BOARD OF DIRECTORS MEETING

Date: 14 February 2018 **Item Ref:** 11

TITLE OF PAPER	**Quality Improvement and Assurance Strategy** **CQC Responsive Domain Plan 2017-18**
TO BE PRESENTED BY	Clive Clarke Executive Lead for CQC Responsive Domain
ACTION REQUIRED	To receive the report for information

OUTCOME	No decision required by Board
TIMETABLE FOR DECISION	Mitigate strategic objective 'Effective quality assurance and improvement will underpin all we do' and BAF Risk A101.
LINKS TO OTHER KEY REPORTS / DECISIONS	Corporate Risk Register Directorate Risk Registers CQC Inspection Reports Internal Audit Reports
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Strategic Aim: Strategic Objective: BAF Risk Number: BAF Risk Description:
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	SHSC Constitution SHSC Provider Licence Trust Strategic Framework Single Oversight Framework Regulatory requirements for CQC Regulatory requirements of NHS Improvement NHS Constitution
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Condition on the Trust's registration with the CQC would affect service delivery
CONSIDERATION OF LEGAL ISSUES	Non-compliance with CQC related compliance action plans could result in conditions to the Trust's registration with the CQC.

Author of Report	Graham Hinchliffe with updates from Julie Walton
Designation	Compliance Manager and Interim Head of Care Standards and Quality Assurance
Date of Report	07 February 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS**

Date: **14 February 2018**

Subject: **Quality Improvement and Assurance Strategy CQC Responsive Domain**

Author: **Graham Hinchcliffe Compliance Manager with updates from Julie Walton Interim Head of Care Standards and Quality Assurance**

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
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Is to update BoD of the progress against the actions agreed following the November 2016 CQC review, and to set advise on the actions that are needed for the next 12 months to move the organisation from "good" to "outstanding " In this domain

This is a sub-plan of the Quality Improvement and Quality Assurance Strategy and sits alongside plans for each of the other CQC domains, Safe, Effective, Caring and Well-led.

This draft plan was developed with input from the Care Standards Team, Deputy Chief Executive, with contributions for the directorates. This plan was received at EDG on 8 February 2018.

2. Summary

This plan outlines the priorities, actions and timescales to enable the Trust to aspire to be 'Outstanding' in the CQC Standards of the Responsive Domain. This will provide continued assurance to the Board of Directors and to the CQC:

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance

- NHS Improvement – Development review of leadership and governance using the well-led framework, https://improvement.nhs.uk/uploads /documents/Well-led guidance June 2017.pdf requires the Trust to have a board assurance framework (BAF) and risk registers in place which are assessed by the board on a quarterly basis as a minimum.
- Mitigate strategic objective 'Effective quality assurance and improvement will underpin all we do' and BAF Risk A101.

3 Next Steps

There will be a serious of workshops to further develop this framework and the framework of 3 other of the 4 CQC Domains (Effective, Caring and Well-led). The Safe Domain Plan is being led by Mike Hunter, Medical Director as Executive Lead for Safe.

As this plan develops it will be received at the Quality Assurance committee (QAC) for information and assurance.

The Trust's Care Standards Team will continue to facilitate and support this process.

4 Required Actions

Receive for information and assurance.

5 Monitoring Arrangements

The developed framework will be presented to the QAC for information and assurance.

The Trust's Quality Assurance and Improvement Strategy provide the overarching framework with a range of development priorities and actions in place.

The governance structures ensure the work is a crucial element of our assurance mechanisms; operationally via clinical and corporate directorates and Board sub-committees to provide assurance to the Board.

6 Contact Details

For further information, please contact:

- The Care Standards Team
- Contact telephone numbers: 01142716296 or 0114271 8378#
- Email address: Denise.Woods@shsc.nhs.uk or Julie.Walton@shsc.nhs.uk

DRAFT- Quality Improvement and Assurance Strategy
CQC Responsive Domain Plan 2017-18

1. PURPOSE

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2. INTRODUCTION

Clive Clarke, Deputy Chief Executive is the Executive Director Lead for the CQC responsive domain.

The CQC defines 'responsive' as "By responsive, we mean that services meet people's needs."

In the CQC's framework for assessing the responsive domain, there are four Key Lines of Enquiry (KLOEs):

R1	How do people receive personalised care that is responsive to their needs?
R2	Do services take account of the particular needs and choices of different people?
R3	Can people access care and treatment in a timely way?
R4	How are people's concerns and complaints listened and responded to and used to improve the quality of care?

