Measuring quality in community nursing: a mixed methods study

Summary for commissioners, provider managers and healthcare professionals

Purpose of the research

An effective, safe and high quality community nursing sector is vital in offering patients alternative or complementary care outside acute services. Care provided in the home is largely invisible to planners and managers and therefore understanding how quality measures for community nursing are identified and their usefulness for assuring service quality is vital. Furthermore, although understanding of how to measure the quality of services is growing in the hospital and primary care sectors, comparatively little is known about how best to measure service quality in the community nursing sector. The use of standardised quality indicators across community services should in theory enable similar services to be compared. However, despite substantial investment in quality indicator schemes, comparatively little is known about how quality measures are used by commissioners and service providers in practice. This is especially relevant at a time when NHS costs are constrained.

This study commenced soon after the implementation of the Health and Social Care Act (DH, 2012), with the newly formed Clinical Commissioning Groups (CCGs) having been in place for just over a year. Increased integration of health and care services and funding to improve the quality of services for older people and those with disabilities were announced in the 2013 Spending Round with the establishment of the *Better Care Fund* (NHS England, 2013) (£3.8bn worth of funding in 2015/16). The programme affected directly the delivery of community nursing, since community nurses play a key role in looking after these patient

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groups at home. Further service integration was encouraged in the *Five Year Forward View* (NHS England, 2014) which introduced new models of integrated care in community services by establishing Multispecialty Community Providers.

A major problem hampering commissioning of community services is lack of robust activity, cost and quality data to measure healthcare outcomes, to benchmark services and to evaluate cost-effectiveness. Despite the policy drive towards measuring quality in community nursing provision, there is a gap in the literature about the type of quality indicators used by commissioners and their effectiveness in really improving quality of care. In this study, we looked at how quality metrics applied by registered community nurses providing care in patients' homes are selected and agreed between commissioners and providers of community nursing services. An additional focus of the study was to explore how these metrics are subsequently used in practice. We also investigated the usefulness of the particular quality metrics in improving quality of care provision from the perspectives of health care planners, frontline staff and service users (patients and/or their informal carers) and identified the challenges facing the providers in collecting information relating to quality of care.

References

DH (2012) *Health and Social Care Act 2012* http://www.legislation.gov.uk/
NHS England (2014) *Five Year Forward View* https://www.england.nhs.uk/
NHS England (2013) *Better Care Fund* http://webarchive.nationalarchives.gov.uk/

Aims and objectives

The study aimed to investigate the selection, application and usefulness of quality indicators currently in use for community nursing. Specifically:

1. Which quality indicators are selected locally, regionally and nationally for community nursing?
2. How are they selected and applied?
3. What is their usefulness to service users, commissioners and community provider staff?

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Methods

A mixed methods design in three phases was utilised, which comprised:

- Phase 1: A national cross sectional survey of quality indicator schemes;
- Phase 2: An in-depth qualitative case study using interviews and observation in five sites;
- Phase 3: A series of national public engagement events.

The study was approved by Yorkshire & The Humber - Leeds West NHS Research Ethics Committee.

Phase 1: The national survey of CCGs (*n*=145) was conducted in order to describe the range of quality indicator and incentive schemes in use in community nursing during 2014/15, and also provided a sample of providers from which to select five sites for the qualitative case study. The case study built on the survey by enabling the identification and probing of the processes of selection and application of quality indicator schemes applying to community nurses to provide an in depth understanding of the relationship between national and regional policy directives and influences on local implementation.

Phase 2: The research focused on five case study sites, selected to include organisational variation and geographical mix (Table 1). Each site included the provider of community nursing and their main commissioner. The case study research generated multiple sources of qualitative data, including interviews with 13 service users, 41 local senior managers (commissioner and providers) with a role in quality implementation, 10 community nursing team leaders; focus groups with 45 frontline nurses and 8 service users; and observations of frontline nursing staff and quality meetings and documentation relating to selection, application or monitoring of quality. Interviews were also conducted with 5 NHS England quality leads.

Phase 3: Public engagement events were an integral part of the study design and started in the final few months of the project. We held eight workshops across the country attended by 120 delegates in order to check the study's emerging findings and develop our good practice guidance with a wider audience. These events were attended by mixed groups of commissioners, service managers, frontline staff and service users. Two interactive conference sessions were conducted with a further 146 delegates.

Patient and Public Involvement

Service users were integral to the study. A service user was a co-applicant and helped refine the research questions, leading a reference group of service users who were consulted throughout the research period. Service users attended workshops and contributed to the interpretation of evidence and formulation of good practice guidance.

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Case study site description

Each site comprised a CCG and a community nursing service provider. Pseudonyms have been used and any similarity with existing place names is unintentional. Community nurses in all the sites work in geographically-based teams serving a number of GP practices.

