Inspecting Informing Improving

Healthcare Commission

Criteria for assessing core standards in 2008/09

Primary care trusts (as providers and commissioners)

December 2008

Criteria for assessing core standards in 2008/09: Primary care trusts (as providers and commissioners)

As set out in the Healthcare Commission publication *The Annual Health Check in 2008/09: Assessing and rating the NHS*, our assessment of primary care trusts (PCTs) for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services) and its role as a commissioner of healthcare services for its local community. We have developed two sets of criteria for assessing PCTs; one for their role as providers and one set for their role as commissioners of services.

The structure of the 2008/09 criteria document for PCTs has also been changed to reflect this difference in the assessment process by dividing the criteria for PCTs as providers and PCTs as commissioner into two parts. Part One of this document will outline the PCT provider criteria, while Part Two outlines commissioning criteria.

Provider and commissioning criteria will have separate overviews and appendices to provide further information relevant to their assessment process in 2008/09.

The Care Quality Commission

The new Care Quality Commission will replace the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission from April 2009, providing an integrated approach to regulation across these bodies' current areas of responsibility. The Care Quality Commission was established on 1 October 2008 with limited preparatory functions to enable it to take over the regulation of health and adult social care from 1 April 2009.

The Care Quality Commission will be responsible for delivery of the 2008/09 annual health check, including the core standards based assessment from 1 April 2009.

Where this document refers to "we" this is a reference to the Healthcare Commission up until 31 March 2009 and to the Care Quality Commission from 1 April 2009.

Contents

Part One

Criteria for assessing core standards in 2008/09 for primary care trusts as a provider of services

Overview

These are the 2008/09 criteria for assessing core standards between 1 April 2008 and 31 March 2009 for primary care trusts (PCTs) as health service **provider** bodies within England . As for previous years, we have set out our criteria as 'elements' for each of the core standards.

What has changed?

Primary care trusts
The main change this year affects PCTs. See *Criteria for assessing core standards for 2008/09: Primary Care Trusts (Providers and Commissioners)* section at the beginning of the document.

What else has changed?
This year, we have expanded on our rationales in order to assist trusts further in the assessment process. Some criteria have also been written for greater clarity and in some cases this has made them longer. Although the document has, in turn, become longer, trusts should find the criteria read with the rationales more explicit, clearer and hence helpful when assuring themselves of their compliance against core standards.

As set out in the Healthcare Commission publication *The Annual Health Check in 2008/09: Assessing and rating the NHS*, while we have split the criteria for PCTs into provider and commissioner criteria, there has been limited change to actual content of criteria. We have however reviewed the elements in order to:

- Continue to increase the focus on the outcomes of the standards. We expect trust boards to consider these outcomes when reviewing their assurance of compliance with the standards.

- Add further clarity to elements by explicitly stating within the criteria the status of guidance, codes of practice, etc referred to. For example, where clear legal duties are referred to, trusts are assessed as to whether they have acted "in accordance with" those duties; or for some statutory codes of practice whether they "have had regard to" them, as required by the code. Where the core standard itself refers to specific guidance, this gives that guidance a "must-do" status and the criteria will also reflect this. Other guidance has varying status and we have tried to make this explicit within the criteria.

  For example:

- The healthcare organisation follows National Institute for Clinical Excellence (NICE) interventional procedures[1] guidance **in accordance with** *The Interventional Procedures Programme* (Health Service Circular 2003/011). (C3)
  (NICE interventional procedures are required by the standard itself).

- Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, **in accordance with** the Medicines Act 1968 ….., and the good practice identified in *The Safe and Secure handling of medicines: A team approach* (RPS, March 2005) **should be considered and where appropriate followed**. (C4d)

Where references are recognised as useful for trusts but are not directly the subject of

[1] 'An interventional procedure is one used for diagnosis or treatment that involved incision, puncture, entry into a body cavity, electromagnetic or acoustic energy.' (Source: *The interventional procedures programme*, Health Service Circular 2003/011).

assessment, again we will provide these in an appendix to the final document. However, as was the case with the documents in Appendix 2 of the 2007/08 criteria, these references will not be the basis on which we will make judgments in inspection.

Trusts should also note that core standards C3, C4c and C22b will be assessed for all provider sectors in 2008/09. See rationales in this document for further details.

How should trusts' boards consider the elements?
The criteria are written to reflect the requirements upon trusts throughout the assessment year; they do not introduce new requirements. As in previous years of the core standards assessment, we ask that NHS trust boards determine whether they have reasonable assurance of compliance with a standard, without a significant lapse, from 1 April 2008 to 31 March 2009. As part of the annual health check, trusts will then be asked to make a declaration of their compliance for the whole year.

Reasonable assurance
Reasonable assurance, by definition, is not absolute assurance. Conversely, reasonable assurance cannot be based on assumption. Reasonable assurance is based on documentary evidence that can stand up to internal and external challenge. In determining what level of assurance is reasonable, trusts must reflect that the core standards are not optional and describe a level of service which is acceptable and which must be universal. Our expectation is that each trust's objectives will include compliance with the core standards. This will be managed through the trust's routine processes for assurance.

Trusts' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the published criteria for assessment. Where healthcare organisations provide services directly, they have primary responsibility for ensuring that they meet the core standards. However, their responsibility also extends to those services that they provide via partnerships or other forms of contractual arrangement (for example, where human resource functions are provided through a shared service). When such arrangements are in place, each organisation should have reasonable assurance that those services meet the requirements of the standards.

Significant lapse
Trusts' boards should decide whether a given lapse is significant or not. In making this decision, we expect that boards will consider the extent of risk of harm this lapse posed to patients, staff and the public, or indeed the harm actually done as a result of the lapse. The type of harm could be any sort of detriment caused by lapse or lapses in compliance with a standard, such as loss of privacy, compromised personal data or injury, etc. Clearly this decision will need to include consideration of a lapse's duration, its potential harmful impact and the likelihood of that harmful impact occurring. There is no simple formula to determine what constitutes a 'significant lapse'. This is, in part, because our assessment of compliance with core standards is based on a process of self-declaration through which a trust's board states that it has received 'reasonable assurance' of compliance. A simple quantification of the actual and/or potential impact of a lapse, such as the loss of more than £1 million or the death of a patient or a breach of confidentiality, for example, cannot provide a complete answer.

Determining what constitutes a significant lapse depends on the standard that is under consideration, the circumstances in which a trust operates (such as the services they provide, their functions and the population they serve), and the extent of the lapse that has been identified (for example, the duration of the lapse and the range of services affected, the numbers exposed to the increased risk of harm, the likely severity of harm to those exposed to the risk (taking account their vulnerability to the potential harm etc...) Note that where a number of issues have been identified, these issues should be considered together in order to determine whether they constitute a significant lapse.

Equality, diversity and human rights

One of the Healthcare Commission's strategic goals continues to be to encourage respect within services for people's human rights and for their diversity, and to promote action to reduce inequalities in people's health and experiences of healthcare. In line with the intention of *Standards for Better Health*, we expect that healthcare organisations will interpret and implement the standards in ways which challenge discrimination, promote equity of access and quality of services, reduce inequalities in health, and which respect and protect human rights.

More specifically, core standard C7e asks trusts to challenge discrimination, promote equality and respect human rights. The criteria for C7e include a focus on how the trust is promoting equality, including by publishing information specified by statute in relation to race, disability and gender. Note that we have run three audits of trusts' websites, looking for this information, and we remain concerned that many trusts are still not compliant with legislation, particularly in relation to race equality.

Using the findings of others

We will continue to make use of the findings of others and have reviewed how we do this in order to increase this where possible, and to ensure that it is effective, both in reducing burden on trusts and also in targeting our inspections. Note that, as in 2007/08, we will make use of others' **in-year findings** – ie, findings based on observance of compliance during the assessment year 2008/09, as evidence of assurance of compliance during the year 2008/09. Findings of others relating to recent years will be used to help target inspections.

Mandatory assessment of the NHS Litigation Authority's Risk Management Standards has been suspended for PCTs for the 2008/09 assessment year. (ie, 31 March 2008 to 1 April 2009). However, we will still make in-year use of their findings for PCTs who undergo volunteer assessment or have achieved **in-year** (ie, 31 March 2008 to 1 April 2009) level 2 (or 3) in 2008/09 where this provides a level of assurance of compliance.

Please see Appendix 1 for more details about this and other changes, in particular a change in the way we use PEAT findings and the Audit Commission's Use of Resources.

In-year revisions to legislation, codes of practice and guidance

All legislation, codes of practice and guidance referred to in the core standard criteria/elements are up to date at the time of publishing. During the assessment year trusts are expected to ensure they comply with any replacements, revisions, amendments or supplements to the said legislation, codes of practice or guidance, and will be assessed on this basis.

Part One – 2008/09 PCT provider criteria

First domain: Safety

Domain outcome: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard C1a

Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.

Elements	Rationale
Element one Incidents are reported locally, and nationally via the appropriate reporting route/s to the National Patient Safety Agency (NPSA), Health and Safety Executive, Medicines and Healthcare products Regulatory Agency (MHRA), Health Protection Agency, Healthcare Commission, the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.	**Elements one & two** Healthcare organisations should report incidents nationally to the relevant national organisations. These organisations include the National Patient Safety Agency (NPSA) and a wider range of organisations that have been listed in the element. Healthcare organisations should analyse incidents rapidly after they occur so that immediate risks are removed for those involved in the incident. Furthermore, where appropriate, incidents should be analysed to identify root causes, and likelihood of repetition in order to prevent the reoccurrence of incidents in the future. The information arising from the analysis of incidents must also enable the identification of actions required to prevent the reoccurrence of incidents and this has been made more explicit in the element.