The Characteristics of an outstanding service in responsive can be found at Appendix 2.

3. KEY PRIORITIES AREAS

Having considered the Trust CQC inspection reports, feedback from the Trust directorates and analysis of internal intelligence, the following eight areas have been identified as key responsive priorities that the Trust will focus on for the next 12 months. The priority areas will be mapped against the effective CQC KLOEs.

1. Achieving and embedding the 'responsive' actions from CQC inspections
2. Timely access to services
3. Accessible Information Standard
4. Facilities and Premises
5. Equality Act/ reasonable adjustments
6. Involvement of families and carers and wider community
7. End of life care
8. Complaints

The following sections describe the planned work around these priorities.

1. Achieving and embedding the 'responsive' actions from CQC inspections

The outcome of the focussed Trust inspection of the responsive domain in May 2016 was a rating of 'good'.

In the Trust comprehensive CQC inspection in November 2016, nine of the Trust's ten core services were rated 'good' in the responsive domain, resulting in a 'provider rating' of 'good' overall for responsive. One core service (Substance misuse services) was rated 'outstanding.

In the Primary Medical Services inspection in November 2016 and September 2017, the responsive domain was rated as 'good'.

In the Adult Social Care services inspections in 2016/2017 the responsive domains were rated as 'good'.

See CQC website for full details of all inspections: http://www.cqc.org.uk/provider/TAH

Across all of the services inspected, including those with a 'good' rating, there is a total of ten related actions that the CQC has asked the Trust they 'should' do to improve, see table 1.

Table 1: Progress update November 2017:

Action	**Action off track**: Subject to executive escalation	**Action on track**: Will progress to timescale	**Action complete**: Evidence available	**Action complete:** Evidence checked by SPI	**Total**
Should do		1		9	10

Service	Area for improvement	Status November 2017
Substance Misuse Services	The trust should ensure the service deals efficiently with the volume of daily telephone calls received. Clients and other professionals should be able to contact the service with the minimum of delays.	Estimated completion Q3 2018
Forensic	The trust should review the facilities at Forest Lodge or the provision of dedicated space for patients' to practice their spiritual and religious beliefs.	Complete
	The Trust should review activity timetables regularly to ensure that meaningful and engaging activities are available across the seven day week for patients to access.	Complete
	The Trust should ensure that the waiting time from referral to assessment for admission to the assessment and rehabilitation wards is reduced.	Complete
HBPOS/Crisis/out of hours	The trust should review how it can further improve response times to ensure that people do not have excessive waits to be assessed	Complete
	The trust should review whether there are any safe, neutral facilities available in which out of hour's staff would be able to conduct face-to-face assessments.	Complete
	The Trust should continue to review and work with relevant organisations towards implementation of a 24 hour dedicated crisis service.	Complete
Long Stay Rehab	The trust should ensure that discharge plans are in place in the Intensive Rehabilitation Service which ensure patients who have extended periods of admission to the service are reviewed regularly to ensure their placement in the service is appropriate for them.	Complete
	The Trust should ensure that patients in the intensive rehabilitation service are allocated a Care Coordinator from an appropriate community based mental health team.	Complete
The Clover Group	The Trust should continue to monitor the access and capacity plan and patient feedback with regard to improving timely access to appointments.	Complete
% Actions Completed		**90%**

Progress

- Action plans were created during the inspection week in November 2016 based on feedback given at the time of the inspections.
- The CQC published findings in reports on 30 March 2017 and responsive action plans were created to address the 'must' and 'should' do actions. The actions taken since the inspection were incorporated into these.
- A monthly Executive led CQC Action Plan Task & Finish Oversight Group was established in May 2017 to monitor completed actions and to track progress against target dates.
- Once actions are completed, the Care Standards team carry out a quality assurance check of evidence as part of the CSPI framework. If the quality check is successful the action is marked as complete and evidence collected. If the quality check is unsuccessful, guidance and support is provided focusing on the evidence required to demonstrate completion.
- Progress is published on the Staff Intranet and Trust Internet every three months and shared with the CQC on a quarterly basis at CQC Engagement meetings.

Embedding actions

2. Timely access to services

To improve delivery of services for adults with mental health and social care needs in the community a reconfiguration of services has taken place. This new model is aimed at improving the quality and effectiveness of care delivery to meet service user's needs, and make efficient use of resources.

