



## LEADERSHIP IN COMMUNITY NURSING

### FINAL REPORT

Report of a study carried out by Queen Margaret University Edinburgh, NHS Lanarkshire and NHS Forth Valley

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## **Background**

In response to national and local agendas, both NHS Lanarkshire and NHS Forth Valley maintain a strong commitment to the development of those in clinical leadership positions. Queen Margaret University programmes in Nursing incorporate leadership as a core element in preparation for practice, and QMU have accredited NHS Lanarkshire's leadership educational programme for several years. This project emerged from that collaboration, from ideas about the nature of leadership and the recognition that few empirical studies exist in nursing in general, and fewer specifically in community nursing.

The two data collection sites were not involved in pilot work of the Review of Nursing in the Community (SEHD 2006) although all staff were working in this context of policy drivers encouraging change (SE 2005a, SE 2005b, Pollock 2007, Kennedy et al 2009, RCN 2009a 2009b).

## **Summary of literature review**

A focused search was undertaken encompassing the period between 1998 – 2009. Key terms were searched in the following databases: EBSCO (including Cinahl), Cochrane, EMBASE, and Medline.

Until recently, the dominant theoretical perspective in nursing literature has been that of transformational leadership, although other models, such as situational leadership (Boumans and Landeweerd, 1993) and congruent leadership (Stanley, 2006) have been proposed for consideration. Transformational leadership has been the model on which many leadership preparation programmes have been designed, and the theoretical framework on which some empirical studies have been based (Bowles and Bowles, 2000). No consensus emerges from the literature on a single theoretical model appropriate to this study of leadership in community nursing. The evidence base for the practice of community nursing is relatively sparse (Kennedy et al 2008), although a significant body of opinion stresses the importance of effective leadership for the future of community nursing in the UK (Smith 2004, Thurtle et al 2006, Tweddell 2007).

No clear consensus emerges from the literature on the nature of this leadership: some writers clearly identify it with management, others make distinctions between clinical leadership and service leadership. A few empirical studies (Antrobus and Kitson, 1999; Cook and Leathard, 2004) focus on identifying necessary leadership styles and qualities and how to develop these. Commonly identified attributes include empowering ability, strategic and reflexive thinking, creativity, respecting, supporting, communicating effectively, approachability, clinical competence and so on. Few researchers specifically address the impact of leadership on practice (Wong and Cummings, 2007).

Two studies (Morton, 1999 and McKenna et al, 2004) relate to community nursing specifically. Morton (1999) identified a link between experience and leadership styles in a small study and generated a set of attributes deemed essential for leaders in community nursing which is similar to other fields i.e. credibility, communicating well, goal setting, supporting and promoting teamwork. McKenna et al (2004) in Ireland demonstrated widespread belief that strong leadership was essential for community nursing to develop however there was no consensus on whether this currently existed. It was also found that community nurses looked to GPs for leadership. In contrast, a study by Stanley (2006) identified that nurses in an acute setting looked for leadership to the person who was perceived to display a high level of clinical expertise and knowledge. The evidence base is therefore both limited and contradictory.

## Aims

The aims of this project were to understand how leadership is perceived within community nursing teams, and to explore how these perceptions are translated into the working practices of Band 6 and 7 community nurses.

## Research questions

How do community nurses understand and interpret the concept of leadership?

How do they perceive themselves as leaders?

What practices and behaviours do they associate with leadership?

How do they translate these understandings, perceptions, practices and behaviours into practice; specifically in working within teams?

What preparation is required for the exercise of leadership within teams?

## Methodology

An exploratory descriptive qualitative study was undertaken. A case study approach using individual interviews and focus groups was selected in preference to a questionnaire for data collection. An expert steering group (see Appendix 4) was convened and met regularly to support the team in maintaining direction and focus of the work.

Two teams were identified within each of two Health Board areas, one with a public health remit and one providing care for people with long term conditions. Within each of the four case studies, data was collected from primary respondents Band 6 and 7 community nurses (see Appendix 1) and other respondents – healthcare support workers, community staff nurses, and managers.

