

How to use Essence of Care 2010



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How to use Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE



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Quick Start

The following is a 'quick start' guide for using the *Essence of Care 2010* to improve practice and care.

Identify which aspect of practice and/or care needs improvement

Questions to ask:

- What do *people* requiring care and/or their carers complain or raise issues about most?
- Why have incidents or accidents happened?
- What areas have national or local surveys highlighted as being of concern?
- For example, have there been any complaints about *people* requiring care not being helped to eat?

Look at the benchmarks, factors and indicators to see what people requiring care and carers say needs to be in place

Things to think about:

- Are there any benchmarks that link with the area of concern identified above? For example, Benchmarks for Food and Drink.
- Are there any factors that link with the specific area of concern? For example, '*People* receive the care and assistance they require with eating and drinking' (Assistance – Factor 9).
- Review the indicators for practical ideas of how to achieve the factors. For example, 'A system is in place to identify that *people* requiring assistance to eat and drink receive it' (indicator 9b).

Review and change practice and/or care

- Ascertain whether current practice meets the indicators. For example, identify whether there is a system in place that identifies *people* requiring assistance to eat and drink. If current practice does not meet the indicators change practice so that it does. For example, introduce a system where food is delivered on red trays for *people* requiring assistance.

Evaluate practice and/or care from perspective of people requiring care, their carers and staff

Questions to ask:

- Do *people* requiring care and/or their carers think that care has improved? Are they happy with the standard of care? For example, are *people* and/or carers satisfied with the assistance given to help *people* eat and drink? Is there evidence that *people* requiring care are well nourished?

Establish improved practice and care or revise further

- Establish improved practice and care across the team, organisation or organisations or improve practice and care further where it does not meet the indicators.

How to use Essence of Care 2010

Essence of Care 2010 identifies best practice and highlights how this can be achieved. *Essence of Care 2010* was developed in partnership with *people*¹ and carers² and as such reflects the views of their health and social care needs and preferences.

It is important to note at this point that *Essence of Care 2010* is a very versatile tool that can be used in a number of ways and at different levels. For example, it can be used as:

- a *quality assurance or benchmarking tool* (see below)
- a reference document or checklist – *Essence of Care 2010* includes what *people*, carers and staff³ agree is best practice and care and this can, therefore, be referred to in order to understand *people's* and carers' perspectives and what might need to be improved to accommodate these
- an *audit tool* – as a foundation and focus for audit data collection tools used to assess practice and care (linked to above)
- a *dissemination tool* – to spread current good practice and care across organisations
- a *root cause analysis tool* – when examining incidents and complaints or addressing risks
- an *education tool* – to educate and train staff of all levels about *people's* and carers needs and preferences, and to highlight the areas where specific competencies are required to provide care
- to provide *evidence of compliance with registration criteria* for the Care Quality Commission

1 For simplicity, the term '*people* requiring care' is shorted to *people* (in italics). *People* includes babies, children, young *people* under the age of 18 years and adults. This is consistent for all sets of benchmarks except those covering the Care Environment.

2 The term 'carers', refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Carers can include children and young *people* aged under 18 years.

3 The term 'staff' refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

- to provide *evidence of achievement and best practice and care* – for example, to the regulator or Health Service Ombudsman, for the National Cleaning Standards, when using the National Service Frameworks, or in commissioning assurance.

Essence of Care 2010 can be used by individuals, teams, directorates, and within and across organisations of all sizes. It can also be used locally or strategically, or ideally, both. It has universal application.

When using *Essence of Care 2010* it is important to remember to:

- make it work for *people* and their carers
 - focus on areas of concern for *people* and carers
 - use *Essence of Care 2010* flexibly to make improvements
 - ensure involvement from *people*, carers and all staff concerned with the delivery of care
- make it work for staff and/organisations
 - save time and effort and integrate *Essence of Care 2010* work with other projects and initiatives, such as those required for the National Cleaning Standards, reports for regulators, infection control guidance, mixed sex accommodation guidance, Dignity Champions work, governance, Patient Environment Action Teams' guidance, National Institute for Health and Clinical Excellence (NICE) guidance, electronic handover, and Better Metrics Projects, etc
 - use within commissioning assurance
- do not reinvent the wheel – be 'smart'
 - share and compare best practice and care (locally, nationally, other team's work etc)
 - where possible use evidence already in existence (for example, current audit data)
 - use valid tools that already exist and
 - use evidence gathered for one set of benchmarks, for instance those concerning, 'Respect and Dignity', to provide evidence for other sets of benchmarks such as 'Communication' and 'Food and Drink'. This applies both to goals that are more specific as well as goals that cover topics such as diversity, consent and confidentiality, *people's* involvement, leadership, education and training etc.

