Herefordshire Council

NHS Herefordshire

Appendix 1

COMMISSIONING FOR QUALITY STRATEGY

Commissioning for Quality Strategy

1. Background

NHS Herefordshire and Herefordshire Council, through the partnership of Herefordshire Public Services (HPS) are committed to four key aims:

1. Improved outcomes for local people
2. Excellence in service delivery
3. Focus on customers' experience
4. Being efficient and delivering value for money

HPS through NHS Herefordshire and Herefordshire Council commissions a range of services and care provision for local people; delivering their health and social care needs and health improvements (for individuals and the wider community) by securing the highest value within limited resources. A fundamental goal of the NHS is to deliver high quality care and is a priority for NHS Herefordshire. It is therefore essential to develop a strategy to ensure a consistent approach to commissioning for quality and to achieve the aims of HPS.

2. Purpose of the Strategy

The purpose of the strategy is to support the HPS aims by ensuring that quality is at the heart of the commissioning process. The framework to support the strategy sets out the approach that HPS will use to ensure that health and social care services commissioned on behalf of the people of Herefordshire are of the highest quality. The framework will apply to all commissioned and contracted health and social care services including the Provider Arm.

It is envisaged that the Commissioning for Quality Strategy and framework will provide positive assurances with regards quality standards to the HPS Steering Group, Board, relevant committees, external inspectors and regulators and to services users and wider population.

The outcome is that all commissioned and contracted services will provide the highest quality of service. It is intended that all contracts and service level agreements will include a quality schedule based on the framework, to include service specific quality performance indicators, which will be monitored as part of the contract monitoring process. It is the intention that the quality strategy will provide a framework for commissioners to work with providers to continually improve the quality of services for the people of Herefordshire.

3. Links to other documents

The Commissioning for Quality Strategy is designed to compliment other essential strategies and plans that are in place or are in development; for example Customer Services Strategy, World Class Commissioning Strategic Plan, Community Engagement Strategy, Children's and Young People's Plan.

4. What is Quality?

There are many definitions of quality and it is clear that quality may mean something different for a manager, professional/clinician and service user.

The Next Stage Review, (DOH, 2008) helpfully described quality as being made up of three key components all of which have to be evidenced to assure quality service provision:

1. Clinical Effectiveness
2. Patient Safety
3. Patient experience

This description of quality encompasses the different perspectives of service provision and therefore would appear to be a comprehensive explanation. These descriptors are very broad however and it is understood there is a greater level of complexity to each one. It is also recognized that the components describe a medical model and would need to be adapted to ensure health and social care are reflected.

The Herefordshire people that were asked have defined quality services as those that:

- Treat people professionally and with courtesy and respect at all times.
- Respond to all enquiries in a timely fashion, at the first point of contact or call people back.
- Provide easy to understand information about what support we can be offered and what people can expect.
- Ensure people are involved in key decisions about their life, with support from an advocate if required.
- Treat people fairly and equally and do not discriminate against them.
- Ensure that people have access to all the available benefits and services that they are entitled to.
- Make sure people know what to do if they are not satisfied with the services they are getting.
- Use people's comments and views and involves them to help improve services and opportunities.

5. Implementing the strategy

To successfully implement the strategy there needs to be a consistent approach to commissioning. It is suggested that a framework for the quality schedules is adopted for all service specifications and contracts. This will facilitate commissioners to work with providers to ensure all providers are clear about the quality that is expected; how that will be measured and how this will result in continuous service improvement.

Key Components of the Framework

The Next Stage Review (DOH, 2008) components of quality have been slightly adapted to ensure the framework is comprehensive and addresses all aspects of the quality agenda from a National and Local perspective.

