

Publication no: 003 535

Measuring for quality in health and social care

An RCN position statement

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1 Introduction

This information sets out the RCN's position in relation to quality and its measurement, and outlines the RCN's input on this issue. Designed to be of value to those for whom quality and its measurement is integral to their day-to-day work, it will also assist the wider health and social community to understand the contribution that nursing makes in this arena.

In conjunction with the wider health care team, nursing has a major role to play in the quality of care experienced by patients and users. This includes the provision of:

person-centred care — working with an individual to identify their values, needs and expectations in regard to their own health and social care; communicating and providing relevant information; enabling shared decision-making, informed choice, and enabling participation in the evaluation of care

effective care — care that is both safe and evidence-based in relation to the treatments provided and the context in which care takes place

systems of care — the context in which care is delivered (for example, safety systems, workforce issues, continuity of care) including the structures, processes and patterns of behaviour that enable person-centred, safe and effective care to be sustained even when health care changes.

Why measure?

In a recent influential National Nursing Research Unit publication, Griffiths et al. (2008) identified the strategic and practical benefits of measuring quality. While improving the quality of nursing and health and social care is part of everyday work and the professional responsibility of nursing, measurement is central to enabling and supporting policy analysis and strategic decision-making — including commissioning, reimbursement systems and accreditation. It can also prompt research around valuable areas such as the relationships between the structural, process and outcome components of quality, and can contribute to understanding the role of nursing care in determining patient safety outcomes.

There is strong evidence that contextual factors, in relation to the nursing workforce's contribution, can be linked to positive outcomes in terms of patient safety; the reduction of medication errors (Needleman et al., 2002), the occurrence of pressure ulcers (Westwood et al., 2003), reductions in re-admission rates (Hewitt et al., 2003), the occurrence of complications such as pneumonia (Needleman et al., 2002) (Hewitt et al., 2003), reductions in falls (Commonwealth Steering Committee for Nursing and Midwifery, 2003) and health care associated infections (Needleman et al., 2002) (Aitken et al., 2003).

At a practical level, local and national quality measurement enables:

- trends and characteristics to be quantified
- performance towards the achievement of health service goals (particularly those elements to which nursing contributes) to be monitored and managed
- the identification of aspects of care requiring improvement.
- informed choices - based on published quality data - by patients, clients and others.

Why now?

In the face of massive increases in public expenditure the NHS, along with other public services, is being asked to justify continued investment by delivering value for money and increased productivity. In part, this requirement relates to a desire for improved public accountability and service quality. However, given the wider economic environment, efficiency savings are likely to become a key future focus.

The recent *NHS Next Stage Review* (England) outlined a number of initiatives designed to improve the measurement and monitoring of quality within the NHS. In the other UK countries, despite a reduced focus on market mechanisms to incentivise quality, data which helps others understand the patient experience and the quality of care delivered by the multidisciplinary team still remains an important theme.

Public concern about the quality of nursing care, coupled with a professional desire to demonstrate contributions and improve quality, have also led to an increased interest in measures of nursing (National Nursing Research Unit, 2008). Furthermore, the systems which underpin care delivery — contracting, commissioning and activity-based payment systems such as *Payment by Results*) — all require a detailed understanding of what happens at the patient level.

By making the contribution of nursing explicit at the patient, organisational and national level it is hoped that the nursing component of quality care can be invested and incentivised, rather than neglected in the drive to meet other performance targets.

2 Defining the key terms

To ensure consistency and ensure we measure and compare the same thing, it is essential to have a shared understanding of key terms. Some of the agreed key terms associated with measuring quality, together with definitions based largely on those used by the NHS Institute for Innovation and Improvement (2008), are shown in Table 1.

Table 1: Key terms for measuring quality

| Term | Definition |
|-----------|---|
| Benchmark | An externally-agreed comparator to compare performance between similar organisations or systems. |
| Data | Information that is fed into indicators. Without context and comparators, data rarely have significant meaning. |
| Dashboard | A visualisation of the most relevant indicators. |
| Indicator | A summary measure that aims to describe in a few numbers as much |

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| | detail as possible about a system, to help understand, compare, predict, improve, and innovate. |
| Metrics | Any set of data. An indicator is a particular sort of metric that identifies issues that may be worthy of further investigation. |
| Outcome | A measurable change in health status, sometimes attributable to a risk factor or an earlier intervention |
| Quality measure | A mechanism to assign a quantity to quality of care, by comparison to a criterion. |

If measuring quality is to be a driver to improving quality of care, it is important that the relationship between standards and indicators is understood. Indicators of outcome need to be linked explicitly to practice standards, audit data and clinical assessment. This relationship underpins the RCN’s principles on quality measurement:

- evidence-based standards of care and associated benchmarks are agreed between relevant stakeholders
- standards are identified before specific indicators are defined, and appropriate methods of measurement sought
- a small number of core valid indicators may contribute to the national quality agenda, but, local specific indicators drive quality improvement in practice
- good indicators are those suited to their intended purpose, are relevant, valid, reliable, feasible and useful in supporting change.