Element two Individual incidents are analysed rapidly after they occur to identify actions required to reduce further immediate risks, and where appropriate individual incidents are analysed to seek to identify root causes, likelihood of repetition and actions required to prevent the reoccurence of incidents in the future.	
Element three Reported incidents are aggregated and analysed to seek to identify common patterns, relevant trends, likelihood of repetition and actions required to prevent the reoccurence of similar incidents in the future, for the benefit of patients / service users as a whole.	**Element three** Incidents should be aggregated (including all incidents reported over a period of time) and analysed, to identify relevant trends, common patterns and likelihood of repetition, in order to prevent the reoccurrence of incidents in the future. Common patterns include factors such as location of incident, time of day of incident, patient characteristics, etc. Analysis of relevant trends includes changes over time. This requirement was previously included in element two in 2007/08 and has been brought out in a separate element to provide greater clarity. As with element two regarding individual incidents, the information arising from the analysis of aggregated incidents must also enable the identification of actions required to prevent the reoccurrence of incidents and this has been made more explicit in the element.
Element four Demonstrable improvements in practice are made to prevent the reoccurrence of incidents based on information arising from the analysis of local incidents and the national analysis of incidents by the organisations stated in element one (above).	**Element four** Healthcare organisations should make changes to practice based on the analysis of local incidents and the national analysis of incidents. The national analysis of incidents is carried out by NPSA and a wider range of organisations that have been listed in element one.

Core Standard C1b

Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.

Elements	**Rationale**
Element one All communications concerning patient safety issued from the National Patient Safety Agency (NPSA) and the Medicines Healthcare products Regulatory Agency (MHRA) via national	**Element one** SABS is being brought together with the UKPHLS to form the CAS. However, it is likely that all three systems will continue to be used in parallel during the introductory phase of CAS.

distribution systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) the UK Public Health Link System (UKPHLS), are implemented within the required timescales.	There are other routes through which this information may be issued. For example MHRA issues field safety notices via its website and targets particular trusts with directly mailed safety letters. While these cannot be considered official distribution systems, they do communicate information regarding patient safety that may occasionally require trusts to take action.

Core Standard C2

Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.

Elements	Rationale
Element one The PCT has made arrangements to safeguard children under Section 11 of the Children Act 2004 having regard to statutory guidance entitled *Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004*.	**Element one** In March 2007 statutory guidance was published, updating previous guidance, which is based on the Children Act 2004. Compliance with this was required by October 2005 and all elements should now be in place. The guidance issued under section 11(4) of the Children Act 2004 which requires each person or body to which the Section 11 Duty applies to have regard to any guidance given to them by the Secretary of State. This means that they must take this guidance into account and, if they decide to depart from it have clear reasons for doing so.
Element two The PCT works with partners to protect children and participate in reviews as set out in *Working together to safeguard children* (HM Government, 2006).	**Element two** Again this element has been extended to include activities that are required, such as participation in serious case reviews and child death reviews, both requirements from 1 April 2008.
Element three The PCT has agreed systems, standards and protocols about sharing information about a child and their family both within the organisation and with outside agencies, having regard to *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004*.	**Element three** There was some overlap between the 2007/08 element three (CRB checks) and Core standard C10a so this is removed. Instead a particular aspect of the Statutory Guidance is drawn out and wording is used from this document to emphasise the importance of information sharing between agencies. This information sharing process can include the Common Assessment Framework, ContactPoint when it is introduced, and a general responsibility on boards to ensure that systems are in place. Outside agencies referred to include for example, local authorities, the police, Connexions, Probation service, Youth Offending Teams, prisons etc.

Core Standard C3

Healthcare organisations protect patients by following NICE Interventional Procedures guidance.

Elements	Rationale
Element one The PCT follows NICE interventional procedures[2] guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011). Arrangements for compliance are communicated to all relevant staff.	**Element one** National Institute for Clinical Excellence (NICE) interventional procedures guidance applies to any trust that carries out interventional procedures. Following clarification from NICE and Department of Health (DH) the application of the standard has been extended to all trust types to better reflect this. The element makes reference to the need to communicate arrangements to all relevant staff. This is to reflect that even where no 'new' interventional procedures[3] have been undertaken in the last year (which may be more likely in non-acute trusts) an organisation should still ensure that relevant staff are aware of the process in case it occurs.

Core Standard C4a

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA)

Elements	Rationale
Element one The PCT has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Element one** The Hygiene Code was revised in January 2008. All healthcare associated infection issues are covered by this criteria with the exception of the following: **Covered by C21 – Cleaning of the environment:** • Hygiene Code Duty 4 (a,b,(in relation to cleaning) c,d,e,g and h). **Covered by C4c – Decontamination of reusable medical devices:** • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b • Hygiene Code 4f. Note that, in complying with a provision specified in

[2] 'An interventional procedure is one used for diagnosis or treatment that involved incision, puncture, entry into a body cavity, electromagnetic or acoustic energy.' (Source: *The interventional procedures programme*, Health Service Circular 2003/011).

[3] An interventional procedure is considered 'new' if a clinician no longer in a training post is using it for the first time in his or her NHS clinical practice.

	any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

Core Standard C4b

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.

Elements	Rationale
Element one The PCT has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the Medicines Healthcare Products Regulatory Authority.	**Element one** No change to this element from 2007/08
Element two The PCT has systems in place to meet the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 [IR(ME)R] and any subsequent amendment.	**Element two** One of the amendments to the IRMER 2000 regulations was in 2006 when enforcement responsibilities were transferred to the Healthcare Commission. Further amendments are likely and so an explicit reference is now made to this.

Core Standard C4c

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

Elements	Rationale
Element one Reusable medical devices are properly decontaminated in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Element one** The Hygiene code was revised in January 2008. Criteria C4c covers: • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b • Hygiene Code 4f. All other aspects of healthcare associated infection and duties of the Hygiene Code are covered by C4a or C21. Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

In 2006/07, this standard was not assessed for ambulance trusts and mental health trusts as the focus for assessment was on the sterilisation of invasive medical equipment that presented a known risk of infection. However, this criteria will apply to all trust types on 2008/09 because:

- Decontamination has a wider meaning than sterilisation alone and is defined as a combination of processes, including cleaning, disinfection and sterilisation, used to render a reusable item safe for further use on patients / service users and handling by staff.
- Medical devices refers to all products, except medicines, used in healthcare for diagnosis, prevention, monitoring or treatment.

A single use medical device is a device that is intended to be used on an individual patient during a single procedure and then discarded. Therefore, any device which is not single use must be considered a reusable medical device. These devices are used by ambulance and mental health trusts.

Core Standard C4d

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.

Elements	Rationale
Element one Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, in accordance with the Medicines Act 1968 (as amended, and subsequent regulations, including the Medicines for Human Use (Prescribing) Order 2005), the Health and Safety at Work Act 1974, as amended, and subsequent regulations including the Control of Substances Hazardous to Health Regulations 2002; and the good practice identified in *The safe and secure handling of medicines: A team approach* (RPS, March 2005) should be considered and where appropriate followed.	**Element one** In referring to the Medicines Act, all amendments and subsequent regulations are now included within this reference. Subsequent regulations include the Medicines for Human Use (Prescribing) Order, which provides additional requirements for prescribing (eg, reauthorising repeat prescriptions every six months). The Duthie Report *(The safe and secure handling of medicines: A Team approach)* has now been included as it describes recognised good practice and requirements underpinned by the legislation referred to in the criteria (Medicines Act, Health and Safety at Work Act and the Control of Substances Hazardous to Health) for several elements of medicines management (with the exceptions being procurement and monitoring). In addition feedback received during the 2008/09 annual health check consultations suggested including this reference within the criteria for C4d.

Element two Controlled drugs are handled safely and securely in accordance with the *Misuse of Drugs Act 1971* (and amendments), *Safer Management of Controlled Drugs: Guidance on strengthened governance arrangements (*Department of Health, Jan 2007) and *The Controlled Drugs (Supervision of Management and Use) Regulations 2006.*	**Element two** The proposed element makes reference to all amendments for the Misuse of Drugs Act 1971. The guidance on strengthened governance arrangements has been replaced with the updated 2007 version. The proposed element additionally makes reference to the Controlled Drugs Regulation, which came into effect on 1 January 2007.

Core Standard C4e

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

Elements	Rationale
Element one The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients/service users, staff, the public and the environment in accordance with all relevant legislative requirements referred to in Environment and Sustainability: Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste (Department of Health, November 2006) and Environment and sustainability: Health Technical Memorandum 07-05: The treatment, recovery, recycling and safe disposal of waste electrical and electronic equipment (Department of Health, June 2007).	**Element one** Element one has been amended to incorporate HTM 07-05 relating to the management of electrical and electronic equipment waste, which was published in June 2007. This supplements the broader HTM 07-01, and addresses the requirements of the European Waste Electrical and Electronic Equipment (WEEE) Directive (2003) and the Use of Hazardous Substances in Electrical and Electronic Equipment Regulations (RoHS). The advice contained in documents HTM 07-01 and HTM 07-05 are not in themselves mandatory, but the legislative requirements described therein are. Healthcare organisations choosing not to follow this advice must take alternative steps to comply with all relevant legislation.

Second domain: Clinical and cost effectiveness

Domain outcome: Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

Core Standard C5a

Healthcare organisations ensure that they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

Elements	Rationale
Element one The PCT ensures that it conforms to NICE technology appraisals where relevant to its services. Mechanisms are in place to: identify relevant technology appraisals; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for relevant technology appraisals.	**Elements one & two** New technology appraisals are always under development, therefore all NHS trusts need to have mechanisms in place to review the appropriateness of these for their service, even if many of them will not be relevant to some trust types. Current healthcare policy emphasises the importance of the quality of clinical care and of having consistent care for all patients / service users. The effective implementation of NICE technology appraisals and use of clinical guidelines that are based on best practice are crucial to the promotion of consistent and high quality clinical care. To reflect this, elements one and two have been made more explicit to give greater focus on the different aspects of the standard against which we would expect an orgainsation to assure itself.
Element two The healthcare organisation can demonstrate how it takes into account nationally agreed guidance where it is available as defined in National Service Frameworks (NSFs), NICE guidelines, national plans and nationally agreed guidance, when delivering care and treatment. The healthcare organisation has mechanisms in place to: identify relevant guidance; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for appropriate guidelines.	

Core Standard C5b

Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.

