Quality Framework Development and Consultation

October 2012

Quality Framework
2013-2018
DRAFT v1.0
For consultation
quality@ssopt.nhs.uk
1. Contents

1.1. Responses to consultation questions ......................................................... 3

2. Aim and method .......................................................................................... 4

2.1. Pre-consultation development of the framework ......................................... 4

3. The consultation .......................................................................................... 5

3.1. Development of the final report ................................................................. 5

4. General comments received ......................................................................... 9

5. Responses to consultation questions .......................................................... 14

5.1. Background ............................................................................................... 14

5.2. Drivers for quality ..................................................................................... 15

5.3. Defining Quality ...................................................................................... 17

5.4. Using the best approach for quality ......................................................... 19

5.5. The aim of the quality framework .............................................................. 21

5.6. How the framework fits the trust ................................................................. 21

5.7. The five strategic goals ............................................................................. 24

5.8. Front line quality ...................................................................................... 24

5.9. Effective Outcomes .................................................................................. 28

5.10. Assuring Quality ...................................................................................... 30

5.11. Delivering Excellence ............................................................................. 31

5.12. Integrating Quality .................................................................................. 34

5.13. Implementation and monitoring ............................................................... 36

5.14. The consultation ..................................................................................... 39

6. Conclusion .................................................................................................... 40
1.1. Responses to consultation questions

A. Are there any other key internal strategies or policies in health or social care that the quality framework needs to take account of? .................................................................14

B. What other drivers for quality should be referenced in this framework? .................15

C. What other definitions of quality should this framework take account of? .............17

D. What should our definition of quality that encompasses health and social care be? .17

E. What other values for quality should we include? .................................................19

F. ‘Service users’, ‘patients’ or ‘customers’? What is the most appropriate term for the people we care for across health and social care? .........................................................21

G. What other local and national learning around quality should we take account of in this framework? ...............................................................................................................23

H. What other strategic goals, if any, should be included in this framework? ..........24

I. How can we empower front line teams and services to deliver quality and continuously improve the quality of their services? .................................................................24

J. How can we get all parts of our organisation to continually focus on outcomes? .....28

K. How can we strengthen our assurance processes around essential quality standards? ..................................................................................................................................30

L. How can we develop a culture of excellence across the whole organisation? .........31

M. What other key tools / work programmes can help us to “move to excellence”? ......33

N. Which actions can we take to fully integrate quality through the organisation? ...34

O. How can we most successfully bridge the culture gap between health and social care quality? .........................................................................................................................35

P. What indicators (and their target directions) should we include to measure progress against this framework for the next five years? .........................................................36

Q. What should we measure to tell us whether we are achieving our quality framework strategic goals? ...........................................................................................................38

R. Who else should be consulted? ..................................................................................39

S. Are there any other impact / assessment processes this quality framework should undergo before approval and ratification? .................................................................39
2. Aim and method

The aim of this report is to provide an overview of the process used to develop the Quality Framework 2013-18, and provide feedback consultation undertaken during September and October 2012.

2.1. Pre-consultation development of the framework

A working group set a series of dates for planning the development of the framework. The first meeting took place on 25 July 2012 and meetings took place through July and August. Initial development of the framework made use of a “blank page” template with key prompts around potential strategy goals (see figure 1). The first iteration involved one-to-one conversations with senior quality directorate staff, using the template to bring a focus to the requirements of the quality framework and ensure high-level alignment with organisational direction.

Figure 1: “Blank page” template for quality framework development

This approach was designed to enable flow of ideas in an iterative manner, while allowing for full development of the framework by subsequent consultation and engagement with all staff.

An initial draft quality framework was produced and presented to the Quality Governance Committee on 5 September 2012. Subsequent feedback and comments from the committee and staff within the quality team were incorporated into a revised draft, which was published for wide consultation from 26 September to 26 October 2012.

It is anticipated that the Quality Governance Committee will approve the final version of the quality framework on 7 November 2012. Development of the implementation plan for the framework will commence during November.
3. The consultation

The consultation made use of the following mechanisms to disseminate and gain comment on the framework draft:

- Emailing stakeholders and inviting them to comment and forward the document to their colleagues
- Attending internal group, team and committee meetings to discuss the document
- Having face-to-face meetings and telephone calls with staff and other stakeholders around the framework
- Posting the consultation document on the Trust internet and intranet site.

The substance of each response is copied into this report, correcting for spelling where appropriate. Names of respondents are not included, although comments have not been altered to strictly preserve anonymity unless explicitly requested. Comments were aligned with the closest matching consultation question where possible. Where possible all comments were incorporated into the final version. Where a comment could not be incorporated into the framework a note of the reasons for this is presented underneath the comment.

Table 1 logs the individuals and groups that were contacted for the consultation, and table 2 summarises the comments from impact and assessment processes.

3.1. Development of the final report

The final phase of development involved streamlining the document and clarification of the text.

- The detailed actions were moved into an implementation plan draft.
- A Quality Framework supplemental document was used to house the drivers for quality, approach to quality, and definition of quality sections.
### Table 1: Consultation summary

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Method</th>
<th>Who was contacted</th>
</tr>
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<tbody>
<tr>
<td><strong>Staff, committees and groups</strong></td>
<td>Stand</td>
<td>Quality team stand at Annual General Meeting marketplace</td>
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<tr>
<td></td>
<td>Discussion</td>
<td>Social Care Quality Group</td>
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<td></td>
<td></td>
<td>South Safety and Effectiveness Operational Group</td>
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<td></td>
<td></td>
<td>North Safety and Effectiveness Operational Group</td>
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<td></td>
<td>Discussion</td>
<td>Cannock Neighbourhood forum</td>
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<td></td>
<td></td>
<td>Seisdon Neighbourhood forum</td>
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<td></td>
<td></td>
<td>Stafford district nursing team leaders / specialist nursing team</td>
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<td></td>
<td></td>
<td>East Staffordshire team leader forum</td>
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<td></td>
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<td>Hospital Management team (North)</td>
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<td>Adult services service board (Stoke and North)</td>
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<td></td>
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<td>Burton Neighbourhood Managers meeting</td>
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<td>Stafford neighbourhood managers meeting</td>
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<td>North Transformation / Operations meetings</td>
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<td></td>
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<td>Medicines Management Group</td>
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<td></td>
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<td>Offender Health Managers meeting</td>
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<td>Executive Management Team</td>
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<td>Quality Governance Committee</td>
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<td>Professional Leads</td>
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<td></td>
<td></td>
<td>Meeting with Associate Director of Performance</td>
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<td><strong>General</strong></td>
<td>Articles</td>
<td>Articles in “the word” and Trust internet site</td>
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<td></td>
<td>in “the word” and Trust internet site. Cascade request throughout organisation</td>
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<td></td>
<td>via</td>
<td>communications team</td>
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<tr>
<td></td>
<td>Individual</td>
<td>Individual email to directors, heads of service, and</td>
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<td></td>
<td>email</td>
<td>managers whose roles are related to the quality framework</td>
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<td><strong>Email</strong></td>
<td>Joint Staff</td>
<td>Joint Staff Partnership</td>
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<tr>
<td><strong>Email</strong></td>
<td>Non-executive directors</td>
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<td><strong>Email</strong></td>
<td>Infection control team</td>
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<td></td>
<td>Head of Adult Safeguarding</td>
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<tr>
<td><strong>Service user</strong></td>
<td>Email</td>
<td>Staffordshire LiNK, Stoke-on-Trent LiNK, Community</td>
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<tr>
<td><strong>representatives</strong></td>
<td></td>
<td>Health Voice</td>
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<tr>
<td><strong>Email</strong></td>
<td>Biddulph &amp; Leek Patient Participation Group, Fifty and</td>
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<td></td>
<td>Counting Team</td>
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<tr>
<td>Cohort</td>
<td>Method</td>
<td>Who was contacted</td>
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<tr>
<td>Partner organisations</td>
<td>Email</td>
<td>Staffordshire Fire, West Midlands Ambulance Service</td>
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<tr>
<td></td>
<td>Email &amp; phone</td>
<td>Keele University, Staffordshire University</td>
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<td></td>
<td>Email</td>
<td>University Hospital of North Staffordshire, Burton Hospitals NHS Foundation Trust,</td>
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<tr>
<td></td>
<td></td>
<td>North Staffordshire Combined NHS Healthcare Trust, Mid Staffordshire NHS Foundation</td>
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<tr>
<td></td>
<td></td>
<td>Trust, Shropshire and South Staffordshire Foundation Trust</td>
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<tr>
<td>Other stakeholders</td>
<td>Email</td>
<td>Age UK (North Staffs), Community Health Equalities Network</td>
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<tr>
<td>Commissioning</td>
<td>Email</td>
<td>West Midlands Strategic Health Authority</td>
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<tr>
<td></td>
<td>Email &amp; phone</td>
<td>Staffordshire Overview &amp; Scrutiny Committee, Stoke Overview &amp; Scrutiny Committee</td>
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<td></td>
<td>Email</td>
<td>Staffordshire CSS, Stoke PCT, Stafford and Surrounds CCG, North Staffordshire PCT,</td>
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<td>South Staffordshire PCT, East Staffordshire CCG, South East Staffordshire CCG,</td>
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<td>NHS South East Staffs and Seisdon &amp; Peninsula</td>
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<tr>
<td></td>
<td>Email</td>
<td>Staffordshire Council representatives</td>
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</tbody>
</table>
Table 2: Impact and Assessment progress

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality Impact Assessment</td>
<td>Attended Equality and Inclusion Scrutiny Committee 17 Oct 2012</td>
<td>Include references to drivers such as the Health and Social Care Act (particularly in relation to reducing inequalities), NHS constitution, Equality Delivery Strategy, and Trust Equality Strategy. Consider adjusting the framework aim and definition of quality towards a more inclusive phraseology. Include a planned review / refresh of the equality analysis as part of the development of each annual implementation plan. Develop an “easy read” version and / or summary version of the framework.</td>
</tr>
<tr>
<td>Financial Implications Assessed</td>
<td>22 October 2012</td>
<td>“From my initial reading of the document it would appear that much of the focus is on doing things differently and through continuous improvement. I would therefore make the assumption that this would not carry any financial impact.” [from finance directorate]</td>
</tr>
<tr>
<td>Staffing Implications, Including Training Needs</td>
<td>19 October 2012</td>
<td>The framework is generic; there are no particular implications on staffing apart from the fact that workforce planning needs to take account of staff time out for training. It is suggested [though there is presently no formal recommendation] that five working days are allowed per staff member per annum for statutory and mandatory training and workforce development. Failure to take training and development into account will inevitably result in excessive use of bank and agency staff. [From Workforce &amp; Development]</td>
</tr>
<tr>
<td>Impact on Existing Strategy</td>
<td>29 October 2012</td>
<td>The Integrated Business Plan needs to be reflective of the quality framework The framework needs to link clearly to the Workforce Strategy and Workforce development strategy, in view of the overlap of objectives</td>
</tr>
</tbody>
</table>
4. General comments received

4.1.1. The draft had one front cover picture of one person … increase the number of pictures to allow for a reflection of the variety and diversity of people that the organisation employs and cares for.

