

A fresh start for the regulation and inspection of community health care

Working together to change how we regulate and inspect community health services



The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work
- We are independent, rigorous, fair and consistent
- We have an open and accessible culture
- We work in partnership across the health and social care system
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others
- We promote equality, diversity and human rights

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Foreword from the Chief Executive

During the past six months we have set out a new vision and direction for the Care Quality Commission (CQC) in our strategy for 2013-2016, *Raising standards, putting people first* and in our consultation, *A new start*, which proposed radical changes to the way we regulate health and social care services.

We developed these changes with extensive engagement with the public, our staff, providers and key organisations. Stakeholders in the care sectors have welcomed our proposals, which include the introduction of chief inspectors; expert inspection teams; ratings to help people choose care; a focus on highlighting good practice; and a commitment to listen better to the views and experiences of people who use services.

We recognise that there is much for us to do to strengthen how we regulate community health services and to better reflect its important role in many people's lives as well as in the wider healthcare system. This document sets out the conversations we want to have with all of our stakeholders in the community health sector, including our own staff, the public, providers, people who use services, their families and carers as we develop our new approach for this sector.

A new start set out the new overarching framework, principles and operating model that we will use; this includes the five key questions that we will ask of all services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

We are clear, however, that we will recognise differences within sectors and will develop and apply our model for each of them accordingly.

“ We recognise that there is much for us to do to strengthen how we regulate community health services and to better reflect its important role in many people's lives ”

In this document we set out our priorities for improving how CQC monitors, inspects and regulates community health services. We also set out our intention to give greater priority to community health and our initial thinking about how we will apply our model to this sector. We will continue to engage with key stakeholders and the public to ensure we get this right.

The programme of work set out in this document is hugely important. It will help us to make sure that we deliver our purpose – to make sure services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. If we can achieve that, we hope it will improve the lives and experiences of people who use community health services, their carers and families.



David Behan
Chief Executive



Introduction from the Chief Inspector of Hospitals

In my new role as the Chief Inspector of Hospitals, I will be responsible for overseeing the regulatory activity and assessments of quality of community healthcare services, as well as acute hospital, ambulance and mental health services.

The work on our new approach is gathering pace; so far, our focus has been on developing our model for NHS acute hospitals. We are now starting to look at the approach to regulating community health services. This is an extremely important sector. It supports people to recover from illness and to live well and independently, whatever their conditions are, without the disruption of being admitted to hospital. It works with families and children, supporting their health and care needs.

For this sector, our initial focus is on large, complex organisations that provide a range of NHS community services to people in a local area, including NHS trusts and social enterprise providers.

Where possible, we will align relevant elements of our approach to community health services with other sectors, including domiciliary care, community mental health or learning disability services, substance misuse services, primary care services and acute hospitals.

We will start by piloting our new approach in five organisations, which we will inspect between January and March 2014. We will build on this experience and further engagement for a second pilot phase and plan to roll out the new model in full from October 2014.

Once we have started testing our approach for these providers, we will consider how we can adapt it to smaller community healthcare providers in the independent, social enterprise and voluntary sectors.

At this point, I think we must acknowledge that, not only has the importance of community health care been underemphasised in the past, but that we have not given it enough specific attention in our regulatory work. We therefore recognise that there is much for us to do to strengthen our oversight of the sector – to develop a picture of the quality of care, and to better reflect its important role in many people’s lives, as well as in the wider healthcare system.

We do not have all the answers to achieve this, but set out our proposed priorities below. We can only develop these by genuinely engaging and working with those who work in and receive community health services.