Clearly it is essential that appropriate and relevant indicators are defined:

“It is often much worse to have a good measurement of the wrong thing — especially when, as is so often the case, the wrong thing will in fact be used as an indicator of the right thing — than to have poor measurement of the right thing.”

John Wilder Tukey, Statistician

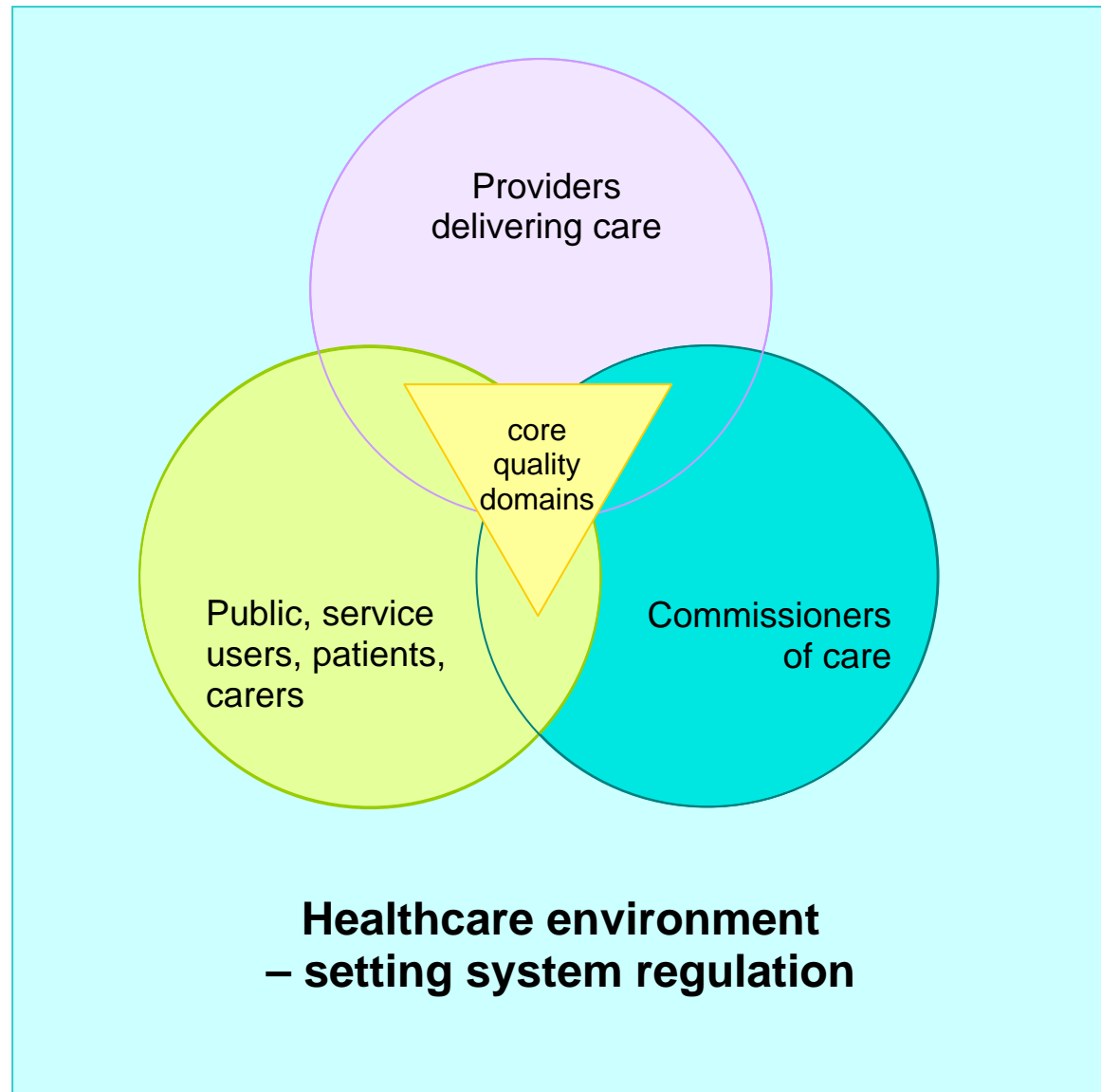
3 Dimensions, scope and stakeholders

As health and social care quality is, by necessity, a multi-factorial and broad ranging concept, the definition, measurement and communication of quality in health and social care should involve multiple stakeholders. However discrepant views between the different stakeholders, ranging from service users (the public, patients and carers) to service providers (nurses, allied health professionals and clinicians) and commissioners of health and social care, exist with regards to the definition and prioritisation of quality issues (Leatherman and Sutherland, 2008) (Campbell et al., 2002).

