

Managing quality in community health care services

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1 Key messages

- This paper reports on the findings from a small primary research study exploring how community health services providers define, measure, manage and improve the quality of care.
- Community health services are an essential component of providing person-centred, co-ordinated care. They are a diverse sector, providing a huge range of different services, and are run by a mixed economy of types and sizes of organisation, including standalone NHS community trusts, existing acute and mental health trusts, social enterprises and independent sector providers.
- Community services providers told us how they were working hard to measure, manage and improve quality. There is considerable local activity to gather and use information on quality, and some providers have impressive systems of quality governance in place.
- However, community services providers are severely hampered by a lack of robust, comparable national indicators that would enable them to benchmark their performance. National datasets provide very limited insight into quality in community services, and the information technology and infrastructure are not well enough developed to support quality measurement.
- This lack of data means that the quality of community services and the outcomes it is providing for patients remain to a large extent unknown at the national level. This problem is greatest for care provided by non-NHS organisations.
- This is particularly dangerous in the coming years as community services providers experience significantly growing demand and face acute workforce challenges. There is a serious risk that poor or declining quality will not be identified promptly.



- Policy-makers and service leaders aspire to a health care system that more effectively supports people to remain well and independent, and cares for people as close to home as possible. The community services sector should be integral to this vision. However, there remains relatively little national policy focus on quality in community health care. This needs to change. If community health services are to fulfil their potential, and indeed to cope in the years ahead, greater attention must urgently be paid to ensuring that quality information and management systems in community services are developed and supported.



2 Introduction

Community health services are a vital part of the NHS for millions of people, with around 100 million contacts each year. They comprise approximately £10 billion of the NHS budget (Lafond *et al* 2014) and cover a huge range of essential services (see Table 1 for a list of some of the largest types of services provided in the community).

Table 1 Overview of some of the main community health services and their principal functions

Community nursing	Community nursing involves district nurses, health visitors, mental health nurses and paediatric community nurses. District nurses typically look after older people, those recently discharged from hospital and people who are terminally ill or who have physical disabilities, in their homes or community settings. Care involves, for example, delivering intravenous antibiotics at home and caring for wounds. They help patients manage long-term conditions (eg, diabetes, stroke, COPD and dementia). Community matrons work closely with patients to provide, plan and organise their care. They mainly work with those with a serious long-term or complex range of conditions.
End-of-life care	District nurses co-ordinate end-of-life care, assessing a patient’s needs and deciding in consultation with the patient and family what support is required. Hospice or palliative care staff work alongside them.
Health visiting	Health visitors support families with children aged 0 to 5. They can refer families to specialist services and are trained to recognise risk of harm to a child. They work in people’s homes, clinics, Sure Start centres and GP surgeries.
School nursing	School nurses can provide services including health and sex education, developmental screening, health interviews and immunisation programmes. They also provide additional support for looked-after children.
Intermediate care	This involves supporting someone when they leave hospital, or helping prevent admission to hospital or residential care. It can be provided by a range of nurses and allied health professionals including community mental health nurses, physiotherapists, occupational therapists and speech therapists. Social workers and GPs can also be involved.



Continued

Physiotherapy	Physiotherapists help people affected by illness, disability or injury to recover and stay independent. Treatment in the community might take place in a patient's home, a health centre or nursing home. It treats conditions like stroke, multiple sclerosis, Parkinson's, back pain and arthritis, and contributes to rehabilitation after heart attack. It involves manual therapy, exercise and advice.
Occupational therapy	Occupational therapists work in patients' homes, nursing homes, community centres and GP practices with people of all ages, to help them overcome the effects of disability caused by physical or psychological illness, ageing or accidents, and to support them with everyday activities.
Speech and language therapy	This is provided in community health centres, patients' homes and day centres. It helps people who may have had a stroke or, cancer of the mouth, or have a learning disability who may have difficulties in producing and using speech or in understanding language.
Podiatry	Podiatrists treat people with lower limb pain or who have problems walking, people needing minor surgery, those suffering with circulation problems caused by diabetes and those with nail problems. They can carry out minor surgery under anaesthetic.
Sexual health services	Sexual health services include contraception, STI testing and treatment and genito-urinary medicine services.
Specialist services	Multidisciplinary teams typically carry out specialist services. For example, musculoskeletal conditions are treated by teams including GPs, physiotherapists and podiatrists. Treatment can include medication, support in self-management, physiotherapy and manual therapy.

More than any other part of the health care provider system, the community sector has been subject to repeated reorganisation (Imison 2009 and see box overleaf). Most recently, the Transforming Community Services programme saw primary care trusts (PCTs) divesting themselves of the community health services they provided so that they could focus on commissioning (Department of Health 2009). Community services were transferred to a range of different organisational forms and structures. Some established themselves as standalone NHS trusts. Others were combined with existing acute or mental health trusts. Still others became charities or social enterprises, and others were taken over by private sector providers.

Recent analysis from the Nuffield Trust indicates that the independent sector has become a significant provider of community services and that spending on non-NHS providers is increasing rapidly. In 2012/13, 69 per cent of the NHS spend on community services went to NHS providers, 18 per cent to the independent sector, and 13 per cent to voluntary organisations and social enterprises (Lafond et al 2014).



This makes the community services sector distinctly more diverse than either the acute sector (where 96 per cent of spend is with NHS bodies) or the mental health sector (where NHS providers account for 81 per cent of spend) ([Lafond et al 2014](#)).

Community health services - a history of reorganisation

1948 Community nursing and child health fell within remit of local authorities

1974 Community health services transferred to the NHS, to tackle poor co-ordination between hospital and community services

1989 'Working for patients' - NHS commissioner/provider split, community services increasingly established themselves as standalone trusts

1997 PCTs established, integrated with community services

2005 'Commissioning a patient-led NHS' - PCTs to contract out community services

2008 Darzi 'next stage review' - recommended separation of PCTs' commissioning and provider functions

2009 'Transforming community services' - required PCTs to come up with new model of provision

The community sector is crucially important to achieving the transformation in services that we need to meet the current and future challenges facing our health care system ([Ham et al 2012](#)). They are an essential component in efforts to provide person-centred, co-ordinated care, closer to people's homes, focusing on keeping people well and independent, and minimising hospital stays wherever possible. Several high-priority national policies, such as the Better Care Fund, are contingent on a larger role for the community sector.

However, despite this crucial role, community services can seem strangely overlooked by the general national agenda around assuring and improving quality. The hospital sector has a relatively long and well-established legacy of and system for monitoring quality, and serious failures in the quality of care in the acute hospital sector have further reinforced the focus on quality in recent years ([Department of Health 2008](#); [National Advisory Group on the Safety of Patients in England 2013](#); [Department of Health 2013](#); [Mid Staffordshire NHS Foundation Trust 2013](#)). In contrast,



there is relatively little national policy focus on quality in community health care, and approaches to measuring and improving quality in community services are less well developed. There is limited national data on quality, the information and IT infrastructure is under-developed relative to other sectors, and services are often commissioned through block contracts that do not incorporate quality standards (Edwards 2014).