## Ethical approval

Ethical approval was obtained from Queen Margaret University and conducted within the terms of NHS Forth Valley & NHS Lanarkshire research governance processes. Informed consent was obtained from all participants. All data remained confidential throughout the project and were anonymised throughout.

## Data Collection

Individual semi-structured interviews were conducted with Band 6 and 7 nurses, and nurse managers. All interviews were recorded and transcribed. Table 1 gives an overview of data collected. (B=Band):

Table 1: Data Collection Overview

<b>AREA A</b>			
PUBLIC HEALTH		LONG-TERM CONDITIONS	
Interviews	1xB6/7	Interviews	1xB7 4xB6
Focus Groups	1xB2 (2 participants) 1xB5 (7 participants)	Focus Groups	2xB2 & B5 (11 participants)
Manager interview: 1			
<b>AREA B</b>			
PUBLIC HEALTH		LONG-TERM CONDITIONS	
Interviews	1xB7 5xB6	Interviews	3xB7 2xB6
Focus Group	1xB5 (7 participants)	Focus Groups	1xB5 (8 participants)
Manager interview: 1			
Total number of participants: <b>54</b>			

## **Data Analysis**

Data were subjected to framework analysis, a method developed for applied policy research, which allows funders' questions to be directly addressed while allowing for the emergence of unanticipated themes (Ritchie and Spencer 1994). Data were therefore analysed in terms of 'a priori' questions, emergent issues and overarching themes.

## **Findings**

### **Effects of team structures on perceptions of leadership**

Team structure, i.e. size, range of grades and experience, and team relationships all affected perceptions of leadership. Organisational structure was perceived as complex and confusing, and a lack of consistency across teams could make a negative impact on communication.

From the perception of Bands 2 – 5, there could be unclear lines of authority, with some unsure of the scope of their autonomy - '*am I allowed to do that?*' - and the differences in roles of Band 6's and above.

*'the big team...I think there's more than one leader' (Band 2)*

The size of team made an impact but this was complex: nominally some of the case teams were bigger than others, however these teams tended to work in smaller sub-units, with close links between these, thus contributing to lack of clarity about who constitutes the team. Larger teams had a wider range of different bands and roles, with consequent opportunities for leadership.

### **Conceptualising and locating leadership**

Nurses recognised a distinction between leadership and management in the abstract. However in discussing practice, they demonstrated a general tendency to see leadership as broadly synonymous with management, for example citing the direction of activity as a leadership function.

*'We sit every morning and we'll say what have you, what have you, right, we'll take that back. You're going to G and that's quite a distance and I'll take that.'* (Band 6)

This perception is less prevalent in Band 7s, who articulated a clear distinction in practice, with a tendency for these nurses to perceive leadership in transformational rather than transactional terms.

*'leadership is about modelling behaviours, enabling others, inspiring people, taking people with you' (Band 7)*

The blurring of these two concepts is reflected in views on locus of leadership: some nurses saw leadership as invested in the individual formally leading the team, others saw leadership as exercising behaviours which any team member could display. Some individuals adopted either perspective, depending on the context of the discussion. Some Band 2 staff identified an area of practice where they had considerable autonomy, organising and planning core work apparently with little supervision. Behaviours associated with leadership were evident here, for example efficient organisation of services.

*'we really do our own thing, we're doing a lot out there on our own and not just.....'* (Band 2)

Some Band 5 nurses perceived that everyone in the team had leadership skills and demonstrated these daily. Examples cited related to the supervision of Band 2 staff, but also included sharing expertise with those in Band 6 positions. Other Band 5 nurses however although demonstrating examples of leadership behaviours and skills, did not see themselves as exercising leadership. Band 6 staff, while regarding themselves as leaders, also clearly recognised the capacity for leadership at all levels of the team, as did nurse managers.