The new model will offer consistency across the city in terms of standardised treatment in line with NICE and quality standards and efficient flow through community services, with a clearly articulated definition of each component of the service. A Single Point of Access (SPA) has been created, which comprises of a Home Treatment Service (North and South), an Emotional Wellbeing Service and an Early Intervention in Psychosis service. Throughout the transition to the new model the needs of service users have been a priority, with capacity built in to allow for staff to 'hold ' any service user and transfer over a longer period if required, putting the service user central to the process.

Launch of the SPA -Improving care for people in mental health crisis
Sheffield Health & Social Care NHS Foundation Trust (SHSC) is improving care for people experiencing a mental health crisis with the launch of a new single point of access (SPA) 24 hour service.

The SPA was launched on Monday 18 December 2017 and provides responsive and accessible out-of-hours care for people in crisis 24 hours a day, 7 days a week, 365 days a year. The SPA also ensures that all referrals from GPs, carers and other statutory and third sector referrals are processed and responded to in a timely way, following a robust clinical triage process.

The SPA is a significant part of the Trust's aim to provide care to people as close to home as possible. The SPA will improve access and mean that people can get the help they need, when they need it, supporting them to recover at home with friends and family nearby and avoiding the need for hospital admission.

Emotional Wellbeing Service - We have also just launched a new Emotional Wellbeing Service, which delivers routine assessment and short term interventions providing a 'bridge' between primary and secondary care mental health services. This will mean we are able to provide more advice and support to people, improving their mental health and wellbeing.

A&E Mental Health Liaison Service - Now Available 24/7 from 27 November 2017 the Liaison Service provides round the clock assessments to patients in mental health crisis attending A&E at Sheffield Teaching Hospitals NHS Foundation Trust.

Following referral from a health professional on an inpatient ward within the general hospital or within Accident and Emergency (A&E), the Liaison Service offers a high-quality intervention, assessment and discharge process that covers all aspects of mental health - including drug and alcohol use and self-harming. The Liaison Service also gives advice on clinical management of patients and, if needed, can make referrals to other relevant services.

Early Intervention in Psychosis - The Early Intervention in Psychosis Service has been operational as a single city wide service since March 2017. Although staffing levels remain limited in comparison to service demand, additional investment was secured from the CCG in September (2017) to allow the service to increase their staffing establishment and minimize the gap between resource and demand. The future staffing model for EIP has been included within the wider community reconfiguration process and it is planned that the staffing model will be fully operational by early February 2018.

The citywide service offers specific pathways of care for those assessed / identified as experiencing ARMS (At Risk Mental State), FEP (First Episode Psychosis) and Suspected Psychosis. Each pathway will deliver a NICE concordant package of care for up to three years.

The standard operating procedures for the identified care pathways and the EIP inclusion criteria have been developed and agreed. These will form the wider operational policy for the service. Work is under way to develop and improve the interface / joint working with other services such as SPA, CAMH's and the inpatient wards and relevant operational policies are being reviewed and updated as part of this process. A case management system has been successfully embedded into practice to allow the team to successfully manage capacity and in some cases to support successful discharge prior to the three year package of care.

The service operates between the core hours of 9:00am until 5:00pm from Monday until Friday with the potential to provide occasional evening support in response to service need. The Single Point of Access (SPA) duty function and Out of Hours Service (OOH) will provide a crisis response as necessary outside of these hours.

IAPT – The IAPT service is based in all GP practices across Sheffield and is fully integrated within the practice team. Using the GP patient record enables communication between IAPT staff and the GP practice teams to such an extent that we have 'direct booking' operational which means the patient can book in at reception to see an IAPT worker in the same way as they would book in to see a GP. IAPT has a central self-referral team for people that live and work in Sheffield to offer choice of venue and the option of direct access rather than access the service at their GP practice.

Through the Sheffield IAPT website patients can directly book online on a range of treatment options that are available across the city. People can access therapy via Skype or telephone and people can choose to access an online CBT programme that is supported by our staff via email or phone. The online programme can be accessed 24/7. To offer choice we have stress control that runs centrally on Tuesday evenings and Thursday evenings.

The service is running a range of groups to improve equality of access and outcomes. This includes, running groups spoken in Urdu, Slovak and Arabic, running groups in older adult's services and peri-natal groups in children's centers as part of on-going quality improvement to be responsive to the needs of the local population.