This report begins to address this deficiency of knowledge about the management of quality in community services. It describes the findings of a small mixed-method primary research study to explore how providers of community health services define, measure, manage and improve quality, and the challenges they face in these tasks. We have included specific local examples of notable practice throughout the paper. This is not a report on the quality of community services *per se*, but the systems in place for leaders, non-executives, commissioners and others to assure themselves of the quality of care – assurance that will be needed if community services are to fulfil their potential as the demands on them grow.

This report aims to support senior leaders, non-executive directors and commissioners of community services, as well as policy-makers, in understanding the current landscape in the management of quality in community services, and in identifying the systems and processes currently in place to provide assurance about quality. We consider some of the key issues affecting the quality of community services in the current system. We also propose some important next steps needed to support better quality measurement and management.



3 Scope, methods and sample

To allow us a reasonable degree of focus in a diverse sector, we have concentrated on physical health services that are provided in non-hospital settings. We have not covered community hospitals (where acute models for the management of quality are better suited) or community mental health services, which warrant more detailed study than was possible within the scope of this project.

We conducted the study between April and September 2014 and combined a survey, interviews and document analysis. We chose a mixed-method approach to maximise our ability to capture important information about the quality systems that exist.

Web survey

We sent a web survey to senior leaders in around 250 providers who provide at least some of the main services outlined in Table 1 (*see p 4*). We asked respondents to rate their organisation's performance across a number of areas and their level of agreement with statements about their quality systems. Identifying organisations for the survey was in itself problematic as the Care Quality Commission's (CQC's) database of community services providers included many providers who did not meet our inclusion criteria because, for example, they provided only community hospital-based services. There is also a complex pattern of provision, with community health services provided by a range of both NHS (acute hospital trusts or mental health trusts, as well as standalone community health trusts) and non-NHS (social enterprises, private sector and community interest companies) organisations. As a result, we used a snowballing approach, identifying services with assistance from the CQC, the NHS Confederation Community Health Services Forum and Social Enterprise UK, and through internet searches and clinical commissioning group (CCG) websites. The survey received 65 responses from 59 different organisations among the 250 we approached. Forty-three per cent of respondents were chief executives (CEOs) or nursing directors. Ten organisations were standalone NHS community providers, 27 were combined trusts with acute, mental health, primary care or social care, 14 were social enterprises and 13 did not state their organisation type. Disappointingly, we had only one confirmed response from the independent sector, which may have been due to difficulties in identifying appropriate potential respondents.



Interviews

We conducted interviews with 17 individuals, including five CEOs, six clinical and nursing directors, three assistant directors and three service line managers selected from nine combined trusts providing acute or mental health services, seven community trusts and social enterprises, and an independent sector organisation. Interviewees were asked about a range of issues including their definition of quality, approach to measuring and managing quality and experience of the new CQC inspection scheme and the external challenges affecting their ability to manage quality in community health services.

Quality accounts

We analysed a sample of 30 quality accounts for 2013/14 to extract community health service providers' quality priorities for 2012/13 and 2013/14, and what they chose to report about their actions taken or plans to achieve these priorities. The sample was stratified by location (region) and type of provider (both whether they also provided any acute, mental health and/or social care services, and whether they were NHS, social enterprise or independent sector). Firefly Research conducted this analysis.

Board papers

We analysed a selection of board papers and minutes in three NHS providers of community health services, selected at random, covering a period of six months from December 2013 to June 2014.

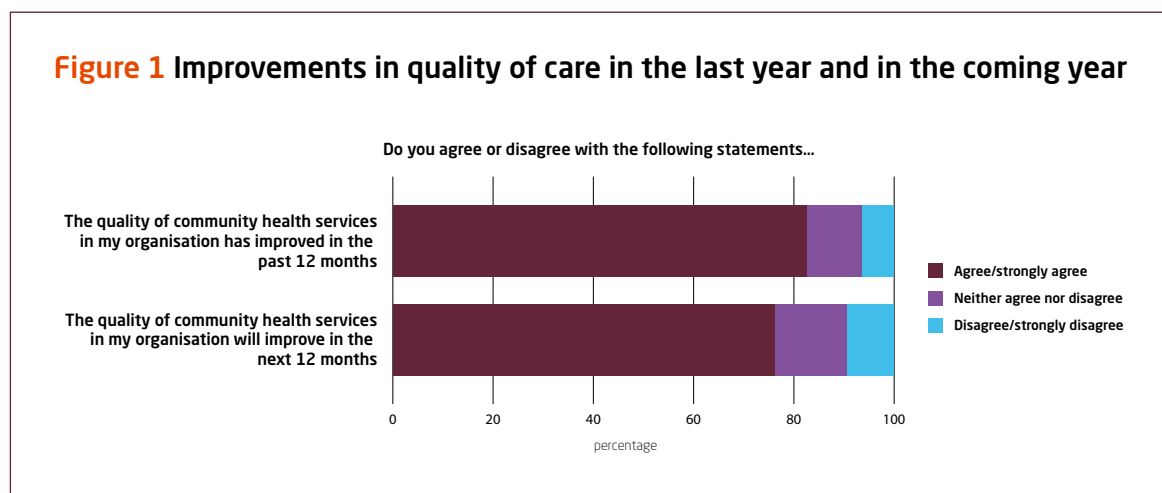


4 Findings and discussion

Self-assessment of current quality

To provide some context for our questions on quality management, we asked our survey respondents to self-rate the quality of care provided by their organisations.

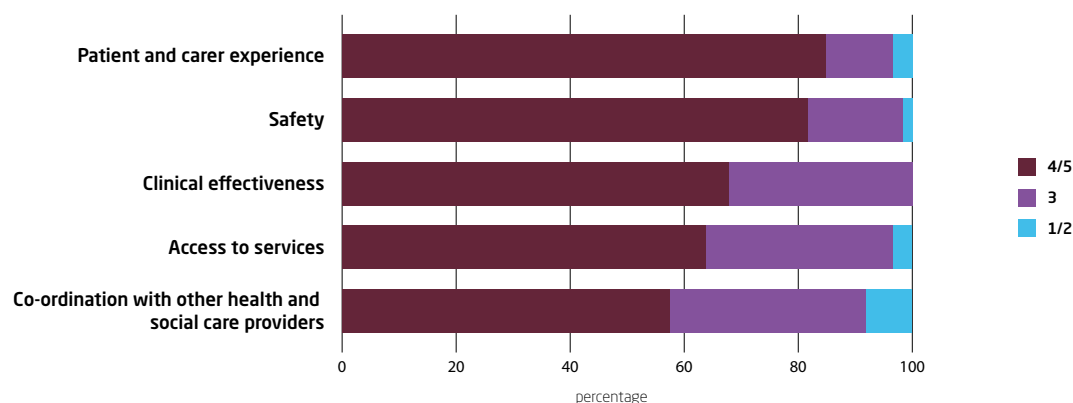
Community providers were confident and optimistic about the quality of care they are providing. As shown in Figure 1 below and Figure 2 opposite, the majority of providers reported that quality had improved in the past 12 months and would improve further over the next year. They were particularly positive about their performance on patients’ and carers’ experience, with more than three-quarters rating their organisation 4 or 5 out of 5 for this domain of quality in the last 12 months.



