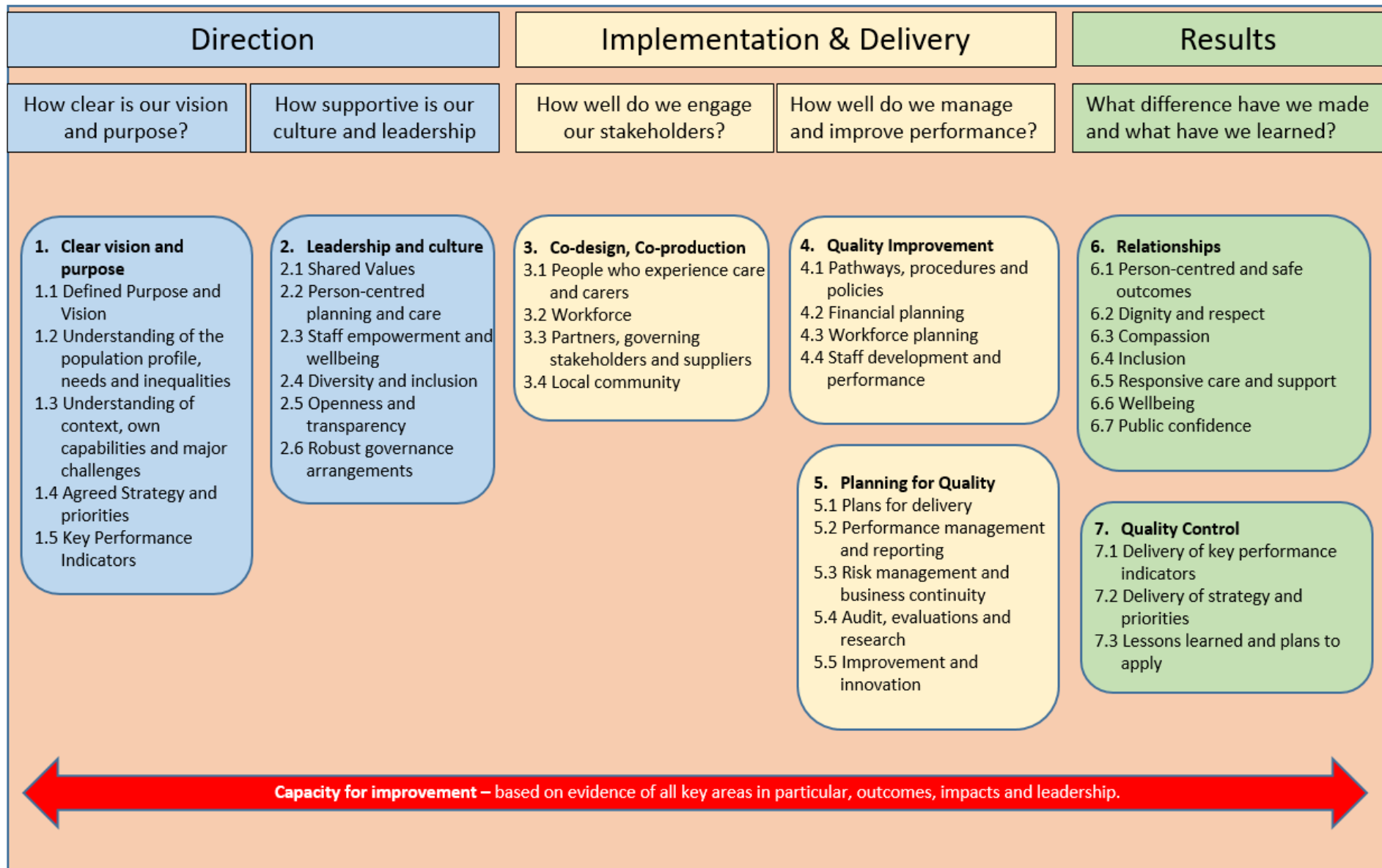# Quality Assurance Framework

Our Quality Assurance Framework allows an assessment of capacity for improvement based on evidence from all domains or specifically selected domains for some programmes of work. The framework will help inform a proportionate discussion about any follow-up activity or support that may be required. It reinforces the HIS Quality Management System by highlighting what good care looks like; and emphasising the importance of leadership and culture; vision and purpose; and the importance of co-design and relationships. The Framework is not a checklist. It is a reference guide to support and inform reflection, evaluation and decision making about how best to improve outcomes for users of services. It has seven areas of focus, known as domains. Each domain has criteria with associated quality indicators.

"The service" could be an organisation, a HSCP or a single service, ward or department within either, such as dermatology services, cardiology wards or outpatient department.

Direction		Implementation & Delivery		Results
How clear is our vision and purpose?	How supportive is our culture and leadership	How well do we engage our stakeholders?	How well do we manage and improve performance?	What difference have we made and what have we learned?