Elements	Rationale
Element one The PCT ensures that appropriate supervision and clinical leadership is provided to staff when delivering clinical care and treatment. Where appropriate, staff also have the opportunity to receive 'clinical supervision'[4]; and where appropriate, this is in accordance with requirements from relevant professional bodies. Arrangements for clinical leadership and supervision (including 'clinical supervision') are communicated to all relevant staff. The effectiveness of these arrangements are monitored and reviewed on a regular basis and action is taken accordingly.	**Element one** The wording of the elements has been amended to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians. Element one has been amended to clarify that supervision of staff in the day-to-day delivery of clinical care and treatment, and the formal process of receiving 'clinical supervision' (see definition below) are two distinct concepts that are both important to ensuring patients / service users receive care which will lead to effective clinical outcomes. When making a declaration against this standard the Healthcare Commission would expect an organisation to assure itself that arrangements for both of the above are in place and effective. Current healthcare policy emphasises the importance of clinician-led services. To reflect this, the elements have been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.
Element two The PCT ensures that it provides opportunities for clinicians[5] to develop their clinical leadership skills and experience.	**Element two** With this additional element, the criteria now better reflects the standard.

Core Standard C5c

Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.

Elements	Rationale
Element one The PCT ensures that clinicians from all disciplines participate in activities to update the skills and techniques that are	**Element one** The wording of the elements has been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the

[4] Clinical supervision is 'a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.' (Quoted in various sources, including *Clinical supervision for registered nurses*, NMC, 2008).

[5] Clinicians are 'professionally qualified staff providing clinical care to patients'. (Source: Standards for Better Health, DH, 2004)

relevant to their clinical work in accordance with relevant guidance and curricula. This includes identifying and reviewing skills needs and skills gaps; providing and supporting on-the-job training and other training opportunities; and where appropriate working in partnership with education and training providers to ensure effective delivery of training.	organisation and not that of individual clinicians. Current healthcare policy emphasises the importance of the quality of clinical care. The skills and techniques of clinicians are vital to ensuring good quality care. To reflect this, the element has been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.

Core Standard C5d

Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.

Elements	Rationale
Element one The PCT ensures that clinicians[6] are involved in prioritising, conducting, reporting and acting on regular clinical audits[7]. **Element two** The PCT ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research.	**Elements one & two** The wording of the elements have been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians.

Core Standard C6

Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

Elements	Rationale
Element one The PCT works in partnership with other health and social care organisations to ensure that the individual needs of patients / service users are properly managed and met: • Where responsibility for the care of a patient is shared between the organisation and one or more	**Elements one & two** The structure and wording of the elements have been amended to better reflect the standard and to clarify that the partnership responsibilities being assessed are those of the organisation as well as those of staff. Element one considers an organisation's responsibility to ensure effective partnership agreements and working at an organisational level. Element two focuses on the

[6] Clinicians are 'professionally qualified staff providing clinical care to patients'. (Source: Standards for Better Health, DH, 2004)

[7] Clinical audit is 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against specific criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.' (Source: Standards for Better Health, DH, 2004)

other health and/or social care organisations.

and/or

- Where the major responsibility for a patient's care is moved (due to admission, referral, discharge or transfer[8]) across organisational boundaries.

Where appropriate, these arrangements are in accordance with:

- Section 75 partnership arrangements of the National Health Service Act 2006 (previously section 31 of the Health Act 1999).
- The Community Care (Delayed Discharges etc.) Act 2003 and Discharge from hospital pathway, process and practice (DH, 2003).

Where appropriate, these arrangements are in accordance with the relevant aspects of the following guidance or equally effective alternatives:

- *Guidance on the Health Act Section 31* partnership agreements (DH, 1999).
- Guidance on partnership working contained within relevant National Service Frameworks and national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National Service Framework for Older People (DH, 2001) and the Cancer Reform Strategy (DH, December 2007).
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH, 2007).

need for groups of staff from different organisations to work together to meet the needs of patients / service users. This may be facilitated through engagement in clinical networks, for example.

Element one has been made more explicit to indicate that we would expect an organisation to be assured that it is using partnerships to ensure that a patient's/service user's needs are met when they move between organisations and when more than one organisation is contributing to a patient's care.

Various guidance and legislative documents are relevant to this standard.

- Organisations are legally obliged to comply with arrangements laid out in Section 75 of the National Health Service Act 2006 and the Community Care (Delayed Discharges etc.) Act 2003.
- The additional documents listed in element one are all good practice guidance or strategic frameworks which organisations are not mandated to follow. The Commission would, however, expect an organisation to have good reason and clear rationale for following a different course of action from that set out in these documents.

Element two

Staff concerned with all aspects of the provision of healthcare work in partnership with colleagues in other health and social care organisations to ensure that the needs of the patient / service user are properly managed and met.

Element two

With this additional element, the criteria now better reflects the standard.

[8] The term *transfer* is as defined by the NHSLA Risk Management Standard, *' the process whereby a patient is moved from one clinical area to another within the organisation or to another organisation'*. (Source: http://www.nhsla.com/Publications/)

Third domain: Governance

Domain outcome: Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Core Standard C7a&c

Healthcare organisations:

a) apply the principles of sound clinical and corporate governance; and
c) undertake systematic risk assessment and risk management.

Elements	Rationale
Element one The PCT has effective clinical governance[9] arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients / service users.	**Element one** Element one has been revised to clarify the link with the domain outcome.
Element two The PCT has effective corporate governance[10] arrangements in place that where appropriate are in accordance with *Governing the NHS: A guide for NHS boards* (Department of Health and NHS Appointments Commission, 2003), and the *Primary care trusts model standing orders, reservation and delegation of powers and standing financial instructions August 2006* (DH, 2006).	**Element two** Element two has been updated to provide more clarity about the relevant directives and guidance against which we would expect trusts to develop their corporate governance structures.
Element three The PCT systematically assesses[11] and manages[12] its risks, both corporate/clinical risks in order to ensure probity, clinical quality and patient safety.	**Element three** Element three has been revised to clarify that it refers to both corporate and clinical risks and to focus on the domain outcome.

Core Standard C7b

Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

[9] Clinical governance is 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish' (Source: Standards for Better Health, DH, 2004).
[10] Governance is 'a mechanism to provide accountability for the way an organisation manages itself' (Source: Standards for Better Health, DH, 2004).
[11] Systematic risk assessment is 'a systematic approach to the identification and assessment of risks using explicit risk management techniques.' (Source: Standards for Better Health, DH, 2004).
[12] Risk management 'covers all processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.' (Source: Standards for Better Health, DH, 2004).

Elements	Rationale
Element one The PCT actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS managers* (Department of Health, 2002), *NHS Counter fraud & corruption manual third edition* (NHS Counter Fraud Service, 2006), and having regard to guidance or advice issued by the CFSMS.	**Element one** There is a change to wording to better reflect legislative requirements. The *Directions to NHS bodies on the Counter Fraud Measures 2004* (as amended) state at Direction 2(1) that "*Each NHS Body must take all necessary steps to counter fraud in the National Health Service in accordance with …….the NHS Counter Fraud and Corruption Manual; ……..and having regard to guidance or advice issued by the CFSMS*". Reference to "having regard to guidance or advice issued by the CFSMS" has therefore been added. However the NHS Counter Fraud and Corruption Manual remains the operational guidance for all Local Counter Fraud Specialists. Note that the CFSMS Compound Indicators are based on this Manual.

Core standard C7d

Healthcare organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources

Elements	Rationale
This standard will be measured under the use of resources quality of financial management assessment.	Not applicable

Core Standard C7e

Healthcare organisations challenge discrimination, promote equality and respect human rights.

Elements	Rationale
Element one The PCT challenges discrimination and respects human rights in accordance with the: ▪ Human Rights Act 1998. ▪ *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health, 2000). ▪ The general and specific duties imposed on public bodies in relation to race, disability and gender (including, amongst other things, equality schemes for race, disability and gender, along with impact	**Element one** This element has been amended to emphasise that trusts need to cover the issues in terms of challenging discrimination in the provision of services, goods and facilities, as well as employment. The Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005, and Equality Act 2006 each have associated codes of practice, listed below: ▪ 'The Statutory Code of Practice on the Duty to Promote Race Equality' (issued by Commission for Racial Equality published May 2002) ▪ 'The Duty to Promote Disability Equality. Statutory Code of Practice' (England and Wales)

assessments) under the “public body duties”*.

- “Employment and equalities legislation”** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time.

*”Acting in accordance with ‘*public body duties*’” means: Acting in accordance with the general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following statutes:

- Race Relations (Amendment) Act 2000.
- Disability Discrimination Act 2005.
- Equality Act 2006.

and, where appropriate, having due regard to the associated codes of practice.

**”Acting in accordance with ‘*employment and equalities legislation*’” means: Acting in accordance with relevant legislation including:

- Equal Pay Act 1970 (as amended).
- Sex Discrimination Act 1975 (as amended).
- Race Relations Act 1976 (as amended).
- Disability Discrimination Act 1995.
- Employment Equality (Religion or Belief) Regulations 2003.
- Employment Equality (Sexual Orientation) Regulations 2003.
- Employment Equality (Age) regulations 2006,.
- Part Time workers (Protection from Less Favourable Treatment) Regulations 2000.
- Fixed Term Employees (Protection from Less Favourable Treatment Regulations 2002).

(issued by Disability Rights Commission published 2005)

- ‘Gender Equality Duty Code of Practice (England and Wales)’ (issued by Equal Opportunities Commission published 2007

Similarly the acts cited under “employment and equalities legislation” have associate codes of practice, including:

- CRE Code of practice on equality in employment 2005
- EOC Code of practice on sex discrimination 1985
- EOC Code of practice on equal pay 2003,
- DWP Guidance on the definition of disability 2006, and
- DRC Code of Practice on Employment and Occupation 2004

These codes of practice and guidance provide guidance to assist relevant persons or bodies to effectively and appropriately carry out their statutory public body duties and employment law obligations (as appropriate). The acts do not impose a legal duty to comply with the codes but those to whom the codes of practice are addressed should have regard to the guidance contained in the codes. The Codes are admissible in evidence in any legal action and can be taken into account by courts and tribunals.