These simple questions inevitably prompt people to give only a high-level and general response, and senior leaders perhaps might tend to be confident and positive when reporting their performance to researchers. But it is striking how positive respondents were about quality, not least in light of some of our other findings in this study about the lack of available data on quality and the tough challenges to quality that community providers are currently facing.



Figure 2 Community providers' self-rated performance on five domains of quality (1=low performing, 5=high performing)



Defining quality and setting quality priorities

Defining quality

To define quality within their services, providers widely used the definition of quality from Lord Darzi's 2008 review *High quality care for all*, with its three domains of patient safety, clinical effectiveness and patients' experience. All providers had at least one quality priority associated with each of the Darzi domains. Several interviewees referred to the five domains of quality outlined by the CQC in their inspection framework, while others had developed their own definitions incorporating the NHS Outcomes Framework or other service-specific quality standards. Some organisations also linked staff engagement and organisational culture to defining quality, and included wider aspects of performance such as equitable care, waiting times and partnership working. For example, when asked what high quality means in their organisation, one interviewee replied:

Safe, effective, evidence research-based services that have to be cost-effective in the environment that you're working in. And that your standards are high, your staff are competent and trained to deliver the services that you're offering.

(Interviewee M)



Some interviewees reflected on the differences between acute and community services when defining quality. Much of what community services provide involves long-term care that helps to prevent more serious problems, or helps people to maintain or regain their health and independence. As such, it does not always lend itself to clear short-term clinical outcomes in the same way a defined episode of treatment for an illness might. One interviewee therefore argued that measures of patients' experience were particularly important for community services:

We talk about quality and service experience very much, as absolutely a barometer of good quality is good service experience, whereas you might have in the acute sector a really grumpy but extremely effective and successful cardiac surgeon. I can't think of an analogy in community because really grumpy would be bad service experience, would be poor quality care.

(Interviewee J)

Quality priorities

Patient safety featured most prominently among the quality priorities stated in organisations' quality accounts, and particularly action to reduce the 'four key harms' (pressure ulcers, falls with harm, catheter-acquired urinary tract infections (UTIs) and venous thromboembolism (VTE)) set out in the 'Harm Free' Care initiative, an NHS patient safety initiative (harmfreecare.org). Other safety risks to patients that were cited as quality priorities included minimising health care-acquired infections, risks during transfer of patients between services or settings, medication errors and reportable incidents.

Other safety priorities included work to develop better systems for patient safety (for example, risk management, strengthening root-cause analysis of incidents, spreading learning from safety incidents, and strengthening safeguarding systems). One provider identified strengthening processes for obtaining consent (to ensure patients fully understood risks of treatment) as a key safety priority.



Priorities in patients' experiences were mainly focused on improving measurement and gathering information and feedback from patients. Examples were: expanding patients' feedback to a broader range of services; using 'real time' data collection to obtain patients' feedback; capturing feedback from particular groups such as people with a learning disability; and including specific 'friends and family test' questions in patient questionnaires.

As with patients' experience, in the domain of clinical effectiveness there was a clear theme around developing more systematic reporting, and a recognition that measurement was an essential prerequisite for improvement.

We have actually made a big difference to the outcomes for patients in those areas that we measure carefully, such as the incidence of pressure ulcers, such as ulcer healing rates, reductions in the incidence of the urinary tract infections in patients with catheters.

(Interviewee J)

Several organisations were developing outcome measures and/or using patient-reported outcome measures (PROMs). Other effectiveness-related priorities included:

- improvements in care plans and the accuracy of clinical record-keeping
- developing electronic records and shared care plans
- efficiency improvements to release more patient contact time for community nurses
- restructuring, integrating and/or co-locating teams, or otherwise developing partnership working to: enable creation of a single point of access for patients; improve care pathways; develop more innovative or collaborative ways of working
- actions to support people with long-term conditions to manage their conditions better
- improvements in reporting of compliance with NICE guidance.



Measuring quality

Lack of data and metrics

The constraint of poor information availability was one of the most recurrent themes of our study. Survey respondents and interviewees repeatedly told us of the historic under-development of data on quality and quality measures, the lack of specific measures for community services and the lack of technology and data systems to support quality measurement:

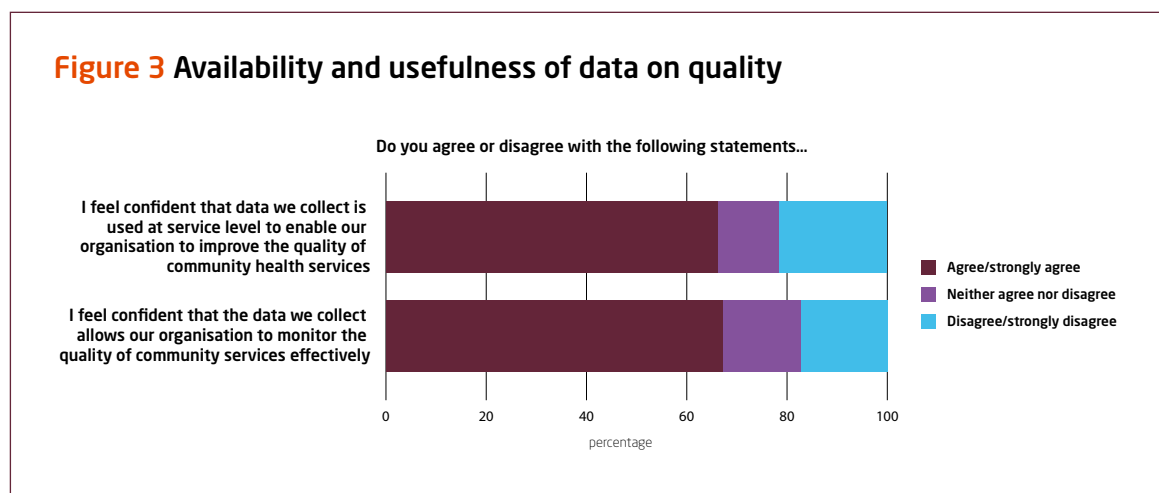
[The] main issues [are a] lack of outcome and effectiveness measures.

The use of data continues to be a source of frustration.

Data quality and relevance of community data is weak.

...we could improve with more development of systematic measurement of outcomes.

In an interesting contrast to this, almost half of survey respondents rated their performance well (3 out of 5) for measuring outcomes and using data for quality improvement, and two-thirds felt confident that their data enabled them to monitor and improve quality (see Figure 3 below).





Given the overall paucity of both data and quality metrics for the community services sector, it is questionable whether this level of confidence is warranted. It may reflect relatively low expectations, perhaps both from the providers themselves and from the other agencies that monitor and assure the quality of community services such as commissioners or national bodies. It is possible that the system is collectively setting its thresholds for the quality measurement agenda in community services lower than other sectors that have better systems and support.