1. Clear vision and purpose
1.1 Defined Purpose and Vision
1.2 Understanding of the population profile, needs and inequalities
1.3 Understanding of context, own capabilities and major challenges
1.4 Agreed Strategy and priorities
1.5 Key Performance Indicators

2. Leadership and culture
2.1 Shared Values
2.2 Person-centred planning and care
2.3 Staff empowerment and wellbeing
2.4 Diversity and inclusion
2.5 Openness and transparency
2.6 Robust governance arrangements

3. Co-design, Co-production
3.1 People who experience care and carers
3.2 Workforce
3.3 Partners, governing stakeholders and suppliers
3.4 Local community

4. Quality Improvement
4.1 Pathways, procedures and policies
4.2 Financial planning
4.3 Workforce planning
4.4 Staff development and performance

5. Planning for Quality
5.1 Plans for delivery
5.2 Performance management and reporting
5.3 Risk management and business continuity
5.4 Audit, evaluations and research
5.5 Improvement and innovation

6. Relationships
6.1 Person-centred and safe outcomes
6.2 Dignity and respect
6.3 Compassion
6.4 Inclusion
6.5 Responsive care and support
6.6 Wellbeing
6.7 Public confidence

7. Quality Control
7.1 Delivery of key performance indicators
7.2 Delivery of strategy and priorities
7.3 Lessons learned and plans to apply

Capacity for improvement – based on evidence of all key areas in particular, outcomes, impacts and leadership.

Domain 1 - Clear vision and purpose	
Direction: How clear is our vision and purpose?	
Criteria	**Quality Indicators (statements of what good care looks like)**
1.1 Defined purpose and vision	a) The service has clear vision, strategy, and aims, which are person-focused easily understood by staff, people who experience care, carers and stakeholders. b) The service involves its stakeholders in defining, shaping and communicating its purpose and vision. The strategy clearly defines how priorities and deliverables contribute to the vision. c) The service regularly reviews the connection between the strategy, vision, workforce and outcomes for people, particularly when scoping new pieces of work.
1.2 Understanding of the population profile, needs and inequalities	a) The service involves people experiencing care, carers, the public, staff and local agencies in strategic planning, to identify the needs of the population and plan delivery of equitable, safe, quality care. b) The needs and assets of the person experiencing care and carers perspectives are understood in terms of securing safe and effective care; the necessary workforce to deliver safe and effective care and continuous improvement. c) The service works to identify and address health inequalities. d) Audit, governance, and planning structures all incorporate health promotion, prevention, and health inequalities. e) Services are developed and promoted effectively to support understanding and engagement with the people who use or might need the services.

1.3 Understanding of context, own capabilities and major challenges	a) The service assesses demand for services and undertakes regular and robust workforce planning in line with relevant legislation to ensure appropriate staffing levels and skills mix match service requirements and ensure safety.
	b) The service ensures that at all times suitably qualified and competent individuals, from a range of professional disciplines as necessary, are working in such numbers as are appropriate for:
	   • the health, wellbeing and safety of patients, service users and staff
	   • the provision of safe and high-quality healthcare
	c) The service utilises data to inform and respond to service and workforce changes.
	d) Real time staffing, including the identification, mitigation and escalation of risk to the health, well-being and safety of staff and patients is in place.
	e) The service takes a proactive approach to contingency planning, including anticipating workforce requirements, to mitigate service or care disruption and help safeguard future delivery.
	f) There is regular review of care system resources to support delivery of services.
	g) The service is aware of and demonstrates flexibility to respond to broader social, political, economic and contextual factors, such as pandemic.

	h) The service has capacity to avoid unacceptable delays to the assessment, treatment, discharge or transfer of people who experience care. i) The service (and leadership at all levels) understands the level of demand on individual services and the elements that constrain the patient journey. j) The service provides assurance that the provision of safe and high-quality healthcare is being maintained during service mobilisation whilst services remain under workforce pressures.
1.4 Agreed strategy and priorities	a) The service reviews strategic plans regularly and they are adapted in response to external or internal drivers. b) Board members actively influence and drive policy and strategy to encourage continuous improvement. c) There is good connection and communication between strategic planning, service redesign (including workforce) and clinical or operational services. d) The vision and strategy support joined-up arrangements with Integration Joint Boards, Health and Social Care Partnerships and Community Planning Partnerships. e) The service has a clear Quality Strategy which aligns with the organisational vision and articulates the key priorities for improvement.
1.5 Key performance indicators	a) The service understands the factors feeding from quality control; and which determine effectiveness of clinical and care governance b) The service sets clear priorities and goals for delivery and improvement c) The service implements statutory requirements d) The service takes into account national guidance, standards, codes of practice, relevant international guidance and guidance from any relevant professional bodies, in its service delivery. e) The service develops a meaningful mix of process indicators/performance targets, clinical audits and related outcome measures, for example, common staffing method, Excellence in Care (EIC), Essentials of Care and Scottish Patient Safety Programme (SPSP).