- Employment Rights Act section 80F-I (relating to the right to request flexible working).
- Working Time Regulations 1998 (as amended).

and, where appropriate, having due regard to the associated codes of practice.

Element two

The PCT promotes equality, including by publishing information specified by statute, in accordance with the general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under:

- *The Race Relations (Amendment) Act 2000.*
- *The Disability Discrimination Act 2005.*
- *The Equality Act 2006.*

and where appropriate, having due regard to the associated codes of practice; and in accordance with *Delivering Race Equality in Mental Health Care (Department of Health, 2005).*

Element two

There have been minor changes to wording to emphasise that this element is concerned with the duties to promote equality, rather than the anti-discrimination focus of the original 1975, 1976 and 1995 Acts.

See the rationale to element one above for detail on the codes of practice.

Core standard C7f

Healthcare organisations **meet the existing performance requirements**

Elements	Rationale
This standard will be measured under the indicators-based assessment	Not applicable

Core Standard C8a

Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.

Elements	Rationale
Element one Staff are supported, and know how, to raise	**Element one** No change to the element. The HSC 1999/198 has been

concerns about services confidentially and without prejudicing their position including in accordance with The Public Disclosure Act 1998: Whistle blowing in the NHS (HSC 1999/198).	confirmed by Department of Health as being extant. It is concerned with the Public Disclosure Act 1998 which is the legislation relating to whistle-blowing.

Core Standard C8b

Healthcare organisations support their staff through having organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

Elements	Rationale
Element one The PCT supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives (IWL) standard at Practice Plus level and in accordance with *"employment and equalities legislation*"* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e	**Elements one & two** The standard deals specifically with the under representation of minority groups and the element now reflects requirements to monitor the participation in personal development opportunities by gender, race, disability etc, not explicitly required under IWL. The addition of discrimination legislation is intended to address this. The phrases "*public body duties*" and "*employment and equalities legislation*" are defined in C7e and information about the codes of practice is given in the rationale to C7e.

Element two Staff from minority groups are offered opportunities for personal development to address under-representation in the workforce compared to the local population in accordance with *"employment and equalities legislation"** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e.	**Element two** The meaning of "under-representation" is now more clearly stated. This element also now addresses under-representation across the whole workforce, not limited to senior roles. Under-representation remains a concern at senior roles but also in other areas e.g., in particular occupations or specialisms.

Core Standard C9

Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the orgainsation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Elements	**Rationale**
Element one The PCT has effective systems for managing records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007). Healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and demonstrate they are complying with supplemental mandates and guidance if they are introduced during the assessment period.	**Element one** Records management involves the creation and implementation of systematic controls for records and information activities, from the moment of creation through to disposal. Information governance is the application of law and good practice that governs the way in which information is obtained, handled, used and disclosed. Records management provides the systems, frameworks and procedures to ensure staff comply with information governance requirements. The *Records management: NHS code of practice* (Department of Health, April 2006) is a guide to the standards of practice required for the management of NHS records, based on current legal requirements and professional best practice. *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007) update guidance on legal, information security and other requirements.

	The NHS Chief Executive's letter of 20 May 2008 to all NHS Chief Executives (Gateway reference 9912) identifies three specific actions for all NHS organisations, two of which are relevant to C9 (actions v and vi): • NHS organisations must make specific reference to information governance and identifying and managing information risks in their annual statements from 2007/08. • NHS organisations must identify a Senior Information Risk Owner. and one of which is relevant to C13c (iv).
Element two The information management and technology plan for the organisation demonstrates how a correct NHS Number will be assigned to every clinical record, in accordance with *The NHS in England: the Operating Framework for 2008/09* (Department of Health, December 2007).	**Element two** A new element has been included to reflect that the NHS Medical Director has written to all NHS chief executives and medical directors on the importance of using NHS numbers as the main patient identifier on clinical records and the numerous incidents, and some cases of serious harm and death, related to duplication in local numbering systems. These deficiencies in records management should no longer be acceptable (letter of 13 May 2008, Gateway reference 9801). The operating framework sets out the priorities for the year; the Department of Health expects that NHS organisations will produce an information management and technology plan in 2008/09 to deliver the mandated use of the NHS Number.

Core Standard C10a

Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.

Elements	Rationale
Element one The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and staff in ongoing NHS employment[13] in accordance with the NHS Employment Check Standards (NHS Employers) 2008)	**Element one** NHS Employers published a revised set of standards in March 2008. These standards are mandatory for all applicants for NHS positions and employment checks should be carried out prior to appointment of individuals to work in health settings. Six documents make up the NHS Employment Check standards which replace, from April 08, the previous publications “Safer recruitment – A guide for NHS Employers” and “CRB disclosures in the NHS” The new standards were launched on 18th March

[13] This includes permanent staff, staff on fixed-term contracts, temporary staff, volunteers, students, trainees, contractors and highly mobile staff supplied by an agency. Trusts appointing locums and agency staff will need to ensure that their providers comply with these standards.

	2008 and include those checks that are required by law, those that are Department of Health policy and those that are required for access to the NHS Care record service. Launch of the standards was announced in the NHS Employers workforce bulletin issue 105 dated 25 March 2008[14].

Core Standard C10b

Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice.

Elements	Rationale
Element one The PCT explicitly requires all employed healthcare professionals[15] to abide by relevant codes of professional conduct. Mechanisms are in place to identify, report and take appropriate action when codes of conduct are breached.	**Element one** Following clarification from the Department of Health, the details of this element have been updated to clarify that the standard is concerned with employed healthcare professionals only.

Core Standard 11a

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.

Elements	Rationale
Element one The PCT recruits staff in accordance with *"employment and equalities legislation"** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender.; and where appropriate, having due regard to the associated codes of practice. * The phrases *"public body duties"* and	**Element one** The changes have been made to include employment legislation covering equalities related issues such as flexible working but at the same time to avoid extending the list of legislation in the element itself at the risk of reducing clarity. The changes also provide more clarity regarding the equality duties requirements in that the criteria now specifically require organisation to meet the employment related duties under RRA, DDA and Equality Act under this standard. The phrases "*public body duties*" and "*employment and equalities legislation*" are defined in C07e and information about the codes of practice is given in the rationale to C7e

[14] The bulletin can be found at www.nhsemployers.org/files/workforcearchive/NHSWorkforceBulletin-105.html

[15] A healthcare professional is 'a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Healthcare Professions Act 2002' (Source: Section 93, National Health Services Act 2006). The bodies mentioned in Section 25(3) which regulate professionals within England are: the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health Professions Council (HPC), the General Dental Council (GDC), the General Optical Council (GOC), the General Chiropractic Council (GCC), the General Osteopathic Council (GOsC), the Royal Pharmaceutical Society of Great Britain (RPSGB).

"employment and equalities legislation" are defined in C7e.	
Element two The PCT aligns workforce requirements to its service needs by undertaking workforce planning, and by ensuring that its staff are appropriately trained and qualified for the work they undertake.	**Element two** The wording has been changed to more clearly reflect the standard by making explicit reference to training and qualification combined with workforce planning.

Core Standard 11b

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.

Elements	Rationale
Element one Staff participate in relevant mandatory training programmes. Note: For PCTs who achieve Level 2 (or 3) in the NHSLA's Risk Management Standards in the assessment year 1 April 2008 to 31 March 2009, we will continue to use that NHSLA data relevant to this element as either partial or full evidence of assurance of compliance during inspections for 2008/09. See Appendix 1 for more information regarding Use of Findings of Others	**Element one** In 2007/08 the NHSLA Risk Management Standards operated in full in the acute sector, and were piloted in other sectors. The Risk Management Standards have now been published (March 2008) and are operating in full in the assessment year 1 April 2008 to 31 March 2009 for the following trust types • Acute and Specialists, • Mental Health & Learning Disability and • Ambulance. However, for PCTs, since publication of draft criteria in September 2008, the HC has become aware that the NHSLA has suspended mandatory assessment of its Risk Management Standards for 08/09 for that sector. It is open to PCTs to request a assessment in 08/09 on a voluntary basis. In the light of this decision, reference to NHSLA in element one has been removed as it is not mandatory. As noted, if a trust chooses to be assessed and achieves Level 2 (or 3) of NHSLA Risk Management Standards in 08/09, this will be used as either partial or full evidence of assurance in relation to this element.
Element two Staff and students participate in relevant induction programmes.	**Element two** No change to this element from 2007/08.
Element three The PCT verifies that staff participate in those mandatory training programmes necessary to ensure probity, clinical quality and patient safety (including that referred to in element one). Where the healthcare organisation identify non-	**Element three** This element has been added to reflect the need for trusts to check uptake of training in order to ensure participation. This will be the case for all types of mandatory training necessary to ensure the domain outcome i.e. probity, clinical quality and patient safety (including risk management training referred

attendance, action is taken to rectify this.	to in the NHSLA risk management standards and element one). An explicit link has been made to the outcome required by the domain.

Core Standard 11c

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.

Elements	Rationale
Element one The PCT ensures that all staff concerned with all aspects of the provision of healthcare have opportunities to participate in professional and occupational development at all points in their career in accordance with "*employment and equalities legislation"** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice; and in accordance with the relevant aspects of *Working together – learning together: a framework for lifelong learning for the NHS* (Department of Health 2001) or an equally effective alternative. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e	**Element one** The wording of the element has been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual staff members. The phrases "*public body duties*" and "*employment and equalities legislation*" are defined in C7e and information about the codes of practice is given in the rationale to C7e Reference to this legislation is included to reflect the need for organisations to ensure that comparable development opportunities are provided to all staff. The document *Working together – learning together* (DH, 2001) is a strategic framework that sets out a co-ordinated approach to lifelong learning in healthcare. While trusts are not legally obliged to conform to the framework we would expect a trust to have good reasons and clear rationale for following a different course of action from that set out in the framework.

Core Standard C12

Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirement of the research governance framework are consistently applied.

