Introduction

Context: The main themes identified in community services are the challenging financial climate; urgent need for hospital admissions avoidance and prompt discharge; the drive for service integration; increasing numbers of patients with more long term, complex conditions being nursed in the community (often involving upskilling existing staff); fewer experienced staff; and high nurse vacancy rates. IT systems are in comparatively early stages of development. Nursing care is delivered in the home and relatively invisible to commissioners and senior managers.

What do patients want from community nursing services? Evidence from patient and carer interviews suggest recipients of care want their community nurses to be well trained and equipped, competent at their job, and able to work in partnership both with other professionals and paid and unpaid carers to provide continuity of care. They want nurses to offer individualised, flexible care – meaning they should not appear to be in a rush during the course of a visit and take time to be pleasant and friendly. For people managing complex conditions at home, or caring for someone with a complex condition who could deteriorate at any time, it is extremely reassuring both for patients and carerto know they can access a nurse, if needed, on a 24 hour basis. When asked specifically about current indicators in use, patients agreed that these are important (for example, the National Safety Thermometer) but not necessarily for them. Many commented on the amount of documentation they observed nurses completing (and the time taken to do so), but found notes left in the home useful and reassuring for themselves.

What is good practice in the selection and application of quality indicators in the light of the context for practice described above? From previous work [1, 2] drawn on by Davies et al, (2011)[3] the following characteristics of 'good' quality indicators were identified:

- Evidence of clinical benefit;
- Within the scope of influence of clinicians;
- Recognised as important by patients, carers, commissioners and community service managers;
- Measurable impact on health gain (scale of the healthcare problem, health inequalities);
- Low risk of 'perverse incentives' or gaming.

Good Practice Guidance

This draft guidance draws together emerging findings on experiential learning from participants involved in the planning, selection and the application of indicators for community nursing in practice.

Indicator planning and selection

It is important that negotiations around selection of indicators have clarity of purpose. At the outset determine what the indicator will be used for used for – is it about accountability (for example, performance data) or about service development and measurement? Will there be an important health benefit as an outcome of successful achievement of the indicator? Take into account that organisations will also be ensuring they are compliant with the CQC quality inspections covering safety, effectiveness, caring, responsiveness and leadership – are there opportunities to align more closely with these? (*Data from frontline observations where CQC visits were taking place and 'Quality challenges' were being implemented to ensure the organisation was ready for inspection*).

Take account of the priorities of users and those at the frontline delivering care. Be aware that clinical outcome measures – often preferred by commissioners – may not reflect process of care measures that might be of more importance to those receiving care or frontline staff juggling care delivery in the context of structural problems such as vacancies, shortfalls in IT infrastructure, and implementing changes to their working practices. This

might mean that commissioners and managers should spend time in the field to experience some of the issues facing nurses and users in order to create meaningful quality indicators - local knowledge is important and should be considered closely.

Be clear about what is essential / desirable information in relation to quality; rationalise the total number of indicators required. With CQUINs too many can be a disincentive as costs of implementation might outweigh any potential financial incentive. CCGs should be aware of the potential for creating a 'bureaucratic monster' in their service organisations in order to provide the required data.

Indicators should be meaningful, specific, patient related, achievable and SMART with full consideration of data capture and infrastructure (including associated costs) taken into account before formal agreement. One caveat is that it might be tempting to use data that is already being captured for other purposes to avoid costs, but this does not always generate real service improvement.

Evidence suggests indicator data come from many sources including electronic systems and paper and has to be assimilated to be useful, thus incurring time and analysis costs for both providers and CCGs. Take into account whether providers will be required to obtain additional IT to collect the desired data efficiently or streamline existing databases. Is the indicator really worth the investment in relation to benefit obtained?

Reality check potential indicators with frontline staff before selection – just because it appears to work well in a hospital setting does not mean it is feasible or appropriate in the community, for example, Friends and Family Test (FFT): community nursing caseloads contain many long term patients, people with cognitive or fine motor co-ordination problems or those who are terminally ill – administration of the FFT might have to be done by the nurse or a family member (introducing bias). The National Safety Thermometer is completed on the same day of the week each month; patterns of community nurse working might mean that the same patients get repeatedly counted so that the sample is not representative.

Involving staff in designing local indicators by asking them what can be done 'on the ground' to improve services will increase the usefulness of indicators and buy-in from staff but time must be built in to do this meaningfully. Obtaining engagement with frontline staff, for example, with developing ideas for quality indicators and giving feedback, can be difficult in the community, as staff are geographically dispersed and usually out in patients' homes or travelling.

Quality indicators can result in task-orientated care delivery and conflict with good clinical practice, for example, in implementing skin assessments across the board (not all patients receiving wound care should have had pressure areas assessed at first meeting; nurses having to undertake urinalysis more frequently than clinically recommended). Indicators should build in sensible exclusions based on good clinical practice.

Avoid overburdening frontline staff with extra data to collect for indicator purposes. There is already too much duplication of documentation for community nurses. It may be worth investing in use of streamlined electronic systems to work as clinical tools for staff in practice, but also enable the data inputted for clinical purposes to be drawn off to support measurement of specific quality indicators. For example, the nurse could complete an electronic care plan containing prompts to record measures for a particular patient pathway that would then feed into data to be aggregated for quality measurement purposes. On the whole nurses do not see it as their role to be completing surveys with patients or collecting completed satisfaction questionnaires.