Domain 2 - Leadership and culture	
Direction: How supportive is our culture and leadership?	
Criteria	**Quality indicators (statements of what good care looks like)**
2.1 Shared values	a) The service has a clearly defined set of values, which staff adopt. b) The service has evidence of a shared commitment to high quality services. c) Those who experience care, carers and stakeholders easily understand the values. d) There is clear evidence that staff live the values. e) Staff describe the culture and morale in positive terms. f) Staff would recommend the service as a good place to work. g) Leaders promote staff autonomy and accountability appropriately. h) Staff feel they are treated with dignity and respect at all times. i) Leadership is well respected by stakeholders, staff and communities. j) Staff understand the principles of safe care, including relevant child or vulnerable adult protection guidance, and apply local or national safety policies and procedures. k) The service promotes a "no blame culture" enabling staff to feel psychologically safe to escalate staffing concerns
2.2 Person-centred planning and care	a) The service recognises people experiencing care or their legal guardians as experts in their own experience, needs and wishes, and are fully involved in planning, assessment and decision making about their care. b) Care, supported and/or provided by several staff or organisations, is well planned and co-ordinated so that the person experiences continuity and consistency. c) The service takes forward national improvement programmes such as Scottish Patient Safety Programme activities, and Excellence in Care. d) The service always considers the needs of people who experience care, and their carers, when developing innovative improvement ideas. e) Services are centred on helping to maintain or improve the quality of life of people and equity of outcomes for people who use those services. f) Development of services is In line with the vision/purpose and the current and future needs of existing and potential people experiencing care, to deliver efficiently **the right care, at the right time, by the right person, in the right setting.** g) The service is working toward being in line with the Health and Care (Staffing) (Scotland) Act 2019 whereby there is a statutory basis for the provision of appropriate staffing in health and care service settings. This is to enable safe and high quality care and improved outcomes for service users and ensuring that the right people with the right skills are in the

	right place at the right time, creating better outcomes for patients and service users, and supporting the wellbeing of staff. h) Staff who are sufficiently trained, competent and skilled meet the needs of people experiencing care. i) The processes and culture of the service supports individuals, families and communities to become equal partners in all aspects of care.

2.3 Staff empowerment and wellbeing	a) The organisation/service has a strategic plan for developing staff capabilities and skills to improve clinical care and services, such as development or leadership programmes.
	b) Staff describe the service as one in which they experience compassionate and inclusive leadership approaches that lead to empowered, trusted and valued staff members.
	c) Staff feel that the service supports and develops them:
	    • shows commitment to a culture of learning
	    • promotes continual professional development
	    • staff demonstrate positive attitudes towards learning and improving.
	d) The service Leaders encourage staff to be responsibly proactive and innovative.
	e) Leadership for improvement is nurtured at every level of the organisation.
	f) Clinical and professional leaders at all levels are encouraged and supported to actively lead and deliver improvement work.
	g) Staff respond effectively to complaints and adverse events, have the knowledge and skills needed and are empowered to do so.
	h) The service's culture is open and fair and recognises that, in the vast majority of cases, it is the systems, procedures, conditions, environment and constraints that people face that lead to safety problems.
	i) Effective staff rostering is in line with rostering policy and maintains guiding principles of staff governance to ensure safe working practice and safe and effective high-quality patient care and staff well-being.
	j) Staff have support, feel confident to challenge bullying, harassment or discrimination and do so when necessary, as leaders manage bullying and harassment issues effectively
	k) The service supports staff to take breaks, particularly on shifts when there are less staff. This is supported by readily available restrooms and catering facilities.
	l) The service considers the safety of staff at the end of shifts; and provides accessible and quiet rest facilities that support staff to sleep on-site when required.
	m) Staff are supported to undertake leadership activities and demonstrate positive leadership behaviour, which motivates and inspires confidence in others.
	n) The service monitors staff physical and mental health and supports and promotes positive wellbeing.

	o) Staff feel supported in their role, by their immediate team and wider leadership and know where to go for support on a clinical or operational issue and have easy access to that support.
	p) Staff have good awareness of the organisation/service's whistle blowing policy and feel confident and supported to raise concerns.
	q) Staff feel empowered with a sense of worth, self-confidence and responsibility to act to manage issues locally where appropriate such as resolving complaints or managing near misses.
	r) The service encourages people experiencing care and families or carers to respect those involved in the delivery of care.
	s) The delegated level of authority supports managers to make decisions locally and there are clear lines of escalation for issues to be raised.
	t) Staff feel that senior managers, leaders and Board members are visible and accessible.