Elements	Rationale
Element one The PCT has effective research governance in place, which complies with the principles and requirements of the *Research governance framework for health and social care, second edition* (DH 2005).	**Element one** Minor amendments have been made to make the criteria clearer: two references to "framework" could be slightly confusing so " principles" replaces the first occurrence, (which also brings the element closer to the wording of the standard)

Fourth domain: Patient focus

Domain outcome: Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Core Standard C13a

Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.

Elements	Rationale
Element one The PCT ensures that staff treat patients / service users, carers and relatives with dignity and respect at every stage of their care and treatment, and, where relevant, identify, and take preventive and corrective actions where there are issues and risks with dignity and respect.	**Element one** The wording of the element has been changed to include identification of risk and appropriate action to reduce the risk of occurrence of compromise in dignity or respect. The change highlights the need for healthcare organisations to ensure dignity and respect throughout the stages of care e.g. End of Life (EoL), dementia etc. and during transfers. It also emphasises the need to take preventive action to ensure compromise in dignity and respect does not happen.
Element two The PCT meets the needs and rights of different patient groups with regard to dignity including by acting in accordance with *the Human Rights Act 1998* and the general and specific duties imposed on public bodies in relation to race, disability and gender (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following "*public body duties*"* statutes ▪ *the Race Relations (Amendment) Act 2000* ▪ *the Disability Discrimination Act 2005, and* ▪ *the Equality Act 2006* *and where appropriate, having due regard to the associated codes of practice* The PCT should act in accordance with the requirements in the National Service Framework for older people (Health Service circular 2001/007), to ensure that older people are not unfairly discriminated against in accessing NHS	**Element two** Note that the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005 and the Equality Act 2006 have associated codes of practice and explicit reference to these has been added this year. The phrase "public body duties" is defined in C7e and information about the codes of practice is given in the rationale to C7e. The codes of practice provide guidance to assist relevant persons or bodies to effectively and appropriately carry out their duties. The Acts do not impose a legal duty to comply with the codes but those to whom the codes of practice are addressed should have regard to the guidance contained in the codesThe Codes are admissible in evidence in any legal action and can be taken into account by courts and tribunals A further addition has been made to include the National Service Framework (NSF) for older people (DH notification letter HSC 2001/007) which specifically addresses age discrimination, amongst other things.

or social care services as a result of their age.

* The phrase *"public body duties"* is defined in C7e.

Core Standard C13b

Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information.

Elements	Rationale
Element one Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) investigations and decisions in accordance with the Human Rights Act 1998, the *Reference guide to consent for examination or treatment* (Department of Health 2001), *Human Tissue Authority: a code of practice* (July 2006), and having regard to the *Code of Practice to the Mental Health Act 1983 and 2007* and the *Code of Practice to the Mental Capacity Act* 2005.	**Element one** The changes from 2007/08 criteria include adding the term "decisions" as well as treatments and procedures to reach a consistent approach across all healthcare organisations as it applies across the board and in particular to those subject to the Mental Health Act in acute or other hospitals. The Human Tissues Authority guidance now referred to supersedes the Families and Post-Mortems guidance referred to in 2007/08.
Element one Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures, investigations and decisions in accordance with the Human Rights Act 1998, the *Reference guide to consent for examination or treatment* (Department of Health, 2001), and having regard to the *Code of Practice to the Mental Health Act and 2007 and 2007,* and *Code of Practice to the Mental Capacity Act 2005*	Note that trusts are expected to have regard to a revised version of The Code of Practice to the Mental Health Act from 03/11/08 when revisions to this Code take effect. The element refers to the Human Rights Act 1998 (HRA) as issues around consent could, and have led, to breaches of the Act under a number of different Articles, namely 8 and 14. The addition of a reference to HRA provides a legal imperative for the guidance on consent that is referred to particularly in relation to Article 8. Consent issues in health have been at the centre of the development of Human Rights case law and associated guidance (e.g. Bournewood and Glass vs UK cases, Bristol, Alder Hey and the introduction of the Human Tissue Act and associated Authority). Continuing to rely solely on reference to the Department of Health and Department of Constitutional Affairs guidance (as in 2007/08) would no longer give sufficient emphasis to the implications for Human Rights. This is particularly true regarding the protection of the human rights of patients who

	are not being treated by Mental Health or Learning Disability Trusts. The Code of Practice to the Mental Capacity Act (MCA) deals only briefly with communication/language issues. The other guidance was produced before recent case law as HRA applies to all patients and service users the additional requirement helps ensure that these criteria for assessment continue to reflect standards now expected of a healthcare organisation in obtaining valid consent for all patients/service users. So as the capacity of patients/service users needs to be considered at all stages of all interventions ,the need to comply with MCA guidance is added to the element.
Element two Patients/service users, including those with language and/or communication support needs, are provided with appropriate and sufficient information suitable to their needs, on the use and disclosure of confidential information held about them in accordance with *Confidentiality: NHS code of practice* (Department of Health 2003).	**Element two** Changes in wording to make clear that information provided must be suitable and sufficient for patient/service user needs.
Element three The PCT monitors and reviews current practices to ensure effective consent processes.	**Element three** This supports an outcome focus to consent standards and to improve consent processes.

Core Standard C13c

Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary.

Elements	**Rationale**
Element one When using and disclosing patients/service users' personal information staff act in accordance with the Data Protection Act 1998, the Human Rights Act 1998, the Freedom of Information Act 2000 and *Confidentiality: NHS code of practice* (Department of Health 2003), *Caldicott Guardian Manual 2006* (Department of Health 2006). The PCT complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and with supplemental mandates and guidance if they are introduced during the assessment period.	**Element one** The element has been updated to take into account the updated Caldicott Guardian Manual. The NHS Chief Executive's letter of 20 May 2008 to all NHS Chief Executives (Gateway reference 9912) identifies three specific actions for all NHS organisations, two of which are relevant to C9 (actions v and vi) and one of which is relevant to C13c (iv): • NHS organisations must include details of Serious Untoward Incidents involving data loss or confidentiality breaches in their annual reports from 2007/08.

Core Standard C14a

Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.

Elements	Rationale
Element one Patients / service users, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system, including information about how to escalate their concerns; and the PCT acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	**Element one** The reference in element one to the NHS (Complaints) Regulations 2004 ("Regulations") has been added because the Regulations place specific legal obligations on healthcare organisations in relation to complaints. The term 'in so far as relevant' has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.
Element two Patients / service users, relatives and carers are provided with opportunities to give feedback on the quality of services.	**Element two** No change to this element from 2007/08.

Core Standard C14b

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.

Elements	Rationale
Element one The PCT has systems in place to ensure that patients / service users, carers and relatives are not treated adversely as a result of having complained.	**Element one** No change to this element from 2007/08.

Core Standard C14c

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

Elements	Rationale
Element one The PCT acts on, and responds to, complaints appropriately and in a timely manner; and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	**Element one** The reference in element one to the NHS (Complaints) Regulations 2004 ("Regulations") has been added because the Regulations place specific legal obligations on healthcare organisations in relation to complaints. The term 'in so far as relevant' has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.

Element two Demonstrable improvements are made to service delivery as a result of concerns and complaints from patients / service users, relatives and carers.	**Element two** Has been revised to emphasise the improvements expected in response to concerns and complaints raised by patients / service users, relatives and carers.

Core Standard C15a

Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.

Elements	Rationale
Element one Patients/service users are offered a choice of food and drink in line with the requirements of a balanced diet reflecting the rights (including the rights of different faith groups), needs (including cultural needs) and preferences of its service user population.	**Element one** There are two changes to the wording of this element: 1. Making explicit the inclusion of drink as an integral part of food which is consistent with the *Food Safety Act 1990* which defines food to include food and drink (note this is the approach also taken with C15b) and 2. Making the rights of faith groups explicit as determined by *article 9 of the Human Rights Act 1998*. The term "balanced diet" is a concept well recognised by users and providers of health services; this is reinforced by considerable publicity by various agencies such as NHS Direct and Food Standards Agency. Additionally the importance of balanced and healthy diet is part of the training for nutritionists and dieticians. It is expected that when these professionals assess dietary requirements they would ensure that the requirements identified include meeting the needs of a balanced diet.
Element two The preparation, distribution, delivery, handling and serving of food, storage, and disposal of food is carried out in accordance with food safety legislation including the *Food Safety Act 1990* and the *Food Hygiene (England) Regulations 2006.*	**Element two** The *Food Safety Act 1990* provides the framework for procuring and selling food in a manner that is safe for the consumer. It also provides for the duties for safe handling of food and provision of training for staff in food hygiene. The amendment to this Act in 2004 brought this in line with the new European Commission (EC) regulations. The Food Hygiene (England) Regulations 2006 provide for the execution and enforcement in relation to England of the EC food hygiene regulations 852/2004 (hygiene of foodstuffs) and 853/2004 (specific hygiene rules for food of animal origin) in England. These Regulations apply to all stages of production, processing and distribution of food.

Core Standard C15b

Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

Elements	Rationale
Element one Patients/service users have access to food and drink that meets the individual needs of the patients / service users 24 hours a day.	**Element one** It should be noted that individual food preferences are not within the scope of this element. However the wording has been amended to make it clear that meeting individual needs are in scope of the element. It is not sufficient for a trust to provide food and drink 24 hrs a day if patients / service users who need it are unable to eat it, for example due to swallowing difficulties, food intolerance, faith/cultural reasons etc.
Element two The nutritional, personal and clinical dietary requirements of individual patients/service users are assessed and met, including the right to have religious dietary requirements met at all stages of their care and treatment.	**Element two** The wording has been amended to include "at all stages of their care" to emphasise within the element the expectation that there are no gaps in the service provision. This continuity is important for continued effective care. For instance, if the condition of a patient changes such as they have lost weight or have developed a need for pureed food it is expected that the changed need is catered for. Similarly if patients/service users have moved to a different ward the nutritional assessment details should be passed on to ensure continuity.
Element three Patients/service users requiring assistance with eating and drinking are provided with appropriate support including provision of dedicated meal times, adapted appliances and appropriate consistency of food where necessary.	**Element three** The wording has been amended to include, "including provision of dedicated meal times, adapted appliances and appropriate consistency of food where necessary". These are essential to providing meals in a safe manner, including support with eating and drinking. These are recommended by NICE and are recognised across the service as acceptable reasonable standards. There is evidence from NPSA that due to inadequate dedicated support at mealtimes both in terms of time and staff assistance there have been incidents, which have led to patients being unable to eat meals.