4.1.2. “This looks like a comprehensive piece of work that has taken a great deal of time to pull together… It is quite a wordy document (I’m sure it needs to be!) however I’m not sure all, will fully read it. Is an easy read version planned for those individuals who may struggle reading a document like this?”

4.1.3. “I have been reading through our quality strategy and it is still looking like an assignment rather than a public facing document. I cannot imagine that front line staff will be able to pick out the key actions we are undertaking over the next 2-3 years to improve quality.

4.1.4. I have had a look at a few other trust strategies and was impressed … with the way they are explicit re what they will do e.g. with falls – this can be translated into a message for staff. Some have focussed on 3 things and identified what they will do and how they will measure them. We need to get ours to that place.

4.1.5. What I think would be good is the key details of what we will do re quality and how we will measure it as a summary at the beginning of the doc and then the rest will be an explanation of how we will actually deliver what we have said.

4.1.6. When I am talking public facing I am thinking more patients / service users / carers and also all of the voluntary third sector such as Age Concern…”

4.1.7. “I’ve just had (a very quick) look at the quality framework, and thought that the enclosed document fits very well within the Trusts framework from the nursing perspective.”

4.1.8. “This is a very well thought out and comprehensive framework which caused me to reflect on all the existing ways that we ensure continuous quality improvement within the service that I manage and additional quality improvements to ensure the best possible outcomes for the children and families that we serve.”

4.1.9. “We need to ‘Keep it real’! Nike sports wear manufacturers have a ‘Strap line’, JUST DO IT! It’s a simple yet emphatic statement which is motivating and empowering. In Social Care today much emphasis is placed on policy, figures and numbers, which I recognise is all part of the political landscape but the landscape is only meaningful if people are the main feature to give it scale and purpose.

I would like to hear more conversations in the workplace which feature the human side of our work and how the work we do impacts upon the lives of those people we work with and for. The arena for such conversations could be:-

4.1.10. Team meetings – time set aside to look at the achieved objectives and the shortfalls related to individual clients – this need only be moments fleshed out to Keep it Real

4.1.11. Area Meetings - Story boards and scenarios which convey some of the positive ways we enable individuals to maintain and move forward in the lives they choose
4.1.12. The community has many resources, groups and organisations and we need to actively encourage smoother, more flowing interaction with these groups and organisations as we can realise greater opportunities for creative working if networking is encouraged. Why not invite representatives from these groups to low key networking breakfast meetings to talk for an hour over coffee and share ideas and foster the positive energy which exists within each of our workplaces. Together we are more than the sum of our parts.

This comment has been adapted and added to the “integrating quality as a core part of the organisation” strategic goal

4.1.13. From a sensory point of view we could host an Eye Day or Help In-sight Day at Samuel Johnson Hospital and invite consultants and Specialist Fieldworkers to present innovative and informative lectures on eye conditions, related issues and rehabilitation and sensory impairment. This could be an annual event which is sold to other authorities.

4.1.14. “Overall, I really liked the document. I found it easy to read, well-structured and particularly liked the way the key messages were clear, repeated and reinforced in easy to remember ways e.g. Quality = safety, effectiveness and experience.”

4.1.15. I realise that your hope is that this will be the framework on which other strategies are developed, and so a lot of the detail will be found in these later documents. However, I would be really keen to ensure that right at the outset, the link between my own area – research, service evaluation and innovation – and quality is made clear in this framework. Having reread the document I did find references to research and development but it was easy to lose this link. To do this would not require much as we are working on the same agenda.

References to research and development have been added to the document to affirm the Trust commitment to supporting and promoting these activities.

4.1.16. “Generally a good document.”

4.1.17. “Distil!”

4.1.18. “Font size – needs to be at least 12”

4.1.19. “The document does not give a list of quality goals and how we will achieve them”

4.1.20. “…I welcome the views already expressed about simplifying the document to suit a variety of audiences.”

4.1.21. “Page 16 – are there words missing in this section? The lists under ‘safety’, effectiveness’ and ‘experience’ are not introduced beforehand therefore some of the bullet points are incomplete sentences. E.g. should ‘staff appraisal and development harnessing their potential for front line continuous quality improvement’ be altered to read ‘staff appraisal and development will harness…’ If there is no overall introduction to the points?

The wording has been altered to read correctly for each list.

4.1.22. In the ‘effectiveness’ section on page 16 – I think that the investment in leaders (first bullet point) is generic and not restricted to clinical leaders. We should all
be striving towards effectiveness and outcomes although I appreciate the clinical services are at the forefront.”

The word “clinical” is removed from the relevant sentence to reflect the generic nature of the point.

4.1.23. On page 13 the bullet pointed strategic goals – how will the trust pursue these goals?

The list has been removed in favour of a more comprehensive description of the goals.

4.1.24. The framework needs to include the following aspects related to social care quality:

4.1.25. Quality assessment of third party contracts

4.1.26. Practice quality framework (supervision and competency) for social care

4.1.27. Social Care Large Scale incidents and safeguarding, focussing on a learning organisation

4.1.28. Addition of third party providers and partner agencies in the conceptual model

These comments were incorporated into the framework.

4.1.29. “I have had a look at this strategy and would propose the following sections are used in the strategy as main headlines as these can then be incorporated and the one you have sent would be a good incorporation.

- Maintain a high reporting culture – evidence from NPSA and organisation patient safety report – ambition to increase reporting rate to above NPSA median which 43.7 incidents reported per 1,000 bed days.
- Degree of Harm reduced
- Improved reporting of Near miss Incident
- Serious incidents reduced
- Reduction of Hospital and Community Acquired Grade 2,3,4 pressure ulcers ref: zero tolerance action plan
- Reduction of Falls resulting in Serious Incidents in community hospitals
- Reduction of Medicine Errors
- No Never Events”

Some of these will be included as indicators in the framework, with the remainder being appropriate for the Safety Strategy.

4.1.30. “There is no reference to research governance in the section on research. Best practice would suggest this should be at least referenced for assurance purposes.”

4.1.31. There is no reference to positive feedback/compliments and how these will be used to drive further quality improvements through shared learning.

The detail behind this comment will be addressed in the Experience strategy.
4.1.32. “The only reference to Quality Accounts refers to the current. How will this framework influence/contribute to the next Quality Account? How might you use opportunities for consultation and engagement to support this?”

We have amended the section on monitoring in light of this comment.

4.1.33. “We wish to acknowledge that this document is currently in draft form and therefore subject to ongoing consultation and welcome the fact that we have been invited to contribute to its development. However, overall we are disappointed that for such a large organisation, and given your organisational aspiration to genuinely integrate with social services, there is no clear vision in respect of clinical effectiveness with little or no specific and measureable quality markers in this respect.

In light of these comments the framework has been strengthened to address high-level effectiveness agenda, leaving capacity for the Effectiveness Strategy to set a clear vision and specific quality markers for effectiveness.

4.1.34. “There is a general sense that staff have not been widely involved and consulted in respect of this document. This is disappointing. Furthermore, there was little reference to engaging and empowering staff in order to create a better culture. The document reads very “top down” both in terms of leadership and principles.”

All staff comments have been considered and built into the framework. It is hoped that the framework model around supporting front line teams will shift the emphasis away from a “top down” approach. The implementation phase of the framework will also benefit from ongoing engagement and consultation with staff and service users.

4.1.35. “In terms of the safety agenda, there was no reference to adult safeguarding yet this would appear to be one of your organisations biggest risks given the patient populations you serve across the Staffordshire and Stoke on Trent health economies.”

4.1.36. “On a general note the document requires further review and streamlining which we assume will result from your ongoing review.”

4.1.37. “Where medicines are used, what would be the trigger for a "safe handling of medicines" audit or inspection? The Medicines Management department have a simple tick chart, listing all of the safe handling elements listed in the "Duthie Report" - which is the gold standard for medicines handling (see: http://www.dhsspsni.gov.uk/the-safe-and-secure-handling-of-medicines.pdf) and this could almost be used by a non-clinician if its not possible for a member of the Medicines Management team can attend. Would that be something we could share with the quality team, so that "safe Handling of Medicines" is embedded in all of our premises, and we can evidence the process.”