The framework is divided into three key components;

1. Care Governance
2. Safety
3. Customer experience

Each component then has several dimensions:

Key Component	Dimension
Care Governance	a. Compliance with Standards • National • Local b. Effectiveness • Evidence based practice • Compliance with pathways (National and Local) • Outcome Measures • Performance targets (National and Local) • CQUINs c. Risk Management d. Efficiencies • Staffing mix • Service Line Economics • Resource utilization e. Workforce • Planning • Training • Recruitment

Safety	f. Safeguarding Children • Policies, Procedures and processes • Audit Plans • Training • Employment checks g. Safeguarding Adults • Policies, Procedures and processes • Audit Plans • Training • Employment checks h. HCAI (Health care associated infections) • Compliance with Health and Social Care Act • Registration with CQC i. Medicines Management j. Incident Reporting • Processes • Learning
Customer Experience	k. Complaints l. Compliments m. Equality and Diversity n. Engagement/Involvement o. Consultation • National • Local p. Feedback • Formal • Informal

6. How will quality be measured?

All contracts and service level agreements will include a **quality schedule** (Appendix 1) which is based on the framework. All the contracts and service level agreements will be monitored for compliance with the quality schedule and appropriate actions taken for compliance and non-compliance.

The quality schedule will be developed with the commissioner and provider. There will be agreement on definition, source of information or data and levels of assurance for each aspect of the schedule. There will be a test of 'reasonable assurance' applied to the information supplied as evidence for each quality indicator.

In order to ensure sufficient evidence is collected to provide comprehensive intelligence and therefore hopefully positive assurance on the high quality of service provision there are two aspects to data collection and therefore measurement of compliance:

1. Quality Performance Indicators that may be derived at different levels
    - National
    - Regional
    - Local

    Service specific quality indicators or targets will be established and agreed with the provider for each of the key quality components and included in the quality schedule.

2. External Reports, for example;
    - Surveys
    - Audits
    - Inspections
    - Links
    - User groups
    - Public Consultations
    - Real time stories

7. Monitoring and Reporting

The quality of the services being commissioned on behalf of the people of Herefordshire will be monitored through the quality schedules, all of which will follow the framework. The quality schedules will be agreed by the Quality Monitoring Group. The individual quality schedules will then be monitored by the Clinical Quality Forums for each of the main contracts and/or the contract monitoring meetings. The reporting will then be to the Quality and Performance sub-group of the PCT Board and appropriate Council committee.

The Quality Monitoring Group will provide reports to the Quality and Performance Group and any other group or committee on overall or specific quality issues as required and/or requested.

8. Review

This strategy will cover the period of 2009-10 to 2012-13 and will be reviewed by a working group and a report sent to the Joint Management Team by December 2010.

Herefordshire Council

NHS Herefordshire

Appendix 1

Quality Schedule

Introduction

The Quality Schedule sets the standards by which quality should be evidenced and will be monitored in all contracts. However not all sections will apply to all contracts, each contract will clearly set out those aspects of the quality that apply to that individual organisations.

FHS Independent Contractor Services

Commissioning primary care is complex. Some factors are broadly common to all primary care contractors (ie GP practices, dental practices, community pharmacies and optometry practices); whilst others are unique to GP services. Some of these factors can make commissioning of GP services more challenging, but they can also provide greater opportunities to make sure that services meet people's needs.

All 4 of the FHS Independent Contractors work under **nationally** negotiated contracts which **do not have a fixed duration**, however local negotiated agreements such as PMS, APMS, PDS contracts map across core requirements of the national negotiated contracts they do allow the PCT greater **local** flexibility.

Customer Experience			
Objective	**Evidence**	**Monitoring**	**Comments**
1) Clear strategy for gaining feedback from customers about the quality of services and their experiences of those services.	a) An up to date strategy document that all staff are aware of b) Timely annual reviews which evidence user / carer feedback on services provided. c) Up to date strategy for ensuring staff adopt person centred practice including feedback from customer	Visits Evidence for customer satisfaction recorded on framework Contract review meetings Announced/unannounced visits Mystery shoppers Commissioner survey (Staff/customer) Audit of person centred reviews monitoring of use of advocacy including IMCA	N.B. the term 'Customer' covers Service users, carers, patients, family members and potential customers.