Core Standard C16

Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

Elements	Rationale
Element one The PCT has identified the information needs of its service population, and provides suitable and accessible information on the services it provides in response to these needs. This includes the provision of information in relevant languages and formats in accordance with the general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following "*public body duties*"* statutes: ▪ *the Race Relations (Amendment) Act2000* ▪ *the Disability Discrimination Act 2005* ▪ *the Equality Act 2006* and where appropriate, having due regard to the associated codes of practice. * The phrase *"public body duties"* is defined in C7e.	**Element one** The element emphasises the need for healthcare organisations to identify the needs of its service population in the first instance. The phrase "*public body duties*" is defined in C7e and information about the codes of practice is given in the rationale to C7e.
Element two The PCT provides patients / service users and, where appropriate, carers with sufficient and accessible information on the patient's individual care, treatment and after care, including those patients / service users and carers with communication or language support needs. In doing so healthcare organisations must have regard, where appropriate, to the *Code of Practice to the Mental Capacity Act 2005* (Department of Constitutional Affairs 2007) and the *Code of Practice to the Mental Health Act* (Department of Constitutional Affairs 1983).	**Element two** The wording has been changed to ensure adequate emphasis on sufficient and accessible information provision for all patients and carers (as well as for patients with particular language and communication support needs).

Fifth domain: Accessible and responsive care

Domain outcome: Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Core Standard C17

The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

Elements	Rationale
Element one The PCT seeks and collects the views and experiences of patients/service users, carers and the local community, particularly those people who are seldom listened to, on an ongoing basis when designing, planning, delivering and improving healthcare services as required by Section 242 of the *National Health Services Act* 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation acts in accordance with the general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following "*public body duties*" *statutes: • *the Race Relations (Amendment) Act 2000,* • *the Disability Discrimination Act 2005, and* • *the Equality Act 2006* ; and where appropriate, having due regard to the associated codes of practice * The phrase *"public body duties"* is defined in C7e.	**Element one and two** Element one has been re-written to make it clear that the trust 'seeks **and collects'** the 'views **and experiences'** of patients/service users, carers and the local community as public views reflect service delivery and are more often based on experience. This helps to clarify that trusts are expected to bring information from patients and the public together across the organisation, and that this information should include the stories of the experiences of users and carers as well as their views of services. The reference to 'disadvantaged and marginalised groups' has been replaced with '**seldom listened to'** groups so that trusts are clear that this is to encompass any people whose views are not commonly gathered Section 11 of the Health and Social Care Act 2001, which placed a duty on NHS organisations to involve and consult, became Section 242 of the National Health Service Act 2006, as of 1 March 2007. Reference to equalities legislation and their associated codes of practice is included to reflect the need for organisations to ensure that their duties are carried out in a manner compatible with the legislation. The phrase "*public body duties*" is defined in C7e and information about the codes of practice is given in the rationale to C7e.

Element two
The PCT demonstrates to patients/service users, carers and the local community, particularly those people who are seldom listened to, how it has taken their views and experiences into account in the designing, planning, delivering and improving healthcare services, in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation should act in accordance with the general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following "*public body duties*"* statutes:

- *the Race Relations (Amendment) Act 2000,*
- *the Disability Discrimination Act 2005, and*
- *the Equality Act 2006* ;

and where appropriate, having due regard to the associated codes of practice.

* The phrase *"public body duties"* is defined in C7e.

Core Standard C18

Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

Elements	Rationale
Element one The PCT enables all members of the population it serves to access its services equally, including acting in accordance with the general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following	**Element one** The reference to public body duties has replaced previous reference to discrimination and equality legislation in order to clarify that the public bodies have a duty with regard to enabling access to services. The phrase "*public body duties*" is defined in C7e and information about the codes of practice is given

"*public body duties*"*statutes: ▪ *the Race Relations (Amendment) Act 2000,* ▪ *the Disability Discrimination Act 2005, and* ▪ *the Equality Act 2006* ; and where appropriate, having due regard to the associated codes of practice. * The phrases *"public body duties"* is defined in C7e	in the rationale to C7e.
Element two The PCT offers patients/service users choice in access to services and treatment, and those choices in access to services and treatment are offered on a fair, just and reasonable basis, including to disadvantaged groups and including acting in accordance with the general and specific duties imposed on public bodies as in element one and including, where appropriate, having due regard to the associated codes of practice.	**Element two** As in element one, wording changed for clarity and to more precisely express the meaning of this element. In particular more appropiate emphasis is given to providers ensuring that all members of the population are offered choice in access to services and treatment equally.

Core standard C19

Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

Elements	Rationale
This standard will be measured under the indicators-based assessment	Not applicable

Sixth domain: Care environments and amenities

Domain outcome: Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core Standard C20a

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the orgainsation.

Elements	Rationale
Element one The PCT effectively manages the health, safety and environmental risks to patients/service users, staff and visitors, in accordance with all relevant[16] health and safety legislation, fire safety legislation, the *Disability Discrimination Act 1995*, and the *Disability Discrimination Act 2005*; and by having regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005). It also acts in accordance with the mandatory requirements set out in *Firecode – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety* (Department of Health, 2006), in so far as the requirements are relevant to the healthcare organisation, and follows the guidance contained therein, or equally effective alternative means to achieve the same objectives. It also considers, and where appropriate follows, the good practice guidance referred to in *The NHS Healthy Workplaces Handbook* (NHS Employers 2007) or equally effective alternative means to achieve the same objectives.	**Element one** The Disability Discrimination Act 1995 has been amended by the Disability Discrimination Act 2005 and includes a new duty of disability equality. The associated code of practice provides public authorities with guidance on how to understand and meet the general duty and specific duties, which include undertaking an impact assessment of its policies and practices on equality for disabled persons and having due regard to the requirement to take steps to take account of the needs of disabled persons. The mandatory requirements relating to fire safety in the NHS are contained within *Firecode – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety* (Department of Health, 2006), which have been mandated by the Minister of State (Delivery and Quality). This document also contains a suite of guidance covering fire safety in the NHS. However, alternative means of achieving the same outcomes may be possible. Where alternative solutions to *Firecode* are proposed, healthcare organisations should demonstrate that they result in equally effective standards of fire safety. The Management of Health, Safety and Welfare Issues for NHS staff (NHS Employers 2005) has

[16] Relevant legislation includes:

- Health and Safety at Work etc Act 1974
- Display Screen Equipment Regulations 1992
- Management of Health and Safety at Work Regulations 1999
- Manual Handling Operations Regulations 1992
- Provision and Use of Work Equipment Regulations (PUWER) 1998
- Control of Substances Hazardous to Health Regulations 2002

	been updated and published as The NHS Healthy Workplaces Handbook (NHS Employers 2007). This covers both NHS employers' legal responsibilities and other elements of recognised good practice with regard to providing a healthy workplace. While this good practice is not mandatory in its own right, organisations choosing not to adopt it should have equally effective alternative measures in place to achieve the overall outcomes of the standard.
Element two The PCT provides a secure environment which protects patients/service users, staff, visitors and their property, and the physical assets of the organisation, including in accordance with *Secretary of State directions on measures to tackle violence against staff and professionals who work in or provide services to the NHS* (Department of Health 2003, as amended 2006) and *Secretary of State directions on NHS security management measures* (Department of Health 2004, as amended 2006)	**Element two** Element two has been amended to include mandatory secretary of State Directions to the NHS on security management arrangements and work to tackle violence, and recent amendments. Trusts should also note that these directions require trusts to have regard to any other guidance or advice issued by the NHS CFSMS, and therefore that this will be assessed as part of this element.

Core Standard C20b

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.

Elements	**Rationale**
Element one The PCT provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation, access to private areas for religious and spiritual needs and for confidential consultations. This should happen at all stages of care and during transfers[17].	**Element one** The wording of the element has been changed to include privacy for spiritual needs and confidential consultations which is an integral part of the requirements of privacy. This year all sectors have been combined on the basis that the types of measures that need to be taken to ensure patient privacy and confidentiality are broadly the same across the sectors (such as locks on bathroom doors which can be overridden in emergencies, partitions that offer auditory and visual privacy, staff not entering closed curtains unannounced etc.) Each sector will of course need to take into account the specific aspects of their service and condition of patients in deciding exactly what combination of measures are appropriate.. It is also recognised that the need for privacy and

[17] The term *transfer(s)* is as defined by the NHSLA Risk Management Standard, *' the process whereby a patient is moved from one clinical area to another within the organisation or to another organisation'*. (Source: http://www.nhsla.com/Publications/)

	confidentiality will often need to be balanced with measures needed to deliver effective and safe healthcare in the various stages of care. Again the specific measures in achieving this balance will vary according to sector and circumstance.
Element two PCTs have systems in place to ensure that preventive and corrective actions are taken in situations where there are risks and/or issues with patient privacy and/or confidentiality.	**Element two** This is important to ensure that the criteria for assessment of this standard includes whether there are adequate checks and proactive approach to prevent situations where patient privacy and/or confidentiality may be compromised.