2.4 Diversity and inclusion	a) Staff ask people-experiencing care about their individual needs, lifestyle preferences and aspirations, and support them to achieve these where possible. b) Support is available for those with particular needs or cognitive impairment such as vulnerable young adults or children, people with dementia or learning disabilities or profound multiple learning disabilities. c) Personalised care plans are in place and up to date for all people especially for those with complex care needs such as multiple morbidities or profound multiple learning disabilities. d) The service promotes a human rights-based approach to care, and people receiving care are made aware of their rights and responsibilities, and how to raise concerns (including children and young people). Human rights-based approach is about ensuring people's human rights are at the centre of policies and practice based on the PANEL principles (Participation, Accountability, Non-Discrimination and Equality, Empowerment and Legality). e) The quality of care provided does not vary or discriminate because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socio-economic status, or any other status. f) People experiencing care, are assessed for health improvement and inequalities as part of their care pathway. g) The service works with stakeholders to contribute to and draw inspiration from the National Health and Social Care Standards, National Performance Framework, Human Rights Approach and Sustainable Development Goals. h) The service ensures that everyone has the ability to be actively involved in their care and takes steps to remove any potential barriers to participation, including reaching out to seldom-heard groups known to be more likely to experience health inequalities. i) There is support for people who experience care to communicate in a way that is right for them. This could include large print, audio, Braille, different languages, induction loops, Talking Mats, Talking Points, translation or interpreting services. j) The care environment considers individual needs and preferences where possible (particularly for those with a disability, cognitive impairment and dementia). k) People who are socially or culturally excluded experience positive attitudes and behaviour from the service and its staff.
2.5 Openness and transparency	a) People experiencing care receive a timely response to their requests or complaints and the service seeks their feedback on the handling of complaints or concerns. b) The service implements improvement plans and notifies people of changes made in response to feedback. c) Staff receive information of the outcome, lessons learned or actions taken forward after they have raised an issue or reported an adverse event. d) Actions are taken in response to staff surveys, feedback and discussions (including formal action plans) and staff are made aware of improvements made because of feedback.

	e) Staff and volunteers feel involved and supported to improve continuously the care, information and support they provide.
	f) Leaders regularly consult their teams for ideas and suggestions and involve staff in shaping and influencing decisions as well as implementing them.
	g) Staff follow the organisation/service's Duty of Candour procedures. For example, people experiencing care receive an apology if things go wrong and the service takes responsibility for its actions.
	h) Leadership encourages both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement.
	i) Leadership is open and honest about pressures and challenges they face, which helps staff and stakeholders understand and have confidence in the decisions taken.
	j) The service works with everyone involved in delivering care services to gain their commitment and support shared ownership of the challenges and solutions.
	k) The service works with key stakeholders to create an atmosphere of openness, trust, confidence and commitment.
	l) Leaders encourage and listen to staff 'voices' and act upon their feedback.
	m) Mechanisms are in place for people experiencing care to request access to their personal information.
2.6 Robust governance arrangements	a) The organisation develops and assesses its corporate governance structure in accordance with the 'NHS Scotland Blueprint for Good Governance' approach or other relevant guidance.
	b) An assurance framework and appropriate governance committees are in place to provide assurance that the focus of the service is safe, and effective and that a safe number of suitably qualified and competent individuals are working i to support delivery of this.
	c) Board members have assurance that effective governance systems are in place and working well by understanding their responsibilities, providing constructive challenge and working alongside executive director colleagues.
	d) The Board has assurance that healthcare and practice, clinical and care governance is subject to rigorous scrutiny, including review by relevant delegated governance committees (including but not exclusively: staff, clinical, risk, information, audit and performance).
	e) There is an integrated approach to governance that draws from all relevant sources of information and data.
	f) The Board routinely receives information on adverse events, complaints, claims, inspections, audits, review findings and feedback from staff and people experiencing care to help gain assurance of appropriate action and shared learning.
	g) The Board is informed of serious issues, or potential concerns and receives sufficient high quality information to enable effective decisions, assess risks and hold directors to account for the service's performance (including results of trainee surveys and variation to care outcomes such as suicide or maternal deaths).
	h) The service has mechanisms in place to recognise vulnerable people and to ensure public protection.

	i) The service has an effective knowledge management strategy that supports evidence-based and transparent decision-making.
	j) Information governance systems and processes are in place and implemented.
	k) Systems provide an audit trail such as an electronic reporting or document management system.
	l) Policies and procedures support staff to manage and learn from adverse events consistently and appropriately.
	m) Clearly documented and robust controls are in place to ensure ongoing information accuracy, validity and comprehensiveness.
	n) Version control is evident on policies and key documents.
	o) The organisation/service has a Caldecott Guardian who is easily accessible to staff
	p) The service develops a meaningful mix of process indicators/performance targets and related outcome measures.
	q) The organisation/service designs and implements a performance management system to support delivery of outcomes and transformation priorities.
	r) A quality assurance system is in place to ensure that the care environment and equipment are safe.
	s) The service has mechanisms in place to support people when things go wrong, such as Duty of Candour.
	t) Workforce reviews are undertaken, and the common staffing methodology applied, where applicable, to ensure that data is triangulated when planning services.