Much of *Essence of Care 2010* is centred on benchmarks and benchmarking for practice and care. The following text discusses this in more depth. In addition, there are more detailed ideas and tips on 'Using *Essence of Care 2010* Benchmarks' in Appendix One and 'Making Changes Possible and Sustainable' in Appendix Two.

Why is benchmarking practice and care necessary?

Many *people* have care that is very effective and appropriate to their needs and preferences. There are lots of examples of compliments being written or made to health and social services staff. However, practice and care is not correct all of the time and, therefore, needs improvement. Poor care is evidenced by, for instance, complaints, untoward incidents, and increased death and illness rates. Therefore, staff, teams and/organisations need to look at how they are working in order to improve practice and care.

Benchmarking is important because it is a systematic process that can be used to improve practice and care.

What is a benchmark and benchmarking?

In the context of this document a **benchmark** is:

'a standard of best practice and care by which current practice and care is assessed or measured.'

Following from this **benchmarking** is:

'a systematic process in which current practice and care are compared to, and amended to attain, best practice and care.'

Briefly the steps involved are:

- **establish priorities** for improving practice and care within the environment or organisation
- **establish and agree best** (evidence-based) practice and care for *people* within the organisation
- ascertain current practice and care
- **compare the differences**, and identify the gaps and barriers between, current and best practice and care and identify achievements
- **develop a plan** of what goals need to be met to achieve best practice and care, that is, working out what needs to be done and how
- **implement the plan** (that is, change things, for example, activity, perspective, approach, culture, education and training, environment, etc) to meet the goals
- **evaluate** practice and care by assessing and measuring whether goals have been met
- **establish improved practice and care** across a team, or organisation(s)
- **establish priorities and further goals** to continuously improve quality of practice and care, that is, go through the steps again.

(see also Appendices One and Two)

Focus of Essence of Care 2010 benchmarks

The benchmarks are focused on 12 topics. These were chosen because the evidence indicated that *people* were unhappy with these fundamental aspects of care. The 12 sets of benchmarks are:

- Bladder, Bowel and Continence Care
- Care Environment
- Communication
- Food and Drink
- Prevention and Management of Pain
- Personal Hygiene
- Prevention and Management of Pressure Ulcers
- Promoting Health and Well-being
- Record Keeping
- Respect and Dignity
- Safety
- Self Care

The overall person outcomes, specific factors and indicators (or goals) within the benchmarks have been developed, reviewed extensively and agreed by *people*, carers, association representatives and staff as vital to providing best practice and care. The result is sets of benchmarks which are truly person-focused. This is because the areas covered are important to *people* and carers, and the indicators are focused on what *people* and carers say they want and expect.

Where can the Essence of Care 2010 benchmarks be used?

These benchmarks are designed to be used wherever health and social care is planned, managed and/or delivered. For example, it can be used in the following settings and environments:

- *people's* homes
- hospitals
- day centres
- clinics
- care homes
- ambulances
- prisons
- GPs' surgeries
- schools

In the following areas:

- care for acutely ill *people*
- care for chronically ill *people*
- emergency care
- long term care
- short term care
- care of *people* with learning disabilities
- care of children and young *people*
- care of *people* with a range of conditions such as cancer, diabetes, medical and surgical problems
- care of *people* with wounds
- care in pregnancy
- care of *people* with mental health problems
- care of *people* who are terminally ill
- care of *people* who are in pain
- care of *people* who are vulnerable

and in the settings and areas in which you work.