Core Standard C21

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Elements	Rationale
Element one The PCT has systems in place and has taken steps to ensure that care is provided in well designed and well maintained environments, including in accordance with all relevant legislative requirements referred to in Health Building Notes (HBN) and Health Technical Memoranda (HTM), and by following the guidance contained therein, or equally effective alternative means to achieve the outcomes of the HBNs/HTMs. The healthcare organisation should also act in accordance with the *Disability Discrimination Act 1995*, the *Disability Discrimination Act 2005*; and have regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005).	**Element one** Modified wording to focus on assurance systems as well as the technical guidance. Health Building Notes and Health Technical Memoranda contain both legal requirements and good practice guidance. While the guidance in the memoranda assists healthcare organisations to achieve well designed and well maintained environments, there may be alternative ways of achieving the same objectives. Where alternative solutions are proposed, healthcare organisations should demonstrate that equally effective outcomes are achieved. The *Disability Discrimination Act 1995* has been amended by the *Disability Discrimination Act 2005* and includes a new duty of disability equality. The associated code of practice provides public authorities with guidance on how to understand and meet the general duty and specific duties, which include undertaking an impact assessment of its policies and practices on equality for disabled persons and having due regard to the requirement to take steps to take account of the needs of disabled persons.
Element two Care is provided in clean environments, in accordance with the relevant[18] requirements of duty four of *The Health*	**Element two** The hygiene code was updated in January 2008. The overarching duty 4 is to provide and maintain a

[18] The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the *Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* are covered by standard C04c

Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, revised 2008).

clean and appropriate environment for healthcare. Sub-duty 4d states that “the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available".

Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and where appropriate follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation. The *National specification for cleanliness in the NHS* (NPSA, 2007) is referenced in the revised version of the Hygiene Code (2008) and provides guidance for trusts on cleaning standards. However, this guidance is not mandatory and a trust may specify its cleaning standards in a different manner to those set out in the NPSA specification so long as the standards meet the overall objectives set out in duty four.

This standard only considers specific aspects of duty four of the Hygiene Code. These are sub duties 4 a, b (in relation to cleaning), c, d, e, g and h. The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections are covered by standard C04c.

Seventh domain: Public health

Domain outcome: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core Standard C22a&c

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:
a) co-operating with each other and with local authorities and other organisations; and
c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

Elements	Rationale
Element one The PCT actively works with other healthcare organisations, local government and other local partners to promote, protect and demonstrably improve the health of the community served and narrow health inequalities, such as by working to improve care pathways for patients / service users across the health community and between the health, social care and the criminal justice system, and/or participating in the Joint Strategic Needs Assessment (JSNA) and health equity audits to identify population health needs.	**Element one** Adding JSNA updates the element to reflect changes in the system. Other partners (social care and the criminal justice system) are included to improve the element and reflect changes to the system.
Element two The PCT contributes appropriately and effectively to nationally recognised and/or statutory partnerships, such as the Local Strategic Partnership (LSP), children's partnership arrangements and, where appropriate, the Crime and Disorder Reduction Partnership.	**Element two** Role of the LSP and children's trust partnerships updates element and reflects developments in partnerships at local level.
Element three The PCT monitors and reviews their contribution to public health partnership arrangements and takes action as required.	**Element three** With this additional element the criteria now better reflect the standard with its focus on outcomes.

Core Standard C22b

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices.

Elements	Rationale
Element one The PCT's policies and practice to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report.	**Element one** This element was removed in 2007/08 with the rationale that reinforcement of other elements in C22 and C23 meant that this was less critical for providers. Inspection has revealed that this has not been sufficiently covered elsewhere, so it has been reintroduced.

Core Standard C23

Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

Elements	Rationale
Element one The PCT collects, analyses and shares data about its patients/service users and services, including where relevant data on ethnicity, gender, age, disability and socio-economic factors, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served.	**Element one** This now matches the criteria for the other provider sectors and better reflects the standard.
Element two Patients/service users are provided with evidence-based care and advice along their care pathway in relation to public health priority areas, including through referral to specialist advice/services.	**Element two** This now better matches the standard and the outcome focus of the domain.
Element three The PCT implements policies and practices to improve the health and well-being of its workforce.	**Element three** No change to this element from 2007/08.

Core Standard C24

Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

Elements	Rationale
Element one The PCT protects the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations (including control	**Element one** The sentence has been amended by adding 'protects the public' in order to ensure outcome, as well as process, is assessed. Guidance on all counts has been updated. NHS

of communicable diseases), which includes arrangements for business continuity management, in accordance with the Civil Contingencies Act (2004), The NHS Emergency Planning Guidance 2005, and associated supplements (Department of Health, 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	emergency planning guidance is best practice guidance - a set of general principles published by the Department of Health to guide all NHS organisations in developing their ability to respond to a major incident(s) and to manage recovery and its effects, locally, regionally or nationally within the context of the requirements of the Civil Contingencies Act 2004. Associated supplements include: ▪ *Planning for the management of burn-injured patients in the event of a major incident (December 2007)* ▪ *Critical care contingency planning in the event of an emergency where the numbers of patients substantially exceeds normal critical care capacity (December 2007)* ▪ *Planning for the management of blast injured patients (December 2007)* ▪ *Strategic command arrangements for the NHS during a major incident (December 2007) – supersedes the command and control section of the NHS Emergency Planning Guidance 2005* ▪ *Mass casualties incidents: a framework for planning (March 2007) – supersedes beyond a major incident* ▪ *New guidance on the provision of public health advice during a major incident (April 2007)* *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007) superseded the previous plan (*UK influenza pandemic contingency plan* (Department of Health, 2005)) in November 2007.
Element two The PCT protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the *Civil Contingencies Act 2004*, *The NHS Emergency Planning Guidance 2005 and associated annexes* (Department of Health 2005, 2007) and *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007).	**Element two** “Protects the public” has been added in order to ensure outcome as well as process are assessed. Guidance has been updated as in element one.

Appendix 1 – Healthcare Commission's use of the findings of others in the core standards assessment 2008/09 of PCTs as Providers

Working with others

The Healthcare Commission has a statutory responsibility to review the provision of healthcare by or for the English NHS bodies and cross-border Special Health Authorities. To do this, we work with other organisations to remove unnecessary burdens associated with inspections, audits or reviews, including targeting inspection activity effectively. Whilst existing inspection methodologies have been developed to meet the needs of the services for which they have been developed (and so a single inspection methodology would not be appropriate) the aim is to achieve greater consistency and cohesion in the inspection of health and healthcare. In line with this, we make use of findings as detailed below in relation to the annual health check.

Use of the findings of others

The Healthcare Commission continues to make use of the findings of others to assist its work and to reduce duplication of assessment when possible. As described in the following sections, some of the findings of others relating to matters identified during the assessment year 2008/09 will be used directly to provide evidence of assurance in relation to compliance.

In year findings of others will also be used in our screening process to help target inspections; so that for example where there are positive findings in relation to a trust, this will reduce the chances of that trust being selected for inspection.

As well as the Healthcare Commission's use of the findings of others in this way, trusts also have the option of using findings of others that relate to matters within the assessment year as part of their assurance processes, but it is not a requirement and it is always open to trusts to assure themselves of compliance with the core standards in other ways.

NHSLA Risk Management Standards

The core of the NHSLA's risk management programme is provided by a range of NHSLA standards and assessments. The NHSLA regularly assesses healthcare organisations against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA.

The NHS Litigation Authority's Risk Management Standards have now been rolled out to all provider sectors enabling us to make in-year use of their findings for all sectors in 2008/09 where this provides a level of assurance of compliance. There is a single set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health & safety risks. The sets of standards that the Healthcare Commission will make use of, as appropriate to the sector are:

- NHSLA Risk Management Standards for Acute Trusts (applicable to all acute and specialist hospital NHS trusts)
- NHSLA Risk Management Standards for Mental Health and Learning Disability Trusts
- NHSLA Risk Management Standards for Ambulance Trusts
- NHSLA Risk Management Standards for Primary Care Trusts

For the remainder of this appendix these are referred to collectively as the "Risk Management Standards (RMS)".

Each of the "standards" within the **NHSLA** *Risk Management Standards* are assessed using *criteria.* It is many of these *criteria* which are directly relevant to the core standards listed below^ and the Healthcare Commission will continue to use positive *RMS* findings in relation to their criteria where appropriate, to inform their assessment of core standards, both to:

- reduce the chance of trusts being selected for inspection (by informing our assessment of the risk of undeclared non-compliance using findings from current and previous years),
- reduce evidence required during inspections of the standards listed below, where findings are from an RMS assessment carried out by the NHSLA during the assessment year 2008/09 **ONLY***.

NOTE that in a change from 2007/08 we will use findings of Level 2 (or 3) in any relevant *RMS criteria* whether or not the trust succeeds in achieving an overall Level 2 (or 3). This means that, we will make use of any findings of level 2 or 3 at *RMS criteria* level for all trusts that are assessed at this level and not just those who also succeed at the overall level.

We would also expect (but do not require) trusts to make use of in-year level 2 or 3 achievements in relevant *RMS criteria* (where they have been directly assessed by the NHSLA within the year 2008/09) to contribute to their assurance of compliance with the core standards listed below, but we do not consider that this on its own, will give trusts sufficient assurance of compliance with any one standard as a whole. It remains the responsibility of trusts to determine whether they have reasonable assurance of compliance with core standards, whether or not they are relying on NHSLA findings from 2008/09.

Trusts will wish to note that the Healthcare Commission will consider achievement of an overall level 2 or 3 in the NHSLA RMS indicative of performance in risk management and this will inform our assessment of the risk of non-compliance with core standard C7a&c (and so reduce the chance of being selected for inspection).

***PLEASE ALSO NOTE** that we are aware that where Trusts have achieved a Level 2 or Level 3 in the RMS they are not automatically assessed against the RMS every year, but that the NHSLA – for their purposes – considers the level awarded to be current until a subsequent assessment. For the purposes of the annual health check, however, evidence of assurance of compliance with Core Standards MUST relate to compliance during the year assessed. We will therefore NOT consider Level 2 or 3 for criteria awarded outside the 2008/09 assessment year alone as evidence of assurance of compliance. The scope of the inspection will therefore NOT be reduced on this basis. (Note that this does not preclude a trust from themselves presenting evidence of current level 2 status, along with other evidence, as part of their evidence of assurance of compliance during inspection. Assessors will then consider all the evidence to assess whether this is reasonable assurance of compliance during assessment year in question)

^NHSLA List: C1a, C4a, C4b, C4d, C5a, C6, C9, C10a, C11b, C13b, C14a, C14b, C14c, C16 and C20a

Audit Commission

We work closely with the Audit Commission to ensure that where overlap exists our assessments are aligned, evidence is shared and duplication minimised. All parties are committed to using each others' work wherever possible. In 2006/07 and 2007/08 the Audit Commission and the Healthcare Commission followed a procedure of information sharing which

enabled the Healthcare Commission to rely on the work of auditors on these areas of overlap, thus minimising duplication of work. We anticipate the same process will be used for 2008/09.