Domain 3 - Co-design, Co-production	
Implementation and delivery: How well do we engage our stakeholders?	
Criteria	**Quality indicators (statements of what good care looks like)**
3.1 People who experience care and carers	a) The organisation uses a range of approaches to 'bring people experiencing care into the boardroom'.
	b) People experiencing care, families or carers have a variety of accessible mechanisms to provide feedback on their experience of care and have support to do so.
	c) The service involves the public in policy and service design and development.
	d) The service encourages and empowers communities of interest, third sector organisations and minority groups to be involved in co-producing local health and care services.
	e) The service optimises the flow of people experiencing care, through sufficient staffing and a joined-up approach, to minimise the number of transfers to provide a smooth journey for those receiving care.
	f) In transitions and handovers of care, the needs and preferences of people experiencing care, including access to services such as pharmacy, social work and allied health professional staff, are considered.
	g) The quality of communication and flow of information supports continuity of care.
	h) The service has capacity to anticipate and resolve IT issues to ensure continuity of care.
	i) For people experiencing care transferring between care areas or services, the reason for transfer is clinically appropriate and clearly documented.
	j) The service anticipates and appropriately plans transitions of care, particularly for people with complex needs.
	k) The service takes a proactive and effective approach to identify and respond to people experiencing care whose condition is deteriorating.
	l) The service has systems in place to reduce the burden and harm on people experiencing care from over-investigation and over-treatment.
	m) The notes for people experiencing care are legible, understandable, accurate, up to date, signed and compliant with any relevant professional requirements.
3.2 Workforce	a) The Board review Staff feedback including feedback from trainees through National Education for Scotland or General Medical Council surveys.
	b) Leaders involve staff in shaping and influencing decisions as well as implementing them.
	c) The service has a clinical engagement strategy and leaders take into account clinical opinion when making decisions.
	d) There is effective communication between management, clinicians, people who experience care and partner organisations.

	e) The service works with everyone involved in delivering care services to gain their commitment and support shared ownership of the challenges and solutions.
	f) Real time escalations, decision making and allocation of resources is clear and transparent to staff.
	g) All trainees or relevant staff have direct access to an on-call senior member of staff at all times, clearly documented and communicated contact details are in place.
	h) At the start and end of each shift, and before the consultant leaves the site, there is routine contact between the on-call consultant and the on-call senior resident trainee.
	i) There is evidence of effective multidisciplinary team working and robust communication across the team such as handovers, team meetings, team newsletters or team cascade discussions.
	j) In clinical areas where there are validated workforce tools, reviews of the outputs of these tools are carried out applying the common staffing method, and feedback is provided for teams.
3.3 Partners, governing stakeholders and suppliers	a) The service works with stakeholders and partners in developing and delivering person-focused services.
	b) The service recognises the importance of its relationship with key stakeholders and partners, and pro-actively gathers feedback from them to maintain or enhance working relationships
	c) The service engages with partner organisations to build collaborative leadership capacity and enable innovation and appropriate risk-taking across boundaries.
	d) The service is able to demonstrate how collaborative working with other agencies, including the third sector, is leading to improved outcomes in a person-centred way.
	e) The service works with community and interest groups to support sustainable care.
	f) The service works internally and with partner agencies to co-ordinate and optimise clinical treatment, health improvement pathways and journeys or transitions of care.
3.4 Local community	a) The service focuses the design of its services around anticipating need and it plans service delivery and workforce in proportion to this in collaboration with Integration Joint Boards, Community Planning Partnership and relevant stakeholders.
	b) The service actively seeks the perceptions of governing stakeholders, partners, suppliers and the wider population regarding their experiences and expectations, and reviews how it is meeting those expectations.

Domain 4 - Quality Improvement
Implementation and delivery: How well do we manage and improve performance?

Criteria	Quality indicators (statements of what good care looks like)
4.1 Pathways, Procedures and policies	a) The service has clear expectations for care excellence, including care bundles or pathways, and uses local and national audits and initiatives to monitor reliability. b) People receive care and support based on relevant evidence, guidance and best practice. c) The service has processes in place to enable staff to evaluate improvement projects. d) Robust processes are in place to ensure suitably trained staff review adverse events thoroughly, to identify all contributing factors and root causes, and any recommendations and improvements implemented. e) There is a review process for action plan progress and completion, including the effectiveness of any changes implemented. f) The service has an established horizon-scanning capability to review UK or international reports, which have relevant learning for care or safety. g) Effective policies are in place and implemented to protect people from abuse, neglect or harm (in particular children, young people, the vulnerable and the elderly). h) The procedure for making a complaint is clear and well publicised. The procedure is accessible to people experiencing care and families or carers, and includes information on the Scottish Public Services Ombudsman for those unhappy with the response they receive. i) Staff are aware of the process for raising or escalating concerns and feel confident to report things that go wrong, including near misses, and to communicate safety issues with their colleagues. j) Staff receive feedback from complaints and adverse events in a timely manner. k) Care and support are provided in a planned and safe way with clear and robust processes for managing and escalating issues or unexpected events. l) Assessments of the individual's health and wellbeing are carried out at admission to identify the care required, and anticipate any issues that might develop such as dietetic, occupational therapy or social care requirements, to inform the care plan m) Re-assessments to ensure that the ongoing care is appropriate and effective are undertaken and documented. n) Procedures support staff to obtain appropriate informed consent and carry out discharge and/or transfer of people experiencing care. o) There are effective handovers with clear communication between staff and services.