4.1.38. “All premises where there are Controlled Drugs should have an annual inspection to comply with the CQC regulations. Is there any way we could incorporate this mandatory inspection into the quality visiting schedule? By adding this element to the quality visit programme, we would be able to reduce the number of visits any site would have. Again- there is a national template produced by the CQC around this- see http://www.cqc.org.uk/sites/default/files/media/documents/final_version_20120830_pro
The North Staffordshire and Stoke on Trent CCGs very much welcome the consultation exercise and found a lot of positives in the document however also found areas where it was felt that the document could be strengthened.

The consultation document clearly demonstrates that SSOTPT have considered carefully how to formulate a quality framework and have included most of the key headings one would expect to find in the document. The general direction of travel described is in line with what commissioners might expect. SSOTPT are to be commended for the approach taken in consulting widely with stakeholders. The framework was presented as a stand alone document and it is accepted that some of the comments might not have been made had the other documents referred to been available.

The layout of the document and the various sections and sub headings means that some of the strong punchy messages are found adjacent to sections that whilst useful read more like a quality text book. The key messages and SSOTPT commitments should jump out at the reader.

We would suggest a few things are missing.

The framework is identified as having a 5 year life. Within the strategic goals we would expect clearer commitments. Some of the elements to be delivered much sooner than 5 years and that there are more specific deliverables set out in the relevant sections with timescales.

To be more specific the CCGs would wish to be able understand and be able to monitor delivery of the initiatives etc described or alluded to within the framework and therefore feel that the framework should include or have appended to it a clear list of measurable changes, actions or other specific deliverables with timescales for completion, internal monitoring arrangements and identifying the leads within SSOTPT responsible for delivering each initiative.

We are aware that this level of detail has not been included intentionally at this stage and that it may well be included in a later iteration, as an appendix or within one of the other strategies.

CCGs feel the framework would benefit from a section which describes possibly graphically the quality process or cycle. For example each year a clinical audit programme is set, there is an annual complaints report received etc. This will then include an annual review and refresh of this framework so that it is kept live and so that progress is being monitored at board level.

The framework might benefit from the current and predicted future priorities for quality improvement.

Safeguarding of Vulnerable Adults and Children is not covered in the way I would expect. Safeguarding is on all quality agendas (small a). It is crucial that it has a high profile in a quality framework.

Some of the detail in this comment will be addressed by the implementation plan and supporting strategies.
4.1.49. “One general comment is that we would like to see more specific deliverables with timescales within each strategic goal.”

The implementation plan for the framework will contain the specifics around deliverables and timescales.

4.1.50. “The framework in places looks workable, robust and comprehensive. Missing from the document is constant reference to stakeholder involvement.”

4.1.51. “Applaud involvement of patients and staff. However, document is not written for staff to own.”

4.1.52. “Good corporate document. Issue around the ownership of the staff and the organisation which enables delivery.”

4.1.53. “How will this be implemented? Corporate document rather than a practical document to help staff to absolutely be in control of the quality agenda.”

5. Responses to consultation questions

5.1. Background

A. Are there any other key internal strategies or policies in health or social care that the quality framework needs to take account of?

5.1.1. “Staffordshire & Stoke on Trent Adult Safeguarding Interagency Adult Protection Procedures. Health, Social care & Police are all signed up to this.”

5.1.2. “Social Quality Framework and S75 quality framework going to PARG”

5.1.3. “SSOTP Workforce Development Strategy [and] SSOTP Workforce Strategy”

The revised framework now links heavily to the workforce strategy and workforce development strategy

5.1.4. “The OD Strategy contains 3 organisational objectives that are aligned to quality: [1] Create a culture where individuals are empowered to fulfil their roles and support the Trust’s vision, [2] Develop our leaders to be ambitious, innovative, empowered role models for other staff, [3] Support the continuous improvement of the Partnership Trust so that it is effective, efficient and delivers quality safe care that meets the needs of the population it serves.”

5.1.5. “Do we need to make reference to infection prevention and control strategies/policies somewhere as in some patients view this is an indicator of quality for them. I.e. to compare like for like organisations.”

5.1.6. “There is a may be a stronger link to shared agendas of the Staffordshire Strategic Partnership which outlines a commitment from partner agencies in regard to ensuring that Staffordshire will be a safe, healthy and aspirational place to live (Staffordshire Strategic partnership/Staffordshire County Council 2011).”

5.1.7. This section should appear later or an appendix linked to other drivers for quality.

5.1.8. The vision on page 4 should be linked to trust vision. Board strategy and the Integrated Business Plan needs to be enmeshed with the Quality Framework.
Many of the indicators in the framework and the measures in the Integrated Business Plan are now reflective of each other.

5.1.9. The Quality Framework needs to underpin the absolute commitment to quality and show how trust vision and values will help us with quality.

5.1.10. “Adult Social Care Outcome Domains: Priorities for Adult Social Care”

5.1.11. “Board to Ward”

5.1.12. “Social care outcomes framework”

5.1.13. “Trust Equality Objectives”


5.1.15. “This relates to internal references, best addressed in SSOTPT. We would however suggest that references is made to those documents that cover

- Safeguarding
- Staffing levels and workforce
- Skills competence training IPDR PDP etc
- Recruitment (pre employment checks etc)
- Whistle blowing policy”

5.2. Drivers for quality

B. What other drivers for quality should be referenced in this framework?

5.2.1. “There needs to be a significant section in here on Personalisation as a key driver and you need to research all the social care related national drivers for inclusion”

5.2.2. “Markers of Quality for Social care … needs incorporating into the framework …”

5.2.3. “…useful to mention patient participation with the trust e.g. ARMA wheelchair user group, Matrons surgeries and walkabouts…..”

5.2.4. The summary of drivers should start with strategic organisational goals – take this to the top of the vision, that we will deliver quality.

5.2.5. “OFSTED and Joint Children and Young Peoples Services inspections e.g. looked after children and children with disabilities inspections.”

5.2.6. “Care Quality Commission, Independent Safeguarding Authority, LIPS Leading Improvement in Patient Safety”

5.2.7. “Skills for Health and Skills for Care are working collaboratively to provide induction standards for support workers. Currently there are Common Induction standards from Skills for Care that should be referenced these are called “Starting Out: Common Induction standards” Skills for Care Shouldn’t we be including Professional standards such as NMV Code of Conduct?”

5.2.8. “Health and Social care Act, National Institute for Health Research, NHS Operating Framework, Payment by Results (Best Practice Tariffs)”

5.2.9. “Other quality initiatives- Essence of care energise for excellence productive series, CARE campaign.”

5.2.10. “I saw mention of investigation when things go wrong but no specific reference to fair blame and open and honest culture apologise if it is”.
5.2.11. “There is the opportunity to introduce a clear link to Health and Wellbeing Boards and Clinical Commissioning Groups in terms of influencing service delivery and the targeting of interventions.

5.2.12. The trusts’ own goals are clearly outlined on page 7 – Could it be more outward focused to include greater multi-agency work or collaboration with partners who will also be contributing to the Trust’ agendas.

5.2.13. The public health outcomes framework identifies clear target … for prevention activity to tackle things like such as falls prevention, reducing A&E admissions, alcohol related health issues, mental illness and dementia which will drive down demand on services. Is there an opportunity to outline how the trust will prioritise prevention work to tackle the wider determinants of health - particularly in the areas of innovation, quality and investment?"

5.2.14. “I am pleased that the following is included in your document: (The Vision for Social care (2010) and Think local act personal (2010) emphasises a system that helps people to live their lives the way they want to, supported by the staff who work with them. The approach aims to free the front line from bureaucratic constraints and support local organisations to focus on the quality of care and the outcomes achieved for people using services and their carers, without the focus on targets.)”

5.2.15. On page 4 (introduction) bullet point “engaging all of the executive team in the agenda as well as front line staff” – why not include other line management?

5.2.16. “Outcomes of Francis Enquiry?”

5.2.17. “Include Equality principles of Fairness, Respect, Equality, Dignity and Autonomy”

5.2.18. “Simplify the strategic goals and develop a simple leaflet for them”

5.2.19. “Aren’t Safety Express and Safety Thermometer the same thing?”

5.2.20. “What about the Net Promoter/Friends and family test?”

5.2.21. “Reference might be made to relevant strategies and frameworks from the SHA and CCGs (noting the development of CCGs).

5.2.22. Predicted increases in age and level of cognitive impairment within the population are a major driver as is involvement of and support for carers. Although mention elsewhere these might stand on their own.

5.2.23. It is important that each commissioning CCG is given the opportunity [to identify] its key drivers for quality and CCG priorities for quality improvement. These should feed future iterations of the framework.

5.2.24. The preceding section would be strengthened by being more specific about what the drivers listed require and what this means to SSOTPT and how it is captured in the framework. The list in table 2 does not add much to the framework. We won’t go through each driver, but couple are worth mentioning.

5.2.25. The Commissioning for Quality and Innovation (CQUIN) scheme paragraph is absolutely correct, but possibly misses the key point. The CQUIN system incentivises quality improvement and innovation over and above that required within the commissioned service. At its best, the CQUIN scheme should be much more that payment linked to meeting quality markers, it was intended to be one of the ways to have shift in focus to a continuous improvement culture amongst commissioners and providers and commissioning for quality. CQUINs
represent an investment by commissioners in quality improvement and innovation.

5.2.26. **National Patient Safety Agency** (This is listed in figure 2.) The NPSA was set up in response to a recognition that the same things go wrong again and again (Organisation with a Memory and some of the follow up publications although old remain some of the key references in the safety improvement agenda). The NPSA leads on initiatives to improve patient safety; it also collects information on incidents and provides feedback to NHS organisations.

5.2.27. As a driver we would therefore expect the framework to set out what the NPSA processes and requirements mean to SSOTP and its commitment to participate in those processes and work with NPSA to support achievement of the relevant objectives re improving safety.

