# CQC Community Health RPIR

## NHS & Combined Trusts

## Information & Metric Additional Guidance for Providers

This document provides guidance to the ‘Routine Provider Information Return (RPIR) Additional Questions’ for Community Health providers, and the supporting rationale for each metric*

*metric in this instance may refer to a request for information or a free text question as well as traditional measures

## Contents

# Routine Provider Information Return – Additional Questions

## Introduction

This document provides a brief overview of the rationale for the information requested in your Routine Provider Information Request (RPIR), details which Key Line of Enquiry requests align to where relevant and provides detail on the type of information required for each individual request. Further to this document detailed guidance is also included in the RPIR workbook itself.

The RPIR is sent to an organisation once annually and provides a provider's view of their own quality, some quantitative and qualitative data and some contextual information around services provided or national data.

The RPIR It is formatted into four separate documents; firstly, a universal PIR that all NHS trusts will receive and are required to complete and then three separate documents with additional requests relevant to either acute, community health or mental health trusts. As routine all trusts will receive the universal PIR and then additional components of the RPIR depending on which services which they provide (i.e. an organisation exclusively providing mental health services will receive the universal PIR and the PIR relevant to mental health only). Combined providers will receive a mix of these that matches their make-up.

The RPIR is formatted as Excel workbooks that contains a mixture of quantitative and qualitative questions that we would like you to answer, as well as a list of documents that we require you to submit. The workbooks allow CQC to gain a deeper understanding of the provider performance and the core services that it provides.

**Please note:** We recognise not every organisation is structured the same way and so we have tried to adapt the PIR to be flexible enough to allow for this. However, in instances where you are worried your structures make it difficult to complete the PIR please contact your named CQC contact as soon as possible to discuss. We have also included an appendix sheet which lists the mapping CQC methodology uses to determine which speciality sits under which core service. You may find it useful to use this to help you extract data.

**Navigation**

Guidance document – in the contents page the Press Ctrl on your keyboard and click on a heading to navigate to that section in this document.

RPIR workbooks - The workbook has a contents page which hyperlinks to all sheets. All sheets have a back button which hyperlink back to the contents page.

**Data sharing agreement**

We will share the data from the RPIR with NHS Improvement (NHSI) as part of our priority to promote a single, shared view of quality. We are also negotiating access to their data which will enable us to drop some questions from this document to avoid duplication of submission.

If there is anything you would not be happy for us to share with NHSI please do let us know.

## Key Points

**When completing your RPIR:**

- Time periods are included for all requests however please note the following:
    - Where we refer to the last 12 months we mean from the time you are filling in the workbook.
        - Where we mean financial year or year to date (YTD) this is specified.
        - When we ask for data monthly we would like month one (M1) to be 12 months ago and month 12 (M12) to be the most recent data.
        - Please use the last complete month of data for the most recent month, please don't use the current month if you do not have a complete month of data yet.
- Cells for provider completion are highlighted in yellow.
- In the tables please do not enter 0 if it is not relevant or provided, please leave blank, for example if a ward/team was closed for a period of time, leave the cells blank. If you do provide the service but the answer is a true zero, then please input a 0.
- If you do not provide a service or cannot provide the data, please let us know why in the 'Question List' tab. Context can be provided in the 'Notes' column.
- Where we are asking for data by team / ward, please provide this for every team/ward unless the sheet advises otherwise. [i.e. for sickness fill in every single team / ward, even if it means adding 0 in].
- Please try and limit narrative answers to 250 words, or the limit designated. We recognise the word limit is tight and welcome brief, high level responses, or even bullet points. As these answers are a starting point for potential discussion or context around data we already hold so do not need to be exhaustive.
- Where we ask you to provide documents you do not always have to do this. We recognise you may not participate in all audits, collect the information we have asked for or in some instances a document may be impractical to send. In the box called 'Provided to CQC' please indicate whether you have provided documents or not and we will follow up as required.
- In sections where we ask for information by staff groups we use the standard ESR grouping specified by NHS Digital which can be found here: https://digital.nhs.uk/data-and-information/areas-of-interest/workforce/national-workforce-data-set-nwd-guidance-documents.
- Please ensure, to the best of your ability, that all Core Service mapping is mapped against the signed off "sites tab".
- We have included a provider validation sheet so you can check the overall calculations used by CQC at provider-wide level. Any discrepancies need to be resolved in the raw data. This sheet is for the provider's use only as a self-validation check. If you have any queries on the formulas used or issues with the sheet, please contact your named CQC contact.
- We have protected the formatting and sheets in the document. Whilst you can work off multiple versions of the workbook so that individual tabs can be completed by the relevant staff member, please ensure the workbook is compiled back into its complete form before submitting. Please note, any individual locked cells in provider documents should be avoided as this will prohibit the data from being changed once pasted into the template. Any feedback on the format or issues inputting data due to validation please contact your named CQC contact or RPIRqueries@cqc.org.uk.
- There is a hidden sheet called 'no edit' sheet which feeds data into other sheets (for example the drop-down boxes). Please do not amend this unless advised to do so by your CQC liaison.