In April 2017 the IAPT service expanded to integrate in to physical health services to fulfill the requirements of the Five Year Forward View for Mental Health. The objective is to increase parity of esteem between physical and mental health. To achieve this objective the service is working across multiple long-term conditions pathways and with medically unexplained symptoms connecting with primary, community and acute care.

The IAPT service is required to see 12, 000 patients each year with an additional 3, 333 in the health and wellbeing service. In both services the waiting times standard of entering treatment within 6 weeks is exceeded.

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3. Accessible Information Standard

Work is progressing with the Trust lead for the Accessible Information Standard (AIS). The IMST has amended the Trust's Insight System in line with the directions of the lead. Additional meetings have occurred with the Insight Trainer to define the requirements, with the resulting specification shared with the Insight Developers. This has led to the addition of the 'Communications' tab to the Insight demographic area. This is a flexible set of fields which allow the needs of service users to be specified. To date 30 people have their needs recorded on the system (the earliest recording being 10 January 2017).
Some Trust services use SystmOne as their patient information system. This is provided by an external supplier so we do not control the functionality of that system.

4. Facilities and Premises

A range of schemes have been undertaken to improve the experience of service users using Trust's premises. At Forest Close three bungalows have been refurbished to provide suitable accommodation for the Intensive Rehabilitation Service. There have been work completed to the premises and facilities to support and enable the Adult Acute CMHT service changes, such as an improvement scheme at Netherthorpe House, which has provided space for the Out of Hours/Crisis services. This is a short term measure and plans are in place to develop appropriate facilities for a Psychiatric Decisions Unit (PDU) and Single Point of Access (SPA) service at our Longley Centre site (as part of its overall redevelopment), which will form the long term base for the out of hours and crisis services. Improvements to premises and facilities include:

- Schemes are underway to improve seclusion room facilities in the G1 Ward at Grenoside Grange (Dementia inpatient services) and we have previously improved such facilities in other inpatient wards.
- To Dovedale Ward (older adults acute service) to ensure compliance with the mixed sex guidance (EMSA).
- To significantly reduce the risk of ligation incidents from the internal design of fixtures and fittings on the inpatient wards.

The main challenge is delivering a range of schemes in a timely fashion and in accordance with clinical services requirements, whilst also complying with Trust governance processes for business case approval and ensuring schemes are competitively tendered in accordance with Trust Standing Financial Instructions (SFIs). Sometimes schemes surface at the eleventh hour (e.g. need to make changes to Netherthorpe House) and there is considerable pressure to deliver within a very short timescale but naturally to good quality.

That said the Capital Development team have delivered or are in the process of delivering this range of schemes, whilst also working on development of the business case for a major capital development for the Trust (ACR/Longley Centre Phase 2) and have worked proactively with clinical services colleagues to deliver good quality outcomes within agreed timescales.

5. Equality Act/reasonable adjustments

Equality Act 2010 – There is a Trust executive and a lead person to ensure appropriate leadership of equality within the Trust. The trust has agreed equality objectives, which is a legal requirement and works in partnership with partner agencies and other organisations whilst also working in the context of the NHs equality delivery system.

We have had a particular focus on Workforce Race Equality and the Trust has been very committed to this supporting on a practical level for example financially funding conference attendance with lead BME members of staff to support taking this forward. Generally work needs to be done on working with services to look in more detail about equality issues. Locally IAPT are doing particularly well with this and we are having a discussion at the quality improvement forum focused on WRES data and BME data about services in April this year.

Key areas to note:

- we have been involved in the Workforce disability standard pilot
- We already meet the requirements of the new Sexual orientation monitoring standard
- We are responding in a constructive way to the gender pay gap reporting and considering the results
- We have undertaken a lot of analysis of ethnicity of service users' across the care pathway this needs to be used now to inform service improvement

Areas where we do less well – we have not had a focus on LGBT issues over the last few years this is an area we need to review.

Reasonable Adjustments

For Service Users –

- Have incorporated monitoring of meeting reasonable adjustments into the Mental Health Act Code of Practice and the Equality and Human Rights Act policy and associated monitoring report.
- All written policies should consider this through EIA
- All service development should consider this through EIA this is not as robust as for written policies tends to depend on who is leading
- We have made changes to Insight to respond to the accessible information standard, and recently audited the use of this system. There is use in a number of services but not reflecting the level of need. Discussions with services indicate they are identifying and responding to communication and information needs but not always recording this.