Content of Essence of Care 2010 benchmarks

The *Essence of Care 2010* benchmarks comprise:

- an **overall person-focused outcome** that expresses what *people* and carers want from care in a particular area of practice
- **definitions** of terms as appropriate
- **general** indicators, or goals, for best practice
- a number of **factors**, or topics, that need to be considered in order to achieve the overall person-focused outcome

Each factor consists of:

- a person-focused statement of **best practice and care** which is placed at the extreme right of the continuum
- a statement of **poor practice and care** which is placed at the extreme left of the continuum
- indicators, or goals, identified by *people*, carers, association representatives and staff that support the attainment of best practice and care

An example is shown on the next page.

Example of overall outcome, factor and indicator

Benchmarks for Prevention and Management of Pain

Agreed person-focused outcome

People and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life

Factor 1 – Access



Indicators of best practice for factor 1

The following indicators support best practice for managing pain:

- a. *general indicators (see page 4 in each benchmark) are considered in relation to this factor*
- b. *up-to-date information about pain management and services, and how to access them, is readily available in all care environments and (where applicable) given in advance of care. Information is provided in a suitable format and in plain language*
- c.
- d. *add your local indicators here*

APPENDIX ONE

Ideas and tips

Essence of Care 2010 benchmarking is a systematic process in which the current practice and care of health and social organisations, teams or individual staff are compared to, and amended to attain, best practice and care. Changes and improvements focus on the indicators, or goals, within the factors, since these are the items that *people*, carers and staff believe are important for achieving best practice and care.

This section includes ideas and tips that have proved useful in taking forward the Essence of Care. It is *not* an exhaustive list of activities that must be followed.

The steps involved are listed in the tables on the following pages:

Steps for Benchmarking:

Step	Activity	Ideas and Examples
<p>Step One</p>	<p>Establish priorities for improving practice and care within the environment or organisation</p>	<p>Be strategic in choosing a set of benchmarks (or a factor or an indicator) on which to focus effort that is relevant and appropriate.</p> <p>Decisions on what to focus on should be based on evidence such as:</p> <ul style="list-style-type: none"> ■ increased concerns about practice and care highlighted by <i>people</i>, carers and/or staff ■ lack of satisfaction of <i>people</i> or carers (for example, collected during surveys) ■ increased risk to safety of <i>people</i>, carers and/or staff (for example, collected as the result of incidents) ■ increased or high number of complaints ■ identification of recently published evidence of best practice and care; ■ identification of an exemplar of good practice and care within the organisation ■ new guidance from organisations such as National Institute for Health and Clinical Excellence (NICE), the National Specifications of Cleanliness in the NHS in relation to Patient Environment Action Teams (PEAT) from the National Patient Safety Agency, or within commissioning assurance or from the Social Care Institute of Excellence. <p>This step is very important for <i>gaining support for improvement throughout the organisation</i>. This is because a wise decision can tie together the expectations of <i>people</i> and carers to the goals of teams, organisations, commissioners or local authorities.</p>

Step	Activity	Ideas and Examples
		<p>For example, the following expectations and goals could be addressed in part via the Benchmarks for Prevention and Management of Pressure Ulcers (such as Factor 1, indicator b):</p> <ul style="list-style-type: none"> ■ <i>people</i> do not expect to develop pressure ulcers in a care environment ■ the team wants to identify and manage more effectively the care of <i>people</i> at risk of developing pressure ulcers ■ the organisation wants to reduce the incidence of pressure ulcers and manage the use of pressure redistributing equipment more efficiently ■ the commissioning organisations or local authority want to improve overall well-being of the population within an area ■ the government wants to deliver maximum improvement in health and well-being outcomes within resources. <p>N.B. Be strategic – the links between expectations of <i>people</i> and carers, as well as the goals of staff, teams, organisations, commissioners and local authorities and government priorities may need to be highlighted to those concerned.</p>

Step	Activity	Ideas and Examples
		<p>It may be appropriate for the organisation to set up an Essence of Care 2010 Steering Group. This steering group can provide strategic focus and direction for the <i>Essence of Care 2010</i> initiative and support staff throughout the organisation(s) to improve the fundamental aspects of care. The steering group can also be used to monitor progress, facilitate evaluation and report on benchmarking activities to the board. In addition, the steering group could have a remit to ensure that the Essence of Care 2010 initiative is integrated with the organisation's other priorities and committees. Lead members can liaise with other organisations at regional and national levels to share good practice, ideas and to disseminate methods of improvement. the Steering Group could have a remit to ensure that the <i>Essence of Care 2010</i> initiative is integrated with the organisation's other priorities and committees.</p>
		<p>ESSENCE OF CARE 2010 STEERING GROUPS</p> <p>Essence of Care 2010 Steering Group membership can include:</p> <ul style="list-style-type: none"> ■ <i>people</i> and/or carers ■ representatives from associations, such as Age UK ■ experts in changing practice (for instance, lead members of the practice development, service improvement, integrated governance and/or quality teams) ■ commissioners of services ■ staff who work directly with <i>people</i> and/or carers ■ senior managers of services ■ support service staff ■ board members