5.2.28. We won’t go through all the drivers, but similar comments could be made about others shown.

Some of the specific details of this comment will be fed into the safety strategy

5.3. **Defining Quality**

C. **What other definitions of quality should this framework take account of?**

5.3.1. “Include the ‘wheel’ from the social care framework and some narrative “Only the customer can define quality””

5.3.2. “A patient/user definition- this is referred to on p15 but I suggest it needs defining further”

5.3.3. “The Donabedian categorisation is out of date.”

5.3.4. “The most important one currently is the Darzi one so none unless you have a specific you wish to include.”

D. **What should our definition of quality that encompasses health and social care be?**

5.3.5. “My answer doesn't directly relate to the question as I feel the definition is correct, however, somewhere in the quality framework we need to include that quality sometimes is expressed in terms of the fidelity to the replication of evidence based, sometimes, licensed programmes e.g. HENRY, Family Nurse Partnership (FNP), and Preparation for Birth and Beyond (PBB).”

Added into the "essential quality standards" strategic goal

5.3.6. “Happy with Safety / Effectiveness / Experience but very clinical. Safety needs to reference protecting vulnerable adults from harm (Adult protection). Experience needs to reference the quality of assessment and care planning for the service users. Effectiveness needs to reference something around how well people achieve personalised care services through the assessment and support planning process”

5.3.7. “It should include working together for a common purpose and understanding and appreciating each other’s contribution”

5.3.8. “Use and quote the Darzi definition … we can substitute the word patient for people as this would fit with what we are trying to achieve with integrated teams
- prevent people getting ill and into hospital. The 3 component parts safety / effectiveness / experience also fit this well."

5.3.9. "Your definition needs to be snappy, catchy and focussed. Forgive the direct approach but it currently reads like you’ve clearly tried to make it meet all requirements but how real is it? The definition should really push the emphasis on patients/service users being central."

5.3.10. "What about the patient perspective as a contributor to the definition line above?"

5.3.11. "We are reasonably comfortable with use of safety, effectiveness and experience.

5.3.12. We would always be tempted to include reference to access and although we know this was not included in the 3 Darzi elements for good reason, it is part of a quality service.

5.3.13. Some phrases that might be useful in supporting definitions of quality

- Right people at the right time
- With realistic expectations
- Getting the right services for them based on sound clinical (scientific?) evidence
- Which are goal based, personalised and planned with the consent and involvement service user (and or carers) [assuming capacity]
- Delivered consistently by experienced skilled competent caring and motivated staff
- Sufficiently flexible to responding to changing need.
- In the best place (default at home or as close to home as possible whilst ensuring safety and effectiveness)
- Using the most appropriate medication and equipment
- Cost effective
- Leading to the best possible outcomes
- With Minimum risk of adverse or outcomes
- And with problems, issues, incidents concerns recognised and addressed as they arise, lessons learned and changes made to improve services and reduce risk of recurrences
- Followed by
- Safe discharge from services or
- Effective and appropriate on going or long term support services where needed
- Minimising for as long as possible the need for more intensive services
- And maximising ability to care for oneself
- And enjoy activities of daily living for as long as possible
- Minimising the risk of future unplanned or emergency services

5.3.14. We would also tend to support a clause that helps define high quality at the end of one’s life which has some specific requirement.
5.3.15. Elsewhere in the report there is reference to quality “Only the customer can define quality; learn what’s important to customers”.

5.3.16. Whilst endorsing the principals behind this, it fails to recognise that ours is an evidence driven, highly skilled and in some cases technically complex function. A skilled professional may well through approach, attitude, and understanding provide service users with a huge amount of confidence and reassurance but the quality of the service is equally dependant on that professional having the competence, skills and experience and applying those skills in a consistent way in line with best practice. Service users can be clear that they expect high quality service in line with best practice, but to monitor this the definition of quality does need to include reference to objective and measurable or testable standards.

5.3.17. The safety element of quality and to some extent the effectiveness element require consistent and standardised processes. It is challenging to find a form of words that encompasses all the elements of quality but it is important that the need for standardised processes and consistency of approach based on evidence and best practice in care is not omitted in order to emphasise the need for flexible and patient centred services. These are two sides of the same coin.

5.3.18. We would support an explicit statement in this section that recognises that there is a minimum level of quality expected now and that any deviation from this will require immediate response, that this minimum level of quality is constantly increasing, but the beyond that quality includes both a culture and programme of continuous improvement with priorities for improvement based on service user carer, commissioner, provider, local regional and national priorities.”

5.4. Using the best approach for quality

E. What other values for quality should we include?

5.4.1. “Too much narrative around tools, scores, data etc but very light on emphasis on user and carer experience. Quality can’t be delivered by dependence on methodologies, theories and best practice without a consideration of the individuals and local issues.”

   The overall value for quality has been amended to include “always being user focussed and responsive”

5.4.2. “Would it be possible to use the term evidence informed practice within the document. After reading page 11 I was left asking the question what is best practice? I think using evidence informed practice and then making a statement about what this includes (hard research evidence, service evaluations, service user feedback, professional peer group review) would help.”

5.4.3. …the evidence informed practice debate is growing a pace within the knowledge mobilisation agenda… It seems to be a term that we will move to. My colleagues within professional education courses at the local universities are aware of it and using it within their courses.

5.4.4. The idea is that it is not possible to fully implement research findings in their pure form. Often they will have been carried out in isolated “clinic” type environments, with a sample of a certain type of patient and our clinicians are often working in community teams with a huge diversity of patients.
5.4.5. Evidence informed practice is based on professional decision making, taking the research evidence, discussing it in line with local knowledge from service users and the format of local service delivery. It would be the model that I suggest we take forward in the Trust."

Evidence informed practice is a relatively new term, in the absence of existing strategy or organisational policy that advocates this approach, the use of the term “evidence-based practice” may be preferable. Both terms will be used in the document.

5.4.6. “Please can this be aligned to the SSOTP values and very clearly articulated so that readers are clear about how this reflects and ‘lives’ our values and are not confused by too many different set of values. They need to be a ‘golden thread’ that runs through. This may be easier to do in a couple of months once we have tested the proposal for distilling the values into 3 more memorable phrases…this will be presented in a paper to Board in December, so is the timing ok for this?”

5.4.7. “Overall I would advise linking to the Trust’s values (unless there have to be quality-specific values) as these will be underpinned by the Organisational Development Strategy.”

In light of the forthcoming work on organisational values and the content of the section it may be prudent to rename the section “our approach to quality”.

5.4.8. “Include Real Time Monitoring in Experience best practice approaches”

5.4.9. “Page 11- bullet points at the bottom of the page could be expanded to include expected behaviours”

5.4.10. “Putting yourself in the shoes of the patient / user”

5.4.11. “Would you be happy for your family to receive the services you deliver?”

5.4.12. “Evidence-based practice”

5.4.13. “Only the customer can define quality? Is the customer well enough informed? E.g. the PSA test for prostate cancer; a customer may demand a service or intervention that is not in their best interest. In podiatry certain toe amputations can lead to overloading of adjacent toes”

It is true that our service users need information to make informed decisions, and in some circumstances professionals will make decisions on their behalf, in their best interests. The phrase “only the customer can define quality” is used as a general principle bearing in mind these caveats.

5.4.14. “What about the evidence based approach?”

5.4.15. “What about recognising and rewarding good practice?”

5.4.16. “Values should include recognition of the commissioners’ priorities.”

We have included commissioner’s quality priorities in the drivers section, and recognition of commissioner priorities is implied in the statement “only the customer can define quality”.

5.4.17. “Values should include explicitly that local or team based improvement initiatives will be supported, developed and where appropriate rolled out.

Page 20 of 40
5.4.18. Leaders in innovation often have “forgiveness not permission” as a value in other words within the confines of not compromising existing quality requirements, there is a culture supporting the testing of quality improvement initiatives at a local level.

5.4.19. We would like to see recognition that staff and service users are the best source of information about quality of services. Whilst the service user element is picked up, the acknowledgement of the role of staff, recognition of staff concerns and suggestions and responding to these could be included in the values.”

5.5. The aim of the quality framework

5.5.1. “The aim of the quality framework could be stronger. The framework should be the vehicle through which SSOTPT will ensure that for the next 5 years it improves year on year the quality of its services in ways that are clearly beneficial to service users. SSOTPT will develop a culture that promotes safer evidence based services with better outcomes, by supporting both proactive and responsive quality improvement initiatives throughout the organisation.”

5.6. How the framework fits the trust

5.6.1. “I am a little concerned that the model on page 14 is a little simplistic when in fact the multidimensionality of quality is well known… I can live with the model as described in the framework as it does show the influence through the various levels of an organisation. My difficulty with it is that it still represents the hierarchical transfer of knowledge - no matter who is on top. I don't know of any other published model (I haven't looked) but wonder if a circular diagram would better represent the negotiation and mediation which goes on at each stage.”

5.6.2. Whilst the picture on page 14 is useful the document might benefit from more explicitly setting out the drive for quality improvement across all levels of the organisation from Board downwards. (Some of this may be in the strategy documents referred to).

5.6.3. “The conceptual model is useful but might be supported by one or more organisational structures that show responsibilities and reporting arrangements plus committee structure in a way that is meaningful to staff and demonstrates that the arrangements are sufficiently robust. This might well be in the strategies referred to earlier already.”

The model has been redrawn to reflect a circular theme, viewed at an angle to demonstrate the layers and preserve the focus on service users and front line teams being “at the top”. Detail on structures, including committee structures, will be included in the strategies and workstreams that support the framework.

F. ‘Service users’, ‘patients’ or ‘customers’? What is the most appropriate term for the people we care for across health and social care?