For Staff

- New Disabled Staff Policy had a big focus on Reasonable Adjustments
- Disability Confident leader working group includes focus on this area
- We are responding to the new Disability Equality Standard - one metric is likely to be focused on if staff have had reasonable adjustments made (i.e. this is asked in the staff survey) if they need them the Trust scores well on this compared to other Trusts.

6. Involvement of families and carers and wider community

A range of actions have been undertaken to increase involvement, including families, carers and young carers and the wider community.

Families – within the Trust there are clinical staff trained specifically in Family Therapy, working on the wards and other venues throughout the Trust. Five day courses are run through the Recovery Education Unit aimed at working families. These are for staff, volunteers and service users. These are entitled, 'Recovery Focussed Family Work'.

Carers and young carers - The Care Act 2004 imposed a specific obligation on Care Trusts to consider the impact of caring on the well-being of carers and what they wanted to achieve in their own lives. The Trust is taking responsibility very seriously and a Carers and Young Carers Strategy was formulated, involving staff, carers, young carers and other groups such as CHILYPEP.

In addition, more creative ways of engaging are being used such as making short films about carer's lives called carers voices, one of which focuses on BME carers. The films aim to raise the profile of carers' issues to ensure that carers get the help and support they need.

The wider community – there is a commitment through voices being heard at every level of the service – even when the voice is a whisper to ensure that the wider community is listened to (A promise to lean – a commitment to act improving the safety of patients in England).

Involvement and feedback also comes through road shows, the Friends and Family Test (FFT), Care Opinion and the use of volunteers.

The Service User Engagement Group Road shows– these form part of the Service User Engagement Strategy and are an opportunity for members to visit different sites and services collecting views on service user experiences and how this can be improved. This embraces working with and learning from external organisation such as the Alzheimer's Society, The Carers' Centre and SACHMA.

The Friends and Family Test – The Trust gains feedback from the FFT with an average response over the last 12 months of over 96% recommending the Trust services.

Care Opinion – The Trust has signed up to an enhanced service with Care Opinion, formally known as Patient Opinion so as to increase service user feedback. In addition, processes in place ensure responses to feedback are timely and influence service improvement.

Volunteers – There are on average between 20 and 40 volunteer enquiries every month. Volunteers are active over a wide variety of areas including recruitment and selection, RESPECT training, Microsystem coaching, chaplaincy support and befriending.

However, challenges remain to engage with harder to reach groups, such as the homeless and travellers. Different ways are being used to improve engagement, for example by working with Sheffield University, the Trust has been able to access the travelling communities and hear their experiences. Engaging with BME communities is one of the priorities within the Service User Engagement Strategy.

7. End of Life Care

In 2016, staff from the older adults bed based services attended a one day workshop around end of life care. This was aimed at delivering key messages from the "One Chance to get it Right" (2014) publication. Staff from three areas attended, G1, Birch Avenue and Woodland View. It was agreed by the Nurse Leaders Group that staff would follow the principals in the document.

To identify a person at the end of their life, staff work in collaboration with primary care services, the GP, District Nurses and with St Luke's Hospice (if required).

Staff at Birch Avenue have taken part in a training and education initiative run by St Luke's Hospice around of end of life care. In addition, staff access web based resources and take part in 4 training sessions each month.
Future plans include ways of up skilling nurses in bed based services to be able to provide the essential physical care interventions such as 'IV' fluid administration and 'advance physical health care skills'.

8. Complaints

The Trust has adopted the following Principles of Remedy as endorsed by the Parliamentary and Health Service Ombudsman: Getting it right, being customer focussed, being open and accountable; acting fairly and proportionately; putting things right and seeking continuous improvement.

The CEO is the Executive responsible for complaints. He personally signs off all formal complaint responses and offers to meet with all complainants. The Trust website contains full information and contact details relating to the complaints process. The information also contains details of local advocacy services and contact details for the Parliamentary and Health Service Ombudsman.

A comprehensive quarterly complaints report is produced and presented by the Head of Corporate Affairs to the Quality Assurance Committee (a subcommittee of the Trust Board). The report contains detailed information in relation to the issues complained about, the findings of the investigation and any lessons learned/recommendations made as a result of any failings.

The Trust's Complaints Annual Report is published on the Trust website.