4.2 Financial planning	a) The service evaluates its financial performance and uses financial resources to best effect in the interests of those who receive or deliver care. b) The service reviews the cost effectiveness of its activities and focuses on how it might use resources more effectively (while supporting safe, quality care). c) The service works to identify and reduce unwarranted variation in practice to achieve optimal outcomes. d) The service works to identify waste of resources such as equipment, supplies, energy, and uses evidence or research results to drive waste reduction.
4.3 Workforce planning	a) People experiencing care receive safe, high quality care, support and improved outcomes, due to the provision of appropriate staffing in health and care service settings. This is achieved by ensuring that the right people with the right skills are in the right place at the right time creating better outcomes for patients and service users, and supporting the wellbeing of staff. b) The service regularly monitors and undertakes assessment of staff workforce to provide assurance that the right people with the right skills are in the right place, at the right time and determine where staffing has impacted on the quality of care. c) Proactive monitoring of rosters/workforce to minimise the risk of resource and skill gaps occurring, review staff skills through formal appraisals, measure performance, benchmark reporting and identify areas of improvement. d) The management and leadership structure, roles and responsibilities are clear to staff and there is no ambiguity between leadership roles or activities. e) The service has an open and honest culture where clinical/professional staff are engaged in relevant processes and informed about decisions relating to staffing requirements. f) The service is working to enable further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice across Scotland. This is achieved through the use of, and outputs from, the common staffing method and associated decision making processes. g) The service promotes engagement, participation and involvement of staff. h) Staff undertaking leadership activities continuously aim to improve their leadership capability, including engagement with staff, through critical reflection and feedback from a range of sources. i) The service has appropriate and safe recruitment processes, for instance all candidate registrations and references (including agency, bank and locum) are checked, disclosure and Protecting Vulnerable Groups membership is in place. j) Staff, including agency, bank staff, locums, temporary staff and volunteers, receive appropriate induction.
4.4 Staff development and performance	a) The service provides a programme of mandatory training for staff to support safe, quality care with regular updates, such as health and safety and infection prevention and control. b) The service has effective training and support for all staff, including Board members. c) Time is available for staff to attend required training.

	d) The service has a range of training methods to give staff the opportunity to be active learners, to reflect and learn from their own and others' experiences.
	e) Training records are up to date and training needs analyses, carried out where appropriate.
	f) Staff feel they have access to good support and training opportunities.
	g) Motivational leadership activity is evident across all levels and parts of the service.
	h) The service has an organisation commitment and resourced plan for developing QI capability that ensures that everyone has the relevant skills and capacity to contribute commensurate with their role.
	i) Staff undertaking leadership activities have access to development programmes to support them in their role.
	j) There is sign off and monitoring of Job plans/performance development reviews annually.
	k) Staff with supervisory roles have sufficient training and time in their job plan to provide adequate support to trainees and staff.
	l) Where supervision is not directly present, trainees have appropriate training and can demonstrate competency to operate with distant supervision.
	m) The service has a system for addressing under performance and recognising good performance at individual, team and service level.
	n) The service supports staff to be competent and skilled, and able to reflect on their practice and follow their professional and organisational codes.
	o) The service ensures that all frontline staff are aware of legislative requirements and their application, for example for people with a cognitive impairment or adults with incapacity.
	p) Staff have a clear understanding of their roles and responsibilities, have a positive approach to their duty of care and demonstrate accountability for their actions and behaviour.
	q) Leaders and staff do not tolerate poor or unacceptable levels of care.

Domain 5 - Planning for Quality	
Implementation and delivery: How well do we manage and improve performance?	
Criteria	**Quality indicators (statements of what good care looks like)**
5.1 Plans for delivery	a) Standard operating procedures and referral pathways are in place that ensure, appropriately skilled staff, are available and easily contactable at all times, to perform all required emergency procedures. b) Quality planning principles focus on understanding the needs and assets from the perspective of those using and delivering the services. c) Systems are in place that ensure planning activities incorporate factors identified through what is learned and through robust quality control and quality assurance at each level of the system. d) The service designs physical systems and technological infrastructures that support improvement and knowledge management. e) The service uses digital information and technology to support service delivery such as remote e-health or telehealth monitoring, and digital personal health records. f) Relevant staff are involved in regional or national discussions such as planning groups or Managed Clinical Networks.
5.2 Performance management and reporting	a) The service participates in relevant third-party accreditation schemes. b) The service has mechanisms to collect and integrate data. c) Measurement and reporting systems are designed to support and enable continuous learning and improvement. d) There are sufficient staff with capabilities in data collection, analysis, measurement, presentation and use of data for improvement. e) Systems are in place that enable access to meaningful data from Board to service level to understand and monitor quality. f) To anticipate potential risks to safety, such as staff or equipment shortages, reviews of data and proactive action is taken on potential threats. g) The service maintains a questioning approach even when data suggest things are going well. h) Lessons learned from adverse events (including near misses), feedback from people experiencing care, inspections, internal audits, and claims are clearly recorded. i) Regular discussions take place of feedback, complaints, and adverse events (including lessons learned) at service or department level. j) Mechanisms are in place to inform staff of findings and outcomes from the data they have collected. k) Board members routinely participate in walk-rounds or discussions with staff and stakeholders to enable them to understand the level of care and treatment provided to people experiencing care and the issues facing staff.

