes. |

## Component 5: Quality

**Aim**

- High quality, innovative, cost effective and compassionate care is consistently delivered by a community nursing workforce, which comprises the right people with the right skills in the right place at the right time.
- Outcomes are measured and there is a reduction in variation of person centred outcomes.
- Effective relationships are developed.
- Quality includes; patient safety, clinical effectiveness and patient experience.

**Rationale**

Recent reports, such as Francis (24) and Berwick (25) have highlighted the need for safe staffing and both suggest that “too few staff” is a key issue in delivering quality care. Ensuring there are enough experienced senior nurses as well as junior staff is essential. Community nursing teams need appropriate skills and competencies to deliver high quality care which embraces innovation, for people in the community. As caseloads become more complex, time for clinical supervision is essential.

Increasingly, individuals with more complex health and social care needs are living in care homes and sheltered housing, requiring support from a community nursing service. The variability in quality, quantity and staff turnover in care homes and the contracts they have can influence the requirements of community nursing services and can vary over time. Community nurses have a key role in supporting and developing staff in care homes to facilitate person centred outcome based care.

| | **Delivery Mechanism** |
|---|---|
| C/P | Contract for investment in prevention, quality improvements and working practices to deliver savings and efficiencies over the longer term. |
| C/P | Use evidence-based metrics to measure outcomes and experience. |
| C/P | Use key performance indicators that demonstrate outcome based care. |
| P | Ensure staff achieve the competencies to deliver the service. |
| C/P | Ensure access to education and professional development to meet the needs of their services and are compliant with the HEE Framework (3) |
| C/P | Consider the implications of the Shape of caring review (26) for a flexible workforce that provides high quality care wherever and whenever a person needs it. |
| P | Deliver nursing care by the right staff in the right place at the right time. |
| P | Quality standards and NICE guidance are used to support delivery. |
| C/P | Monitor the impact of care homes on the community nursing workforce and agree how to meet the needs in a person centred, outcome based approach- using workload tools. Learn from examples where care homes reduce the impact on community nursing. |
| C/P | Monitor the needs/unmet needs of care homes and impact on the community nursing service using workload assessment tools. |
| P | Proactively plan and recruit the workforce, monitoring and evaluating the impact of temporary staff. |
| P | Develop senior community nursing leadership ensuring recruitment and training plans are in place. |

## Component 6: People and culture

### Aim

- To engage community staff to deliver better patient experience, more appropriate care and improved outcomes.
- Providers identify, recruit and retain an appropriately skilled workforce to deliver high quality care.
- Ongoing workforce development to meet changing demands.
- Deliver person centred outcome based care supported by a culture of collaboration, innovation and quality improvement.

### Rationale

Evidence clearly shows that organisations with engaged staff deliver better patient experience, more appropriate care and improved outcomes (27).

Workforce planning is affected by the following factors which need to be considered in maintaining an effective workforce.

- The district nursing workforce is ageing with 50% of the workforce planning to retire in the next ten years (14).
- The number of, qualified district nurses has fallen by over 40% in the last decade (28) and an increase in other staff by other grades of nurse by 34% (3).
- There is increasingly a national difficulty in recruiting staff into the community setting and in particular to the more senior band 6 and 7 roles, with some organisations quoting over 40% vacant positions for band 6 and above.
- There is a need for a more comprehensive community nursing workforce dataset to inform workforce supply modelling.

| | **Delivery Mechanism** |
|---|---|
| P | Ensure planning and investment is made well in advance to enable effective recruitment, flexible working and retention, exploring creative ways of recruiting new staff and retaining staff. |
| C/P | Develop cultures, values and behaviours, across organisations delivering services. Recruit for NHS Constitution values. |
| P | Develop a flexible workforce across pathways and population groups to meet the changing needs and demands. |
| P | Facilitate staff to work across organisational and professional boundaries. |
| C | Commission providers who demonstrate capacity and capability to meet the population need and respond to changes in traditional delivery models. If a Transfers of Undertakings (TUPE) process applies the cultural changes may require more clarity for changing practice. |
| P | Provide training and organisational development to support and embed the new and innovative ways of working. Develop organisational learning needs assessment to enable HEE and LETBs to commission education and training opportunities that sit outside of the employer responsibility. |
| C/P | Ensure that there is a clear organisational development plan which includes a workforce strategy that is inclusive and able to reflect new ways of working and support the wellbeing of staff. |

## Component 7: Technology

### Aim

Technology is used to

- support the delivery of outcomes and ensure care is centred on the individual
- share person centred outcomes and performance information across organisations
- collect and interpret workforce/workload data.