Professor Sir Mike Richards
Chief Inspector of Hospitals

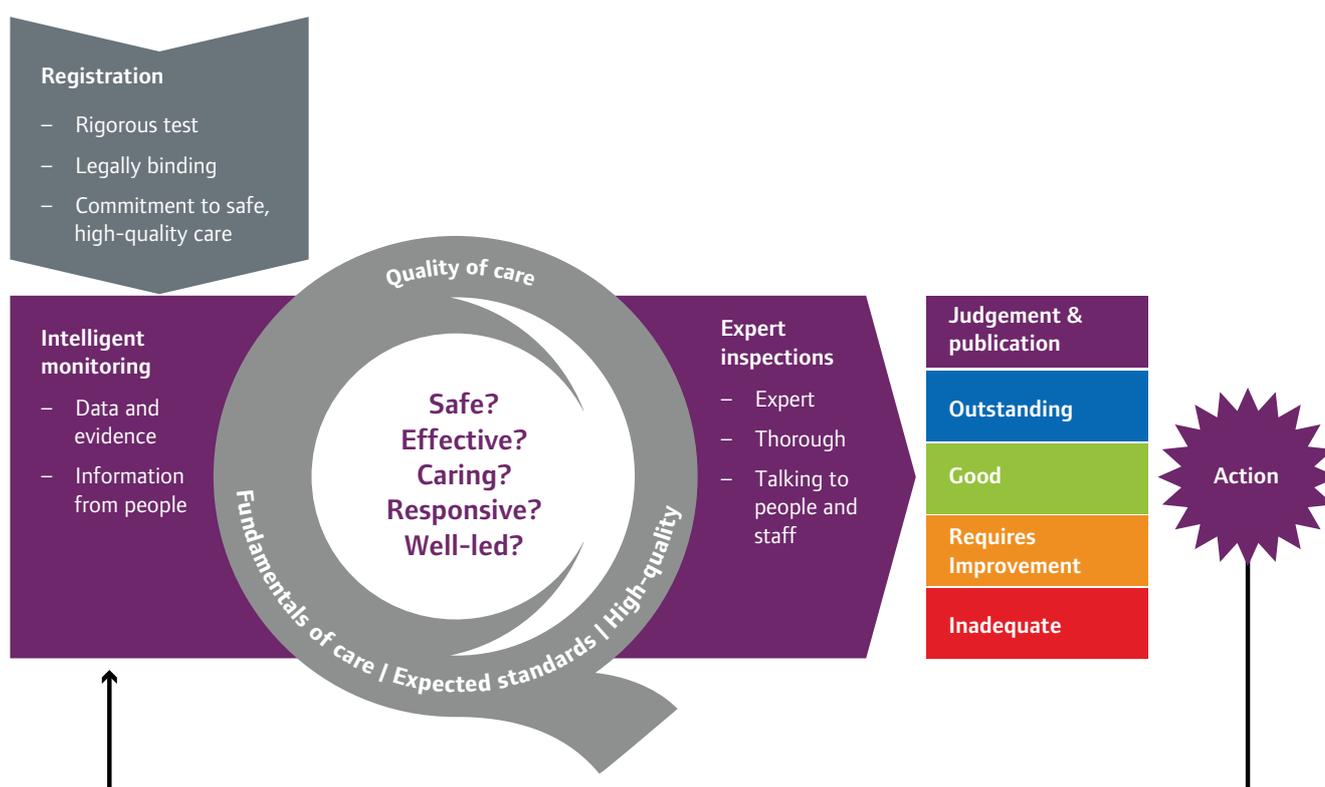


Monitoring, regulating and inspecting community health services

Our consultation *A new start* set out the principles that guide how CQC will inspect and regulate all care services. It described our future ‘operating model’ which includes:

- Registration with CQC to provide health and care services.
- Standards that those services have to meet.
- Better use of data, evidence and information to monitor services.
- Inspections carried out by specialists.
- Information for the public on our judgements about care quality, including a rating to help people compare services.
- Action to require providers to improve, making sure those responsible for poor care are held accountable for it.

FIGURE 1: OVERVIEW OF OUR FUTURE OPERATING MODEL



These principles guide our regulation of community health care, but the detail of how we will do this will be specific to the sector and to the services within it.

Community health services sector that the Chief Inspector of Hospitals will be responsible for

The Chief Inspector of Hospitals will oversee and be responsible for the monitoring, inspection and regulation of community health services, as described below. Other broad healthcare sectors which fall within his remit include acute hospitals, ambulance services and mental health services. Responsibilities cover all services, whether they are provided by NHS trusts, private providers, the voluntary sector or social enterprises.