2) The organisational culture is customer focused and values customer feedback.	a) An annual plan of how customer feedback will be sought. b) Customer feedback made available to commissioners. c) Action plan relating to changes introduced as a result of customer feedback. d) Evidence of implementation of service change/improvement e) Evidence of monitoring and review of any service change/improvement f) The organisation uses a range of mechanisms of gain feedback from its customers g) Feedback is gained from a cross section of customers h) Clearly identified lead within the organisation i) Systematic process for customer feedback j) All providers to maintain up to date person centred care plan in respect of individuals k) Customer experience targets form part of appraisal for key staff l) Providers systematically provide evidence of changes in demand, service shortfalls and customer unmet need to commissioners m) Reviews of safeguarding protection plans evidence outcomes achieved and better risk management	Contract review meetings. Quarterly report from provider. Near real time customer feedback to Customer Experience Team on a regular basis. Customer Experience Trackers Routine analysis of care plans and reviews by commissioners Care management routinely provides evidence on the 'customer experience' as identified through the review process Analysis of safeguarding reviews and feedback from the quality concerns triumvirate provided quarterly	

3) Organisations have robust, up to date Complaints, Comments and Compliments policies and procedures in place	a) Up to date policy and procedure b) Customer experience feedback c) Promotional/public information material. d) Staff have a good understanding of policy and procedure. e) Evidence of staff training.	Visits Commissioner survey (Staff/customer) Mystery shoppers Announced/unannounced visits Evidence of active implementation through care management reviews Contract review meetings	
4) Staff trained in the value of customer feedback.	a) Evidence of staff training b) Customer experience feedback c) Staff have a good understanding of the value of customer feedback	Visits Announced/unannounced visits Mystery shoppers Commissioner survey (Staff/customer) Surveys of person centred planning and evidence of improves outcomes from annual reviews Contract review meetings	

5) Customer/Public Involvement	a) Customers and or the public are involved in policy, service, planning and delivery b) Specific involvement activities c) Promotional/public information material. d) Evidence of staff training e) Analysis of unmet needs identified by customers with recommendations for improvement	Commissioner survey (Staff/customer) Announced/unannounced visits Mystery shoppers Visits Contract review meetings Commissioning intelligence reporting to Board	
6) Organisations have processes in place to respect service user's privacy and dignity.	a) Up to date protocol/policy in place b) Annual service user/patient survey c) Complaints policy and monitoring d) Up to date person centred plans in place	Receipt of survey Receipt of action plans in respect of complaints regarding breaches in privacy/dignity Analysis from care management reviews and contract monitoring visits	
7) Organisations must ensure that equality of opportunity and outcomes is at the heart of all its work.	a) Equality Impact assessments b) Impact assessment action plan. c) Providers evidence improved outcomes for individuals on a routine basis	Self declaration Random audit of Equality Impact Assessments. Outcomes based contract monitoring in place Regular outcome based reviews	

8) Access - To ensure that all patients/clients can access services commissioned and there is equity of access according to need.	a) Access policy or referral criteria b) Information with regard to service which is accessible to all	Analysis of complaints with reference to access Available to view	

Safety			
9) Organisations must have a clear statement of intent specifying that the organisation does not tolerate any abusive practices and safeguards vulnerable people.	a) A clear statement which is available for both staff members and service users. b) Information available to staff users, carers and advocates about how to raise alerts	Visits/web sites Access to public information and up to date training audited	
10) Organisations have robust, up to date policies and procedures in place to ensure that staff know how to prevent abuse, identify abuse once it has occurred and understand the process to be followed should they have safeguarding concerns about an individual. (All child safeguarding policies and procedures must contain a cross reference to LSCB procedures, all adult safeguarding policies and procedures must contain a link to the relevant Adult Safeguarding Board). Whistle blowing policy and process are promoted by organisations.	a) Copies of policies and procedures are available for both staff and service users b) The ability to demonstrate that staff are aware of the policy and understand its content through regular audit c) Evidence that an individual's care plan has been reviewed to ensure they are properly supported following and allegation of abuse d) Evidence that staff are aware of whistle blowing policy and confident in how to proceed e) Evidence that following an investigation, appropriate protection planning is implemented f) Evidence that outcomes of protection plans are routinely reviewed	Self declaration Random audit Audit of policies received Reviewed anonymised care plans Audit of outcomes from safeguarding investigations, protection planning and reviews provided to commissioners Contract monitoring to quality assure improvements from safeguarding investigations	
11) Organisations have an information sharing governance framework to provide clarity to all staff of the organisation's position on information sharing	a) Evidence of information sharing protocols in place b) Evidence of audits regarding the organisation's information sharing governance	Self declaration Random audit Audit received	