5.6.4. “We are an NHS organisation therefore patients should be our commonly used term, but clients should be agreed for those who are not unwell”

5.6.5. “Individuals’ always works for me or to make sense individuals who use the service.”
5.6.6. “Customer [or] service user for me as they can both capture both health and social care “

5.6.7. “I think Social care will want service user and health patient so may be best going with customer?”

5.6.8. “I think they (the people we care for) have to decide this- many current ‘patients’ dislike the term ‘service user’ but clearly the term ‘patient’ needs updating to reflect the more equal and collaborative relationship in care that we aspire to. Perhaps ‘customer’ is the best option, if the word ‘people’ doesn’t work…”

5.6.9. “Service Users” (x3)

5.6.10. “Patient (meaning one who suffers) is a disempowering term that is oppositional to our value of supporting independence, promoting self efficacy and empowerment. (Patient (grammar), in linguistics, the participant of a situation upon whom an action is carried out.)

5.6.11. I believe it may contribute to the power imbalance between the person receiving the service that the person giving the service. This power imbalance needs to be reduced, as far as possible, and a more partnership relationship needs to be promoted. This would be beneficial to both SSSOTP and the clients as the demands on the NHS/social care could be reduced and satisfaction with the service would increase.

5.6.12. Customer does imply choice and also implies someone who is valued, on which we depend for success, but it also implies a business relationship and some may find this offensive when we are thinking about the NHS which is free at the point of access. Consumers have the right to make their own choices and the ability to act on them and not all of the people we work with really have choices as they may not be aware of them or have the ability to act on them due to their illness, or age, or limited options available to them. Many are reliant on us and others to ensure they get the best possible care/service in accordance with their wishes.

5.6.13. In our service (Family Nurse Partnership) we use the term’s "client", 'parent', infant/baby/toddler, and we often refer to ‘Mums’ and 'Dads' or partners, but most often, when speaking more formally we use 'Client'. It would be difficult to imagine infants and small children as customers or consumers as it implies an active seeking of a product or service and infants and small children are incapable of doing so, reliant and totally dependent on caregivers to make appropriate provision for them and listen to their voice in creative ways. In FNP the parent or carer is the client, however, the objective is to work through the client to get the best possible outcomes for the infant/toddler - the interests of the child are paramount and the child is at the centre of the therapeutic relationship; the work, in a parallel process, enables the best outcomes for the parent and carer.

5.6.14. In conclusion I would like to offer the term ‘client’ as I believe it implies that we are working, on behalf of the person, with their best interests and their wishes at the heart of what we do. It implies some level of advocacy but that the receiver of the service has control and the provider is using their knowledge, skills and expertise to assist the client to get the outcome that the client wants and has agreed. Nursing literature often refers to the nurse-client relationship and it is used within therapeutic relationships which is part of SSOTP’s direction of travel, but it also fits in with transactional relationships, which is the other way in
which we deliver services. I feel that the term ‘client’ would fit well in an NHS and social care context equally, I feel the values are extremely similar.”

5.6.15. “Allowing for these constraints, the evidence of this study is that the majority of those who use our service and expressed a preference do not want to be called “Customers” and would prefer the department to use the title “Patient” to describe them.” (Summary of a submitted study: Do people receiving services from Social Care and Health wish to be viewed as “Customers”?)

5.6.16. “Perhaps the use of the social care based term “service user” should/could be coupled with ‘patient’… would suggest service users and patients but avoid customers.”

5.6.17. “Although we will refer to patients often, my personal preference would be service users if one term is needed which includes social care. The customers are the commissioners of services in my view. We are aware when we talk about customer services, we include patients and service users and that “service user services” will never catch on.”

In view of the responses given, and endeavouring to find a consistent term compatible with health and social care, the term “service users” is generally used through the document. (Instances where the terms “patient”, “individual”, or “customer” are used are context-specific, such as when referring to “patient safety” or “customer service excellence”.)

G. What other local and national learning around quality should we take account of in this framework?

5.6.18. “A mention of Quality Circles as a way of bringing together feedback from the user with actions developed by operational teams. Removing the steps in-between”

This comment has been added into “moving to effective outcomes”

5.6.19. “NHS Consultants Clinical Excellence Award Scheme”

While this scheme is broadly related to clinical effectiveness it may be more appropriate to consider it within the scope of organisational development and human resources.

5.6.20. Opening paragraph on the “conceptual model” needs to be in lay speech as this is a public facing document.

5.6.21. Page 14 mentions, “Our service users ultimately define what quality is.” Do they, or do they confirm we have it right?

This phrasing may not be fully compatible with the choice and personalisation agenda, and the Darzi definition of high quality care, which is care “where patients are in control…”

5.6.22. “There are countless reports available on the CQC website; perhaps this chapter could include a general statement about CQC reports. Perhaps further reference to the NQB early warning system document would be helpful here. Although old, there’s always value in Shipman, Bristol Royal Infirmary. There are other high profile cases such as Lakeland (abuse of elderly patients), Cornwall report. The list is relatively endless! There are of course key safeguarding reports such as Haringay, Victoria Climbie etc.”

5.6.23. “There is a plethora of national learning. It changes all the time. Rather than list them, maybe the framework should set out how SSOTPT can ensure that all
relevant information is received analysed and key implications shared at all levels of the organisation, including for the most critical / relevant learning at Board level.

This suggestion is included as an action in the Effectiveness strategic goal

5.6.24. “The listed examples might be better placed in the drivers section”

5.7. The five strategic goals

H. What other strategic goals, if any, should be included in this framework?

5.7.1. “Also, a lot about the mechanisms but would we want a goal around “Effective mechanisms for improving quality””

This framework provides a foundation for the safety, effectiveness, and experience strategies to provide more detail on mechanisms for improving quality. Therefore an additional strategic goal for mechanisms was not considered necessary here. Detail on the mechanisms outlined in the draft framework, particularly around “front line continuous improvement, benchmarking, and customer service excellence has been removed or condensed to allow for its inclusion in other strategies.

5.7.2. “I applaud the emphasis and Quality. As clinicians we agree with the strategic goals chosen: Empowering Front Line Quality, Moving to effective outcomes, and Assuring Essential Quality Standards”

5.7.3. “Refine the strategic goal descriptions so that these present well at face value.”

5.7.4. “These goals could be further enhanced by one which puts patients/service users at the centre of all you do – possibly illustrated in the model above. Further reference to safety would enhance this further.”

5.7.5. “The goals themselves seem appropriate, but we would like to see a goal that is service user centred (we know this is picked up within the other goals, but having a service user centred goal might send a positive message. The focus should be on the services getting it right first time and designed in partnership with the service user / carers.”

5.8. Front line quality

I. How can we empower front line teams and services to deliver quality and continuously improve the quality of their services?

5.8.1. “Empowering Front Line Quality – No narrative on what this means. I personally don’t like the pie chart as it suggest separate elements and not the themes working together.”

The pie chart has been removed and replaced with a more descriptive spider diagram.

5.8.2. “Consistent frameworks for supervision, appraisal and induction. This ensures individuals understand the expectations of quality and are held to account to deliver on their responsibilities”

5.8.3. “I am pleased to see that we are aiming to be nationally acclaimed within the quality support team and I believe that we need to set our sites this high in everything that we do; we aim to be the best in the country within the team that I
manage. I think the framework clearly reflects the intention to be the best as it is an excellent and aspiring document."

5.8.4. “In Empowering front line quality – I would like to see references to empowering staff to ask questions, to search the evidence, to generate their own evidence and to share best practice. I would like references to research and service evaluation added here.”

5.8.5. “Through education! By making all clinical staff engage in audit to measure quality as part of their routine work. All teams to be involved in audit at least twice a year. We can make it a standard that all clinical staff should attend clinical updates every year on topics linked to their area of clinical practice”

The more specific aspects of this comment lend their inclusion into the effectiveness strategy rather than the quality framework.

5.8.6. “Owning and therefore able to ‘live’ the SSOTP values and embedding them in practice. Use or evidence based, and recognised tools and models for a consistent approach that all staff can become familiar with and therefore be able to conduct more per and team review sessions to share and test best practice and critically review when necessary.”

Added aspects of this comment into “empowering frontline quality”

5.8.7. “Team away days to reflect and review.”

5.8.8. “Easy access to evidence/information/audit”

This detail will be addressed in the effectiveness strategy.

5.8.9. “Sharing knowledge”

5.8.10. “Clinical leadership”

5.8.11. “Actively support and facilitate the generation of and update of new ideas”

This comment was incorporated into “moving to excellence”

5.8.12. A system of earned autonomy, linked to CQC registration? Service lines to individual team level.

5.8.13. “…this quality framework will only result in an improvement of the actual quality of our service when the following from the document will actually be acted upon:

- Our workforce will be empowered and supported to deliver care in a way that is consistent with our values.
- **Our service users** ultimately define what quality is. They are at the heart of what we do, and we recognise that front line staff and teams deliver the care and services they require.
- **Front Line Teams** and services are the next most important element – both clinical and managerial staff, who directly deal with service users and carers and are responsible for their competencies, conduct and for the quality of care they provide for service users.”

5.8.14. The paragraph on page 13 ("where we are now", starting “The trust has multiple teams…”) does not make sense.

5.8.15. Under “where we want to be” on page 13 how will we evidence that “Teams are recognised regionally and nationally for quality and set the direction for effective team working in the organisation”? 

*Page 25 of 40*
5.8.16. On Page 20 “Essence of Care” is mentioned. This tool is out of date and not fit for purpose – remove.

5.8.17. On page 18 (where we are now) the trust welcomes the challenge of moving to FT status, which will create additional criteria for maintaining quality and safety.

5.8.18. On Page 18 (where we want to be) the document describes “teams are recognised regionally and nationally for quality and set the direction for effective team working in the organisation”. Which teams?

  The sentence refers to frontline teams.