The Head of Corporate Affairs meets on a quarterly basis with the clinical directorates to not only review and discuss their own complaints but also to review complaints made to other services. This helps to expand/share the learning across the organisation.

Learning the lessons, making the changes and raising standards are a vital part of the complaints process. Where recommendations are made by an investigating officer, the Corporate Affairs Team will monitor the implementation of any recommendations.

While the Trust's written acknowledgement of all formal complaints has always been within the regulatory three days from receipt (100%), our investigation of complaints within our own twenty five working day timeframe has fluctuated in the past three years. We are actively seeking to meet the CCG target of 75%, our response time for the past quarter being 71%. We will continue to monitor investigation response times, taking whatever action is necessary to bring the response times back to a more acceptable level.

GOVERNANCE ARRANGEMENTS

The Trust's Quality Assurance and Improvement Strategy provides the overarching framework with a range of development priorities and actions in place focussed on maintaining and improving the quality of care provided. These are defined within the Quality Account which addresses transformation priorities and a range of quality improvement programmes including building capacity to deliver high standards of quality care.

The governance structures ensure the work is a crucial element of our assurance mechanisms; operationally via clinical and corporate directorates and Board sub-committees to provide assurance to the Board. This includes:

- A new Clinical Director Structure
- Dedicated Clinical Mobilisation Leads
- Transition planning being clinically led
- Standard Operating Procedures co-produced, which will be auditable setting out what the service user can expect for staff and services
- Peer inspection regime
- Service user and staff driven key performance indicators
- Accreditation for all our functions
- Use of experts by experience

Next Steps

It is important that we consolidate and sustain good performance to date, and build on this going forward, for example not just achieve performance target expectations but aim to exceed them. As stated earlier there are eight priority areas for the next twelve months:

1. Achieving and embedding the 'responsive' actions from CQC inspections
2. Timely access to services
3. Accessible Information Standard
4. Facilities and Premises
5. Equality Act/ reasonable adjustments
6. Involvement of families and carers and wider community
7. End of life care
8. Complaints

We are at a point where the introduction of a single point of access (SPA) for crisis assessment and referral triage has been rolled out, it is now important to establish and support staff with embedding these changes. At the same time drive to optimise the performance of this service to ensure clear clinical pathways that are timely, effective, and understandable to service users, carers, staff and stakeholders and involves the individual.

To support the Trust's crisis response is the development of a centre 'Crisis Hub' before the end of 2018/19, which will bring together:-

- SPA
- Liaison
- Psychiatric Decision Unit offering an alternative to inpatient admission
- City-wide AMPH
- Crisis Café

This will enable the delivery of alternatives to secondary care mental health services that:

- Embed emotional wellbeing to reduce the number of people entering adult secondary care and people receive assessment and appropriate short term interventions.
- No service user will be internally referred within SCHC services unless it is clinically appropriate to do so.

A focus remains for service development, delivery and performance ensures that service users are at the centre of what we do and is done with their involvement. By embedding and improving service performance and in response to service user/carer consultation and feedback we aim to move from providing not just good services but outstanding.

Appendix 2

CQC Responsive Key Lines of Enquiry: What Outstanding Looks Like

"Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care"

R1: How do people receive personalised care that is responsive to their needs?

People's individual needs and preferences are central to the delivery of tailored services. There are innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. The services are flexible, provide informed choice and ensure continuity of care. Facilities and premises are innovative and meet the needs of a range of people who use the service.

R2: Do services take account of the particular needs and choices of different people?

There is a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which is accessible and promotes equality. This includes people with protected characteristics under the Equality Act, people who may be approaching the end of their life, and people who are in vulnerable circumstances or who have complex needs

R3: Can people access care and treatment in a timely way?

People can access services and appointments in a way and at a time that suits them. Technology is used innovatively to ensure people have timely access to treatment, support and care

R4: How are people's concerns and complaints listened and responded to and used to improve the quality of care?

People who use the service and others are involved in regular reviews of how the service manages and responds to complaints. The service can demonstrate where improvements have been made as a result of learning from reviews and that learning is shared with other services. Investigations are comprehensive and the service uses innovative ways of looking into concerns, including using external people and professionals to make sure there is an independent and objective approach.

The full CQC document can be found here:
http://www.cqc.org.uk/sites/default/files/20171020-healthcare-services-kloes-prompts-and-characteristics-showing-changes-final.pdf