Step	Activity	Ideas and Examples
		<p>Remember: Consider resource implications – there is no bottomless pot of money!</p>
<p>Step Two</p>	<p>Establish and agree best (evidence-based) practice and care for <i>people</i> within the organisation</p>	<p>Guidance for best practice and care is provided by the specific and general indicators (goals) that <i>people</i> and carers have stated are important from their perspectives. Some of these goals are about putting processes in place and others are the outcomes that <i>people</i> and carers want and expect.</p> <p>Examples of goals are:</p> <ul style="list-style-type: none"> ■ <i>people</i> are addressed as they wish and spoken to using their preferred name (Benchmarks for Respect and Dignity, factor 4, Indicator b) ■ resources to aid communication and understanding are available, for example, hearing loops, text phone, large print text, pictures, books, toys, Braille, multilingual literature and other electronic methods of communication (Benchmarks for Communication, factor 5, indicator b) ■ incidents, such as acts of violence, aggression and seclusion are reviewed and evaluated and the knowledge is used to improve care (Benchmarks for Safety, factor 6, indicator d) ■ <i>people</i> and carers know how to access services and resources, for example, by using the Citizen’s Advice Bureau, NHS Direct etc (Benchmarks for Self Care, factor 6, indicator c) ■ <i>people</i> who are identified initially as having pressure ulcers or who are vulnerable to the development of pressure ulcers should receive a full assessment using an evidence-based tool (Benchmarks for Prevention and Management of Pressure Ulcers, factor 1, indicator d).

Step	Activity	Ideas and Examples
		<p>N.B. Not all the goals are applicable to all health and social settings and environments and others may need to be adapted.</p> <p>It is often important to agree what constitutes best practice and care across a team, an organisation or organisations in order to ensure improvements are achieved and sustainable across health or social care settings. For instance:</p> <ul style="list-style-type: none"> ■ in relation to pressure ulcer management and goals, agreement may have to be reached about what is meant by the term <i>'vulnerable to development of pressure ulcers'</i> and what constitutes a <i>'full assessment'</i> or an <i>'evidence-based tool'</i>. This may involve setting up an 'Expert Working Group' (see below) to put forward standards and assessment tools which can then be agreed throughout the team, an organisation or organisations ■ the goal of <i>'nature and quality of lighting and use of colour in furnishings and decorations support a therapeutic and/or healing environment'</i> (Benchmarks for Care Environment, factor 3, indicator c) would require an 'Expert Working Group' of people and carers as well as a range of staff including those delivering care and those managing the physical environment, such as estate management staff etc. In addition, staff managing budgets would need to be involved to support or sanction any cost ■ the goal of <i>'barriers to accessing information, services and support have been identified and are being addressed'</i> (Benchmarks for the Promoting Health and Well-being, factor 5, indicator c) may require an 'Expert Working Group' in order to ascertain the barriers and how best to address them.

Step	Activity	Ideas and Examples
		<p>EXPERT WORKING GROUPS</p> <p>Expert Working Group membership can include:</p> <ul style="list-style-type: none"> ■ <i>people</i> and/or carers ■ representatives from associations, such as Age UK ■ experts in the topic under review (for instance, if developing best practice and care for <i>people</i> who do not speak English, representatives from organisations that provide competent interpreters could be involved) ■ staff who work directly with <i>people</i> and/or carers ■ managers of services ■ support service staff ■ board members, trustees and governors
		<p>Therefore, this step usually necessitates the work of a group with some expertise or knowledge of the topic under review (n.b. this invariably includes <i>people</i> and/or carers), in order to discuss and define best practice and care. In addition, some members of the group also need to have an overall view of the management of care in a particular area and other members will have the authority (or access to authority) to obtain agreement for the group's decisions from the relevant committees within their organisation(s).</p>