12) The organisation contributes to the effectiveness of multi agency working when safeguarding vulnerable people	a) Contributing to safeguarding investigations b) Attendance at Case Conferences when requested c) Attendance at CAF training and involvement d) Attendance at safeguarding training e) Contribution to protections planning and implementation f) Contribution to training needs audit to adult safeguarding board training strategy	Evidence of contribution Audit received Audit of CAF attendance Audit evidence of improves competency as outlines in ASB training strategy.	
13) Evidence that the organisation has policies to ensure that any concerns/allegation of a safeguarding nature made against a member of staff are responded to appropriately. Fulfilment of alerting agency responsibility within stated timescales	a) A whistle blower policy b) A complaints policy and a process in place to ensure complaints are responded to c) A policy and guidance on how to report and manage any allegations against a member of staff d) Evidence of handling such an allegation	Self declaration on policies Random audit of policies Anonymised evidence Routine performance reports on safeguarding	

14) The organisation has a policy on restraint which enables staff to: a. Know whether restraint is permitted within the service in which they are working b. Know and understand the different forms that restraint can take. c. Understand when restraint is or is not appropriate.	a) An organisational policy on restraint b) Evidence that staff are aware of the policy c) Evidence that an audit has taken place regarding the policy. d) Evidence of staff attending training with regard to restraint e) Evidence of incident reports being completed with regard to constraint f) Evidence of DOLS applications where necessary g) Evidence of MCA and DOLS training for all staff h) The organisation has a policy and procedure on the implementation of MCA and OLDS	Self declaration on policies Random audit of policies Commissioning site visits to triangulate with staff Audit received Training matrix received Completed incident forms Analysis of DOLS applications Audit of policy and procedure Evidence of up to date staff training and competency	
15) The organisation ensures that the environment in which service users are cared for is safe and service users are protected from the effects of a person's challenging behaviour.	a) The facilities are DDA compliant b) COSHH reports c) Complaints received from service users or their families d) Completion of Incident reports e) Monitoring of peer on peer safeguarding alerts	Self declaration Commissioning visits Learning from COSHH reports Learning from Complaints Learning from Incident reports Routine performance analysis	
16) Patient/Client Safety- Incident Reporting and Learning from Incidents. To ensure that the organisation has appropriate systems and processes in place to protect patients, clients and staff from untoward incidents and to	a) Incident reporting system, policy and procedures in place b) Evidence that incidents are monitored c) System for Reporting serious untoward incidents (SUI)	Receipt of policy/protocol/guidelines Review of evidence as required - announced /unannounced visits SUI database kept - audit of	

learn from local and national investigations following incidents	immediately to PCT following protocol - SUI flowchart d) Evidence that incident trends are analysed and action plans developed for areas that are either rising or are higher than national trends e) Evidence that serious incidents are investigated (Root Cause Analysis) action plans developed and lessons learn disseminated f) Policy/protocol/guidelines in place detailing the dissemination of NPSA alerts, and system for ensuring actions are completed. g) National Patient Safety Agency Alerts implementation processes and procedures (if applicable to service/organisation) h) Annual audit of SABS/System process. Report submitted i) Monitoring tool in place detailing dissemination, and implementation progress of SABS alerts actions j)	response time. 1/4ly report Receipt of annual incident report Copies of all RCA's for SUIs within time frame set out in SUI flowchart monitored individually Receipt of policy/protocol/guidelines Available to view on request - announced visits Random audit of audit Random Audit	
17) Infection Prevention and Control. To ensure that the organisation has appropriate systems and processes in place to protect patients, clients and staff from healthcare associated infections.	a) Policies and protocols- relevant should be available Implementation of policies Audit of policy compliance Annual audit report to include scores achieved and relevant action plans with timeframes Audit tools used b) Hand hygiene -programme of hand	View documents on request announced and unannounced visits Receipt of report receipt of annual audit report/ summary Receipt of tools Receipt of educational	

	hygiene education Monitoring systems in place eg audit, observation Provision of policy c) Decontamination- decontamination lead identified Audit programme Policy in place and implemented Training programme for relevant staff d) Implementation of National guidance- Evidence that current applicable national guidance has been applied - hygiene act, CQC registration, etc e) Training / education- system of identification of training needs and frequency required. f) Staff training records and any competencies achieved g) Education programme h) Design and maintenance of the environment Provision of relevant policies, protocols. Evidence of regular monitoring i) Surveillance/ reporting- System for reporting mandatory surveillance system for reporting RCA/ SUI j) laboratory support- relevant support provided/	programme Receipt of audit results/ summary Report, Random audits Receipt of policy Job description Annual report View documents on request, Announced and unannounced visits Review training programme Registration, Receipt of results of Inspections actions plans View on request View on request. Annual report View on request View documents on request receipt of report(annual) Announced and unannounced visits MRSA, C diff surveillance data? Frequency Reports received - Random audits SLA on request	

