Overview

- CQC’s role and purpose
- Our new approach to the inspection of community health services
- What we have found in year one
Our purpose

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

Our role

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

Registration
- Rigorous test
- Legally binding
- Commitment to safe, high-quality care

Independent voice
Thematic reports, statutory reports (e.g. State of Care), events, articles and other publications

Intelligent Monitoring
- Data and evidence
- Information from people

Fundamental standards

Expert inspections
- Expert
- Thorough
- Talking to people and staff

Rating and publication
- Outstanding
- Good
- Requires improvement
- Inadequate

Enforcement

Improvements in care

Key: CQC’s core functions
Registration | Monitor, inspect and rate | Enforcement | Independent voice
A new approach: Why?

Previous CQC inspections

- Missed important problems
- Focused on compliance vs non-compliance
- Did not give a picture of overall quality of care
- Were undertaken largely by ‘generic’ inspectors without expert clinical input
- Did not command confidence (e.g. from providers)
- Is it effective?

But … had good elements (e.g. evidence gathering)
Four core services will always be inspected:

1. Community health services for adults
2. Community health services for children, young people and families
3. Community inpatient services
4. End of life care
## Community Health Services Ratings Grid

<table>
<thead>
<tr>
<th>Category</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health services for adults</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
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What have we done so far?

Over 50% (13) of standalone Community Health Trusts, and several which are managed by Acute or Mental Health Trusts (April to December 14)
Variation

The degree of variation between the best and the worst is large and unacceptable.

There is variation:
- Between trusts
- Between services within a trust
- Within individual services (e.g. one ward may be inadequate, while others are functioning well)

However, a majority of providers are rated as ‘good’ or ‘requires improvement’.
Looking at ratings by type of provider and at key question level is more revealing.
Ratings analysis – MH/CHS

Ratings at key question level for Mental Health/CHS combined providers

- Outstanding
- Good
- Requires improvement
- Inadequate
Some outstanding and inadequate ratings at key question level although all overall ratings for these trusts were ‘good’ or ‘requires improvement’
Published ratings to date show that all providers have been rated as good for ‘caring’

Safe and well-led are areas for improvement

Community health all published ratings by key question

- Safe
- Effective
- Caring
- Responsive
- Well Led

% -100 -80 -60 -40 -20 0 20 40 60 80 100

Inadequate
Requires improvement
Good
Outstanding
Key findings: overview

Our inspections showed most community health services were providing a caring service. However, some recurring issues included:

- Staffing levels – either staff shortages or an unsuitable skill mix
- Inconsistent training
- Multidisciplinary working – while mostly good, some services struggled to bring everybody together to work in a coordinated way
- Leadership – recent restructures and changes had had both positive and negative influence
Compassionate care is alive and well in the NHS in all trusts inspected.

In a relatively small number of individual services or wards we found that the standard of care was not as good as it should be. This largely related to wards that were understaffed especially those for the frail elderly or escalation wards.
Key findings: culture

Culture may be difficult to define but relatively easy to recognise.

The staff survey and staff sickness levels give a good indication of culture, which can then be explored at focus groups.

In several trusts we saw a truly open and learning culture, with very positive views from staff about the leadership of the trust – these trusts generally performed well across all or most of the core services.

In contrast, we observed some trusts with a ‘them and us’ culture between clinicians and managers.

Staff engagement programmes appeared to be changing the culture in some trusts.
Next steps

- Need for a clearer understanding of what effective care looks like and how it can be measured
- Developing our thinking about new care models and how we adapt our regulatory approach. Regulation should not be a barrier to new models of care delivery.
- Development of agreed indicators with an emphasis on care pathways and the patient experience
The new inspection programme has come a long way in the past 15 months. It is undoubtedly better than the model it has replaced. We are finding wide variation within the NHS.
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Website link for provider guidance

http://www.cqc.org.uk/content/hospital-community-mental-health-providers