How commissioning affects community nursing

In this article...

› Why community nurses should get involved in commissioning
› Findings of a survey of relevant commissioning indicators
› Impact of the findings on community nursing

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Abstract

Community nurses have direct experience of how changes in the local health economy affect the quality of care patients receive, so it is important that they engage with commissioning to influence decisions made about the quality and direction of their service. This article seeks to demystify commissioning priorities by drawing on findings from a survey of Commissioning for Quality and Innovation indicators for community nursing conducted in England, 2014-15. The article focuses specifically on organisational goals, highlighting the impact of the Francis report and other NHS priorities on quality assessment in community nursing.

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Impact of the findings on community nursing

By understanding and being involved in the commissioning process, community nurses can ensure that their voices are heard and positively shape the service they can provide.
arguably one of the most potent because it links a proportion of the provider’s income (2.5% of their overall contract) to the delivery of locally agreed CQUIN targets (Olfert, 2015). If targets are not met, providers lose this part of their funding; in this way, service improvement and quality standards are heavily incentivised to reflect the commissioning agenda.

This article shares the emerging findings from a survey of CQUIN indicators for community nursing, conducted in England in 2014-15, with a particular focus on the organisation of services (Horrocks et al, 2015). The findings give an indication of what commissioning priorities looked like across England, within the limitations of the survey, and potentially enable community nurses to:

» Have a better understanding of the broader picture in terms of commissioning priorities;
» Make connections with what they are involved in implementing as part of their clinical roles.
Community nurses need to become engaged with commissioning to:

» Influence decisions;
» Raise the visibility of what the quality of care looks like for patients and frontline staff.

The survey
In total, 159 clinical commissioning groups (75% of all CCGs in England) sent evidence of their CQUIN schemes to the research team; 889 indicators (74% of all indicators submitted) were judged to apply to community nursing, with an average of seven applied in each provider organisation. There were 405 national CQUIN indicators (46% of all indicators submitted relating to community nursing); the remaining 484 (54%) were locally derived.

National CQUIN indicators
National CQUIN indicators are set by the Department of Health and are mandatory for healthcare providers. In 2014-15, only two of four possible national CQUIN indicators were deemed compulsory for community services. These “community” national CQUIN indicators include the:

» Friends and Family Test – introduced to obtain feedback from patients receiving community services;
» National Safety Thermometer – nurses collect data in a survey on one day each month on the reduction of pressure ulcer prevalence, falls, new venous thromboembolism and urinary infections in patients with a catheter (NHS England, 2014).

National, precisely defined CQUIN indicators allow the standardisation of these aspects of care across England, enabling reviews of national progress and comparison between different areas (Raleigh and Foot, 2010).

Local CQUIN indicators
Local CQUIN indicators are agreed by CCGs and based on local service development needs. Each CQUIN indicator comprised a goal, a stated aim or an aspiration to improve the service, which were categorised into 13 care themes.

Categories included:

» Patient and carer experience;
» Dementia;
» End-of-life care;
» Admission and discharge;
» Pressure ulcers.

The largest categories were “organisational issues” and “organisation of care”, with a combined total of 163 indicators (33% of all CQUINs relating to community nursing), indicating that the structure and arrangement of community services was a key local commissioning priority in 2014-15.

Organisational issues
Closer examination of the combined categories of “organisational issues” and “organisation of care”, with a combined total of 163 indicators (33% of all CQUINs relating to community nursing), indicating that the structure and arrangement of community services was a key local commissioning priority in 2014-15.

The care model
The indicative findings suggest many commissioners and providers were in various
stages of moving more closely towards a distinctive care model, primarily relating to the organisation of community nursing services around clusters of GP practices. The care model was described in many ways, such as the “virtual ward”, “community ward”, “neighbourhood teams” or “integrated teams”, and comprised some or all of a series of elements (Box 1). Within the care model indicators, the dominant themes consisted of care planning, particularly increasing the number of care plans and the timeframes in which they were completed, and multidisciplinary team meetings. The amount of direction from the CQUIN indicators around the MDT meetings could imply that there were concerns about a lack of engagement for this aspect of the care model. CQUIN indicators related to increasing the frequency of these meetings, assuring full multidisciplinary attendance. This highlights the importance of building relationships with GPs and primary care to secure teamwork and commitment.

Lewis et al (2013) bore this possibility out in their review of “virtual ward” case sites. They observed that the multidisciplinary aspects of the model had been difficult to maintain over time and recommended active involvement of GPs and regulation to reinforce attendance at the MDT meetings to avoid regression to old patterns of working.

Integration
Increased integration was a clear aim of local CQUIN indicators. This was largely defined as sharing information by linking IT systems across organisational boundaries and improving working relationships between disciplines and organisations, thereby reducing fragmentation of care and ensuring better coordination.

The integration of IT systems concentrated on sharing communication across acute, primary and community services, or on linking general practice IT systems more closely with community providers. Few direct references were made to social care IT systems.

Patient information, in terms of what was being shared across service interfaces, was managed by the provider with the patient’s consent. There were only a few local indicators relating to patients holding their own health records and these centred on patient discharge passports.

The care model was fundamental to integration in the community with its multidisciplinary approach. It was clear that the role of, and the relationship with, the GP was pivotal within the MDT. Less overall emphasis was placed on relationships with acute trusts and with social care within the indicator set, and few references were made to working partnerships with the voluntary sector, mental health services or engaging with local community initiatives. It is likely that representatives from these services were attendees at the MDT meetings, but CQUIN documentation did not provide this level of detail in the survey.