	available k) Communication-provides information to patients, staff and public eg internet, leaflets	View on request. Patient surveys	
Medicines			
18) Organisations must have appropriate medicines policies with regard to good practice and compliant with legislation and regulations	a) Copy of medicines related policies b) Medicines formulary which adheres and contributes to local NHS economy c) Ongoing medicines audit d) Controlled drugs policies e) CD occurrence reports f) Safeguarding alerts / investigations	Audit of policies The ability to demonstrate that staff are aware of the policy and understand its content through regular audit Review records of staff medicines management training Contribution to CD local intelligence network and reports to Accountable Officer Quantification of medication errors raised through safeguarding process	
19) Organisations have robust risk management of medicines	a) Copies of policies and procedures are available b) Regularly send NPSA incident reports c) share learning locally from incidents	audit of policies review summary of medicines incident reports and shared learning examples	

	d) Medicines reconciliation policy in line with NICE		
	e) Discharge information audits	provides required discharge/ admission data sets	
	f) Provide appropriate prescribing and monitoring information in line with NPSA and NICE	provides timely medicines supplies and information to relevant health care professionals ie GPs (in future to community pharmacists) relevant monitoring information eg anticoagulation	
	g) Provide agreed shared care documentation in priority areas such as unlicensed and high risk medicines		
	h) Provide appropriate medicines risk assessment for patients	provides appropriate medicines support for patients with identified needs or referral ie reminder charts, monitored dosage systems	
	i) Care standards regulations fully adhered to		
	j) Safeguarding alerts referred by regulated services of CQC	CQC pharmacy audits contract monitoring Contract monitoring with PCT pharmacy Medication errors referred to PCT pharmacist on a routine basis	
20) Organisations endeavour to seek cost effective medicines management solutions in terms of	a) Invest to save proposals b) Joint working on medicines management guidance	Review/audit Joint guidance Adherence to guidance	

medicines and systems across the local health and social care economy	c) Provide systems/data to monitor and flag high cost medicines and subsequent audit d) Joint work to reduce specials e) Have a policy on commercial sponsorship and clinical trials in line with NHS policy f) Policy on non medical prescribing issues and other related documentation eg PGDs g) Contribute to joint meetings	Monitor costs Provide feedback to commissioner in agreed format and audit where appropriate Attend appropriate meetings eg Hfs Medicines management Committee Provide cost saving solutions	
21) Organisations provide seamless medicines management solutions in terms of patient quality and experience across the local health and social care economy. Reduction in use of medication to manage behaviour	a) Provide and contribute to joint policies b) Participate in national and local medicines management campaigns c) Assess patient feedback d) Alternative strategies in place	Review joint policies, participation in campaigns, patient feedback incidents Review of individuals care plan indicating improves outcomes	

Effectiveness			
22) Clinical audit. To ensure that organisation/service have a robust system in place to undertake clinical audit ensuring that the full clinical audit cycle is completed.	a) Annual audit programme in place b) Annual clinical audit report incorporating the documentation of outcome from audits. c) Monitoring system in place (i.e. database) to ensure full audit cycle completed d) Up to date clinical audit protocol/policy/guideline in place e) Conducting of an annual audit of the protocol/policy/guidelines to ensure compliance with the system specified in document.	Receipt of annual audit programme report Receipt of annual clinical audit report Available to review on request including supporting relevant documentation (i.e. action plans) - Announced visits. Receipt of document Receipt of audit report, random spot check audit	
23) NICE guidance and standards implementation (*Technology Appraisals, Clinical Guidelines, Public Health Intervention Guidance, Public Health Programme Guidance, Interventional Procedures and Cancer Service Guidance*). To provide assurance that the organisation/service have systems and processes in place to assess, implement and monitor NICE guidance (if applicable to organisation/service)	a) Up to date protocol/policy/guideline in place detailing the process for assessment, implementation and monitoring within the organisation/service (based on the NICE document "How to put NICE guidance into practice) b) Monitoring tool in place relating to the assessment, implementation and monitoring of NICE guidance within the organisation/service (i.e. database) c) Variance reporting on guidance not obtaining full assurance. d) Evidence of evaluation/review of the implementation of guidance (i.e. through audit)	Receipt of documents Available to view on request Announced visits. Report quarterly or more frequent if risk. Random spot check audits on specific NICE guidance	