Although the need for good information on the quality of community services is well recognised and growing, the lack of comprehensive, consistent and robust national data on the quality of community services has been apparent for many years. Implementing a robust information base for community services is a challenge because of:

- the diversity of services provided by the community care sector
- the plurality of service providers
- the multiplicity and complexity of data flows required to cover the numerous and diverse services, settings and client base covered by community care
- the comparatively weaker information infrastructure in community care compared with the primary and acute care sectors where IT and computerisation are better developed
- the intrinsic difficulties in monitoring quality when care is provided in users' own homes.

The box overleaf lists the main data sources currently available or in development for measuring quality in community services. This shows their limited coverage, which contrasts significantly with the data available for other health care sectors such as hospital services. A recent report from the Nuffield Trust and the Health Foundation set out how limited the available national data is on the quality of care provided by allied health professionals ([Dorning and Bardsley 2014](#)).



Some national datasets that provide information on the quality of care in community health services

- NHS Safety Thermometer: Used across a range of health care settings, including nursing homes, care homes, independent sector care providers, community nursing and hospitals, this dataset includes reported incidents of pressure ulcers, falls with harm, UTIs in patients with a catheter and new incidents of VTE. A significant proportion (45 per cent) of the total 2.7 million events reported in the year to July 2014 occurred in the community setting and patients' own homes.
- All sectors including community use the Datix software system to submit data on serious incident reporting and 'never events'.
- Maternity and breastfeeding: Data on women assessed within 12 weeks of pregnancy, and initiation and duration of breastfeeding.
- Data on written complaints: Data by service area, profession, region, area team and organisation.
- Workforce census data: Data on, for example, numbers of health visitors, community psychiatry nurses, community learning disability nurses, physiotherapists, allied health professionals (AHPs), school nurses.
- Monthly workforce data: Data on headcount and turnover of NHS hospital and community health service staff (excluding primary care staff), using data from the electronic staff record.
- PLACE (patient-led assessments of the care environment) for outpatient clinics.
- Referral-to-treatment times for consultant-led services.
- Referral-to-treatment times for AHP services (data collection is mandated locally although the data is not yet reported centrally).



Datasets in development

- Community Information Data Set (CIDS): This dataset is potentially one of the most promising for the future, as it comprises patient-level records of users of community services, similar to hospital episode statistics for hospital patients. The aim is to deliver robust, comprehensive, nationally consistent and comparable person-based information on patients in contact with community services. For now, CIDS is a local data collection for local data extraction only; decisions about the central flow of this dataset are pending.
- Maternity and children's dataset: This dataset will provide comparative data for mothers and children to support improvements in quality and service efficiency, and commissioning of services.
- Children and young people's dataset: A dataset for community services funded and/or provided by the NHS for people aged under 19 years. It covers activities at locations including health centres, Sure Start centres, daycare facilities, schools or community centres, mobile facilities or the user's own home.

As we have reported previously ([Foot et al 2011](#)), the shortage of information is particularly acute for non-NHS service providers.

...being a CIC [community interest company], we can't always report into certain things, so we almost have to do our own internal reporting, and developing the information, and then looking on those websites to look at what other providers are doing.

(Interviewee N)



Given the high proportion of non-NHS providers in the community sector, this is a particularly important issue for understanding and assuring quality. National bodies such as the Care Quality Commission (CQC) are at present limited in the extent of data monitoring that they are able to do in their inspections in the non-NHS community sector, making it even harder for them and others to be confident of the quality of services currently being provided.

There are examples of important research and practice initiatives seeking to support NHS community providers in sharing data and best practice in quality measurement. Several interviewees mentioned the national indicator development project for community services (funded by a group of providers) and the NHS Benchmarking Network. These are briefly outlined in the boxes below and opposite.

National indicator development project

Driven by a need to demonstrate quality and effectiveness in the NHS community sector, a collaborative self-funded programme was initiated in 2012 by a core group of community NHS trusts in England.

The principal aim of the programme is to develop a range of meaningful quality metrics, with an emphasis on patient-reported outcomes and experience measures for services delivered in community settings, irrespective of the NHS provider's organisational form. The approach has been to draw on experience, examples, aspirations and current applications of quality measures from community services across England, through a series of clinician-led workshops.

The first iteration of measures has been linked to specific services. Alongside their further development into descriptors with identifiable data items, and preparation for piloting, is a concurrent process to map them to existing quality frameworks, including the CQC domains.

Another focus has been the potential for measures to be clustered around care groups or populations and needs-based care pathways, with applications for outcome-based commissioning ([see **www.bridgewater.nhs.uk/demonstratingthevalueofcommunityservices**](http://www.bridgewater.nhs.uk/demonstratingthevalueofcommunityservices)).



NHS Benchmarking Network

The NHSBN is a member-led organisation that exists to identify and share good practice among NHS providers. For the past seven years, the NHSBN has been collecting, analysing and benchmarking the performance of a range of NHS community services from the majority of NHS providers. It compares investment, access, activity, quality and workforce data, covering services offered to children, older people and those with long-term conditions, such as district nursing, health visiting and therapies. Its work enables members to identify areas in which there is scope for improvement as well as to offer assurance to providers and commissioners that services are operating in line with national performance.

Quality measurement in community settings is also the focus of academic research. The ongoing Measuring Quality in Community Nursing Study is looking at what quality indicators are used in community nursing and how they are used by commissioners, providers and frontline nursing teams. The study also includes patient and carer perspectives on quality indicators (<http://public.ukcrn.org.uk/Search/StudyDetail.aspx?StudyID=17337>).

Measures and indicators used

Despite the lack of shared national data on quality, community providers are adopting a range of methods and metrics to measure quality locally. Data from the NHS Safety Thermometer was commonly reported in our interviews and in board papers, and several interviewees told us that their boards routinely listened to a story from a patient as part of their meeting. Board reports on quality varied, but generally consisted of a number of quantitative indicators, categorised and rated red/amber/green (RAG) against targets, with some analysis and description of mitigating actions. Examples of the indicators used are shown in Table 2 overleaf.

Using technology to get feedback and drive improvement, Virgin Care Surrey

Virgin Care sexual health service in Surrey introduced a confidential text messaging service to get feedback from its users. As a result of feedback from young people, chlamydia test results forms were redesigned to be clearer and simpler.



Table 2 Examples of performance measures reported monthly to boards

<i>Patients' experience</i>	<i>Workforce</i>
Friends and family test	Staff feedback
Patients' experience surveys	Sickness absence
Complaints or compliments	Staff turnover
<i>Patient safety</i>	Vacancies
Pressure ulcers	Performance appraisal compliance
Falls	Training
UTIs	Staffing levels
VTEs	Staff caseloads
Medication errors	Agency/bank usage
Infections	<i>Processes of care</i>
Nutrition	Non-attendance rate
Reportable incidents	Waiting times
<i>Clinical effectiveness</i>	
Implementation of NICE guidance	
<i>Data quality</i>	
Recording of outcome code	

Most organisations in our survey reported that they were collecting bespoke data on patients' experience and many said they were collecting patient-reported outcomes data. Patient surveys, the friends and family test and complaints data are widely used for measuring patients' experience. Qualitative data was also mentioned, with providers collecting compliments and complaints, holding focus groups or using patient advice and liaison services (PALS). However, there was considerable variation, with some providers at the early stages of developing data collection and others deploying a range of methods for collecting patients' experience data such as use of tablets, website surveys, feedback stations located within services and contacting by telephone patients receiving home care. The lack of national patient surveys for community services means that many organisations have been using and developing their own surveys but also that there is a lack of comparative data for benchmarking.