Step	Activity	Ideas and Examples
Step Three	Ascertain current practice and care	<p>Current practice and care can be ascertained in a number of ways. For example:</p> <ul style="list-style-type: none"> ■ observation of care (such as whether <i>people</i> are spoken to using their preferred name, or whether they have the necessary communication aids) ■ reviewing documentation (such as to ascertain whether incidents are reviewed, evaluated and used to improve care, or whether those who are vulnerable to developing pressure ulcers receive a full assessment) ■ monitoring access to services (such as local interpreting services or NHS Direct) ■ monitoring outcomes of care (such as prevalence and incidence of pressure ulcers) ■ surveys of <i>people's</i> and carers' views and satisfaction (such as attitude and helpfulness of staff). <p>It is important to decide how (criteria and method) current practice and care will be measured or assessed. There may be standard ways of achieving this (such as the National Patient Survey Programme or existing services user surveys) or local criteria and methods may need to be used. For example, what criteria will be used to assess whether <i>people</i> are spoken to using their preferred name? It could be the number of times that a person's referred name was used as a percentage of how they were referred to during an episode of care; or a person's perception of whether their preferred name was used 'not at all', 'sometimes', 'mostly' or 'all the time' etc. The method used could be observation and taking notes, or recording events by camera, or by asking <i>people</i> or staff. It is imperative that the criteria and method used reflect the topic under investigation that is, is what is being measured or assessed what is supposed to being measured or assessed?</p>

Step	Activity	Ideas and Examples
		<p>The Better Metrics Project (Health Care Commission 2007) and State of the Art Metrics for Nursing: A Rapid Appraisal (National Nursing Research Unit, King's College London 2008) may provide some useful ideas in terms of measurement.</p> <p>Remember to keep the evidence!</p>
<p>Step Four</p>	<p>Compare the differences, and identify the gaps and barriers, between current and best practice and care and identify achievements</p>	<p>Use the evidence collected on current practice and care to assess achievement towards best practice and care. Evidence can include that collected from, for example, the National Patient Survey, PEAT programmes, other national and local initiatives. Do not duplicate!</p> <p>Identify the gaps. For example, if only 50 percent of reception staff speak to <i>people</i> using their preferred name, there is evidently a gap between this and best practice and care where everyone is spoken to using their preferred name.</p> <p>Identify barriers to best practice and care. To continue to use the example above – in order to identify why reception staff are not using a person's preferred name a manager may choose to discuss this with the staff members. The barriers may turn out to be that the preferred name was not asked for or was not entered into the computer database by the staff assessing the person.</p>

Step	Activity	Ideas and Examples
Step Five	<p>Develop a plan of what goals need to be met to achieve best practice and care that is, working out what needs to be done and how</p>	<p>Produce an action plan detailing:</p> <ul style="list-style-type: none"> ■ the changes that need to be made to meet goals (for instance, the computer needs to indicate the need for a 'preferred name' to be entered onto a person's records) ■ any resource implications and how these will be met (for example, how much time the above would take to organise and to enter) ■ who is responsible for leading the changes ■ the time scale in which these should occur. <p>Actions should be:</p> <ul style="list-style-type: none"> ■ realistic ■ achievable (but do not let that limit your vision of what is possible) ■ measurable or assessable. <p>N.B. The 'Essence of Care 2010 Steering Group' and/or 'Expert Working Group' (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations. Think differently! It is important to consider practice and care from people's and carers' points of view (see also Thinking Differently, NHS Institute for Innovation and Improvement, 2007).</p>

Step	Activity	Ideas and Examples
<p>Step Six</p>	<p>Implement the plan (that is, change things, for example, activity, perspective, approach, culture, education and training, environment etc) to meet the goals</p>	<p>Carry out the plan. Keep the evidence (document, document, document):</p> <ul style="list-style-type: none"> ■ activities ■ any improvements ■ problems ■ unexpected observations. <p>N.B. The ‘Essence of Care 2010 Steering Group’ and/or ‘Expert Working Group’ (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations.</p>
<p>Step Seven</p>	<p>Evaluate practice and care by assessing and measuring whether goals have been met</p>	<p>Analyse data and evaluate actions:</p> <ul style="list-style-type: none"> ■ Did the experiences or outcomes of people and carers improve? ■ Did service delivery benefit from changes made? ■ If there is no improvement review activities in the action plan. <p>N.B. The ‘Essence of Care 2010 Steering Group’ and/or ‘Expert Working Group’ (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations</p>