### Rationale

Technology is central to new ways of working and the changing demands on community nursing services. There are opportunities to work more effectively with people, utilising telehealth, emails, texts, near patient testing, personal care alarms, provision of patient information and web based forums (29).Technology provides opportunities to reduce geographical challenges and efficiency with the use of effective mobile devices, including access to up-to-date electronic clinical records, mobile working and remote consultations. A recent survey showed that on average nurses working in the community spent 85 minutes a day travelling (30) for some this has reduced significantly following the introduction of mobile working demonstrated by this recording District nursing in the digital age (31).

Technology is essential for effective collection and interpretation of accurate workload and workforce information. Electronic clinical record keeping that enables automatic data collection of workload/workforce data and person centred outcome measurements, will support improvement and assist in the reduction of variation in service delivery and patient outcomes. By 2020 there is a vision that healthcare will be a paperless system and all records will be shared across professionals at the point of care Personalised Health and Social Care 2020 (32)

| | **Delivery Mechanism** |
|---|---|
| P | Facilitate a culture change to embed and promote technology in clinical care |
| C/P | Develop effective use of clinical records, IT, data sharing and technological solutions to ensure best use of clinical time. |
| C/P | Share assessments and plans for care delivery using technological solutions. Exploring the use of the Trusted Assessor Model (33) |
| C/P | Develop telehealth to increase independence and self-care and to provide early warning of a need for intervention. |
| P | Develop mobile working using lessons learned from other community providers to drive improvement. |
| P | Ensure workforce/workload data is collated and evaluated automatically without duplication of time. |
| P | Utilise technology to reduce travel time. |
| C/P | Use technology to facilitate remote consultations with experts. |
| C/P | Direct individuals to self-help technology to improve person centred outcomes, such as the online tool for Shared decision making and patient decision aids (34) to help people make difficult decisions. |
| C | Use technological applications that promote patient led care planning. |
| C/P | Ensure all patients will have access to their healthcare and nursing records. |

## Component 8: Effective workload management

### Aim

- Commissioners and providers understand and can articulate the workload of community nurses.
- Community nursing demand (including planned and urgent), activity, dependency/acuity and risk is regularly assessed to identify the required nursing resource.
- Caseloads are managed effectively utilising appropriate technology where available.

### Rationale

“Not understanding capacity may lead to imbalanced workforces, assigning too much work, resulting in missed or late sessions, or not having enough time to deliver services in line with specification. This may also miss seasonal fluctuations”. (35 p. 17)

The winter of 2014/15 highlighted challenges for accident and emergency services across the country with anecdotal reports about the increased complexity of patients impacting on extended lengths of hospital stay. The complexity and dependency/acuity of individuals requiring nursing care in the community has also been seen to increase over recent years.

The changing dependency/acuity of people receiving care, needs to be identified and evaluated. As complexity changes, the skills, skill mix and workforce capacity will need to change. Effective workforce planning needs an accurate assessment of both supply and demand and matching them both. (36) Using workload tools can assist this and the results need to be translated into a workforce plan. Section 7 describes some available workload tools.

The importance of accurate information to support commissioning decisions about skill mix and services is vitally important to ensure provision of high quality care for both the community nurse and those receiving interventions. (36)

Caseload management is a vital component of the community nursing role, which requires effective and efficient management. In 2014 the QNI identified through its survey that one third of district nurses continue to allocate their workload via paper based systems, which reduces effectiveness of caseload planning and evaluation. The importance of understanding caseloads, referrals and capacity of the service to meet the demand is essential. Measures of workload and output are not routinely robust, leading to poor understanding of the district nurses’ role and work.

Workload is generated from the caseload and the extent of the workload can be dependent on administration support, systems and processes and the skills and knowledge of the caseload holder. A lack of skills or confidence can lead to inappropriate care planning and over visiting, reluctance to discharge and large caseloads for the population served.

Larger caseloads and working in more integrated care teams requires effective workload planning and coordination of care. A survey in 2013 identified that case managers and team leaders spent more time in management and administration and only 27% of their time on direct patient care (30). The balance of this and the impact on service delivery need to be considered for the best use of resources.

The work that is left "undone" due to time pressures, lack of skills or resources is often articulated poorly by clinicians. Likewise the unmet need of individuals who are not known to have an active nursing need, but are housebound may not be addressed.