5.8.19. South Staffordshire PCT used to have a scheme where staff could nominate teams / individuals on “going the extra mile”. Joint Staff Partnership involved in choosing the winner, the team received a £25 voucher and a personal letter from the CEO.

5.8.20. “Fair blame culture”

5.8.21. “Showcase what we mean by quality”

5.8.22. “Help frontline teams to be able to close the loop”

5.8.23. “More Resources – or some mechanism for front line teams to be able to say when they are over capacity (e.g. caseloads) or cannot function safely with current resources. Some kind of escalation systems”

5.8.24. “Standardisation, and clearly defined service specifications that align cost improvement programmes with team level activity and caseload forecasts”

5.8.25. “Detailed discussion of contracts and service specifications with frontline staff – so that they know what is expected of them from commissioners, and so that commissioners know what they can get for their money, as sometimes we cannot provide without going the extra mile or going over budget. It feels like we are working to unseen historical service specifications.”

5.8.26. “Adequate IT”

5.8.27. “Faster recruitment process”

5.8.28. “Better record keeping and communications”

5.8.29. “Feedback on how we are doing – we need systems so that we can monitor quality and see whether we as front line teams are meeting patient expectations. We need data on what our quality targets are, and whether we are achieving them.”

5.8.30. “Address inequalities of service provision and staffing cross the patch”

  This suggestion will be implemented as part of the Transformation agenda, with the move toward integrated teams.

5.8.31. “The quality of our services is impacted on by outside organisations [e.g. hospital discharge and prescribing initiation] which we have no control over”

5.8.32. “Giving Front Line staff permission and confidence to work according to a business model” [working to clear service specifications rather than absorbing all activity]

5.8.33. “addressing little niggles, like team leaders not having time to provide leadership to their teams because of doing admin & clerical tasks”
5.8.34. “Training and support for front line staff so that they know they are doing it right, e.g. new staff should get all the training they need before they start, and have good in-service training built-in as part of their ongoing work”

5.8.35. “we are getting more challenge [about treatments and quality] from our service users and customers”

5.8.36. “our roles have changed – do other staff know what we do”

5.8.37. “As clinicians quality is innate to most”

5.8.38. “I would ensure that their preferred communication is provided without hassle such as BSL interpreters, Electronic Notetakers, Lipspeakers and deafblind interpreters.”

5.8.39. “Large print, audio tapes/CD.”

5.8.40. “Accessible website for all with different sensory needs.”

5.8.41. “To be able to contact any team using a range of contact methods – phone, sms texting, textphone and emailing; and in the near future face to face video calling to allow deaf people to lipread what is being said.”

5.8.42. “Coaching! Leaders cannot dictate quality. Giving the right resources and skills to staff. Newly qualified staff are young, lack experience, and need to be given responsibility to think for themselves.”

5.8.43. “Supporting staff, allowing them to make some mistakes, reflect on them, and learn from them. Different motivations of staff (some who do the job only, and others who are driven to do more). How will you motivate individuals to move forward, delivering the high standards.”

5.8.44. “What about evidence of acting on staff feedback? Also, what about reference to responsibility for quality in job adverts, descriptions etc, creating this as a core value from the outset.”

Some aspects of these comments would lie within the remit of the specific workforce and development strategies

5.8.45. “There is an acknowledgement that improvements are delivered by front line teams. This might be expanded to reflect the fact that improvements are often conceived and developed by front lines teams when the culture is such that this is supported and encouraged.

5.8.46. Regular assessments of staff safety and quality culture for example one of the evidenced based safety culture tools or a SSOTPT developed quality culture assessment, using these to identify exemplar teams and teams with scope for improvement. Aim to show improving culture year on year.

5.8.47. Commitment to have an innovation and quality improvement programmes including innovations conceived and developed at pilot scale by individual teams and support to roll out those locally developed initiatives which have the most positive potential impact.”

5.8.48. “Quality Champions in front line teams.”

5.8.49. “Support for implementation and maintenance of initiatives like the “productive” series or equivalent. Whilst this is certainly implied, it might be helpful to explicitly state which initiatives are currently in train.”

The detail within this comment will be addressed by the Transformation Programme
5.8.50. The FLCI box is useful. The framework would benefit from an acknowledgement that the front line teams mostly need small amounts of support and protected time at the early stages of an initiative to get things off the ground and at periodic intervals to maintain the improvement.

5.8.51. “The following extract may need to be modified: “The ongoing requirement to demonstrate value for money, improving efficiency while maintaining quality in the context of a reducing financial envelope, will require every team to own the quality agenda.” My view is that over the next 5 years maintaining quality will not be sufficient.”

The sentence has been amended in light of these comments

5.8.52. Need to give designated time for this process, in the form of at least annual team away days – independently facilitated by the quality improvement team, in order to constantly remind the team of the trusts objectives/visions, give a structured approach to analysis of service provision and formulate action plans for service delivery, which then continue to be evaluated/audited. Without hits, teams continue to be embroiled in day to day delivery, with no time to contemplate change.

5.9. Effective Outcomes

J. How can we get all parts of our organisation to continually focus on outcomes?

5.9.1. “Build into assessment/care planning/evaluation process and documentation. Have a reporting mechanism that monitors.”

5.9.2. People still don’t understand the difference between outcomes and outputs. Usually in a discussion about measuring outcomes, people find themselves coming back to development of metrics to monitor ‘outcomes’. Even the narrative talks about “outcome-based measures” – These are outputs and not outcomes.

5.9.3. “On the section moving to effective outcomes I think service evaluation should be strengthened as a concept here.”

5.9.4. “…we could introduce competence based job descriptions so that measurement of effectiveness could be undertaken more easily”

This suggestion is considered more appropriate within Human Resources and Workforce development strategies.

5.9.5. “I … have comments pertinent to obtain the best outcomes for patients linking health, social care and housing; specifically around access to third sector and voluntary services. “A quality outcome is; accessing third sector resources, expertise and social capital, for example those providing intervention services in housing and support.””

5.9.6. “Embedding the values will facilitate this…”

5.9.7. “Make them meaningful and that collating the information goes on to be used to invest/improve the service”

5.9.8. “Supporting innovation and an innovative culture”

5.9.9. “Make [it] easy and provide support to collect/collate/analyse outcome data”

5.9.10. “Engage with patients on meaningful outcomes”
5.9.11. “From my very limited experience often clinical outcomes based on Evidence Based Practice don’t always fit with what patients would like as an outcome (sometimes appropriate, sometimes not).”

5.9.12. “Unfortunately in the recent past there has been too much emphasize on “standard operating procedures”. This focus was not patient centred because it created too much emphasize on petty rules and was not personalised to the patient nor to the situation. Fortunately this framework goes away from that, with statements such as “measuring quality by means of outcomes in preference to process targets”.

We have added an action under “moving to outcomes” around using Evidence Informed Practice to ensure outcomes are not overshadowed by “standard operating procedures not personalised to the service user.

5.9.13. “One of the problems we currently have as clinicians is the excessive paperwork. A considerable amount is duplication and is not used to benefit the patient nor does it fairly evaluate the service. When we read a positive document like this, the threat for us still is that the “measuring quality by means of outcome” results in more bureaucracy and flawed measurements and judgements on outcomes.”

5.9.14. “Please continue to consult us [front line staff] before signing off outcome deliverables in contracts with the commissioners.”

5.9.15. “Develop and introduce guidelines for all service developments/reviews etc which specifically reference the need to identify and focus upon outcomes, requiring evidence base/best practice with clear outcome measures.”

5.9.16. “Set out a timescale for clinical services to identify and start to use the most appropriate and meaningful clinical outcome measures. A mixture of Clinician Reported Outcome measures (CROMS) and Patient Reported Outcome Measures (PROMS) are preferred, with both concentrating on the health wellbeing and quality of life of the service user.”

This detail will be addressed in the effectiveness strategy

5.9.17. “Care plans should be linked with personalised service user goals and the outcome measures should allow monitoring of progress towards those goals. For some service users goals might be maintenance of current quality of life or even slowing down the rate of deterioration (for example with a degenerated condition). Goals have to be realistic, but all service users should have goals (the terminology might vary).

5.9.18. For individual service users the clinical teams should be using the right outcome tools to monitor the effectiveness of the services, making decisions to vary interventions or services where there is evidence that better outcomes might be possible.

5.9.19. Collectively outcome tools can be used to determine which interventions or services are having the greatest benefit to service users and this will support continuous improvement of services and also support appropriate recommendations to commissioners.

5.9.20. Given that the framework has a life span of 5 years, the “How will we get there” section may not be sufficiently ambitious. We would hope to see widespread use of clinical outcome measures as well as safety and experience measures
across the majority of services well within the 5 year time frame. There may be exceptions, for example where there is a national debate about which outcome tools work best.”

5.9.21. The key measure for me is not just about teams implementing outcome measures but that these use the results of the measures to inform quality improvements within the service. This is the key aim of the CQUIN such that at Level 3 teams will have robust and reliable data to identify key priorities for improvement and be able to monitor the effectiveness of those planned improvements. At this stage (level 4) teams will have a programme of planned improvements against priorities identified from the outcome data and will use future outcome data to monitor effectiveness of planned improvements.

5.10. Assuring Quality

K. How can we strengthen our assurance processes around essential quality standards?

5.10.1. “Appreciating the need for inclusion of national or statutory standards, we also need to have quality standards which are developed with involvement from the areas that the standards try to monitor (making the standards ‘real’). You then need a consistent measurement and monitoring framework as standards will always be open to interpretation”

5.10.2. “As question I– by making audit the norm and giving individual’s ownership of this. Individual’s audit activity could be reviewed at appraisal. By supporting more staff to undertake accredited development so that they have been assessed to a certain level, and as employers we can be confident that they are therefore conducting evidence based care”

This detailed suggestion was considered to be a better fit within the Effectiveness Strategy.