Once indicators have been agreed, set realistic thresholds for CQUINs, otherwise it can disincentivise providers who might otherwise comply. There may be a case for taking into account the context for service delivery into the indicator, as different localities within the same provider organisation area can have less or more challenging environments for care delivery. This could be reflected in varying the thresholds for achievement according to agreed social demography indicators.

Be aware of the potential pitfalls of choosing what, on the surface, might appear to be purposeful and measurable indicators, as the current context

for care delivery might make them less feasible than would be apparent at first glance! Indicators designed to upskill nurses and offer them training, for example in dementia awareness, might be appreciated by staff and lead to better quality care, but service conditions might mean that staff cannot be released on that day, due to unexpected staff cover requirements. Not achieving evidence of the threshold for rolling out training might mean the organisation incurs unwanted further costs, placing further pressure on an already stretched service.

There are opportunities for using indicators creatively for supporting the integration agenda. Integrated indicators (for example on discharge of patients from hospital) should have separate measures for the individual components to comply with good indicator guidance[3]. Indicators could be used for the benefit of patients to facilitate nurses working more closely with voluntary organisations, thus capitalising on an important resource in the community. However, there are costs related to the complexities of co-ordinating different organisations and measuring different inputs from different providers that might outweigh the benefit of the component measures.

Providers should consider CQUIN very carefully in terms of the costs it incurs, as the first year it comes with money but will subsequently be incorporated into the contract with nothing extra to support it.

Indicator application

For successful buy-in from staff and real benefit for patients, meaningful involvement in the planning and selection of indicators from frontline staff as outlined above, is essential. However, language and terminology used in relation to quality are also important to consider. For example 'harm reduction' can suggest there is already harm that needs to be reduced and staff can interpret this as critical of the care they provide. Staff can feel patient safety quality indicators are about how bad they are if these are expressed in terms.

If commissioners and managers pose questions about quality, but allow staff to choose indicators meaningful to themselves this will have the benefit of buy-in from staff and be likely to bring benefits to patients and carers.

To ensure good quality data are being collected it is essential to ensure the instructions for quality measures obtained in the field are clearly worded and unambiguous. Instructions for application of the safety thermometer have been cited as a poor example of such instructions. Avoid introducing too many processes; they may be simple in themselves, but when there are a number of them it can become complex for the people having to use them.

To motivate and encourage commitment from staff they should be able to see the benefits of quality indicators being achieved in direct investment into their service, not just to the organisation as a whole.

- Ask the staff themselves how they would prioritise the potential spend.
- Vary how quality is measured by using a mix of metrics and narrative:
- Case studies have been used successfully and enable patients or carers to be directly involved in quality feedback.
- Employ a quality lead to audit a small sample of case files across nursing teams.
- Ensure staffing is sufficient to enable more senior members of the team to visit with other members of the team to observe or work alongside lower grade staff to check quality of clinical care, quality of interaction with patients and relatives and collaboration with paid carers.
- Harness the patient's own priorities for care as expressed in the care plan (for example, pain reduction) and measure against this at discharge (PROMS).

- Feedback to front line staff should be regular and accessible to all grades. Consider how your organisation can do this effectively. There are numerous examples of practice:
- Put up a home page on the staff intranet to ask for people's ideas.
- Clinical leads for quality could regularly produce informal 'blogs' for staff, or attend staff team meetings.
- Perhaps convene an annual occasion (Quality Forum) where commissioners, provider managers, frontline staff and patients get some feedback face to face on quality about: What worked well? How can this be moved forward? How is the context for care changing? This would give people an opportunity to meet each other without being interrupted by phones and other meetings.
- It is important that managers thank their staff for all their hard work. It is the little things that make a difference, for example, take a cake to a meeting. Present them with findings so that they can see the usefulness of indicators in relation to their patients.

Ensure IT introduced is fit for purpose; ask frontline staff what they need first. A system that works efficiently in hospital might not be compatible with community nursing working practices, caseload turnover, or work well with other IT systems currently in use by other community providers such as GPs or social services. Information sharing can be a hurdle: organisations collecting different data from one another; knowing who to talk to. Examine why things have worked well and try to learn from that as well as unpicking what works less well. There are barriers to mobile working (which might otherwise offer the answer to many of the problems). Many nurses do not like taking a computer into the patient's home and see it as intrusive or feel unsafe completing records on a computer in the car. Wi-Fi is not always available. Patients and carers say they like being able to refer to their nursing notes, because they feel they know exactly what is going on and it helps continuity if an emergency occurs. It is preferable not to introduce a range of different IT systems, for

example one system for caseload management and another for calculating mileage.

Drafting the good practice guidance statements

The above paper was circulated to the research team. After discussion, a set of good practice guidance statements were formulated. During the stakeholder engagement events, delegates were asked to give feedback about the statements associated with the findings selected for presentation to them (see Chapter 9). The final set of good practice guidance statements, incorporating suggestions made by delegates, can be found in Appendix 4.

References

1. NHS Institute for Innovation and Improvement. *The Good Indicators Guide: understanding how to use and choose indicators*. www.apho.org.uk/resource/item aspx?RID=44584 (accessed 19 May 2010).
2. Mainz J. Defining and classifying clinical indicators for quality improvement. *International Journal for Quality in Health Care* 2003; 15:523–30.
3. Davies et al: Developing quality indicators for community services: the case of district nursing *Quality in Primary Care* 2011;19:155–66