Some providers have separated their services into planned and unplanned care[3]. Workforce tools are able to assist in identifying and quantifying the predictable nature of the unplanned work to enable more effective management by using statistical techniques. Although further work is needed to be undertaken to develop this further (36).

Services need to be responsive 24/7 and 365 days per year to continue to respond to healthcare needs and the urgent and emergency care agenda. There is a need to facilitate effective pathways across organisational boundaries to reduce unnecessary hospital admissions, treat people in their own homes and deliver cost effective services and sustainability of the NHS.

| | **Delivery Mechanism** |
|---|---|
| P | Use electronic caseload management tools to facilitate data gathering, benchmarking service variability, interpretation and reporting. |
| P | Ensure the electronic tools used promote a feeling of ownership by nurses by providing:<br>• nurse input with validation processes to reduce error<br>• nurse access to meaningful and immediate data reports<br>• articulation of caseload and workload demand. |
| P | Ensure systematic and consistent caseload review across the provider to reflect risk, dependency/acuity and nursing input to the caseload. Monitor and evaluate changes over time using a workload tool (see section 6) such as the length of time people remain on the caseload, referral to follow up ratio for identified care pathways and outcome based care. Understand the limitations of the tool in use. |
| P | Deliver care based on best available evidence and caseloads monitored against this. |
| P | Ensure caseloads reflect dependency/acuity of the people on the caseload not size. Allocate the workforce to meet the need of the workload using an effective tool/ system. |
| C/P | Identify unmet need and report systematically using capacity and demand workload tools. Develop solutions to identifying and meeting unmet need. |

[3] Planned care refers to work that is pre-planned by the service and unplanned care is any unplanned contact by a person requiring or seeking help, care or advice that can occur at any time.

| | **Delivery Mechanism** |
|---|---|
| C | Commission for achievement of the contract requirements based on person-centred outcomes, risk management and not tasks or activity. |
| P | Collect and evaluate data to demonstrate the planned and unplanned demand for the service and response to this. |
| C/P | Work to create “real time data” and reports across health and social care providers and commissioners. This will assist in identifying the impact of pressures in the system enabling reporting, evaluating demands and workforce pressures. |
| C/P | Proactively manage anticipated changes in demand such as winter pressures and continuity planning. Providers and commissioners to work together to understand the relationship and impact between planned and urgent care both within the service and across other services. |
| C/P | Ensure staffing establishment reflects the need of the workload according to time of day or night and the level of nursing care required. |
| C/P | Develop mechanisms through benchmarking to identify and reduce unwarranted variation of outcome across a pathway or defined population. |
| C | Ensure quality equipment such as pressure relieving equipment is available to meet the population needs. Provision to be reviewed alongside population need and complexity to ensure a lean, safe and efficient system. |
| C/P | Provide a 24/7/365 community nursing service (4), taking into account the local specialist nurses and third sector nurses such as hospice at home, alongside district nurses and intermediate care teams. Clinical leaders to provide guidance on changing needs. |
| P | Use Lean working techniques or Productive Community Services (37) to reduce inefficient working practice. |

# 7 Workforce planning tools

A theme throughout the eight commissioning components is for accurate and robust workforce planning. A variety of organisations are utilising workload planning tools to plan and design their workforce providing evidence to commissioners of the work that community nurses are delivering. These tools demonstrate the changing nature of community services, complexity and acuity, staffing requirements, workload and efficiencies.

The QNI (35) was commissioned by NHS England to review workforce planning within district nursing and a variety of tools were explored. This review identified a significant gap in the availability of workforce tools that enable and support strategic workforce planning.

Following on from this, through the QNI work and networking across the sector, fourteen UK community nursing sites and nine workforce planning tools were identified and reviewed. The tools are presented in a matrix (diagram 3).

These tools have principally been developed in response to the commissioning landscape, being based on activity and demand rather than outcome based commissioning. They have mainly focused on community nursing rather than on an integrated workforce.

None of the tools that were reviewed appear to offer a single solution to addressing all of the commissioning components, neither do they focus specifically on a long term or strategic view of workforce planning for community nursing or integrated care, therefore further work is needed. This is consistent with other reviews. (6) (36)

Commissioners and local providers need to agree what kind of workforce/ workload information is required and if a tool is currently being used. Working together commissioners and providers need to evaluate the impact and benefits of the tool and whether this meets the future person centred outcome focussed service they wish to provide.