5.3 Risk management and business continuity	a) To support and promote the health, safety and wellbeing of people experiencing care, visitors and staff the service has clear strategies or plans for safety. b) The care environment, including buildings, grounds and estate services, is designed, maintained, and reviewed in line with relevant regulations. c) The care equipment is installed, used, maintained and replaced in line with regulation and guidance d) The service does not wait for things to go wrong before trying to improve safety. e) There is a proactive approach to risk management. f) Effective risk management systems are in place to record clinical, legislative, finance and other risks focused on the safety of staff and people who experience care. g) Operational and organisational risks are formally identified, reviewed, and subsequently controlled, with evidence of action to mitigate the risks. h) Decisions about the management of adverse events are risk-based, informed and transparent to allow appropriate level of scrutiny.
5.4 Audit, evaluations and research	a) The service has a robust process for implementing national standards, indicators and guidelines, and undertakes self-assessment and audit where required. b) Evidence-based practice is implemented in line with national guidance, for example, infection prevention and control, prevention of pressures ulcers c) Current and evidence-based advice on the use of medicines is readily available to relevant staff when making clinical decisions about medicines use. d) Current and evidence based advice on clinical procedures is readily available to relevant staff. e) There are mechanisms embedded in teams/services to detect variation from agreed standards/desired quality in relation to the delivery of safe, effective care and improved outcomes.
5.5 Improvement and innovation	a) The Board and leadership maintain a state of intelligent wariness even in the absence of poor outcomes. b) Leaders encourage and listen to staff 'voices' and act upon their feedback. c) The Board and senior leadership undertake leadership activities in improvement and commit time and/or money for delivering quality improvement initiatives. d) Quality improvement is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions. e) The quality strategy enables the embedding of knowledge/skills and permission at team level to fix/ improve problems within team control. f) Individuals, teams and services working on similar challenges are enabled to learn together. g) The service has a consistent approach to delivering quality improvement using appropriate methods to address the relevant improvement priority.

	h) Teams/the service routinely take time out to consider their capacity for change, reflect and document upon their objectives, strategies, processes, environments and any barriers to change and adjust change plans accordingly. i) Staff and volunteers feel involved and supported, to improve the care, information and support they provide. j) Staff are informed of the outcome, lessons learned or actions being taken forward after they have raised an issue or reported an adverse event. k) Staff are supported and feel empowered to challenge poor or unsafe practice so that care is safe and effective. l) The service takes a proactive approach to engaging with people who currently, or potentially might, experience care to identify issues and learning points and to shape improvements. m) Staff are able to identify improvements made in response to a complaint or adverse event. n) Leadership responds well to new challenges or obstacles and addresses problems directly. o) Leadership provides support to identify opportunities for innovation and improvement.

Domain 6 – Relationships Results: What difference have we made?	
Criteria	**Quality indicators (statements of what good care looks like)**
6.1 Person centred and safe outcomes	a) People feel safe while in the care of the service (including feeling safe with staff, people who experience care, families or carers). b) The service actively engages people who experience care, members of the public, staff and other key stakeholders using feedback and data to identify trends to inform quality improvement initiatives and improve care. c) People experiencing care report that their care is consistent and stable. d) There is clear signage to guide people receiving care and families or carers around the care environment, including dementia-friendly signage. e) People experiencing care and support are fully informed about what information about them is shared with others.
6.2 Dignity and respect	a) People experiencing care feel that staff speak and listen in a way that is courteous, dignified and respectful, with their care and support being the focus of staff's attention. b) People experiencing care feel that staff respect their privacy, keep private information confidential and offer opportunities for confidential discussions.
6.3 Compassion	a) People experiencing care, are supported and cared for with kindness and compassion. b) Staff work with legal guardians, families, carers and volunteers to support person-centred care. c) Staff demonstrate compassionate and encouraging care and are sensitive to the individual needs of people experiencing care.
6.4 Inclusion	a) People experiencing care and families or carers know who is in charge of their care. b) People experiencing care receive clear and timely communication and have their condition and treatment explained to them. c) There is support for people experiencing care, families or carers, to make informed choices and decisions about risks. d) People experiencing care are kept informed of their clinical or care progress and discharge plans.
6.5 Responsive care and support	a) Staff work to understand concerns or issues raised by people experiencing care, families or carers and what outcome they wanted to see and reassure them that raising concerns will not negatively influence their care delivery. b) Staff follow the organisation/service's Duty of Candour procedures. For example, people experiencing care receive an apology if things go wrong and the service takes responsibility for its actions. c) The service and its staff demonstrate positive attitudes and behaviour towards those who may be socially or culturally excluded.