Experience was seen as more important than grade. An example of this was a perception that a nurse with a lower band with more experience was more qualified to be a leader than a band 6 with little experience. Despite this, some examples of hierarchical working were offered, such as Band 5's accorded more respect than band 3's, and Band 5's feeling they were not expected to 'take charge' over higher grades.

Some nurses clearly saw leadership as an integral part of their role, while others perceived it as an 'add-on function'. This latter perception appeared more closely linked with Band 6 staff.

*'We probably do our leadership outwith when we really should, because we're so conscious of the fact that we're busy and we need to be hands on' (Band 6).*

A clear difference in the conceptualising of 'leadership' emerged between the perceptions of Band 7 staff and those in other grades. The leadership practices and behaviours identified and valued by band 2, 5 and 6 nurses could largely be grouped into efficient management, ensuring practice standards, and 'looking after staff'. The single most dominant identified behaviour associated with concepts of leadership was supporting team members, with frequent mentions of being listened to and supported.

*'giving you praise as well, the encouragement...'* (Band 5)

*'...the person who's leading me where she is very nurturing, if you like, and very how can we improve this and what can we do about this..... Never is the finger lifted'* (Band 7)

Within this third category, the necessity for 'respect' was seen as significant, and this appeared to translate into recognising staff achievement, involving and communicating with staff, and enabling and empowering them. 'People skills' were viewed as particularly important in leaders by nurses in Band 5 and 6.

*'I think if you're not trustworthy or approachable then you're certainly not going to be a good team leader, I think that's fundamental. That to be a leader in any way you need to be trustworthy and approachable'* (Band 6)

Band 7 staff placed much less emphasis on these behaviours. Service development, ensuring best practice, demonstrating drive and motivation, forward thinking, flexibility and reflexivity were all practices and behaviours they associated with leadership.

*'It's adapting your behaviour to different environments and situations'* (Band 7)

*'Went home and thought about what I could have done differently'* (Band 7)

Although technical or clinical knowledge was cited - 'knowing the work' - this was not a particularly dominant attribute, evinced largely by Band 6 nurses.

Other leadership practices identified were 'knowing the work' and 'communicating', with the latter being used in the sense of transmitting information necessary for work to proceed. Band Seven staff saw this as both 'upward' and 'downward' transmission, informing teams of policy

directives, and informing management of activities of the team. Band 5 and Band 6 nurses tended to focus on the 'downward' channelling of information.

## **Translating understandings of leadership into practice and behaviours**

### ***Personalised relationships***

The nature of relationships between team members was identified as highly significant to leadership. A significant emphasis was placed on the necessity for leaders to establish strong personal relationships. This was apparent across Bands, including nurse managers, but was less prevalent in the perceptions of Band 7 staff. Personal relationships were seen to facilitate effective working relationships and provide essential support. Without these, the team would not be 'a happy team'.

*'We're not just colleagues, we're friends' (Band 6).*

*'I think just people understanding each other, having a good laugh in the office can relieve stress. Socialising, having a social aspect to it, sitting down together for lunch is another huge thing that I think breaks down barriers. Even just getting out of the office for that half hour and all sitting together, not talking about work, but having a laugh together. And you build up the relationships and you know each other's family and you can talk about different things. And then if you are stressed about anything that's nothing to do with work, you can bring that to someone within the team.'* (Band 6)

There were differing views on how far these relationships should develop, and costs were acknowledged by some Band 6 staff pointing out the difficulty that the culture of support and nurturing posed for the effective management of workload.

*'If you're quite friendly with people at the same grade, or even lower and you have to delegate work, it can cause a bit of friction.'* (Band 6)

*'she was very much shielded ..... and supporting her to the level we did, we actually didn't do her any favours, because in fact, it took us years and years to reverse that again ..... That was hard, and that's because there was friendships there before it.'* (Band 6)

The nature of the relationships suggested the teams operated as a quasi-family. Colleagues were referred to as 'the girls', and there was a strong emphasis on supporting each other through both professional and personal difficulties. A good leader was seen as one who offered a sheltering, nurturing and protective environment.