**When submitting documents:**

- For all documents submitted please ensure that the appropriate RPIR ID indicated for each return is included as part of the file name (e.g. P1 etc.) and is the first word in the document title. We request you use the following naming convention for files RPIR ID /trust ODS code/ Document name (e.g., P69 RZZ Infection Control Report 2017).
- When returning documents please do not embed documents. We often have issues downloading these from our document storage system.
- If documents are password protected or coded please remember to tell us.
- Documents may be submitted in any commonly recognised office format (e.g. Word, Excel, PDF) but we ask that quantitative data is not submitted as a PDF so that we are able to analyse it.
- Whilst you can work off multiple versions of the workbook so that individual tabs can be completed by the relevant staff member, please ensure the workbook is compiled back into its complete form before submitting.
- Please refer to the accompanying letter for instructions on how to submit your completed PIR workbook and any related documents via our online portal.

# Community Health (CHS) Provider Information Requests

**Description of all CHS services**

| | |
|---|---|
| RPIR ID | CHS1. Context CHS |
| Question | Please provide a brief description of each core service as it is reflected in your organisation. |
| Definition | An opportunity for trusts to give their own description of how the core services are reflected in their organisation. |
| Points to note | • You can draw our attention to any unusual commissioning arrangements or organisational structures here.<br>• There is also the chance to highlight any additional services you provide that we may wish to consider inspecting. Detailed guidance about what we might consider can be found on our website http://www.cqc.org.uk/guidance-providers/nhs-trusts/when-we-will-inspect-nhs-trusts<br>• Where possible please try to adhere to the 250 word-limit.<br>• If you do not provide a particular core service, please leave blank |
| Time Period | Current |

**List of End of Life Care – Networks and partners**

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|---|---|
| RPIR ID | CHS2. EOLC - Networks |
| Question | Provide a list of hospices EOLC networks and partners you work with |
| Definition | A list of any EOLC networks the provider is part of and any partners (for example local hospices or Macmillan Cancer Care). This provides context, so we can make sure we only look at the services you provide, but also allows us to contact partners for feedback if we would like to do so. |
| Points to note | • The word limit is not fixed to 250 if you need to use slightly more (up to 10% more)<br>• End of life care is support for people who are approaching the last months or years of their life and following death. |
| Time Period | Current |

**Maternity Overview**

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| RPIR ID | CHS3. Mat overview |
| KLOE Heading | How are people's care and treatment outcomes monitored and how do they compare with other similar services? |