	d) Those providing care and support are informed about the person's relevant life, health and care history, and the impact of this.
6.6 Wellbeing	a) Staff are able to access support for people's spiritual needs.
	b) The service provides health promotion information, education and sign posting to encourage and help people who experience care towards independence and self-care to achieve their full potential.
	c) The service works with stakeholders to encourage people experiencing care (including those with disabilities, frailty or long-term conditions) to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
	d) Where relevant, the service and staff encourage people experiencing care to take positive risks which enhance their wellbeing or quality of life (positive risk refers to recognising the potential benefits in taking risks in day-to-day life and making balanced decisions around taking calculated and reasoned risks).
6.7 Public confidence	a) Members of the public have good awareness about how to report concerns about the quality of care, safety or people's wellbeing.
	b) The public has confidence in the effectiveness of services.
	c) Performance information and quality improvement outcomes are made public (and accessible) and include objective coverage of both good and bad performance.
	d) The service shares learning out with the service with relevant stakeholders and partner organisations.

Domain 7 - Quality Control	
Results: What have we learned?	
Criteria	**Quality indicators (statements of what good care looks like)**

7.1 Delivery of key performance indicators	a) Systems are in place that enable access to meaningful data from Board to service level to understand and monitor quality.
	 b) Systems and culture enables the embedding of knowledge/ skills and permission at team level to fix/ improve problems within team control.
	 c) Processes and culture ensure an appropriate response to issues that individuals/ teams can't fix such as, escalation, additional support/resource.
	 d) Teams at a local level have access to meaningful data on cost, workforce and performance and use this to:
	    • monitor reliable delivery of high quality care,
	    • identify where improvement focus is required, and
	    • assess the impact of new changes
	 e) Procedures are in place to monitor performance regularly against key indicators.
	 f) There is evidence that re-audits to assess levels of improvement are undertaken.
	 g) Reviews of data and evidence drive improvement.
	 h) There is evidence of action following debriefs, adverse events, safety walk rounds, inspections, audits, complaints or performance data.
	 i) The service complies with nationally agreed standards and indicators of care to ensure that people are safe and well cared for, and their needs met.
	 j) Board members challenge performance data to support assurance that it is reflective of what is happening operationally.
	
	 The following list provides examples of potential key performance indicators. This list is not exhaustive and there may be further or specific measures or outcomes relevant to particular programmes, themes, sectors or legislation.
	
	 • Clostridium difficile infection, staphylococcus aureus bacteraemia, surgical site infection and catheter associated urinary tract infection.
	 • Falls, pressure ulcers, cardiac arrests and sepsis.
	 • Violence, restraint and seclusion in mental health.
	 • Medicines harm.

	• Maternity, neonatal and paediatric harm. • Stillbirth and neonatal. • Hospital Standardised Mortality Ratio. • Mortality or longer survival. • Unscheduled care episodes. • Reported outcomes from people experiencing care. • Local health inequalities. • Access to GP or out-of-hours services. • Patient waiting lists or time from referral to treatment. • Sufficient skilled staff to deliver safe care. • Turnover. • Vacancies. • Sickness absence. • Positive feedback from people experiencing care, families, carers, stakeholders, staff, partners and the wider population. • Staff are positive about the organisation and care provided both internally and externally. • Real time staffing escalations/mitigations • Complaints
7.2 Delivery of strategy and priorities	a) The service monitors and links both key performance results and outcomes for people and keeps the strategic plan up to date and appropriate. b) Individual objectives aligned to the key priorities for improvement are reviewed regularly. c) The service can demonstrate fulfilment of key stakeholder expectations. d) The service can evidence improved performance and positive transformation. e) The service identifies predictive measures aligned with its strategy, resources and stakeholder expectations.
7.3 Lessons learned and plans to apply	a) The service can demonstrate how it identifies transformation and change needs that reflect the strategy and aims, and relevant external challenges and opportunities. b) The service can demonstrate how people to come together to share and learn, to build and action new knowledge and speed up improved outcomes. c) The service demonstrates preparedness to help ensure safe care today and in the future.

	d) The service makes judgements on quality improvement based on evaluation of quality indicators, tests of change, feedback and good practice. e) Lessons learned from people's care experience, adverse events, improvement and redesign initiatives and staff feedback informs quality improvement activity. f) The service uses a variety of mechanisms to ensure shared learning throughout the service from adverse events, complaints and safety alerts, including actions and improvements. g) The service identifies good practice (within the service or from external sources) or key themes and shares and replicates across the service where relevant and appropriate. h) Leadership is aware of sustainability issues and any gaps in service provision and work to address these.