*'This team, I don't think it's a team, it's more a family, and we do all work very well together'* (Band 5)

This ethos of nurture and protection was explicitly likened to maternal behaviour by respondents, suggesting that leaders of staff need skills similar to parents of children – bringing out latent abilities, encouraging, and 'letting go'. The importance of the maternal nurturing role was apparent across all grade bandings and teams to a greater or lesser extent: in some teams this was a very strong clearly articulated ethos.

*'You're nurturing your team, the way I would nurture a family, and you know that you're bringing the best out in them, and you're slightly changing it and you're protecting them, and you're making sure that they're developed, nurtured, safe...'* (Band 6)

Band 7 staff tended not to express themselves in these terms, talking instead of promoting autonomy and self confidence in staff by 'leading from behind':

*'within a few minutes I knew that I don't need to take a lead here...it's knowing what level you need to interact with others and give direction' (Band 7).*

### **Nature of visions, goals and aims of leaders**

There were significant differences with regard to the goals and aims identified. In general, Band 7s appeared to adopt a strategic, 'big picture' approach to their leadership, in contrast to staff at Band 5 and 6, who adopted a localised, more pragmatic approach. This might perhaps be expected, given the difference in role remits. Although the importance of patient care was apparent at all levels, Band 7s appeared, perhaps surprisingly, to be more directly focussed on a primary goal of high standards of patient care.

*'I think it has a huge impact because it filters down through. Ultimately that is your end result is how the service is provided and what your patients or clients think of the service and what service that they're getting. So quite often when I think is that service being provided I think of myself as a client and look at it, who's providing the service for me, what are they doing, and health visiting. So if I've just had a baby what service would I be getting in this locality? I can quite easily then see the good bits, the bits where there's room for improvement, and the gaps that definitely need to be filled. So it's quite often going to the client, putting yourself in the client's shoes, quite often informs you of where the service should be provided' (Band 7)*

One Band 7 nurse cited patient feedback as a factor in driving her actions, and appeared to use 'knowing the patients' as a key requisite for her planning. Although staff in other grade bands did identify client-related goals when asked directly, their expressed goals and aims were primarily focused on the individual and the team. Goals and aims expressed were either internally or externally focused. Internally focused goals related to maintaining the health of the team per se and these were expressed largely by Band 6's.

*'I think the primary goals for any team is just to be a successful team. Just to be a successful team and provide the best quality care that you can give to your clients. A happy team!' (Band 6)*

*'I think just to be able to all work together and be happy at work, and feel that if anybody needs to talk about anything I'm there, you know, and we have quite a happy relationship at the moment (Band 6)*

Externally focused goals related to policy drivers and meeting patients' needs were largely identified by Band 7 nurses.

*'It was time to look and see how we can change the service to meet patient need, 'cause patient need was changing' (Band 7)*

A few nurses expressed goals related to advancing the profession by raising the profile of community nursing. An exception to this general polarisation of goal perception is that those nurses of all grades who were involved in child protection saw keeping children safe as an important goal.

## **Achieved outcomes of leadership**

Outcomes identified as achieved by virtue of good leadership were largely individual and team- related, rather than patient focused. Such examples included low absence and attrition, improvements in skill-mix, and improvements in team morale.

*'And our sickness here is almost zero because everybody's happy to come here...they're needing to look at the areas where sickness is almost zero. Why? Because it's effective team working with good leadership' (Band 6)*

*'If everybody's happy at work I think a better job is done, and the patients feel happier' (Band 5)*

Band 7s tended to see successful outcomes in terms of workforce development, such as added skills, a 'contented' team, improved self esteem, developing confidence and initiative, and staff empowerment.

Respondents in the main found it difficult to articulate the relationship between leadership and patient care, although they thought there would be an impact. Staff made a link between the internally focused preoccupations above and patient outcomes, by suggesting that 'cared for' staff would give good care, although respondents found it difficult to articulate why this was the case.