24) Benchmarking -To ensure all organisations/services benchmark themselves against best practice and develop action plans which support continuous quality improvements	a) System of benchmarking practice in place (e.g. essence of care tool). Reports or monitoring tool detailing progress review of benchmarking and any subsequent actions b) System to review completed benchmarking practice in place c) Evidence that all services provided participate in benchmarking	Receipt of quarterly report Available to view on request - announced /unannounced visit. Random audit Annual report received	
25) Professional and Clinical Education and Training- to ensure all staff within organisations are appropriately trained for the roles that they undertake.	a) A system of identifying the training needs of staff and the frequency which this should be undertaken b) System and processes which record staff training undertaken, competencies achieved with dates c) Competency frameworks for clinical skills are available and recorded either at an organisational or service level.	Annual Report Available to review - announced visits Available to review - announced visits	
26) Supervision and leadership - To ensure that supervision and professional/clinical leadership is available to all staff	a) Evidence of clearly identified roles and responsibilities within the service with clear lines of accountability b) Audit of appraisals/ supervision c) Policies protocols and implementation (audit)	Job descriptions and structures available to view Receive audit, random check audit Random audit	
27) Care Governance Arrangements To ensure that care services have adequate care governance arrangements	a) Evidence of systems and processes to ensure that the clinical governance arrangement are explicit in all clinical pathways	Random review of services and/or clinical pathways as part of announced and unannounced visits.	

	and service delivery b) Evidence that the care governance structure supports the board assurance programme c) Record keeping policies/protocols and evidence of implementation (audit)	Available to review Random and or risk audits	
28) Care Pathways, To ensure organisations participate in the development of and implement Herefordshire wide care pathways. Contributions to be development of multi-agency care pathways.	a) Evidence of participation in the development of care pathways b) Care pathways are followed and any variance reported c) Evidence of participation in multi-agency care pathways.	Review of care pathways Exception reports received Process established for care pathway development and monitored	

Workforce Development			
29) Providers have robust and systematic approaches to workforce planning to meet commissioned service delivery.	a) Senior managers can demonstrate an understanding of the importance and value of workforce planning. b) There is a named senior manager lead for workforce planning and development who performance manages the activity. c) There is an named operational lead who has a recognised competency to deliver the workforce planning function. d) The locally used workforce planning approaches are known by staff and in evidence. e) The workforce plan is refreshed routinely and no less frequently than annually. f) Workforce plans include innovative and creative solutions demonstrating how the provider can meet the changing nature of service delivery. g) The local workforce plan is understood across the organisation and embedded within the service plan as core business. h) Workforce data and progress is reviewed routinely by the senior management team.	Workforce plans are reviewed as part of contract monitoring. Key providers will be required to submit annual workforce plans for quality assurance by Integrated Commissioning. • Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment • Submission of plans • Contract monitoring • Unannounced visits • Announced audit	Completion of standard workforce planning tool. Key providers will be expected to fully engage with and inform workforce planning across the wider health and social care economy. Inc. attendance at events and meetings.
30) Providers have comprehensive workforce development mechanism in place to maximise capacity and	a) The organisation can evidence that employees are appropriately trained for the roles they	Sample review by Workforce Team within Integrated Commissioning	

capability.	undertake b) All employees receive an annual appraisal and regular 1-2-1 support and supervision. c) Evidence of a routinely undertaken training needs analysis is available. d) Evidence of mandatory training for all relevant staff is routinely available.	• Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment • Submission of plans • Contract monitoring • Unannounced visits • Announced audit.	
31) Providers actively engage with their employees to obtain feedback and formally respond to that feedback.	a) The organisational culture seeks, values and positively responds to employee feedback. b) Clear mechanisms are in place to obtain employee views. c) A staff driven action plan is produced annually to respond to issues, concerns and experiences.	Sample review by Workforce Team within Integrated Commissioning. • Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment • Submission of plans • Contract monitoring • Unannounced visits • Announced audit.	Minimum requirement to respond to six key questions.
32) Providers have robust recruitment and retention practice to attract and retain a high quality, competent workforce.	a) A recruitment and retention strategy is in place to reflect delivery of commissioning intentions. b) Up-to-date policies and procedures for all aspects of recruitment and retention c) Equality and diversity d) National occupational standards,	Sample review by Workforce Team within Integrated Commissioning. • Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment	