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| For KLOE Prompt(s) | E2.3 How do outcomes for people in this service compare with other similar services and how have they changed over time? |
| Question | Maternity Overview: Birth Numbers, Still births and early neonatal deaths, consultant hours, epidural, admission to delivery time, delivery environment, transfers. |
| Definition | An overview of maternity services provided including numbers of births by location type, still births and neonatal deaths, transfers, consultant cover and planned delivery location. |
| Points to note | • If possible, please try to align all dates to the same 12-month period.<br>• Please complete table 11 if you cannot complete any of the other tables.<br>• Please try to adhere to the 250-word limit where possible.<br>• All date fields should be in standard date format, and not include any text.<br>• Include home births as a separate location.<br>• List all sites and locations separately.<br>• Please ensure you input percentages in the correct columns.<br>• Please ensure your percentage calculations in table 8 are accurate.<br>• Ensure that you use hours where requested, and use minutes where requested.<br>• Ensure the data provided in table 8 & 9 are present in the relevant area of table 10 – as they should total the same number. |
| Time Period | Year 1 Last 12 months, Year 2 Previous 12 months |

**Clinical Supervision**

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|---|---|
| RPIR ID | CHS4. Clin Supervision |
| KLOE Heading | How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment? |
| For KLOE Prompt(s) | E3.4 What are the arrangements for supporting and managing staff to deliver effective care and treatment? |
| Question | Clinical supervision rates at team level |
| Definition | A description of what clinical supervision arrangements are in place for your staff. |
| Points to note | • This is NOT an appraisal<br>• We define supervision as “an accountable process which supports, assures and develops the knowledge skills and values of an individual group or team”<br>• Please try to adhere to the 250-word limit where possible. |

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| Time Period | Current - Last 12 months |

**Multidisciplinary Team Working**

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| RPIR ID | CHS5. MDT |
| KLOE Heading | How well do staff, teams and services work together within and across organisations to deliver effective care and treatment? |
| For KLOE Prompt(s) | E4.2 How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved? |
| Question | Provide brief details of the MDT provision for the intermediate care team |
| Definition | Provide a brief overview on what MDT provision is available to the intermediate care teams, how this is accessed and any other comments you wish to make |
| Points to note | Please try to adhere to the 250-word limit where possible. |
| Time Period | Current |

**Education**

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|---|---|
| RPIR ID | CHS6. Education |
| KLOE Heading | Do services take account of the particular needs and choices of different people? |
| For KLOE Prompt(s) | R2.7 Where the service is responsible, how are people supported to follow their interests and take part in activities that are socially and culturally relevant and appropriate to them, including in the wider community and, where appropriate, to have access to education and work opportunities? |
| Question | Education Overview |
| Definition | An overview of how their educational needs are met and links to any external reviews of education provided (e.g. OFSTED reports). |
| Points to Note | • Only relevant if you have children and young people as inpatients.<br>• The word limit is not fixed to 250 if you need to use slightly more (up to 10% more) |
| Time Period | Current – within last 12 months |

**Bed Occupancy and Length of Stay**

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|---|---|
| RPIR ID | CHS7. Bed Occ & LOS |
| KLOE Heading | Can people access care and treatment in a timely way? |
| KLOE Prompt(s) | R3.3 What action is taken to minimise the length of time people have to wait for care, treatment or advice? |

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|---|---|
| Question | Please provide bed occupancy figures by ward by month for a year. Also, length of stay in the same format. |
| Points to Note | For bed occupancy:<br>• The calculation is inpatient days / available bed days<br>• For wards open overnight, an occupied bed day is one which is occupied at midnight on the day in question.<br>• Bed occupancy should not be 0% when there is greater than 0 length of stay days.<br>For length of stay:<br>• Leave must be included (including Home Leave, Mental Health Leave of Absence or Mental Health Absence Without Leave)<br>• Patients admitted and discharged on the same day have a LOS of zero days |
| Time Period | Last 12 months |