*'I think if you're happy in the team, or the area where you work there's a knock-on effect on the patient anyway. Don't get me wrong, you go in, you're to do your task, the patient should be first and foremost anyway. But I think if you're happy within your team and the people you work with, it does have a knock-on effect to the patient because you know you can come back and say 'listen, I'm not too happy there, go and just come back out with me, there's just a few niggles I've got...' (Band 6)*

*'I think it impacts on patient care in a positive way in our team because we're pushed to go on training, we're pushed to learn...we're bringing families to peer support' (Band 6)*

One nurse manager pointed out that a high staff turnover had a potential negative impact on therapeutic relationships with clients and families, and that the lower turnover in 'happy' teams therefore had a direct benefit.

Although staff found it difficult to identify specific outcomes of good leadership it was evident from the data that achievements such as meeting targets e.g. HPV vaccination, clearing waiting lists by changing how clinics were managed, and addressing client needs, could be attributed to team members exercising leadership in their roles.

*'It's good to see getting healed up, because it's not often you do.....and your four layer bandaging and your different sort of techniques, you can see a great difference in the change of people's lives...we're now teaching all the other areas to do these clinics, because ours was the kind of first up and running in area B' (Band 6)*

## **Factors inhibiting the exercise of leadership**

The majority of these were identified by the Band 6s and 7s. The most frequently cited factors were related to time and resources, e.g. staff shortages and lack of IT support.

*'Pressures of work and that you're so busy, you're running about trying to just make ends meet service-wise that you don't take time to look at what's been done, how it's been done and maybe even realise that something could be done better' (Band 6)*

Caseload pressure was cited frequently, and appeared to be a key factor in nurses perceiving leadership as an 'add-on' part of their role. Caseload was problematic not only due to volume, but due to increasing complexity and lack of visibility.

*'you know the demands of the role and community nursing is changing so dramatically that we are expected to do more and more and more; early discharges from hospital, palliative care increasing etc...dynamic things at home and yet your staff doesn't go up, your staffing levels stay the same, you just absorb this like a sponge and also as well the Agenda for Change. We get more holidays, that is a nightmare' (Band 7)*

Despite their apparent autonomy, Band 5's identified a lack of opportunity to develop as leaders in terms of accessing education.

*'I think that's probably the biggest fault that's wrong in community is the fact that you cannot become a Band 6 without going and doing another course, so there's lots of really good staff nurses there, and the way area B works financially, lots of people can't afford to go and do the course, so there's no promotion, you stay as a staff nurse, so you will have all these great attributes that you can't actually progress' (Band 5)*

On the other hand, Band 6's expressed difficulty in encouraging staff, especially part time staff, to undertake training, and returned to the theme of personal relationships, on this occasion identifying these as potential barriers.

*'No matter how good your leadership is, if they don't like you, or whatever, then that could be a big barrier, they won't carry out your instructions or your help' (Band 6)*

Other constraints viewed as barriers to leadership were 'top-down' decision making and policy changes, leading to reduced autonomy.

## **Discussion**

This exploration of leadership practices in community nursing has produced some thought-provoking results. The first of these was **the influence of grade banding on perceptions and practices**. The study was designed on the assumption that perceptions and practices related to leadership might vary depending on the local context, the nature of the team, and the nature of clinical practice, and that it might be possible to set out clear differences between the 4 cases. However it became very clear that differences in perceptions and practices were significantly more related to individual grade banding across the teams than to any of these, despite the fact that teams varied considerably in size, structure and nature of locality. There were more commonalities between grade bands across teams, than within teams. This does make sense as broadly speaking grade banding reflects role description. However it was not the case that there was a simple division between Band 7 staff as leaders and all other bands as followers. It was evident that staff in other bands were working autonomously and demonstrating leadership.