5.10.3. Improve intelligence: focus on board to frontline. Promoting a culture where staff feel comfortable about questioning and challenging. Day to day culture of curiosity and engagement. This may be in training and briefings to keep the framework live, so it does not go on the shelf. It needs to be supported by enabling strategies, all interconnected.

5.10.4. “Our leaders need to recognise the unique and diverse environments of care that exist through the trust.” (In relation to responding to negative feedback from internal and external assessments)

5.10.5. “Reduce the burden of inspection”

5.10.6. “Positive feedback, [giving staff a] well done for the work they do”

5.10.7. Develop internal inspection and review programme (if not already in place) and if currently in place, review to ensure it meets all recommendations in relation to appreciative inquiry visits. Involve commissioners in internal review programme as well as continuing to embrace commissioner led visiting programme. Provide strong evidence of action to address concerns identified through review process. Ensure evidence to support all standards.

5.10.8. Streamline data reporting, meeting reports etc without losing value to release capacity to address shortfalls proactively rather than reliance on reactive approach.
5.10.9. “The description of the Quality Early Warning Intelligence System is very helpful. The processes can be strengthened by:

- Describing how quality will be at the top of the board agenda and that decisions made at board are made with an understanding of potential improvements and risks/potential adverse impacts on quality.
- Ensuring that information at Board level is truly representative of the current position with respect to quality (positive and negative).
- Stating and regularly refreshing at Board the key priorities for quality improvement at that point in time.
- Describing how NEDs might be used to provide assurance at Board level.
- Describing how patient stories [will be used]
- Describing how Board members including those who do not have quality as part of their primary remit participate in quality visits, improvement initiatives etc.
- Indicating how risks to quality or potential impact on quality will be assessed as part of all business and service development, cost improvement etc initiatives and that decisions take this into account.

5.10.10. We would not recommend that the level of responsive visits is used as a marker of quality. Standards increase as fast as quality improves, and there will always be an area which isn’t doing quite as well as other areas.”

The detail within this comment will be addressed in the Quality Assurance Programme

5.11. Delivering Excellence

5.11.1. “Recognition for staff ‘Celebrating Excellence’, national awards, effective communication”

5.11.2. “People need to understand what excellence means and how this differs from doing your day job. The organisation needs to be continually researching and understanding what excellence is so that individuals know what they are striving towards. What does excellent look like?”

5.11.3. “On Moving to Excellence: research and innovation is mentioned but could we strengthen it by talking about engagement in research and innovation activities that have an impact on direct patient outcomes. I also think that, as a trust, we need to engage with the knowledge mobilisation agenda – the impetus of the timely and effective communication of health care research in ways that increase its impact. This is not just at the tail end of implementing research, but also at the front end being involved in asking the questions that need to be answered and advising on ways of investigation to aid uptake of results.”

5.11.4. “By prioritising education and workforce development, and being more consistent with performance management. Staff who are not permitted to attend workforce development opportunities on more than one occasion should have a direct line to complain to the Director of Nursing and Quality who could then investigate as to whether this was justified.”

The overall ethos of this suggestion has been included in the document.
5.11.5. “Making sure that all staff accept students within their team so that a culture of learning and development is embedded – this will lead to excellence in practice. Staff Award ceremonies should receive a high profile, and there should be an Award for Mentor of the Year – to someone who has been particularly supportive in developing students or junior staff.”

5.11.6. “A structured approach to Talent Management should be introduced. This would involve early identification of high performing staff and linking them to opportunities for further development.”

This detailed suggestion would be better placed within a Organisational Development / Workforce Development strategy.

5.11.7. “Reward and recognition schemes and roll out of best practice. Using the concept of ‘adopt, adapt, embed’ as outlined in the Organisational Development strategy.”

5.11.8. Good idea re the efficiency sharing scheme – good to have an incentive. There also used to be a scheme noted as the Innovation Fund with £5k awarded to schemes that improved quality (introduced in the South by Stuart Poyner when he was the CE).

5.11.9. “For Staffordshire Fire and Rescue Service the investment to develop a service cultural framework – developed by the staff for the staff, has been essential in improving performance and culture. A similar approach could be considered for the trust. The document is very much patient focused with details in regard to training, consultation and benchmarking that will improve the delivery and quality of care.

It is hoped that the quality framework will achieve similar aims.

5.11.10. “Is there a consideration for the use of technologies in improving quality of care? (Assistive technology within residential or domestic settings for example)”

This detailed suggestion is aligned closely with the transformation agenda, and has been included in the “moving to excellence” section.

5.11.11. On page 23 “Pockets of service excellence exist” – are we sure there is evidence of excellent quality? Are there any examples in addition to the National Nurse of the Year 2013?


The wording has been changed to “national standard”.

5.11.13. “Growing public recognition and sharing best practice”

5.11.14. “include research, service evaluation and innovation as part of excellence; harness the innovators. Being at the cutting edge”

5.11.15. “hold celebrating excellence days / events”

5.11.16. “Clinicians strive for excellence on a daily basis”

5.11.17. “What is excellence? Going the extra mile? Better than ‘good enough?’ The country cannot afford excellent [NHS healthcare]! E.g. Skoda vs. Rolls Royce. We need to manage expectations of the population; they have been told that efficiency savings can be made. Is excellence then unachievable? Excellence can cost more money. In some places we have gone backwards after becoming ‘good enough’ in the past. This could be demoralising for staff who could never reach expectations of excellence.”
These comments are valid and welcomed. It is hoped that the quality framework will be successful in promoting excellence as a way to empower staff, rather than demoralise them. Also, while some examples of excellence result in higher cost, excellence can also be being more efficient, or using new developments to reduce the costs of care.

5.11.18. “Some strive for excellence and make themselves ill pushing to the limit. How do we get the balance right? Terms and conditions shrinkage will lead us to lose good staff. Incentive and reward are key to move to excellence. How do you incentivise excellence? How do you celebrate and recognise excellence? How do we celebrate the people who turn up and work every day, without going off sick? Do we neglect our competent quiet staff? Or devalue them?”

5.11.19. “This is an encouraging and welcome approach. Further reference to research and development, innovation would enhance this section further. Also worth seeking further opportunities to recognise and reward innovation within the organisation, e.g. seeking further awards like the nurse of the year etc.”

5.11.20. We should be more mindful of suggesting whole teams/services for awards either national or trust wide – to select one member out of an integrated team for an award can often de-motivate others in the team, and conversely have a negative effect.

5.11.21. Liaise with service user/voluntary organisations for them to develop best practice awards for their organisations, e.g. the Staffordshire Neurological alliance is just launching some best service awards aimed at health and social care teams in SSOTP area who have been recognised for high quality innovative services, and are encouraging service users to nominate also. This process could be encouraged with other condition specific voluntary groups.

5.11.22. Ensure that our trust philosophy of care is one which all staff can subscribe to, and really internalise as their essential core of practice.

M. **What other key tools/work programmes can help us to “move to excellence”?**

5.11.23. “Supervision and clinical supervision for all staff, particularly those offering direct care is vitally important for our Learning culture. It has numerous functions and outcomes including quality improvement, professional development, personalisation of care, emotional containment. It would have a great impact on the promotion of dignity and respect for each and every employee and, most importantly, the people we serve and has a proven positive impact on sickness rates. … I have only touched the surface of what supervision can offer towards our agreed vision and values and the achievement of the best possible outcomes for the populations we serve.”

5.11.24. “I don’t see why we are listing tools and programmes for excellence but not the other sections in the framework “

5.11.25. “Gaining 100% compliance in statutory training!”

This suggestion was added to the “assuring essential quality standards” section

5.11.26. “Reward and recognition schemes and roll out of best practice. Using the concept of ‘adopt, adapt, embed’ as outlined in the OD strategy.”
5.11.27. “Develop the Ele-lite patient feedback devices, changing and tweaking in response to staff and service user feedback”

5.11.28. “Visit other organisation to view what goes on. (Not necessarily NHS.) For team leaders and above to spend time (a week?) embedded in another organisation, maybe a job swap”

5.11.29. “Innovation and research”

5.11.30. “Hold focus groups (and brainstorming sessions) to generate ideas for innovation and excellence”

5.11.31. “Incentivise innovation with reward and recognition”

5.11.32. “What about the NHS constitution?”

5.11.33. “To move towards excellence- we are restructuring the Medicines Management team to reflect more closely the needs of the organisation- and that's a start. Optimisation of medicines and improving the patient's journey is a key element. In fact- nationally- a lot of … Heads of Medicines Management are being re-named as … Heads of Medicines Optimisation. And that shows what a lot of others are doing- they are thinking about using medicines more effectively.”

The detail in the suggestion may be appropriate to include within the Effectiveness Strategy.

5.11.34. The excellence section is helpful. There are some examples of areas where the trust intends to be excellent.

5.11.35. We would like to see other examples outside the safety domain and going beyond what are today’s priorities (some examples however SSOTPT might have its own key priority areas for excellence).

5.11.36. Excellence in relation to: (And these are just possible examples)

- Very few patients with long term conditions attending A&E or having short unplanned acute admissions as a result of exacerbation of their LTC.
- High numbers of Inpatients admitted for rehab meet clinical goals and are still meeting them 12 months later.
- Increased numbers of LTC patients managing their own care or having fewer interventions.
- Improved outcomes re physical health services for service users with cognitive impairment and reduced gap between the outcomes for this group and similar patients without cognitive impairment.
- Year on year increase in service users rating services as excellent (or the highest option)
- End of life care.
- Numbers of patients with improved quality of life rating on discharge from services and maintained 12 months after discharge.