Table 1: Case study site descriptions

Name	Demographics	Commissioner	Provider	Local CQUINs for Community Nursing	Additional/main focus for care in 15/16
Alderton West	Large, urban area. Deprivation is higher than average. Life expectancy for men and women is lower than the England average. Smoking related deaths are higher than the England average. Under 75 mortality rates from cancer and cardiovascular disease are just above the 25th percentile.	NHS Alderton West CCG manages a contract on behalf of two further CCGs. It covers approximately 40 GP practices. There are a total of four CCGs in the area.	Alderton Community NHS Foundation Trust (ACFT) provides over thirty different community services for adults and is the only community service provider in the area. The community nursing service is organised in multi-disciplinary integrated teams of varying sizes, covering a population of more than 1,000,000 people.	14/15 – 1 CQUIN: Multidisciplinary working. 15/16 – 3 CQUINs: Multidisciplinary working, Patient activation, Safeguarding.	Partnership working, prevention, patient consultation and education. Also: improve life expectancy, improve patient experience, and move care outside of hospital.
Beech-bury	Large urban area with high level of deprivation compared to the England average and a higher than average proportion of people dying from smoking related diseases. Under 75 mortality rates from cardiopulmonary diseases and cancer are also higher than the England average.	NHS Beechbury CCG is one of a total of three CCGs in the area which jointly commission community services. Beechbury CCG covers approximately 40 GP practices.	Beechbury Community NHS Healthcare Trust provides a range of community-based health services across the area. Community nurses work in multi-disciplinary teams, serving approximately 800,000 people.	14/15 – 5 CQUINs: Dementia care (3), Discharge planning/review, Multidisciplinary working. 15/16 – 2 CQUINs: Multidisciplinary working, Patient experience.	Patient safety, responsiveness of the organisation, staff experience and capacity.

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Table 1: Case study site descriptions (continued)

Name	Demographics	Commissioner	Provider	Local CQUINs for Community Nursing	Additional/main focus for care in 15/16
Cedar-ham	Large urban area. Deprivation is higher than average. Life expectancy for men is lower than the England average and for women it is higher than average. Smoking related deaths and under 75 mortality rates for cancer and cardiovascular disease are higher than the England average.	Cedarham CCG is one of two neighbouring CCGS in the area. They commission community services together. There are nearly 50 GP practices associated with Cedarham CCG.	The provider, Cedarham NHS Foundation Trust (CFT), delivers both acute and community care. Community nurses work in uniprofessional nursing teams. CFT provides services for approximately 600,000 people.	14/15 – 3 CQUINs: Patient education (2), Patient experience. 15/16 – no CQUINs.	Pressure ulcer prevention, falls, medicines management, serious incident reporting, training of staff for safeguarding adults, patient experience and patient safety.
Dogwood-heath	Large urban area Population health is generally worse than the England average, with the rate of smoking related deaths and the number of people dying prematurely from cardiovascular disease and cancer being considerably worse than the England average.	NHS Dog-woodheath CCG has responsibility for commissioning community-based care and covers approximately 60 GP practices. There are two other CCGS in the area. All commission services independently.	The provider is Dogwoodheath Respond (DHR), a social enterprise. Community nurses work in multi-disciplinary teams. DHR provides services for approximately 300,000 people.	14/15 – 12 CQUINs: Catheter care, Dementia care (2), Discharge planning/review, Falls (2), Multidisciplinary working (2), Patient education (2), Patient experience, Organisational communication. 15/16 – 6 CQUINs: Catheter care, Discharge planning/review, Multidisciplinary working, Patient activation/well-being, Patient experience, Pressure Ulcers	Waiting times, End of Life Care and patient experience.

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Table 1: Case study site descriptions (continued)

Name	Demographics	Commissioner	Provider	Local CQUINs for Community Nursing	Additional/main focus for care in 15/16
Elmhamp-ton	Large rural area with several large towns. Population is slightly older than the national average with a higher than average life expectancy. Deprivation is below the national average, although pockets of deprivation do exist. Smoking and obesity in adults are within the national average, and smoking related deaths, as well as mortality in under 75's due to cardiovascular disease or cancer, are lower than national rates.	Elmhampton CCG is the sole CCG for the area, covering approximately 80 GP practices.	Elmhampton NHS Foundation Trust (EFT) provides community nursing services for the CCG. Community nurses work in uniprofessional teams. EFT serves a population numbering approximately 500,000 people.	14/15 – 3 CQUINs: Care plan development, Dementia care, Pressure ulcers. 15/16 – 2 CQUINs: Discharge planning/review, Pressure ulcers.	Patient safety, transfer of care and organisational responsiveness.

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Main findings

There was very little variation found among the different sites in terms of participant views and opinions about the processes used to select and apply quality indicators in the community nursing. Similarly, participants across all five case sites were in general agreement about the usefulness of indicators currently in use. Some of these key study findings were also considered appropriate and applicable by delegates who attended ten workshops held nationally to test the findings' validity. The main findings are therefore presented for the study as a whole in Tables 2 and 3 below.