Seeking feedback from vulnerable groups, Solent NHS Trust

To capture feedback from vulnerable groups and those unable to use standard methods for giving feedback such as patient surveys, Solent NHS Trust piloted a range of methods including:

- pictorial versions for those with dementia and learning disabilities
- focus groups for the homeless
- carers' discussions in palliative care
- visual scoring scales and spoken surveys for people for whom reading or English language is a challenge.

Using PROMS, community musculoskeletal service (MSKCAT), Gloucestershire Care Services

Gloucestershire Care Services' MSKCAT service has amassed clinically validated patient reported outcome measures (PROMs) from more than 2,800 patient responses since 2010. The condition-specific PROMs scores (measuring pain, function and impact on daily living) show improvements in every type of presenting condition from +10.5 per cent (shoulders) to +36 per cent (hips). Overall MSKCAT patients' general health and wellbeing score (measured via EQ-5D) improves by 16 per cent. Service managers have been able to use this data to provide evidence on the quality of their services to referring GPs, and to influence their referring decisions.

Data access and record-sharing

Sharing of patient information between service providers is an essential prerequisite for providing co-ordinated services to patients and targeting services to those at greatest risk. This issue is not unique to community services. Several quality accounts included improvements in record-keeping and record-sharing in their quality priorities. Some providers also said they were working on developing electronic records and shared care plans.



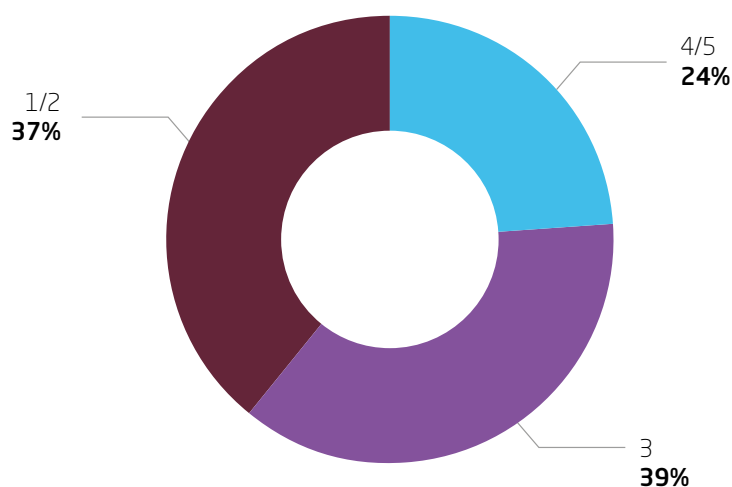
However, the lack of shared records and IT issues were common themes emerging from our survey. As shown in Figure 4 opposite, more than a third of respondents rated their organisation’s ability to access and share patients’ records as low.

One of the big hold-ups that a lot of the services face is how do we overcome that [issue of patient confidentiality] so that we’re certain our patients are happy that the information we’re sharing about them is what they want us to see.

(Interviewee M)

As IT infrastructures can vary in sophistication, the challenges become more complex when implementing systems involve collaboration between multiple partners. Several organisations reported technical difficulties with the information infrastructure, for example, of diverse IT systems in use, and information governance issues with data-sharing. Concerns about data-sharing and the risk of breaching legislation relating to confidentiality of patient data are commonplace, and the issues around information governance are complex. There is an urgent need for clarification of policies, guidance and sharing of good practice in relation to information governance for data-sharing.

Figure 4 Community providers’ self-rated performance on their ability to access and share patient records (1=low performing, 5=high performing)





Quality governance

We found good evidence of a clear focus on quality management within community health services providers. Although systems for quality governance and management were at different stages of development, there were some common themes that emerged from our research. The providers in our review of board papers each included some form of qualitative patients' feedback in their board meetings and quantitative measures of patients' complaints, including the time taken to respond, and analysis and comparison of the number of complaints received over time by services. While quantitative quality performance indicators were presented at monthly board meetings, more detailed challenge, discussion and monitoring of action plans relating to quality performance tended to take place at a designated sub-committee of the board. There were fairly consistent systems for reporting quality information, involving a monthly service or division-level report or meeting to review quality information, which then fed into an executive sub-committee. Inevitably, given the huge range of organisational sizes and forms, these differed in structure. They ranged from monthly clinical operations boards that reported up to the executive team, to service-line governance meetings, to quality committees chaired by an executive director or quarterly sub-committees of the executive board focusing on a different service each time.

In terms of the activities of these committees, more than 60 per cent of survey respondents reported that information on patient safety incidents and patients' feedback and complaints was reviewed at every meeting. Staff feedback or staff survey data was reviewed quarterly. Approximately 40 per cent of our respondents said they agreed on future actions or reviewed progress on past actions at every meeting. These actions often centred on further analysis of information. Other common actions for improvement included providing training for staff, or forming groups, for example a 'share and learn' group for pressure ulcers. Several providers were developing organisation-wide responses to the Francis, Berwick and Keogh reports, and working on quality governance as part of that. A small number of interviewees mentioned having rapid escalation procedures to identify problems outside the usual quality governance cycle.



Robust quality governance processes at The Royal Marsden

The Royal Marsden has developed a quality governance system within community health services. Quality is discussed with service managers at a monthly divisional management team meeting. Relevant information is reported upwards to a monthly integrated governance review meeting chaired by the chief nurse, and this meeting in turn reports to a sub-committee of the trust board, the Quality and Risk Committee (QAR). This committee is chaired by a non-executive director and attended by members of the trust board. Quality issues identified at service-line level are reported through this chain to the QAR; those deemed urgent are flagged by a divisional risk register and escalated to the corporate risk register. Quality is also reviewed with commissioners at monthly clinical quality review meetings.

Early identification of quality issues in Cambridgeshire

Cambridgeshire Community Services NHS Trust has implemented the Quality Early Warning Trigger Tool to flag up potential quality and safety issues within teams. The tool has been adapted for community services and consists of 22 measures that can affect the ability of teams to deliver high-quality care. Team leaders assess team performance each month against measures including stability of leadership within the team, complaints and collection of patients' feedback every three months and the percentage of shifts covered by bank or agency staff. The scores produce a red, amber or green rating, and the trust has added a purple rating to indicate very high risk. These scores are reviewed at service level and actions to resolve or mitigate the risks are agreed. Red and purple scores are reported to the trust board each month.