Main characteristics of community healthcare services

Community healthcare organisations provide a range of services for adults and children. These include universal services to specific groups, particularly children and families, as well as more specialist and enhanced healthcare services.

Care and treatment services that fall within the community healthcare sector include the following:

- District nursing services
- Health visiting services
- School nursing services
- Community rehabilitation
- Community therapist services
- Specialist nursing services for people with long-term conditions
- Hospital at home services
- End-of-life care delivered at home
- Specialist community dental services.

People may receive community health services on an ongoing basis; to provide additional support to manage an episode of poor health; or following serious illness or injury where they may receive a

package of rehabilitation care. These services are focused on providing person-centred, coordinated care, to people who often have multiple and complex needs. This includes supporting people to live independently and managing transitions between different types of services. Community health services also have an important role in health promotion and prevention and early intervention.

More and more healthcare services are delivered in community settings, including people's homes, health centres and community hospitals. Care is getting more complex as some acute services are moved out of hospital settings and, where appropriate, people are being cared for where they feel most comfortable, such as in their own home. Some people may receive a range of community health services, as well as other care and support services, at the same time. This increases the need for services to be coordinated within an organisation and for it to work well with other local providers and agencies.

“Community health services have an important role in health promotion and prevention and early intervention”

Community health care often involves multi-disciplinary teams which may include a range of professionals such as:

- Community nurses, including district nurses, health visitors, nurse specialists and school nurses.
- Allied health professionals, such as physiotherapists and occupational therapists.
- Doctors, including paediatricians, geriatricians, and GPs.

Our initial focus for our approach to regulating community health services will be on the large

organisations that are commissioned to provide a wide range of NHS services to local people. We will then adapt our approach to smaller, or single-service community healthcare providers in the independent, social enterprise and voluntary sectors.

Community health services – large, complex NHS providers

There are around 100 organisations across England that provide a wide range of NHS care and treatment services in a community setting to local people.

These organisations provide a mixture of universal and specialist services for adults and children. They usually have large numbers of teams and services, and deliver care in a variety of ways across a range of locations. Key features include:

- Care locations that are spread across a local community.
- Care given at home, including in care homes and nursing homes.
- Clinics held locally, such as in health centres, children’s centres, GP practices.
- Community hospitals.
- Remote advice and support over the telephone and using telemedicine (via the internet).
- Coordination of services.

This is a varied group of providers, which includes NHS community health trusts, as well as a large number of mental health trusts and acute trusts that provide local community services. There is also a group of large social enterprises and independent sector providers that are commissioned to provide these NHS services in a number of local areas.

Even within community health trusts, provision may not be limited to community health services as they may also provide things such as prison health care, urgent care centres or social care services.

Our regulatory model for community health services focuses on the types of services described above. It does not, for example, cover community mental health and learning disability services, community substance misuse services, domiciliary care services, primary care services or prison health care services. We are developing specific regulatory models for each of these areas and other health and social care sectors. Wherever relevant we will align our approaches across sectors where they have common characteristics and we will use a combination of sector modules where more than one type of service is provided.

“ We plan to inspect a greater number of services and have better coverage across all areas of care handled by a provider ”

Main changes to the way we regulate community health services

There are some aspects of our current regulatory approach that we will build on, but there are some significant issues that we must address for this sector. The main changes we plan to make are shown below.

Main changes to the way we regulate community health services

We plan to:

- Inspect a greater number of services and have better coverage across all areas of care handled by a provider.
- Have a greater focus on services provided in community clinics or in people's homes, which is where most people receive care, as well as locations where care is directly provided, such as in community hospitals.
- Set a clear expectation about what good-quality care looks like in this sector.
- Make better use of the different inspection methods we use to assess care in people's homes.
- Be more consistent in how we gather views from people who use community health services, their families and carers as well as staff before and during inspections.
- Improve our understanding of how well services are governed across widely dispersed locations and teams.
- Introduce bigger and more specialist inspection teams, reflecting the way services are structured.
- Introduce ratings for community service providers.