5.11.37. Over the course of 5 years, there will be a gradually changing list of markers of what represents excellence.

5.12. Integrating Quality

N. Which actions can we take to fully integrate quality through the organisation?
5.12.1. “Make Quality a standing agenda item on agendas and clarify what this should cover. Or ensure link to quality on issues that are already covered.”

5.12.2. “A framework that reflects all areas of the organisation! This framework is still very clinical and health focussed without the same level of detail or attention paid to social care. Integrated quality is only going to happen in an integrated organisation – neighbourhood teams, single management structure etc”

5.12.3. “Encourage staff to peer assess standards – determining if the care delivered is good enough for their own relatives or loved ones”

5.12.4. “Page 25 recognises the values of multi-agency working through the example of the MASH but the benefits described are centred upon shared intelligence and policies – We believe that multi-agency work can bring about significantly more benefits with an integration of planning and the joint contribution of partner agencies in supporting the health and well-being of the communities.”

5.12.5. “Need to remember that Net Promoter is only an indicator there may be a problem or +ve”

   This comment will be more applicable to the detail within the experience strategy.

5.12.6. On Page 25 (Where we are now) the document states “Multiple work streams exist for improving quality, but these are not yet orchestrated centrally”. What does this mean?

   This paragraph has been altered.

5.12.7. “On page 25 the sentences “The organisation has developed a new language of quality that combines the best of health and social care approaches” and “We will develop a clear language for quality and quality improvement that reduces reliance on health or social care jargon” are contradictory.

5.12.8. “Working in partnership with the Joint Commissioning Unit”

5.12.9. “Be clear on expectations and ensure quality is higher profile than financial issues in all key forums.”

5.12.10. “Continue to request and act on staff feedback, continue to request and act on commissioner feedback. Have the courage to address performance issues with any staff who fail to meet the required standards for their posts, establish fair blame culture but be prepared to act when blame is appropriate to support demonstration that quality is key.”

5.12.11. “This section is useful. The only comment we would make is again there is specific mention made of safety in the where we want to be section. We would recommend that the framework needs to be explicit in the benefits to quality that can be delivered through integration in terms of effectiveness and service user experience.”

5.12.12. “The actions seem appropriate”

O. How can we most successfully bridge the culture gap between health and social care quality?

5.12.13. “Joint teaching/learning opportunities. Reviewing and transforming culture and practice”
5.12.14. “I don’t think it’s about bridging gaps but combining the two. We need to retain clinical quality as well as more subjective measures of quality but appreciate they both hold equal importance. We don’t want to compromise but go for the best of both worlds.”

5.12.15. “Introducing seminars for staff on what health staff actually do, and what Social care staff actually do. There is a lack of understanding about this including a lack of common knowledge (e.g. do health staff really understand what personalisation is) “

5.12.16. “Need to follow an OD process to fully understand what the culture gap is (diagnostics), then plan interventions to close the gap. Team integration is a key driver here and quality needs to be embedded within the programmes that are supporting and enabling better integration.”

5.12.17. “one committee” (for health and social care quality)

5.12.18. “Continue as current, balance staffing mix between two previous organisations along with balanced approach to integrated governance i.e. polices, procedures etc. Embrace the benefits of legacy organisations, eliminate the waste!”

5.12.19. “By focussing on service user centred quality of life outcomes and improving these outcomes as one of the key markers of quality.”

5.12.20. “By identifying those elements of the service where integration works well and taking a regional or national lead in sharing with other organisations.”

5.13. Implementation and monitoring

P. What indicators (and their target directions) should we include to measure progress against this framework for the next five years?

5.13.1. I think we need to agree the mechanisms first and understand what indicators etc that we are able to produce first. Also, we shouldn’t be defining all the targets as they will need to be based on user expectations.

Some indicators will be needed in the document to track progress against the framework, and whether we are achieving the aim of the framework. However, the benefits of service user involvement are recognised.

5.13.2. “We should include student evaluations within performance dashboards; these are currently RAG rated and reviewed on a regular basis but need incorporating with other performance measures to effectively triangulate evidence”

This comment will be passed on to the teams developing performance dashboards, rather than including student evaluations in the indicators of progress against this framework.

5.13.3. “ Complaints, incidents, compliments, Patient reported outcome measures. CQC rating, audits”

5.13.4. On page 27 (Monitoring the quality of care) we need to say something about the frequency of reporting.

5.13.5. On Page 26 (implementation) note or link to the Organisational Development Implementation Group; actions in the resulting implementation plan will be relevant to this group.
5.13.6. “…Speech and Language Therapy is somewhat different to the more medical professions and therefore our quality indicators may be a little different to others.

5.13.7. We are under pressure to meet the 18 week deadline, which we usually do, however, seeing a child for an initial assessment is somewhat different to other services because often having seen us they go on to another waiting list for therapy that nobody is concerned about. It would be nice to actually have someone taking more interest in the children where we have opened a duty of care and then are left waiting for input rather than satisfying the 18 week deadline. To actually be able to provide a timely intervention would provide a better quality service than merely meeting 18 weeks and then having lots of children waiting a long time for therapy.

5.13.8. If outcomes were available electronically on Lorenzo it would be a far better system than paper files and may provide a means of analysing data that doesn't currently happen.

5.13.9. Knowing what we are commissioned for rather than having block commissioning may mean that we would not have to take every referral that comes our way, a reduction in caseload numbers would mean a better quality service for those accessing it.

5.13.10. Having assessments and toys that are in good serviceable condition would suggest to parents that our service was of a high quality rather than having assessments that are torn etc.

5.13.11. Having a system that rewards staff for their progression and development would mean that we could retain staff rather than losing them to other organisations and then having to start again developing newly qualified staff every couple of years.

5.13.12. I think the resources issue is the biggest one for us both in terms of staffing to allow us to provide a prompt service and in terms of the equipment we have within our clinics.”

Some of the detail in this multifaceted suggestion will fit well into the Effectiveness strategy.

5.13.13. “This will be dictated to a degree by national, regional policy and local quality requirements. Assuming your framework is over and above this, the indicators need to be limited, specific etc to ensure you don’t create an industry linked to data which uses time you need to address shortfalls and proactively address quality improvement work.”

5.13.14. “The list in the table is not particularly ambitious. Possible suggestions:
- Year on year improvement in safety / quality culture
- Increasing number of locally developed quality improvement initiatives rolled out
- Increasing numbers of service users experiencing harm free care (beyond the current 4 harms)
- Hosting annual or biannual (or other) quality events in which SSOTPT are a nationally recognised leader in ... (whatever the subject) hosts an event designed to share best practice and promote excellence.
- Increasing Number of services / teams using evidence based outcome tools (Close to 100% by ...)
- Evidence that monitoring outcomes leads to focussing on more effective interventions and improving less effective services.
- Increasing use of patient stories, Board member quality visits
- Quality improvement initiatives being monitored through definitive service user benefits (such as improvements in quality of life).
- Service user populations experience fewer crises or emergencies.
- Fewer service users requiring emergency admission to hospital multiple times.
- Service users in hospital requiring SSOTPT services on discharge are in hospital for less time and fewer have delayed discharge once medically fit.
- Same issues rarely arise multiple times though serious incident investigation / complaints investigation / at visits etc. – Where this does happen, Trust will determine why initial action not effective.
- Demonstrating that as integration progresses service users ...
  - Have to provide basic information once only
  - Go through fewer duplicate or similar assessments
  - Have single point of contact for help or support
  - Have fewer but more effective contacts
  - Improved quality of life
  - Describe more positive experience.”

Q. What should we measure to tell us whether we are achieving our quality framework strategic goals?

5.13.15. “Number of staff accessing workforce development opportunities”


5.13.17. “Audit the understanding of staff”

  This suggestion would need further refinement before it could be included in the framework.

5.13.18. “We could also feed in some aspects of the Staff Survey results – however these are of course staff perceptions and not patient-reported experiences or outcomes.”

5.13.19. “staff opinion survey quality indicators”

5.13.20. “… the number of quality visits should read increase in proactive rather than reduced responsive, maybe they mean the same! What about including progress re CQUINs, commissioning KPIs for quality, SHA ambitions etc.? Links to net promoter in NHS – “would you recommend to your friends and family” – action to address what you will do with negative responses and negative feedback”

5.13.21. “Appraisals and personal development plans”

5.13.22. “Start point = CQUIN outcome measures”

5.13.23. “Evidence of Compliance with CQC essential standards as reported by HealthAssure system”

5.13.24. “Number of Co-located teams”
5.13.25. “Number of teams that are matched to the needs analysis of their areas.”
5.13.26. “Patient measures that show level of start-to-finish experience”

5.14. The consultation

R. Who else should be consulted?

5.14.1. “Again the document refers to updating staff and training staff in order to provide an excellent quality service. There are 4 community practice teachers in the North of which I am one of them and many more in the South of the Trust. It makes sense to involve the Practice Teachers in this consultation as it is us that attempt to teach staff and ensure quality is maintained.”

5.14.2. “Fairly comprehensive but probably need an explicit mention of Staffordshire County Council”

5.14.3. “Trade unions”

5.14.4. “LINKs”

5.14.5. “Wider staff groups”

S. Are there any other impact / assessment processes this quality framework should undergo before approval and ratification?

5.14.6. “We need to ensure it satisfies requirements for Foundation Trust application and compliance against S75 with SCC”

5.14.7. “Could this be considered using the Quality Impact Assessment approach currently used for service reviews?”
6. Conclusion

This report demonstrates that the quality framework has benefited from wide consultation. Further consultation, particularly with service users and front line staff, will be beneficial to;

- raise the profile of the framework aims and strategic objectives,
- refine the framework actions and indicators, and
- develop robust supporting strategies that the framework relies on.

Also, the comments received from this consultation will be a valuable source of information to shape the Safety, Effectiveness and Experience strategies.