Our survey did not reveal major differences in the coverage of quality issues at board level between different provider types. However, in the quality accounts analysis we found very few stated quality priorities for community health services in the quality accounts of combined acute and community providers. This raises questions about the profile of community health services' quality issues in the context of large, combined trusts. One interviewee from an acute trust stressed how she felt that community services were a low priority for the board: on the other hand, others argued that acute providers tend to be more established in their systems and processes for quality assurance and governance, suggesting perhaps that quality governance in combined providers could be better.



... in an acute trust ... you're far more governed by national requirements and targets... it works pretty well, so you know that you've got your A&E targets or your 18 weeks... The notable thing with community trusts is that, nationally, no one's really been terribly bothered how they perform... there [is] a slightly more laissez-faire attitude towards performance and quality.

(Interviewee R)

[We've] brought the acute methodology, if you like, for managing quality into the community... The services are different but it doesn't mean that the way in which you assure yourselves of quality and all the rest of it is any different... [we] now have systems and processes that are mirrored within acute trusts, I would say. But I suspect lots of community trusts don't.

(Interviewee R)

More in-depth work with the boards of a range of different community service providers could be fruitful to investigate further whether there are any systematic differences in the degree of executive-level scrutiny on quality in community services in different organisational structures.

CQC inspections were a high priority for boards. We asked interviewees to reflect on the CQC inspection process and whether this influenced their approach to quality management. Several providers responded positively to the process, viewing the inspection as an opportunity to develop peer review systems and mock inspections. There were several examples of a positive impact where the inspection resulted in changes to practice and improvements in quality governance systems. Others expressed mixed views, seeing it as an opportunity to focus on driving up quality but also a potential distraction.

Staff engagement in quality and quality improvement

Providers showed commitment to engage staff in quality improvement.

Distributed leadership for quality is really the only kind of leadership that makes sense in community services, since our staff are out in the field providing services on their own in people's homes or ... scattered across 100-plus different locations.

(Interviewee A)



We heard of examples where organisations were working with staff to engage them in quality measurement and the use of data for improvement; where staff were developing their own quality metrics; where services were being challenged to identify and make quality improvements year-on-year; and where training staff were becoming coaches for quality improvement. However, coverage of these initiatives was patchy.

‘Under Pressure’: preventing pressure ulcers, Berkshire Healthcare NHS Foundation Trust

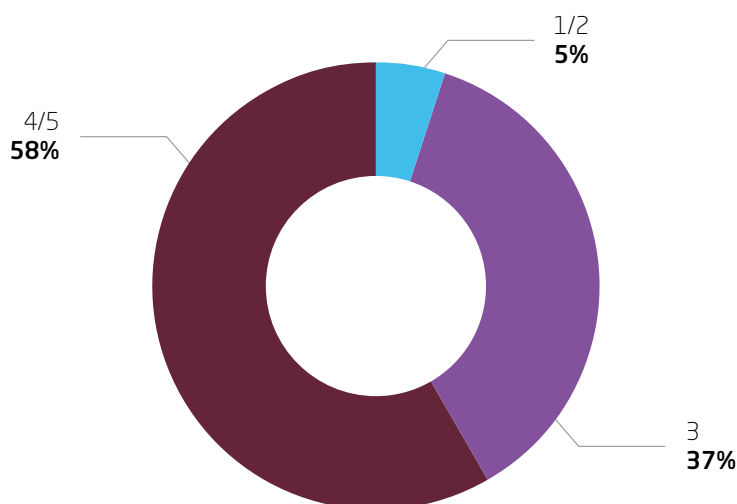
Berkshire Healthcare NHS Foundation Trust introduced a pressure ulcer prevention campaign, providing training for nursing staff and identifying a pressure ulcer prevention champion in each team. Champions are led by tissue viability clinical nurse specialists to share knowledge and support new ways of working, using the ‘Plan Do Study Act’ cycle to ‘Do something different’ and delivering 10-minute ‘power talks’. Teams measure the number of days free from pressure ulcers. Incidents reported on community inpatient wards have reduced significantly, with two wards reporting more than a year free from pressure ulcers.

Enabling staff to lead quality improvement, Bromley Healthcare

Bromley Healthcare challenges each of its services to make three quality improvements each year, enabling frontline staff to identify the improvements that would be most beneficial for their patients. Examples of initiatives developed by staff include a phone app to help patients find their nearest sexual health clinic and the addition of pictures to the food menus in the stroke unit.

There was a high degree of confidence in staff engagement in and skills relevant to quality improvement, which is perhaps surprising given the complaints of poor data on quality. Overall, just over half of providers rated their organisation’s skills in quality improvement as 4 or 5 out of 5, as shown in Figure 5 opposite.

Figure 5 Community providers' self-rated performance in ensuring that staff have skills in quality improvement (1=low performing, 5=high performing)



Social enterprises were particularly positive about staff engagement. These results may reflect real differences in organisational responses to the quality agenda, with, for example, staff in these organisations perceiving that they have a greater role in organisational decision-making than those in a large combined trust, for instance, where it is more difficult for community services to have a high degree of visibility.

However, differential expectations and self-assessment standards between organisations may also play a role. Acute providers have longer experience of developing quality improvement systems, and have largely been the focus for policy development and attention. In contrast, community trusts and social enterprises have had less time to develop their systems, less support to do so and, at the simplest level, struggle to obtain the relevant data to measure quality. They also have little opportunity to benchmark services. So it is possible that the self-confidence of community services providers in quality improvement reflects lower expectations about the essential requirements of a rigorous quality monitoring programme relative to other sectors.



We also heard about obstacles to staff engagement in the quality improvement agenda. These are not dissimilar to those reported in other health care sectors, and included: a general lack of analytical capability in the organisation; the difficulty of engaging staff when services are subject to instability and potential reorganisation; and finding the staff time to reflect on the care provided and identify improvements.

A challenge for us is changing and enabling staff to feel that they can take time out to reflect and have supervision, because that is important to maintain the quality and maintain their self-preservation really, as much as anything, which then impacts ... then influences the quality of the care they're able to deliver to patients. But staff always see it as, no, I must go and visit that patient because Mrs X needs me, you know.

(Interviewee M)

Issues affecting quality in community services

Community providers are working to measure, manage and improve quality in an increasingly pressured and challenging environment. We asked our interviewees and survey respondents to reflect on the wider context for their work on quality. A number of recurrent themes emerged.

Workforce issues

We encountered serious concerns about workforce pressures within community services. This narrative was even more negative about the future, with providers pointing out that recruitment issues were likely to worsen in community nursing as many nurses approached retirement while not enough new nurses were entering training or developing specialist skills.



I think community services suffered, I suppose, because for a number of years it was, kind of, homeless... Community nursing I think has really suffered over the years. Firstly because for a period of time they stopped doing the district nursing training course so you weren't getting new people coming into the service that had been trained to that specialist level. Thankfully obviously that's been reintroduced but you've got a gap... I think partly because of that and also because in district nursing or community nursing, as I say it's gone through a number of different hands as to which organisation it sat in, it's meant that it's found it increasingly difficult to recruit to. Obviously there's a shortage around nursing anyway but it's not had the attention of the focus on the benefits for working in community services. So across our nursing teams we've got between 15 and 20 per cent vacancies in nursing

(Interviewee H)

Finding and training and having the right workforce in place is getting increasingly difficult.