Other ideas we want to discuss

How can we:

- Work with the sector to improve the availability of data?
- Look at pathways of care for people with particular conditions to assess the quality of care and how well services are working with each other?
- Use technology better to capture people's views and experiences?
- Ensure that we are looking at community health services in the same way, regardless of who is providing them?



Our priorities for developing the new regulatory approach

Priority 1: Shining a light on a vital set of services

As far as possible, our new approach for community health services will align with our work in other sectors, ensuring that we are consistent and proportionate, while providing meaningful information for people who use services. However, there are some key features of the new approach which we need to develop for community health services. These are set out below. The development of these areas is at different stages, and we will use the piloting, development and engagement phase to explore and evaluate different options for our new approach.

Developing a rating system

We will not give a rating, formally or informally, for any of the community health services that we inspect in the first pilot group (wave 1) between January and March 2014. However, once we fully launch our new approach, we will rate services on a four point scale:

- Outstanding
- Good
- Requires improvement
- Inadequate

Between now and March 2014, we will develop our approach to determining a rating by:

- Evaluating the questions we need to ask about the quality of care and the information we need to support this.
- Considering what the key characteristics of community services are at these different rating levels.
- Ensuring that these ratings represent a level playing field across the different sectors that we regulate.

We will also use this time to consider the best approach for determining a rating from our inspections and the tools and methods that we will need to support it.

We will work with a range of stakeholders, including those who provide and use community services, in determining our approach to rating this sector. We will seek their advice on the unit that we will rate, particularly for large complex providers, to ensure that ratings are provided at a level that is most helpful to those who use services (for example, each community hospital, or in smaller local areas).

Once we have implemented our ratings system the frequency of our inspections will be based on our ratings of a service. However, we will be able to bring forward an inspection of a provider rated ‘good’ or ‘outstanding’ if we receive concerns from people who use the services, staff or others, or if we are alerted to a potential decline in quality through our intelligent monitoring analysis.

Clear quality standards for community health services

At the moment, it is not always clear what good, effective care looks like in community health services. We will change this by defining what good-quality care looks like in relation to the five key questions above. We will work with the public, people who use services, providers of community health services and professional groups – such as nurses – to do this. Our definitions will drive our ratings, which will be the authoritative judgement of the quality of care provided.

Expert, multi-disciplinary teams

Our inspection teams will be bigger and include specialists. As far as possible, we want to make sure that people on the teams have relevant experience of the specific areas they are looking at. Teams will include:

- Expert inspectors – CQC inspectors will have, or will develop, specialist knowledge of community health services.
- Sector specialists and clinicians – we will use a range of external specialists to help us with our inspections; for example, nurses, health visitors, allied health professionals such as occupational therapists, GPs, paediatricians, sector directors and managers.
- Experts by Experience – our comprehensive inspections will always involve people who have experience of using care services.

As a large proportion of acute and mental health NHS trusts also provide community health services to their local population, we need to develop an

effective and efficient approach for combining our separate modules of assessment that gives sufficient weight to each element. Our working assumption is that our inspections will involve a combined team carrying out a joint inspection, rating services (for example, acute services and community health services) separately, but providing an overall rating for the trust.

We will use our testing during 2014 to consider what this means for:

- The size, composition and leadership of inspection teams.
- Our assessment of integration between care pathways across different parts of an organisation.
- How we rate a combined provider and reflect the different types of core services.
- What information we provide to the public about combined providers.

“ We will work with the public, providers and professionals to define what good looks like in community health services ”

Inspecting large and dispersed services

Our inspection teams will be bigger and will spend more time visiting providers. However, it is still very unlikely that we will be able to inspect every location and every community team within a large, complex community health provider. Our inspection approach will need to use sampling to ensure we have an appropriate level of coverage and look at a good range of services, locations and local areas. As there will still be some gaps, our assessment of a provider’s approach to governance will look for evidence that quality and risks are

well managed across all services. We will also ask how assurance is given at different levels of an organisation from board level to frontline delivery.