The tools are evolving; the ability to adapt the tool to each local situation needs to be explored by commissioners, such as its ability to connect and interact with local clinical information systems that providers are using. Many of the tools currently available are based on linear collection of data and do not reflect the multidimensional complexity of care being delivered. None of the tools capture the impact of interventions using behaviour change and promotion of self-care.

The reviewed tools do not represent the total number of tools or systems in use in community nursing. Workforce planning tools which deliver at both a strategic and an operational level are particularly important with the changing requirements of an integrated care agenda. They must meet population need and provide the right staff, with the right skills, in the right place at the right time.

## Diagram 3 - Matrix of tools and focus [4]

| | | | Functions of the tool | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | The tool uses population health needs and demographics to inform the workforce requirements of the caseload or service. | Dependency/ acuity/ level of intervention of people requiring care on the caseload is monitored. | Demand on the service/ caseload is monitored. | Skill mix of the team is matched to caseload/ service need. | Data capture is efficient with an automated process with consistency in the data. | Has been used or is being planned for use in more than one type of team. | Outcomes of care are captured: this includes patient safety, clinical effectiveness and patient experience. |
| | | | **Health Needs** | **Dependency/ Acuity** | **Demand** | **Skill Mix** | **Data Capture** | **Integration** | **Quality** |
| **Site/Provider/Model/Tool** | **Site** | **Tool** | | | | | | | |
| | Stafford and Stoke on Trent Partnership Trust | In House | ✓ | | ✓ | ✓ | | ✓ | |
| | Isle of Wight NHS Trust | In House | | ✓ | ✓ | ✓ | | | |
| | Northern Ireland | eCAT – Electronic Caseload Analysis Tool | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| | England Centre for Practice Development | Cassandra Matrix | | | ✓ | ✓ | ✓ | | |
| | Cumbria Partnership NHS Foundation Trust and Derbyshire Community Healthcare Services | Hurst Model | | ✓ | ✓ | ✓ | ✓ | | ✓ |
| | Scotland model | Scottish Community Nursing Workload Measurement Tool | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Virgin Healthcare and Bristol Community Health | Total Mobile | | ✓ | ✓ | | ✓ | | ✓ |
| | eCommunity - QES | eCommunity | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Sheffield Teaching Hospital Trust | Various | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

For the purposes of this framework the Benson Model has not been included in the matrix above as it is currently used in health visiting and school nursing, not in community nursing. A specification exists to develop this for community nursing but as yet is untested.

Whilst recognising the limitations of the above tools they are presented as a range of examples rather than an endorsement of any one specific tool. At present these tools are shared in advance of the multi-professional approach to safe staffing levels by NHS improvement and the CNO for England.

[4] Acuity means how ill the individuals are, their increased risk of clinical deterioration and how complex their care needs are. The term dependency is used to establish the level to which an individual is dependent on nursing care to support their physical and psychological needs and activities of daily living.

# 8 Next steps

This framework aligns with the vision outlined in the Five Year Forward View, and will support commissioning of high quality, innovative and cost effective community nursing in the future. Implementation and embedding of the framework will require significant courageous leadership and commitment from both commissioners and providers, necessitating a move from current service provision to a service which meets future need. The rate of progress to embed this will reflect the ambition of both commissioners and providers.

Commissioners and providers will develop an implementation approach that provides:

- agreement on how to implement the framework
- agreement of a common purpose and outcome for population health need
- a method of working together with the public to identify the composite measures that demonstrate the value and impact of community nursing in a multidisciplinary environment
- service models which deliver NHS and Public Health England outcome frameworks
- provide NHS England with an evaluation of how the framework has been used, the impact and how it might be developed.

Commissioners are encouraged to:

- overcome barriers to moving limited resource from hospital to community, at a time when demand for hospital based care has not decreased
- use the components within this framework to understand and effectively commission community nursing
- use the framework to support partnership working in more innovative ways
- support providers with workforce challenges and understand how these are accurately assessed.

Providers are encouraged to:

- deliver cultural and skills based change to develop proactive approaches to keeping vulnerable people at home
- utilise the framework to increase efficiency of the service through new technologies and partnership working
- provide evidence of impact on patient centred outcomes and the effective management of services
- use the components outlined in the framework to address the challenges in planning, delivering and evaluating community nursing
- use a workload/workforce tool to drive service improvement in a multi professional environment
- evidence outcomes for community nursing to reflect the true value that community nursing brings in a multi professional team.

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# 11 Appendix 1 - Community Workforce Expert Reference Group Members

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