	KSF and competences are used to develop and review roles. e) Risks to recruitment and retention are identified, analysed and action is taken to mitigate. f) Evidence of compliance with legislation is routinely available g) Evidence of compliance with registration is routinely available.	• Submission of plans • Contract monitoring • Unannounced visits • Announced audit.	
33) Evidence that organisations have adopted effective measures to minimise the risk of employing (in a voluntary or paid capacity) a person who would present a risk to vulnerable people (either children or adults).	a) A robust recruitment policy which contains details of which positions require a CRB check (and ISA check when established), due regard given to gaps in employment, references to be requested and scrutinised and any professional registration to be checked. b) An audit of the above policy	Self declaration Random audit of agency's policies Audit received Outcomes of contract monitoring visits feeds back to care management and CQC through quality concerns process	
34) Organisations provide access to role appropriate training (for the children's workforce appropriate is defined by Safeguarding Children and Young People:Roles and Competencies for Health Care Staff Intercollegiate Document 2006) for their staff to ensure that there is a competent workforce who understands the signs of abuse and take effective action when they have safeguarding concerns for an individual.	a) A copy of the organisation's training matrix or plan with both adult and child safeguarding as mandatory training b) Evidence of staff attendance at safeguarding training c) Evidence of 3 yearly updates on safeguarding d) Evidence that attendance at safeguarding training has influenced practice e) Evidence of appropriate referrals to ISA	Copy or training matrix/plan received Audit of staff who have attended training Evidence of improved outcomes Monitoring of mandatory checks	

Organisations to provide appropriate training to ensure competence to provide quality care and take effective preventative action to reduce incidence of abuse. Organisations to make staff aware of duties / responsibilities under the independent safeguarding authority.			
35) Professional Education and Training- to ensure all staff within organisations are appropriately trained for the roles that they undertake.	d) A system of identifying the training needs of staff and the frequency which this should be undertaken e) System and processes which record staff training undertaken, competencies achieved with dates f) Competency frameworks for clinical skills are available and recorded either at an organisational or service level.	Annual Report Available to review - announced visits Available to review - announced visits	

FHS Independent Contractor Services. Locally negotiated agreements (PMS, APMS and PDS)			
Objective	**Suggested evidence**	**Monitoring**	**Comments**
36) Each practice has clear negotiated objectives and a development plan which demonstrates organisational quality (including safety),effectiveness and patient experience. Objectives are linked to the PCT's commissioning strategy for primary care eg specifics linked to individual practices - extended opening hours, increased patient satisfaction.	a) Achievement of the clinical domain of the Quality and Outcomes Framework (QOF). QOF exception rates and comparison between reported prevalence and expected prevalence of long-term conditions. Practice data, eg prescribing, referrals, clinical governance. b) Compliance against Standards for Better Health criteria	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	
37) The development plan includes key areas in relation to **access and responsiveness:**	a) Each practice has mapped its core services and can demonstrate: • Capacity • Opening times • Wheelchair access • Consultation facilities • Languages spoken	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	

38) The development plan has a section dedicated to the practice **premises** which demonstrates compliance against national standards.	a) Result of patient surveys b) Patients should be seen in premises that are pleasant, accessible and meet the relevant national standards. c) Information governance requirements should be accommodated within the design of workspaces, for example computer screens positioned to protect patient confidentiality, and security of sensitive information. d) Feedback from site visits by local involvement networks (LINks) e) Compliance against Standards for Better Health criteria	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	
39) Each practice can demonstrate that they empower and support **patient choice**	a) Use of the choose and book system and NHS choices website b) Survey results on offer of choice of hospital c) Results of new GPPS d) That GP practice has an open list and accept new registrations e) Practice Boundary	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	