Virtually all writers on leadership claim that the purpose of leadership is to achieve goals in order to realise a vision (Cain, 2005; Morton, 1999). The team anticipated that a clear

expressed primary goal for community nursing teams would be client or family welfare. Although this was expressed, it did not appear to be significant, and was phrased in service terms e.g. 'to meet service gaps', rather than in individual welfare terms. A clear exception here however, was those nurses involved in child protection work. Many nurses expressed one of their goals as 'having a happy team'. When asked to identify how that impacted on delivery of services to users, they had considerable difficulty articulating this, indicating that this was self evident. One nurse manager however identified how increased staff turnover and loss of staff impacted on the development of therapeutic relationships with families, and could set progress back considerably. Band 7 staff, despite having less client contact, talked about 'putting themselves in the patient's shoes', while Band 2 and 5 staff did not. It may be that this is a goal which is so highly internalised it is assumed to be self evident to outsiders. This may explain the following observation:

*What's the primary goals? I don't know.....The primary goals? Our primary goal is to provide nursing to clients patients with... house bound patients with long term illnesses or acute episodes of treatable illnesses that we can deal with to prevent hospital admissions using expert clinical knowledge and up-to-date practices. I don't know, what the aim of the team is [laughs]. Yeah, we aim to provide a high standard of nursing to patients in the home. (Band 6)*

One nurse manager offered as an explanation for these differences that Band 7's were focused on strategic objectives, and Band 6's their case loads. Another manager felt that this could be due to the Band 7's failing to develop the Band 6's. However neither of these explains why Band 7s' articulation of primary goals is patient rather than team focused. Overall therefore, with the exception of Band 7 staff, these teams primarily **expressed visions and goals focused on the team, rather than on the service or client groups**, while acknowledging the impact their activities had on service users.

Possibly the most intriguing and unexpected finding was the identification across all teams of behaviours associated with leadership which could be characterised in terms of family dynamics – **the team as quasi-family**. This was especially marked in Bands 2, 5 and 6, and less so in Band 7. Band 7 nurses placed less importance on family/relationships, perhaps because theirs is an overarching role across different teams, whereas the Band 6 staff are more intimately involved in smaller units.

Nurses expressed very clear needs to be acknowledged, respected and valued. These needs have been demonstrated in other studies of leadership, but far less common is the finding that staff clearly indicated a need to be cared for, nurtured, and supported, and those who provided them with this were regarded as good leaders. These findings are in contrast to Stanley's study of acute nurses (2006) where the nurses emerging as leaders were those who displayed clinical knowledge and competence. Although these community nurses identified these factors as important ('knowing the work'), they placed far more emphasis on the psychological health of the team. There was widespread acknowledgement that 'a happy team' was a legitimate and significant goal. Several respondents explicitly likened the leader/team relationship to that of the mother/child relationship, and gave examples of listening, encouraging and supporting, and creating conditions for independence. Elements of this were demonstrated in the personalisation of relationships, with individuals remembering birthdays, managing workloads to protect staff with difficulties in their personal life, and contacting each other about work outside of working hours. The metaphor of the team as family and leader as parent as far as we can determine has not been identified in previous literature. Interestingly, only one respondent, a nurse manager, extended the 'family' to include the patient.

## **Conclusion**

No clear fit with any existing theoretical framework was identified. Band 7 staff in particular however appeared to be working with a set of concepts associated with transformational leadership. There was little congruence with any other theoretical model. The striking thing about these findings is that they are not consistent with the (admittedly few) empirical studies which exist.

There is no reason to suppose that community nurses as individuals differ from nurses elsewhere, and yet their leadership perceptions and practices are different. Clearly the community nursing context differs from other nursing settings. This setting is characterised by the relative isolation and low visibility of the nurse working in the home or community, in contrast with acute care. In acute care, nurses relate directly to other team members at the bedside, where the patient is highly visible. In community nursing, nurses relate to each other at a distance from the patient, and this may account for the relatively low significance given to clinical competence, compared to Stanley's findings (Stanley 2006). It may also be possible that working alone in stressful situations requires very strong emotional and psychological support from colleagues – hence the 'quasi-family'. Another explanation might be related to the nature of their work: because they are primed to think in terms of family health they may therefore be predisposed to think of the team in this way.