Step	Activity	Ideas and Examples
Step Eight	Establish improved practice and care across a team, or organisation(s)	<p>If improvements are identified, disseminate good practice and care and implement the changes as widely as appropriate through other organisational systems.</p> <p>Include in the business planning cycle, integrated governance plan and quality initiatives and reports of teams, organisations or commissioning bodies via relevant leads. Can also be included in annual reporting to the regulator.</p> <p>N.B. The 'Essence of Care Steering Group' and/or 'Expert Working Group' (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations</p>

Step Nine/ One etc	Establish priorities and further goals to continuously improve quality of practice and care, that is, go through the steps again	As above
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The process can be accomplished using the PDSA cycle (Plan, Do, Study, Act) see Langley GJ, Nolan KM, Norman CL, Provost LP and Nolan TW (1996) *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* Jossey-Bass Publishers: USA cited in Modernisation Agency, 2002).

APPENDIX TWO

Making changes possible and sustainable: Ideas and tips

Things to put in place:

	Organisation	Team	Individual
Culture	<p>The culture of the organisation actively supports benchmarking the fundamental aspects of practice and care.</p> <p><i>People's and carers' involvement and perspectives are ensured wherever the fundamental aspects of care are considered.</i></p>	<p>The culture of the team actively supports benchmarking the fundamental aspects of practice and care.</p> <p><i>People's and carers' involvement and perspectives are ensured wherever the fundamental aspects of care are considered.</i></p>	<p>Individual staff actively support benchmarking the fundamental aspects of practice and care.</p> <p><i>People's and carers' involvement and perspectives are ensured wherever the fundamental aspects of care are considered.</i></p>
Structure	<p>There is an organisation-wide structure that supports benchmarking the fundamental aspects of practice and care.</p>	<p>Teams and team leaders are an integral part of the organisation-wide structure.</p>	<p>Individuals liaise with their local teams and team leaders and, as appropriate, with organisation and commissioning teams.</p>

	Organisation	Team	Individual
Mechanisms	<p>Organisation-wide mechanisms are in place to manage the benchmarking process and to integrate this with other quality initiatives and priorities.</p>	<p>Team mechanisms are in place to manage the benchmarking process locally and to integrate this with other quality initiatives.</p>	<p>Individuals manage relevant parts of the benchmarking process. This may involve activities such as taking part in audits, surveys etc.</p>
Responsibility	<p>The organisation takes action to meet its responsibilities in terms of benchmarking the fundamental aspects of practice and care.</p> <p>The chief executive officer (CEO) (or registered person in a social care service) is ultimately responsible for ensuring that the fundamental aspects of practice and care are met.</p>	<p>The team takes action to meet its responsibilities in terms of benchmarking the fundamental aspects of practice and care.</p> <p>The team leader is ultimately responsible for ensuring that the fundamental aspects of practice and care are met within their team.</p>	<p>Every member of staff is responsible for supporting activity towards benchmarking and delivering the fundamental aspects of practice and care.</p>

	Organisation	Team	Individual
Leadership	There is a designated post or role at senior management level to lead the Essence of Care Initiative. The post-holder is the link between commissioners, the board, managers, team leaders and staff working directly with <i>people</i> and carers.	There is a specifically designated role to lead the Essence of Care Initiative within teams.	Individuals have access to support and advice from the designated leader and also support the leader in their work.
Commissioning Assurance	Benchmarks of the fundamental aspects of practice and care are central and integral to how services are planned, commissioned and delivered.	Teams are able to demonstrate that fundamental aspects of care are part of how services are planned and delivered.	Individuals contribute to the planning and delivery of the fundamentals of care
Resources	Sufficient human and financial resources are provided to sustain the benchmarking process in the fundamental aspects of care and to maintain improvements in care.	Teams can provide evidence of probity in managing human and financial resources to support improvements in the fundamental aspects of care.	Individuals can provide evidence of probity in delivery of care to support improvements in the fundamental aspects of care.



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