Francis CQUINs
A number of organisational CQUIN indicators were influenced by recommendations from the Francis report, which followed a public inquiry into care failings of acute services at Mid Staffordshire Foundation Trust (Francis, 2013).

The local Francis indicators focused on putting systems in place to ensure organisations were robustly responding to incidents and complaints. Some required independent panels to review complaints procedures and to share the learning across organisations; others examined staffing levels, with a view to greater transparency around safety. Notably, very few indicators were linking safe staff levels to a caseload weighting classification system, which would link staffing levels and skill mix to the intensity of cases within each community caseload.

Workforce development was aimed at not only expanding competencies, but also embedding the 6Cs (care, compassion, competence, communication, courage and commitment) and processes to promote regular staff supervision. Staff surveys, particularly the “cultural barometer”, were also being used to access the views of staff about the care they provided, along with their attitudes to their working environment. Staff experience is considered to be an important measurement of the quality of healthcare provision. Hazell (2015) reported a close correlation between high levels of staff satisfaction, and “good” and “outstanding” ratings of care quality by the Care Quality Commission.

Inadequate arrangements for patient involvement and feedback was a conspicuous failing at Mid Staffordshire Foundation Trust (Francis, 2013), so it was surprising that patient experience did not feature heavily as a theme in the organisational CQUIN.

However, there was a separate category specifically for patient experience within the care themes, and the Friends and Family Test was being rolled out in line with the national CQUIN indicator.

Seven-day working
There was an emphasis on incentivising a seven-day approach to community provision, which may have been driven by the NHS Improving Quality publication, *NHS Services Open Seven Days a Week: Every Day Counts* (NHS IQ, 2013). A few indicators aspire to providing weekend provision equal to that provided during a normal weekday. But the majority looked at enhancing a particular aspect of care to develop weekend working, such as setting targets for services to manage more hospital discharges at weekends or seven-day working specifically for patients known to the MDT with a care plan in place.

Few of these indicators described steps to scope current provision and plan the development and extension of services; however, these details could have been explored by commissioners through other contractual levers.

Additional resources required to maintain an enhanced seven-day service appeared to be expected to be managed through the service contract.

Implications for community nursing
This is the first survey of community nursing CQUIN indicators undertaken and, as such, offers valuable information on commissioners’ views of these largely overlooked services. CQUIN schemes are, however, only one lever used by commissioners to direct services and examining other levers, such as key performance indicators, might expand the findings and fill gaps about commissioning priorities that are not apparent when looking at the
CQUIN schemes in isolation. The emerging findings of this survey of community nursing CQUIN indicators offer a broad, quality snapshot of CQUIN priorities in 2014-15 for organisational issues. Many of these priorities will be instantly recognisable to frontline community nurses.

The main thrust of the organisational CQUIN indicators is towards greater integration in terms of multidisciplinary working, with particular emphasis on developing closer relationships with GP practices. The care model, with its various local interpretations, is the principal organisational strategy for enhancing the coordination and quality of community services, with the proviso that the multidisciplinary aspect is vital.

Nursing is the largest workforce in community service provision; the success of achieving and sustaining CQUIN goals depends on community nursing engagement with the process. However, Henry (2013) maintained that community nurses are becoming alienated because they feel that their priorities are neither listened to nor acted upon.

District Nursing: harnessing the potential (RCN, 2013) describes a lack of integration between initiatives designed to augment services in the community (such as the virtual ward) and mainstream district nursing services, which provide the majority of nursing care in the community. Ball et al (2014), in a survey of community and district nurses, highlighted challenging and unpredictable caseloads, inadequate staffing levels and much local variation in the skill mix of teams. This raises questions about whether the community infrastructure and workforce is sufficiently resilient to make initiatives such as integrated community-based care a reality.

Frontline community nurses have first-hand experience of how changes work in practice and how they affect the quality of care that patients receive. As the NHS struggles to manage increasing demand and burgeoning debt, expediency might lead to the paring down of home-based services, where quality is less visible or harder to measure and where the patient group might have difficulty expressing a united voice.

More than ever, community nurses need to become a strong voice in determining what benchmarks distinguish the quality of their service and in describing the practical reality of what is feasible for extending and developing community nursing provision. Consultation with frontline community nurses is essential to supporting the design, implementation and monitoring of the effectiveness of quality measures set in CQUIN.

Many community nurses find it difficult to become actively involved in commissioning. Parr and Wild (2011) found that only 21% of district and community nurses felt included in commissioning processes. Despite their unique insight into what innovations might work effectively, there are many barriers to community nurses achieving greater engagement. These include:

- Opportunities;
- Time;
- Confidence;
- Attitudes about whether it is their role to do so.

There is a need to examine the mechanisms available to frontline community nurses to contribute to commissioning in a meaningful and systematic way, as much still seems to be left to individual persistence, facilitative line managers and provider attitudes to transparency.

The survey discussed in this article is part of a wider study examining how the quality of community nursing is measured and who is involved at different stages to gain a better understanding of the process. The progress of the study can be accessed at qucin.uk.

Conclusion

Community nurses need to be more involved in commissioning at all levels to raise the visibility of the quality of their services and how changes affect quality in practice. In the current climate, engagement with commissioning processes is as essential to quality patient care as clinical input. If community nurses do not become involved in commissioning, they will lose an opportunity to positively influence decisions about the quality and the direction of their service, which impacts on patient care. NT