Yet another explanation may be the national context, within which community nursing has been and will continue to be subject to extensive and rapid changes, causing stress and vulnerability which requires the maintenance of strong personal support mechanisms. It may be that nursing in the community requires models of leadership different from those elsewhere. One size may not fit all.

## **Limitations**

This was a small scale study and caution should be exercised in generalising from these findings. Data about practice and behaviour were acquired by self-reporting. No observational data were gathered, due to both the difficulty of operationalising the concept of 'leadership in practice' sufficiently and the limitations of resources. It is acknowledged that there may be aspects of leadership in community nursing which go unrecognised and unreported.

## **Recommendations**

These findings suggest that staff practising at grade 7 bands are well prepared for and committed to their leadership role. Many of them are clearly thinking on a broad strategic level, and facilitating the translation of high level strategy into practice. Most of them have had specific leadership preparation, and were identified for this by virtue of already being acknowledged as expert practitioners, demonstrating initiative and managing relationships well.

This study identifies the need to continue to prepare community nurse practitioners through specific leadership education, and to support those at band 7 to retain their skills.

**Recommendation 1: to continue to prepare staff in this way, and to support those at these grades to retain their skills.**

This is the first time to our knowledge that a 'family model' of leadership has been identified, and this requires further exploration.

**Recommendation 2: to support research exploring and evaluating the ‘family model’ of leadership**

Further work needs to be undertaken to identify and remove organisational barriers to leadership

**Recommendation 3: work to remove the organisational barriers to leadership.**

Community nursing teams reported some stress and experienced need for support, depending on the internal structure of the team.

**Recommendation 4: streamline and clarify organisational structures to improve communications and lessen stress**

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## **APPENDIX 1**

### **Glossary**

Band 5 staff are required to deliver planned programmes of care to individuals, families and communities within their context of care and to assist the Band 6 nurse in the provision of evidence based quality nursing care to a defined population.

Band 6 staff are accountable and responsible for the clinical and professional leadership of their team in a defined area.

Band 7 staff provide the strategic lead in the co-ordination of care, working with partnership agencies and key stakeholders to ensure effectiveness of outcomes. (Adapted from Scottish Government Generic Job Descriptions.)

## **APPENDIX 2**

### **Dissemination**

The research team are currently arranging dissemination meetings to participants in NHS Forth Valley and NHS Lanarkshire. All study participants will receive a copy of the executive summary, as will Nurse Directors in NHS Lanarkshire and NHS Forth Valley.

Dr Shona Cameron will be presenting the results at the QNIS Conference in March 2010, and presenting a seminar at QMU in April 2010, open to all. Jean Harbison is presenting the findings to an NHS Lothian leadership seminar at the request of the project manager for Modernising Nursing in the Community.

The team will be preparing the findings for at least 2 publications to be submitted to an international journal.

Conference presentations will be actively sought, e.g. the RCN International Research Conference and the International Conference on Community Health Nursing Research in Edmonton, Canada.

## **APPENDIX 3**

### **Financial Statement**

A Research Assistant, Vicky Lambert, was employed from January 2009 until January 2010. Some savings were made in relation to travel and catering costs, and these were used to extend her contract to February 2010. Other costs were as agreed and the project has used the allocated budget. Monies are still being disbursed for expenses costs, but it is anticipated that a small remaining sum will remain which will be used to offset costs of dissemination.

## **APPENDIX 4**

### **Steering group members**

Dr Julia Quickfall, Queens Nursing Institute for Scotland

Professor Jean McIntosh, Honorary Professor, Glasgow Caledonian University

Professor Catriona Kennedy, Edinburgh Napier University

Nicola Connor, Lead Nurse, Kirkcaldy and Levenmouth Community Health Partnership

Kristina Mountain, Lecturer in health visiting, QMU

Members of research team