Celebrating good care and exposing poor care

The main objective of our new approach is to more effectively assess the quality of care and identify concerns at individual providers, and also to generate a picture of quality for the sector. Our assessments and information will be used to shine a light on quality and to encourage services to improve so that people receive good-quality care.

Based on our inspection and the information we receive about a provider, we will make judgements on how well it is performing. We will publish reports which clearly set out our judgement and the evidence we have used. Where we have concerns and we decide it is necessary, we will take enforcement action. Where we have significant concerns about an NHS trust we will work with and make recommendations to Monitor or the NHS Trust Development Authority about the actions which may be required to ensure people receive good-quality care. This may include a trust being subject to the new single failure regime, including being placed in special measures. We will publish further information about the development of this during the next few months.

Following an inspection we will hold a quality summit with the provider, commissioners, other

regulators, local Healthwatch and other local partners. These summits will give them the opportunity to hear about the findings of the inspection and to focus on the next steps needed if the provider needs to improve. We will publish our inspection reports on our website as soon as possible after the quality summit in a way which is meaningful and accessible to the public.

Providing assurance about foundation trust applicants

We acknowledge that many community healthcare NHS trusts are currently going through the application process to become a foundation trust, or are intending to start this soon. These trust applications are dependent on our new approach inspections being successfully implemented, as they will play a key part in giving assurance about the quality of services.

Where a trust has a new approach inspection, including as part of our pilot, one of our clear objectives will be to generate a view about quality that can feed into the application process. We will work with Monitor, the NHS Trust Development Authority and providers to schedule our pilot inspections to ensure, as far as possible, that we prioritise trusts appropriately. Once the new approach is fully launched, a trust will only be able to become a foundation trust if it is rated as good by CQC.

Priority 2: Basing our judgements around whether people's needs are met

What does 'good' look like?

Our new approach will ask our five key questions of all services:

- Are they safe?
- Are they effective?

- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

For community health services, we will reflect the characteristics of the sector, what people who use these services want to get from them, and their

central role in the care system. When we consider these five key questions for community health services, we will pay particular attention to:

- The need for services to provide person-centred, coordinated care, to people who often have multiple and complex needs. This includes supporting people to live independently and managing transitions between different types of services.
- The provision of universal services to specific patient groups, such as new mothers, babies and children, with a focus on improving health and early intervention to identify people who need enhanced services.
- Their role in preventing people being inappropriately admitted and re-admitted to hospital.
- The increasing provision of acute services in community settings.
- The need for services to have good partnerships and coordination with primary care, secondary care and social care services.
- The need to ensure the quality of services dispersed across a large local area, delivered by multi-disciplinary teams, and often in people's homes or by the increasing use of telemedicine.

People's experiences will be at the heart of our assessments and we will work with stakeholders to describe standards based on 'what good looks like' through their eyes. We also need to take account of good clinical practice from a professional perspective. Areas we may cover include:

- Access to services beyond core office hours.
- The effectiveness of care and supporting people to live at home.
- Preventing people from being admitted and re-admitted to hospital inappropriately.
- The quality of long-term conditions management.
- The quality of integration across health and care services, for the benefit of the patient.
- The sharing of medical records (with the patient and across the system).

What are the core services that will always be inspected?

We will identify a set of services that we will always inspect for a community health provider. It is likely that these core services will also be rated. The choice of core services must be relevant to people who use services and the public and it should be clear what is in the scope of each area.

In our pilot phase, when we will be testing our approach, we will structure our inspections around services for:

- Children and families (including universal and specialist services).
- Adults with long-term conditions (including district nursing, specialist and rehabilitation services).
- Adults requiring community inpatient services (we will visit all community hospitals).
- People receiving end-of-life care.

We will work with the sector and with patients and the public to look at a range of other options. These include:

- Specific services – for example, district nursing, community hospitals, health visiting, intermediate care, specialist dental services.
- Areas of practice (broadly based on the areas of practice defined during the Transforming Community Services programme) – for example, rehabilitation, long-term conditions, children's services, end-of-life care, acute care closer to home, health and wellbeing.
- Care pathways – for example, stroke, diabetes, chronic obstructive pulmonary disease, continence care, dementia, wound care, and people with complex needs.