Table 2: Commissioners and provider managers

Selection	Application	Usefulness
• There was agreement between commissioners and providers about issues concerning the complexity and time-consuming nature of the process. • It was generally agreed that indicators should be meaningful, specific, patient-related and achievable. • Some difference of opinion about the extent to which provider managers and clinicians are involved in selecting indicators. • Acknowledgement that patients and carers are not generally involved in this process.	• Common difficulties on application of indicators appear to arise from frontline's staff lack of familiarity with new IT systems and/or the quality of the software in use. • Inter-organisational IT systems are generally incompatible and mobile working is hampered by connectivity problems. • Many frontline staff do not always appreciate the importance of the collection of quality data, preferring instead to prioritise direct care for patients. • Indicators are generally considered to help drive quality, but this effect is seen to be limited and application of indicators is not without unintended and undesirable consequences at times e.g. creating additional unnecessary activity.	• Agreement that quality in community nursing is very difficult to measure, and that current indicators do not reflect the true quality of care delivered. • Most participants would prefer to see a mixture of quantitative and qualitative evidence being used to demonstrate the quality of the service. • Some provider participants stated that some indicators in use were not fit for purpose e.g. having been directly imported from hospital settings.

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Table 2: Commissioners and provider managers (continued)

Selection	Application	Usefulness
• A common opinion among participants was that indicators should incorporate clinicians' perspectives, especially staff involved in implementing them. • A number of commissioners thought that the future direction of travel will be towards outcome-based measuring, dependent on patient input.	• Some commissioners relied only on provider self-reported data but others supplemented data from providers with visits to various practice settings, both announced and unannounced. These visits contributed to commissioners' understanding of the work of community nurses. • Commissioners complained that the guidance for the national CQUINs is not always clear. • It was noted that improving quality requires close collaboration between commissioners and providers. Many participants mentioned the importance of maintaining good relationships. • The quality data collected by the frontline teams were sometimes considered to be poor or incomplete.	• The case sites offered very little evidence of direct positive impact on care resulting from the application of quality indicators (Qis), most commonly associated with the prevention of pressure ulcers. • Participants felt that monitoring QIs regularly was useful in terms of increasing transparency of services, provider accountability and confidence about the quality of service being delivered. • Some commissioners reported seeing the value of CQUINs as incentivising specific service improvements.

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Table 3: Frontline staff, patients and carers

Selection	Application	Usefulness
• Frontline staff reported they have little or no input into the selection of the QIs being used to assess their work. • Many weren't even sure who was involved in this selection and were suspicious of QIs. • Nurses indicated that they would appreciate being involved in the whole process of quality assessment. • Service users suggested that managers should go out on visits with staff in order to increase their understanding of the context of care and service quality.	• Nurses complained they were not given sufficient notice prior to implementation of a new quality indicator. • Staff complained of lack of training prior to implementing a new quality indicator, perhaps due to time pressures. • Staffing shortages could potentially result in hasty or incorrect completion of indicator data. • Staff felt that collecting data for some QIs was a paper exercise and did not really measure quality e.g. collecting data for the national safety thermometer on a specified day every week. • Nurses felt that care delivery was driven by a quality indicator protocol as opposed to professional judgement. • External factors such as the patient environment or other staff providing care or equipment can impact on successful implementation and achievement of quality indicators in the community. • Community nurse interactions with other healthcare professionals such as GPs, hospital and care staff can also impact on implementation and achievement of quality standards. • IT implementation issues, workforce shortages and organisational change were challenges in all the sites.	• While there is general agreement between service users and staff that some of the quality indicators are important for patient outcomes, and useful to nurses as prompts for care, doubts were expressed as to whether these are necessarily all within the reach of the nurses. • There appear to be some areas of nursing care that are important to patients and carers that are not being monitored in relation to quality. Examples of such 'softer' aspects of care are: nurses offering individualised, flexible care; being friendly and approachable; and being able to spend a reasonable amount of time when visiting, rather than being in a rush to move on to somewhere else. • Service users were open to different ways of assessing quality of nursing, such as involving managers in inspection of frontline staff and incorporating personalised goals to care-planning that could be used to measure service effectiveness.

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Conclusion

The current methods for assessing quality of community nursing services, while comparatively useful from a management perspective in relation to accountability and patient safety, are not thought to be as useful for assessing service effectiveness. This is due to the difficulty of identifying suitable indicators for the context of the community. The processes involved in selecting and monitoring payment for performance quality indicators is time consuming. Moreover, evidence suggests such schemes, while having the potential to improve care in one area and in some cases be useful for clinicians, may have unintended consequences that are detrimental to service users. The values of frontline staff and service users in relation to the quality of care (time spent, kindness, respect) are not fully represented in the suite of quality indicators currently being used. It is suggested these values can only be assessed through direct observation or more directly involving service users and frontline staff in feeding back experience of care to health service planners and managers.

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