DEFINING 'GOOD' IN HEALTHCARE

TOPLINE SUMMARY 1: COMMUNITY HEALTH AND HOME CARE

1.   INTRODUCTION, BACKGROUND TO THE RESEARCH AND OBJECTIVES

In April 2013, CQC published its new strategy *'Raising Standards, Putting People First'*. In this document, CQC stated its intention to redevelop its inspection methodology and the information that is provided to the public following an inspection. This change focuses not only on how services are inspected, but also the five key questions which inspectors will ask about services: Are they safe? Are they effective? Are they caring? Are they well led? Are they responsive to people's needs?

CQC is working to develop new fundamental standards that focus on these five questions. As part of this work, CQC seeks to define the criteria that will be used to assign a rating to a service provider – in other words, understanding the features of a service that is considered inadequate, a service that 'requires improvement', is 'good' and 'outstanding'.

For this new inspection model to be credible with the public, it is essential that these criteria reflect the public's expectations. There is a particular focus on understanding what the public expects 'good' and 'outstanding' services to look like, across all care settings, and at all service levels.

Qualitative research was commissioned to provide a clear understanding of what the public and service users think 'good' and 'outstanding' look like in community health care and home care settings.   In addition, the research will explore what information requirements the public have in relation to inspection reports about all of the above services. The business objective is:

> **To inform the criteria that are developed for rating services and to inform the development of a new style of inspection reports for each of these services.**

2. COMMUNITY HEALTH CARE SUMMARY

2.1 Method and sample

6 triads (3 respondents, 1.5 hours duration) and 6 x depth interviews (1 hour duration) were conducted w/c 28th May.

- 2 x triads with those using Health Visitor services (parents with children under 5 years old and parents of children with long-term conditions)
- 6 x depth interviews with those using District Nursing services
- 2 x triads with those using Sexual Health services
- 2 x triads with those using community therapist services (occupational therapy, speech and language therapy, physiotherapy)

All had experience of the relevant community health care service within the past 3 months.

In-home depth interviews were conducted with those using District Nursing services because respondents tended to be based at home and would probably find it difficult to travel to a group session.

2.2 Care standards experienced

The care standards experienced ranged from 'good' to 'inadequate'.

Respondents did not feel that they had received any element of 'outstanding' care – and indeed some found it difficult to imagine what 'outstanding' might look like in this setting.

Research exploring perceptions of outstanding in the acute sector and in the home care setting has established that **'outstanding' is largely associated with personal characteristics of health care professionals.** In a community health care setting, there were limited expectations of health professionals needing to provide 'outstanding' care amongst those who did not feel vulnerable when using community health services and who regarded their use of the service in

a functional way i.e. people using physio and sexual health services.   This group who found it difficult to imagine what 'outstanding' might look like in this setting.

Those who felt more vulnerable were those using Health Visitor and District Nursing services. This group had more appetite for 'outstanding' service, represented by Health Visitors and District Nurses demonstrating an enhanced understanding of their needs.

Respondents had a functional interpretation of what 'good' looked like in relation to community health services. They simply felt that providing the expected service constituted 'good' quality i.e. offering patients timely appointments, providing the service required and any further support e.g. onward referral. For example, young people using sexual health services felt that procedures to maintain confidentiality were a key way in which services could demonstrate 'good' care.

When the expected service was not delivered (i.e. long waiting times for appointments, cancelled appointments, lack of follow up), services were described as 'requiring improvement'. One example of what the respondent felt was 'inadequate' care was waiting 3 weeks for an OT appointment which was cancelled the day before. After the rescheduled appointment, she waited a further 3 weeks for a letter confirming next steps. The next steps were referring her on to another service, which the service doubted they would be able to achieve and they stated would take a very long time.

When thinking about 'what good looks like', respondents tended to focus on service-related elements such as waiting lists, waiting times for appointments, sufficient staff, communication and follow up. Compared to other settings there was less emphasis on staff as responsible for delivering 'good' by being caring and more emphasis on the service delivering 'good' by being efficient.

2.3   Definition of good care

Overall, service users' description of good in each domain was shorter than CQC's, and clearly focussed on patient priorities.

General public priorities for safety varied by service. For example, hygiene was an important factor for those using sexual health services; being protected from physical harm was an important factor for those using District Nursing services; sufficient and suitably qualified staff was an important factor for those using therapy services; and safeguarding vulnerable children was a priority for those using Health Visitor services. Although priorities differed, all factors were included in the description of 'safe' (apart from *'sufficient and suitably qualified staff'* which is currently included in the 'effective' domain).

Effective was perceived as an important domain for community health services. Good systems were perceived as effective i.e. short waiting lists, prompt appointments, timely/accurate communication with patients and efficient discharge, transfer or transition arrangements. Although all agreed with the description of 'effective', the elements from which patients identified as particularly relevant to their needs were: the *'multi-disciplinary collaborate approach to care';* and *'discharge, transfer and transitions to other services are planned in advance and involve holistic assessment of people's ongoing needs'.* Timely communication with patients was the element currently missing from CQC's description of good 'effectiveness'.

There was less time spent discussing what 'good' looked like in the caring domain compared to other settings previously researched. Although all agreed with the description of 'caring', the elements from which patients identified as particularly relevant to their needs were*: 'all staff involve people who use the service as partners in their own care and in making decisions, with support when needed'* and *'staff are kind and have a caring, compassionate attitude and build positive relationships with people using the service'.*

In other settings, 'responsive' has been interpreted as staff being responsive to service-users' needs. **In the community health setting, a good level of responsiveness was described in relation to the service** e.g. short waiting times, prompt appointments, prompt follow-up, efficient communication. For this reason, the following elements were identified as particularly relevant to service-user needs: *'people wait as short a time as possible for services, treatment or care'* and *'people and those close to them are involved in decision-making about referral, discharge, transition and transfers'.*

Well-led is a domain that the general public typically struggle to articulate. In the context of community health services, a 'good' 'well-led' service was felt to result in an effective service. The description of 'well-led' was very difficult for service-users to understand. The language was particularly alienating in this section because it refers to management concepts which were unfamiliar to the general public.

Service users struggled to engage with the language used in the descriptions of 'good' in each domain. The inaccessibility of the language suggests that if CQC wish to make this information available to the general public, they will need to consider more user-friendly language. If a general public facing version of the descriptions is developed, we suggest presenting a version which reflects and emphasises patient priorities, as described above.

More generally, service users also resisted the idea that the characteristics described were 'good'. They very much felt that the characteristics described what they would *expect* from a service. CQC will need to explain their interpretation of 'good' i.e. that these are the characteristics that we can reasonably expect.

2.4 Information requirements

Word-of-mouth recommendation was clearly the most influential source of information about services. If considering choice of services, word-of-mouth recommendation would be used to support decision-making. The type of information service-users felt they would need to know from a summary document would reflect the type of information they would seek from a friend/family member. This was a mix of:

- **Functional questions** about the service: how quickly did you get an appointment; how many sessions did you get/how often did they come; and were they any good (meaning did they know what they were doing and were they professional).
- **And qualitative questions** about whether staff were 'nice', meaning were they friendly and caring.

Information requirements from a summary document were largely focussed on reporting inspection findings from the 'effective', 'caring' and 'responsive' domains. Initial findings suggest that service users would be satisfied with minimal information about the safety and well-led domains, as long as CQC's overall rating for these domains was 'good'.