**Caseloads**

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| RPIR ID | CHS8. Caseloads |
| KLOE Heading | How well do staff, teams and services within and across organisations work together to deliver effective care and treatment? |
| KLOE Prompt(s) | R3.3 What action is taken to minimise the length of time people have to wait for care, treatment or advice? |
| Question | For all community staff teams, we would like to know the caseloads they have had by month for a year. We would also like to know the ideal number or target number and the maximum number. |
| Definition | A volume or list of patient referrals belonging to a healthcare professional. |
| Points to Note | • Please add up your patient caseloads and divide it by the number of staff within each team (i.e. do not double count cases which may be shared between staff members).<br>• This information is required on a team by team basis.<br>• Please see appendix for core service definitions, map teams/wards to the same core services agreed in the sites tab<br>• Please provide a narrative in the box at the bottom, even if you cannot provide any data in the table |
| Time Period | Last 12 months |

**Children & Young People Mental Health Services (CYPMHS) and Transition Services**

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| RPIR ID | CHS9. CYPMH |
| KLOE Heading | Can people access care and treatment in a timely way? |
| KLOE Prompt(s) | R3.4 Do people with the most urgent needs have their care and treatment prioritised? |
| Question | Children and young people mental health services and child transition services |
| Definition | An overview of CYPMHS services. Who provides them and how they are accessed during times of crisis or out of hours. The number of CYPMHS patients who were admitted as inpatients to an inappropriate area for their safety (e.g. adult unit/wards). An overview of the transition from children to adult services, not CYPMHS specific but any service provided |
| Points to Note | • Transition service = Transition from children to adult services<br>• The word limit is not fixed to 250 if you need to use slightly more (up to 10% more) |
| Time Period | Current |

**Referrals**

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|---|---|
| RPIR ID | CHS10. Referrals |
| KLOE Heading | Can people access care and treatment in a timely way? |
| For KLOE Prompt(s) | R3.1 Do people have timely access to initial assessment, test results, diagnosis or treatment? |
| Question | Provide the referral pathways data for each team. Days from referral to initial assessment and then the days from referral to onset of treatment. Tell us what the target is, how this target was agreed and what the actual performance is. |
| Definition | Referral to treatment should be calculated as described in NHS data dictionary:<br>Referral to treatment<br>Referral to treatment start date<br>Referral to treatment end date<br><br>For the 'service type' column the definitions used correspond to the ones in the Data Dictionary:<br>Service type<br>Service or team type for community health |
| Points to note | • Please see appendix A for core service definitions, map teams/wards to the same core services agreed in the sites tab<br>• Please include all wards/teams for CHS core services<br>• Please provide a comment for any ward/team you cannot provide any targets or data for. |
| Time Period | Most recent full 12-month period |

# Document Requests

**Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) report and Radiation Protection Advisor reports**

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|---|---|
| Information Request ID | CHS11 – Document(s) to provide |
| KLOE heading | Risks to patients assessed |
| KLOE Prompt(s) | S2.6 |
| Guidance | Copy of the latest IR(M)ER report and Radiation Protection Advisor reports |
| Time Period | Last 12 months |

**Minutes Psychiatric Liaison Service**

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| Information Request ID | CHS12 – Document(s) to provide |
| KLOE heading | How are people's care and treatment outcomes monitored and how do they compare with other similar services? |
| KLOE Prompt(s) | S2.5 How do staff identify and respond appropriately to changing risks to people, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? Are staff able to seek support from senior staff in these situations? |
| Guidance | Provide the minutes of meetings with psychiatric liaison teams |
| Time Period | Last 3 meetings |

**Quality Indicators for District Nurse response times**

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|---|---|
| Information Request ID | CHS13 - Document(s) to provide |
| KLOE heading | How do people receive personalised care that is responsive to their needs? |
| KLOE Prompt(s) | R1.2 Where people's needs and choices are not being met, is this identified and used to inform how services are improved and developed? |
| Guidance | Only relevant if you provide district nursing staff. Please provide the local quality indicators, agreed with commissioners, for district nurse response times and the current performance against these. |
| Time Period | Last 12 months |

**Waiting times for diagnostics**

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|---|---|
| Information Request ID | CHS14 - Document(s) to provide |
| KLOE heading | Can people access care and treatment in a timely way? |