The final approach may be a combination of these options.

Priority 3: Developing our information to monitor providers

Finding out what people and staff think about services

We will make better use of information from people who use services, their families and carers and put the views of people at the centre of what we do. We will explore different ways of gathering and using feedback. For example, we will:

- Find ways to proactively seek views from local representative and advocacy networks and groups before and during inspections. This will help us target our activity around particular groups of people and to particular areas of risk.
- Encourage community health staff to share their views on how services are operated in an area, and whether this provides the best way of meeting people's needs.
- Develop more consistent and innovative methods of gathering the views of people using services during our inspections. This will include thinking about the use of technology and how we gather the views of people who receive care in their own homes.

In addition to developing a sector-specific approach for gathering views, our vision is that CQC will become a more trusted organisation, to whom anyone with any concerns or comments, including whistleblowing, will turn to. People will feel listened to with compassion, and be assured that we will use their feedback to inform our inspection activity and our judgements.

Building a better data and intelligence resource to compare similar services

In future, CQC will make much better use of intelligence and data to target our inspections and to ensure we focus on areas of particular risk or concern. We will gather and analyse a wide range of available information, including nationally comparable data, feedback from people who use services, feedback from staff, information from national and local partner organisations, and information directly from providers.

In the community healthcare sector we recognise that the availability of nationally comparable data about the quality of services is very limited. We will gather what we can, but the development of this part of our monitoring activity is likely to take more time than in other sectors. We will work with key stakeholders and the sector to improve and influence the range and quality of data that is collected and shared across the system.

As there is limited national data available we will focus our attention on gathering other available information about quality before our inspections start. We will engage with providers, commissioners and other national and local partners to ensure we have access to up-to-date information about the quality of services to inform the planning of our inspections and our judgements and ratings. We will use our pilot inspections to test out different methods for gathering this information, to understand the range of information that is available and how we can make best use of it.

What will happen next?

CQC is committed to developing changes to how we inspect and regulate in partnership with the community health sector, the public and with groups representing patients, families and carers.

We have set up a reference group to engage with key stakeholders from within the sector and have recently met for the first time. This group will continue to support us by contributing to the design and development of our methods and approach by providing expert advice, opinion and challenge. In addition to this group, we will set up smaller task and finish groups to ensure experts from the sector can contribute and help us to develop our inspection framework. For example, we will be doing specific engagement to develop our approach to assessing children's community health services and also on how we assess governance and leadership of large community health providers with dispersed services.

Current proposed timeline

As we develop our new approach we will engage with key stakeholders and the public to ensure we reflect the key characteristics, risks and quality issues within the community health sector. We will refine and learn as we go to produce a meaningful system of inspections and ratings. The timeline for the development and implementation of our new approach is set out below.

January – March 2014:

- Engagement with internal and external stakeholders on the five key question areas, intelligent monitoring, ratings development and methods
- Meetings with the external advisory group and other working groups
- Department of Health consultation on amendments to regulations (may be subject to change)

- Formal consultation on guidance for the new regulations and CQC's enforcement policy; information on the Single Failure Protocol published for information (may be subject to change)
- Wave 1 pilot inspections of NHS community health services with ongoing evaluation of the new approach and methods. Wave 1 providers are:
 - Bridgewater Community Healthcare NHS Trust
 - Derbyshire Community Healthcare Services NHS Trust
 - Provide (Central Essex Community Services Community Interest Company)
 - Solent NHS Trust (community health and mental health services)
- Wave 2 pilot inspections of NHS acute hospital trusts, includes inspections of community services for one combined trust:
 - St Georges Healthcare NHS Trust (acute and community health services)

March 2014:

CQC public consultation on approach for community health services published

April – September 2014:

CQC community health services wave 2 pilot

October 2014:

Rollout of the new CQC community health services inspections and ratings

Although this is not a consultation, we would like to hear your views on any of the priorities and changes that we have set out in this document. If you would like to get in touch, please email us at: cqcinspectionchangesCHS@cqc.org.uk

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