The measurement and communication of health and social care quality therefore requires assessment of key and consensual variables that reflect the breadth and

complexity of health care. Engaging with multiple stakeholders to identify core elements of health and social care quality is essential to this process (see Figure 1).

Figure 1: Engaging with multiple stakeholders to identify core elements of health and social care quality



4 Data and data management

Indicators are derived to ‘operationalise’ collaboratively developed standards, and data is the information that feeds into indicators. A major concern for nursing is that a glut of data may result, overwhelming practitioners with a data burden that prevents them from progressing with the key task of addressing actual improvement strategies. To reduce the data burden, and ensure that data collected provides a positive purpose, it is essential that nurses are critically involved in:

- the decisions about what data is collected, and how

- developing and using the electronic patient record as a nursing data resource, using data derived from individual patients and users
- receiving feedback from the data nurses have collected.

The RCN endorses the Department of Health's *Quality and Outcomes Framework* (QOF) regarding principles for good data collection.

Principles of good data collection

1. Indicators should, where possible, be based on the best available evidence.
2. The number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care.
3. Data should never be collected purely for audit purposes.
4. Only data which are useful in patient care should be collected. The basis of the consultation should not be distorted by an over-emphasis on data collection. An appropriate balance has to be struck between excess data collection and inadequate sampling.
5. Data should never be collected twice, that is, data required for audit purposes should be data that is routinely collected for patient care and obtained from existing practice clinical systems.

(DH, *Quality and Outcomes Framework*, 2004).

In relation to the contribution that nursing makes to quality, individual patient data alone will not provide the whole picture. There also needs to be data that reflect the quality of the workplace and the systems, teamwork and leadership in place to sustain quality. In addition, there is a requirement to consider the incentives for behaviour change; individually, for teams, and at the system level.

Interpreting the resulting data requires the participation of all key stakeholders if the conclusions made are to be relevant to service improvement. This interpretation will then inform a collaborative action plan for implementing and monitoring improvements in quality through, for example, the Plan Do Study Act (PDSA) cycle or other quality improvement or practice development approaches.

5 The RCN's role and contribution in relation to measurement of quality

The RCN has a major role in role to play in relation to quality and standards.

The main priorities identified by the RCN for indicator and metrics development are summarised below:

RCN priorities for indicator development:

- indicators for high risk/high cost topics, particularly pressure ulcers, failure to rescue, further work on falls and other front runners identified by Griffith et al.(2008)
- indicators for essence of care
- patient reported outcomes, such as patient experience and perception of patient involvement, which will provide fruitful measures for providing feedback on person-centred care
- indicators for systems of care (for example, continuity of care, teamwork and also staffing levels) with links to patient satisfaction.

In relation to measuring quality the RCN has three key purposes:

- engaging and informing members, profession and public
- representing nursing
- developing the evidence base.

Table 2: RCN activities in relation to measuring quality

| | |
|---|---|
| Engaging and informing members, profession and public | <ul style="list-style-type: none"> ➤ engaging the membership, profession, and public about quality and metrics ➤ implementing a public and patient involvement strategy to support the development of standard ➤ clarifying the different terms, methods and data, the how and the why ➤ promoting the key steps necessary to define quality: <ul style="list-style-type: none"> - consensus agreement - metrics that support action with: <ul style="list-style-type: none"> ○ standards ○ stakeholders ○ strategy. |
| Representing nursing | <ul style="list-style-type: none"> ➤ leading and promoting the contribution of nursing to quality and measurement ➤ working on developing metrics in collaboration with key stakeholders ➤ lobbying for specific core indicators nationally and across the UK ➤ supporting and helping with the development of specific indicators locally ➤ bring together members experience through our executive networks, practice forums, Research Society and Quality Improvement Network. |
| Developing the evidence base | <ul style="list-style-type: none"> ➤ participating in and recognising good quality research and clinical audit around quality, audit and measurement |

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| | <ul style="list-style-type: none">➤ mapping the work being undertaken by others to:<ul style="list-style-type: none">• know who is doing what• enable learning• identify any gaps. |
| Linking to system regulation | <ul style="list-style-type: none">➤ liaising with the DH in England and the new Care Quality Commission to consider the use of metrics in the regulation of health and social care. |

A response to the DH (England) proposals on metrics has been submitted by the RCN, setting out its position in relation to the contribution of nursing and its principles around quality and measurement.

The RCN is currently moving towards establishing a quality and standards unit.

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