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|---|---|
| For KLOE Prompt(s) | R3.1 Do people have timely access to initial assessment, test results, diagnosis or treatment? |
| Guidance | The waiting times, by team/core service for diagnostics presented by month |
| Time Period | Last 12 months |

**Reporting times for radiology**

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|---|---|
| Information Request ID | CHS15 -Document(s) to provide |
| KLOE heading | Can people access care and treatment in a timely way? |
| For KLOE Prompt(s) | R3.1 Do people have timely access to initial assessment, test results, diagnosis or treatment? |
| Guidance | Provide the Radiology reporting times for the last year. |
| Time Period | Last 12 months |

# Appendix A: Community health core services

**CHS – Adults Community**

This includes any health services provided to adults in their homes and community based clinics. Services covered by this core service include: Community nursing services, including district nursing, community matrons and specialist nursing services and also integrated care services: A range of care is provided such as long-term condition management, case management and coordination of care for people with complex needs or multiple conditions, wound care, medicines management and acute care provided at home. Intermediate care in the community: Usually short-term care involving a range of professionals providing symptom and condition management or more intensive rehabilitation provided after people leave hospital or following an exacerbation of symptoms with the aim of helping to maintain independence, or avoiding the need for hospital admission or residential care. Community rehabilitation services: - Rehabilitation and reablement following illness or injury usually involving a range of therapists, nursing and medical staff. Community outpatient and diagnostic services. Prevention and health promotion services.

**CHS - Children, Young People and Families**

This covers any services provided to babies, children, young people and their families in their homes, community clinics, or schools. The services include: Universal health services and health promotion (such as health visiting and school nursing). Delivery and coordination of specialist or enhanced care and treatment including specialist nursing services, therapy services and community paediatric services. These services provide and coordinate care and treatment for children and young people with long-term conditions, disabilities, multiple or complex needs, and children and families in vulnerable circumstances.

**CHS – Urgent Care**

24/7 services providing face-to-face patient care (such as, walk-in centres, minor injury units and urgent care centres –also known as Urgent Treatment Centres). All urgent care services should act as a consistent access point to urgent care 24/7. This does not mean that the service will be open and staffed 24/7 but, when closed, arrangements will be in place to ensure patients can access alternative services, such as NHS111, GP out-of-hours, the ambulance service or similar arrangements.

**CHS - Sexual Health**

Services for people of all ages. This includes services provided to people in community clinics, at outreach events (such as sexual health stalls run by clinics at school, university, LGBT events) and in some cases in their own homes. Example of services covered by this core service: STI screening, diagnosis, treatment and prevention, Contraception services – including emergency contraception, Other GU services, Specialist HIV testing, treatment and care services, Health promotion and healthy relationship advice, Psychosexual medicine and counselling, and Contact tracing/ partner notification for sexual partners at risk of STI.

**CHS - Community Dental**

Services for people of all ages. Community dental services are all commissioned by NHS Area Teams and are either delivered through Personal Dental Service (PDS) agreements with NHS trusts or Community Interest Companies (CIC), or though NHS contracts for specified services. They usually provide care which is not provided by primary dental practices.

**CHS - Community Inpatient**

This includes all inpatient and day case wards in community hospitals. Examples of the care provided include: Inpatient rehabilitation, Inpatient intermediate care, Inpatient nursing and medical care for people with long-term conditions, progressive or life-limiting conditions or for those who are old/frail people, and Minor surgical procedures.

**CHS - End of Life Care**

End of life care encompasses all care given to patients who are approaching the end of their life and following death. End of life care helps people with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

End of life care may be delivered by community health services in a community hospital, to people in their own home or in hospices. It includes aspects of nursing and personal care, specialist palliative care, and bereavement support. End of life care may be provided by specialist palliative care teams, including nurses, doctors and therapists, or they may be more general services, for example delivered by district nurses. Multidisciplinary working is a key feature of care and there will usually be links with various other local services including acute hospitals, voluntary sector providers, GPs and social care providers.