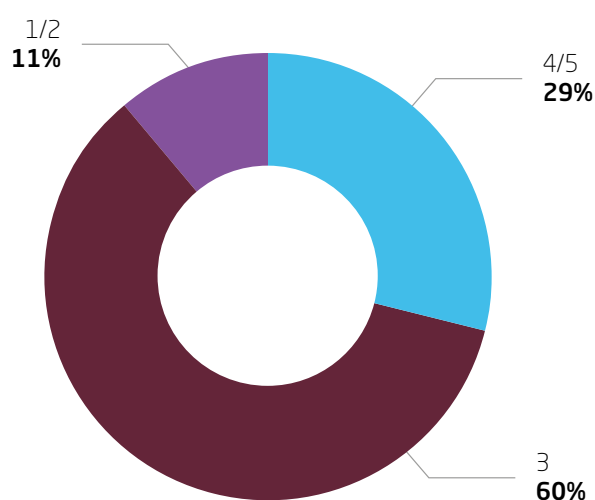
(Interviewee B)

Providers reported that planning and managing the workforce within community services was challenging, largely due to the volume of demand and increases in patient acuity, with patients being discharged earlier into the community to relieve pressure on acute services.

Staff shortages were a recurring theme, particularly in district and community nursing where there were growing caseloads and increasingly complex patient needs. The majority of organisations surveyed gave their organisation a score of 3 out of 5 or less for their performance in ensuring adequate staffing numbers, skill-mix and caseload, as shown in Figure 6 opposite. This was the area where providers were least positive about their performance. These issues were raised in board papers although there was little measurement of staff workloads.



Figure 6 Community providers' self-rated performance on ensuring adequate staffing numbers, skill-mix and caseload size (1=low performing, 5=high performing)



The risks associated with staffing were clearly articulated by many respondents. One provider's board papers had identified these as 'leading to potential risk of delivering poor quality care, increased stress and failure to deliver contracts'. Some interviewees suggested that temporarily closing the district nurse training course had had a disastrous effect on the pipeline of specialist nurses, while others had encountered specific problems recruiting within their geographical areas and had increased their use of agency staff at significant cost.

The staff development plans that we saw tended to focus on promoting organisational values and a learning culture among staff, ensuring compliance by individuals with mandatory staff training and HR issues such as annual appraisals and personal development plans: all relevant and important for developing quality management systems. Monthly performance reports to boards showed that providers were failing to meet targets for appraisal compliance, staff sickness and mandatory training rates, although our survey respondents thought their organisations were performing well in this aspect. Sixty per cent rated their organisation 4 or 5 out of 5 for staff training and development; and a similar percentage for providing a supportive organisational culture or work environment.



Demand pressures

In our research we heard serious concerns about financial, demand and capacity pressures on community services and the threat these posed to quality. Demographic changes (population increase and ageing), increased demand in acute and primary care, and the shift of care out of hospitals were reported as increasing pressure on community services.

Actually our sponge is full now and we can't absorb any more. That's going to need to be addressed I think fairly soon. I think most community services will probably tell you that they're at breaking point.

(Interviewee H)

Providers overwhelmingly reported that increasing complexity and acuity of patients' needs was affecting their ability to provide high-quality care, and that changing policies and practices of other local providers had affected their ability to provide high-quality community health services.

We often try and provide gold standard care, whereas actually the commissioners only want, now, or can only afford, you know, probably bronze standard care and there's a disconnect, probably, between the two.

(Interviewee I)

Partnerships and relationships with other parts of the system

Community service providers' efforts to manage and improve quality do not exist in isolation – effective partnerships with other parts of the system are essential. Providers were generally very positive when assessing their organisation's performance in building effective local partnerships across health and social care. But in other responses, and through the interviews, several frustrations and challenges with effective partnership-working emerged.



Several interviewees expressed frustration that the acute sector had little knowledge of or respect for community services. One (Interviewee F) stated that there was a ‘lack of recognition of the skills of community clinicians among acute colleagues’. There was still a sense that acute services were the priority in the system. Several respondents to the survey referred to difficulties in communications with other parts of the system and to concerns that partnership-working was not a priority when other services were under pressure.

[There is] a poor culture relating to communication from the acute sector to community hospitals and community teams.

(Survey respondent)

Relationships with GPs and local authorities were particularly important to community services providers. Views about relationships with GPs were mixed. Some felt that GPs had lost confidence in community nursing services with the move away from district nurses located in or linked to GPs’ practices. Others felt GPs had a good knowledge of the services they interacted with directly, but didn’t seem to understand the range of community services or wider organisational issues and funding issues faced by providers.

They just think they understand everything because they’re GPs, and the secrets of the universe are theirs. They don’t understand that there are commercial things, organisational things, management things, that they may know nothing about.

(Interviewee K)

One provider conducted an annual GP satisfaction survey, which highlighted the need to ensure GPs were aware of all community services offered and the support available to GP practices.

Relationships with local government were also mixed, with one interviewee working closely to develop integrated services while another was concerned about ongoing cuts to services funded by the local authority. Financial pressures in local government were raised as a serious risk, with the Care Bill described in a board paper as ‘very likely to increase demand for community health services’. One provider’s board paper described a ‘lack of robust governance framework for partnerships including those with the local authority’.



However, there were several examples given to us of organisations working jointly with local partners to provide co-ordinated, integrated care, and providers were taking steps to develop better relationships with acute and social care sector colleagues working to improve patient pathways and patient flows.

Issues with commissioning community services

Community health services providers had mixed views about commissioners' impact on quality, with some reporting positive, active engagement and others describing commissioners as less responsive. More than half of providers reported that their commissioners were 'not particularly engaged' or only 'somewhat engaged' in quality, with around a third 'very engaged'. Several aspects of the commissioning process were described as problematic.

Block contracts and rising demand

Providers highlighted block contracts and rising demand as risks to the quality of care, as these result in them not being paid accurately for the activity delivered.

There is a drive to get more and more services delivered in the community, and I think it's a perfectly feasible thing to do, it's much better for patients not to go into hospitals. But you know, the move of patients from hospital to community has happened, and the workloads have increased, but we're also on a blanket contract, where we just get a fixed sum to deliver, we're not on a case-by-case basis.

(Interviewee N)

The extent of the use of block contracts in community services is likely to be in part due to the lack of data and absence of quality metrics we have already described.

One provider's board papers described this situation:

The majority of our income (70 per cent) is through a block-contract arrangement with local CCGs. This means managing increases in demand within existing resources, and therefore a heightened sensitivity to demand pressures.



Multiple commissioners

All providers reported having more than one CCG commissioning services from them, in addition to NHS England and local authorities. Forty per cent of survey respondents had five or more commissioners, with a quarter of these reporting that they had seven or more commissioners. Having multiple commissioners and ensuring commissioners' strategic plans are aligned to their own were viewed as a challenge, especially when these plans diverged between commissioners. For example, involvement in multiple plans for the Better Care Fund was causing additional complexity among several respondents.

Lack of support for 'invest-to-save' changes

Providers reported the challenge of achieving year-on-year efficiency savings at the same time as needing to invest in new service models that were designed to achieve greater savings in the long term but that require investment initially.

Competing against providers with different costs

Some NHS providers argued that competing with non-NHS providers is unfair since they do not have the same employment requirements (such as NHS pensions and Agenda for Change).

Short contracts

Short contracts were reported to be a key obstacle to long-term planning and developing the quality agenda. Examples that we heard included deterring providers from investing in IT systems. Others included the impact on staff engagement of anxiety over future roles and job security, compounding already difficult staffing challenges.

Underdeveloped commissioning

While some commissioners were beginning to move towards outcome-based commissioning, others were focusing even more on activity, without acknowledging or responding to providers' concerns about workforce challenges. Local authority commissioners were seen by providers as having a poor knowledge of the sector, focusing on cost-cutting when existing services were already under pressure.



5 Conclusions and recommendations

This brief, high-level study has enabled us to begin to explore some of the major issues in measuring, managing and improving quality in community services.

Our interviews and document analysis revealed a sector full of innovative practice and local activity to manage and improve quality. Many providers were expanding their use of patients' feedback and patient-reported outcome measures, and had systems for staff and senior leaders to monitor quality on a regular basis. Many also told us of their work to develop a culture of quality and safety in their organisations, and to empower staff to take responsibility for quality and quality improvement. Respondents to our survey were optimistic about quality, both now and for the future. They often felt confident in their abilities to measure and monitor quality, and felt their staff had the skills they needed to improve quality at the front line.

But this confidence sits in contrast to a series of fundamental challenges and concerns that were clearly exposed through our research. These are difficult times for the whole health and care system, but community services are experiencing severe challenges, with demand pressures growing and workforce difficulties acute and worsening – particularly in areas such as district nursing.

In this pressured environment, the dearth of robust nationally available data on the quality of our community services is a dangerous blind spot in our knowledge. The long-term and preventive nature of so much of what community services provide does make for particular challenges in developing clear and attributable measures of quality and outcomes. But this only strengthens the case for greater national effort to develop meaningful and robust indicators and data. The presence of a high proportion of non-NHS providers of community services raises particular issues. The diverse provider sector in community services needs a level playing field in terms of the monitoring of quality, and transparency about performance.



If policy-makers are truly serious in their commitment to quality and transparency and in their aspirations to deliver more care closer to home, then greater levels of national support and commitment to developing robust national quality data for community services are needed. The work of the Care Quality Commission through its new inspection approach is providing rich evidence about the quality of community health services, but its capacity to monitor quality between inspections is hampered by the lack of national data. Better and more consistent routine measurement of quality is essential to:

- give staff and management in organisations the information they need to monitor and improve quality
- develop meaningful prices for community services to move away from block contracts and drive genuinely quality-focused commissioning
- provide transparency and accountability for quality in this important sector.

The goal needs to be a framework for understanding and measuring quality that accurately and fully covers the whole range of community service activities and impact. To take the example of patient safety, the ‘four key harms’ in the NHS Safety Thermometer are important indicators of avoidable past harm caused to patients, but in reality patient safety in community settings is about so much more than that. Safety in community services means staff having the skills and systems in place to recognise the early signs of deterioration in a patient or a family at risk and putting in place the support and services to stop them reaching an avoidable point of crisis. We have a very long way to go to develop measures and systems that support this more proactive, anticipatory way of thinking about safety, but that should be the aspiration.

As with any national system for accountability, there is a balance to be struck between effective national quality assurance and supporting local innovation and local ownership of quality improvement. We found many examples of innovative practice in the community sector, in terms of service design and in approaches to measuring and improving quality. As The King’s Fund has argued elsewhere, the community services sector is ripe for opportunities to redesign service models and structures to enable it to co-ordinate more effectively with both primary and acute care (Edwards 2014). It will be important to ensure that more effective national oversight of quality in the sector is not achieved through requirements that stifle this capacity to innovate and change.



The continued development of robust quality governance processes – from frontline services to board level and beyond to commissioners and national bodies – is crucial. But oversight and assurance will only ever be limited in the case of services provided by individual professionals in patients’ homes. Providers must prioritise engaging community services staff in quality, motivating them to take responsibility for accurate reporting. They must support them with the tools and skills in quality improvement and leadership for quality that they need to improve the care they provide.

The community services sector is a diverse and complex part of our health care system offering a huge range of very different services. These services are provided in places that do not fit a simple model of the NHS that thinks solely in terms of hospitals and GP surgeries, and they deliver outcomes for patients that do not fit a simple model of ‘treat and cure’. It has for too long remained poorly understood, under-supported nationally and perhaps also undervalued. Now more than ever, it is time that we become serious about quality in community services.

Recommendations to national bodies

- The Department of Health, the Health and Social Care Information Centre, the Care Quality Commission and other national bodies should work together with providers and researchers to develop and implement a clear road map for radically improving quality measurement in community services, across both NHS and non-NHS providers.
- The Community Information Data Set (CIDS) must be developed urgently.
- The Department of Health, Health Education England and Skills for Care should work together with the Local Education and Training Boards to develop a robust workforce plan and strategy for community health services.
- Monitor, NHS England and clinical commissioning groups (CCGs) should work to develop better pricing and contracting models for outcomes-based commissioning within community services.
- Portals such as those of NHS England, HSCIC and NHS Choices should make available quantitative metrics on the quality of community services, as they do for other sectors.



- These bodies need to offer national support to provider-led initiatives to benchmark data and develop shared indicators.

Recommendations to local service leaders

- Take the initiative locally to improve how quality is measured and monitored. Take advantage of opportunities to compare and learn from others, including outside the community services sector.
- Continue developing provider-led initiatives to benchmark data and develop shared indicators across the sector.
- Prioritise engaging community services staff in quality, motivating them to take responsibility for accurate reporting and supporting them with tools and skills in quality improvement and leadership for quality.



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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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Community health services provide vital care for millions of people. Children, families, people with injuries or long-term conditions, older people, and people in their last years of life all use this huge range of services. Demand for community services is growing as more and more people are cared for closer to home.

These community services are a key component of our health and care system, but they have been too often overlooked by the national focus on quality.

Managing quality in community health care services uses surveys, interviews and document analysis to gauge how community providers are defining, measuring, managing and improving quality.

Our findings show that:

- there are many examples of local innovation in measuring quality and some robust systems of quality governance in place
- community service providers feel that poor availability of information is constraining quality improvement
- staff shortages and workforce concerns pose serious risks to delivering quality care as do growing financial, demand and capacity pressures

At a national level, our lack of knowledge about quality in community services is a dangerous blind spot. If policy-makers are truly committed to quality and transparency - and to bringing more care closer to home - then action must focus on developing robust national quality data for community services.

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