The assessment undertaken by the Audit Commission has changed and in 2008/09 the auditor's local evaluation assessment has been replaced by the **Use of Resources assessment (UoR)** which is undertaken on the PCT as a single body. Further information on this can be found on the Audit Commission's website. We are working with the Audit Commission to finalise how we will apply this single assessment to both arms of the PCT as they are assessed through the core standards assessment process.

We expect that evidence collected by trusts to provide assurance for UoR for the assessment year 2008/09 can also be considered by trusts when making their core standards declaration for those relevant aspects of the standards. It is also important that Statements on Internal Control are fully aligned with core standards declarations. Where a trust has declared non-compliance with core standards as part of the self-declaration process, it should disclose a control weakness in the Statement on Internal Control and vice versa.

Relevant in-year UoR data is used within our screening process when we select trusts for inspections in the summer.

We also intend to use the UoR findings directly as part of our inspections. For particular standards which have been selected for inspection, where positive assurance is provided from UoR this information is used as evidence and substitutes the need for additional assessment by the Healthcare Commission and therefore reduces the number of questions that we need to ask a trust in the event that they are selected for inspection. Other (negative) findings from UoR would not be used alone to determine a lack of assurance of compliance but will inform questions that assessors will ask during inspection

UoR List: C7b, C8a, C7ac, C21

PEAT Patient Environment Action Teams

PEAT findings are also relevant to core standards, and the Healthcare Commission will continue to use these findings, but only to inform our assessment of the risk of non-compliance (and so reduce the chance of being selected for inspection) in relation to the standards listed below. However, we will not this year be using these findings ourselves as assurance of compliance during inspection. This does not prevent Trusts themselves using PEAT findings as part of their assurance. Indeed we would expect (but do not require) trusts to make use of findings of "excellent" as part of their assurance of compliance with the core standards listed below, but do not consider that this, on its own, will give trusts sufficient assurance of compliance with any one standard.

PEAT List: C15a (Element 1), C15b, C20b, C21 (Element 2)

Appendix 2 – Reference documents

For the 2005/06 and 2006/07 assessment of core standards, we published a number of elements that included references to guidance that we asked trusts to "take into account". Our intention had been that this guidance would, in many cases, provide a starting point for trusts to consider, when reviewing their compliance with a standard. However, as this guidance is not sufficient or necessary for trusts to use to determine whether they have met a particular standard, we have taken the decision to remove these references.

We have provided the references below as some trusts may still find them helpful when considering their compliance. The list is not an exhaustive list of references for each standard, but instead may be useful to trusts as a starting point.

Standard	Guidance
C1a	*Building a safer NHS for patients: implementing an organisation with a memory* (Department of Health, 2001)
C2	*Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (Royal College of Paediatrics and Child Health April 2006) *Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities* (DCSF 2008) *Sharing personal information: How governance supports good practice* (DCSF August 2008)
C4a	E*ssential steps to safe, clean care: introduction and guidance* (Department of Health, 2006) *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 *Infection control practices for ambulance services* (Infection Control Nurses Association, April 2001)
C4d	*Building a safer NHS: improving medication safety* (Department of Health 2004)
C5a	*How to put NICE guidance into practice* (NICE, December 2005)
C7ac	*Clinical governance in the new NHS* (HSC 1999/065) *Assurance: the board agenda* (Department of Health 2002) *Building the assurance framework: a practical guide for NHS boards* (Department of Health 2003)
C7b	*Directions to NHS Bodies on counter fraud measures* (Department of Health, 2004)
C8b	*Leadership and Race Equality in the NHS Action Plan* (Department of Health 2004)
C10a	The set of six documents that make up the NHS Employment Standards: *1. Verification of identity checks* *2. Right to work checks* *3. Registration and qualification checks* *4. Employment history and reference checks* *5. Criminal record checks* *6. Occupational health checks* These are downloadable from www.nhsemployers.org/primary/primary-3524.cfm

	The Criminal Record Bureau website provides additional information on Criminal record checks. See www.crb.gov.uk The UK Border Agency website provides information on their checking service for employers. See http://www.bia.homeoffice.gov.uk/employers/employersupport/ecs
C11a	*Code of practice for the international recruitment of healthcare professionals* (Department of Health 2004)
C11c	*Continuing professional development: quality in the new NHS* (HSC 1999/154) *Continuing professional development: quality in the new NHS* (DH, 1999)
C13a	*NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff* (Department of Health, 2003).
C13b	*Good practice in consent: achieving the NHS plan commitment to patient centred consent practice* (HSC 2001/023) *Seeking Consent: working with children* (Department of Health 2001)
C16	*Toolkit for producing patient information* (Department of Health 2003) *Information for patients* (NICE) *Guidance On Developing Local Communication Support Services And Strategies* (Department of Health 2004) and other nationally agreed guidance where available
C17	Key principles of effective patient and public involvement (PPI) (The National Centre for Involvement, 2007) *Community Engagement in Health* (NICE public health guidance Feb 2008)
C18	*Building on the best: Choice, responsiveness and equity in the NHS* (Department of Health 2003).
C20a	*A professional approach to managing security in the NHS* (Counter Fraud and Security Management Service2003) and other relevant national guidance *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C21	*Developing an estate's strategy* (1999) *Developing an estates strategy* (Department of Health, 2008), updated version of previous document, but was not published until August 2008 *A risk based methodology for establishing and managing backlog* (NHS Estates, 2004) Add *BS EN 1789: 2007 Medical vehicles and their equipment* for ambulance trusts only *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) for ambulance trusts only

	BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C22ac	*Choosing health: making healthier choices easier* (Department of Health 2004) *Tackling health inequalities: a programme for action* (Department of Health 2003) *Making partnerships work for patients, carers and service users* (Department of Health 2004) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C23	*Choosing health: making healthy choices easier* (Department of Health 2004) *Delivering Choosing health: making healthier choices easier (*Department of Health 2005) *Tackling Health Inequalities: A programme for action* (Department of Health 2003) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C24	*Getting Ahead of the Curve* (Department of Health, 2002) *Beyond a major incident* (Department of Health, 2004)

Part Two

Criteria for assessing core standards in 2008/09 for primary care trusts as a commissioner of services

Overview

These are the 2008/09 criteria for assessing core standards between 1 April 2008 and 31 March 2009 for primary care trusts (PCTs) as **commissioning** bodies within England. As for the provider criteria in previous years, we have set out our criteria as 'elements' for each of the core standards.

What has changed?

As set out in the Healthcare Commission's publication *The annual health check in 2008/09: Assessing and rating the NHS,* our assessment of PCTs for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services) and its role as a commissioner of healthcare services for its local community. We have developed a set of criteria for assessing PCTs as commissioners. These revised criteria clarify how the assessment of standards relates to commissioning.

For the purposes of assessing PCTs as commissioners, the core standards, and their component elements, have been considered from three perspectives, which are combined into a single declaration. Each of these is described below:

- **PCT commissioners (as corporate bodies)** – ie, standards as they apply to any organisation, regardless of its functions. These standards are about how organisations function. Examples of standards in this category include those which relate, for example, to the wellbeing of staff.

- **PCT commissioners (commissioning functions)** – ie, the standards that are relevant to a PCT's role as a commissioner. There are aspects of many of the standards applicable to PCTs which relate to their commissioning function. In addition there are a number of standards that **particularly** concern commissioning activities, namely: C5a, C6, C7e, C17, C18, C22 a&c, C22 b, C23 and C24. These cover issues such as assessing the health needs of the population.

- For the purposes of this overview section, when we refer to PCTs commissioning services, we are referring to commissioned services in their broadest sense (including those commissioned from NHS providers, the independent sector, and independent contractors) unless otherwise specified. However, within the detail of the criteria, the "commissioned services" and "independent contractor" tests remain distinct from one another.

- **PCTs' role in relation to the quality and safety of its commissioned services** – ie, whether it has 'appropriate mechanisms' in place and has taken 'reasonable steps' with regard to commissioned services and independent contractors respectively. **These tests apply to every standard, in the same way as they have in previous years. More information on these tests is given later in this section.**[1]

[1] Further information regarding the commissioned services and independent contractors tests can be found on pages 54 – 62 of this document.

Declaration

In its declaration as a commissioner, the PCT will be required to declare its assurance of compliance against every standard in two ways:

1) as a corporate body and commissioning activities **and**
2) in relation to its commissioned services and independent contractors

The declaration will encapsulate its corporate and commissioning activities, as well as its assurance of compliance with regard to commissioned services and independent contractor tests (as described above). **This declaration will be entirely separate from their declaration as a provider organisation**, and the criteria have been amended to reflect the focus on the PCT as a commissioning body and with regard to its commissioning functions.

There may be occasions where the same evidence will inform a PCT's declaration as a commissioner, and its separate declaration as a provider (for example, where services are shared). This will depend on the way in which PCTs have separated out their governance arrangements for commissioner and provider functions.

PCTs have asked the Healthcare Commission to ensure that the system of assessment is as stable as possible. We have therefore made only those changes to the criteria which are necessary to enable us to provide the necessary focus on commissioning.

In addition, there are changes to criteria and rationales which aim to increase their clarity. Where these relate to the criteria for provider organisations, these are explained fully in Part 1 of this document which relates to PCTs as providers.

How should trusts' boards consider the elements?

The criteria are written to reflect the requirements made of PCTs as commissioners throughout the assessment year; they do not introduce new requirements, but they do make more explicit some of the obligations on PCTs as commissioners. As in the two previous years of the core standards assessment, we ask that NHS trust boards determine whether they have reasonable assurance of compliance with a standard, without a significant lapse, from 1 April 2008 to 31 March 2009. As part of the annual health check, trusts will then be asked to make a declaration of their assurance of compliance for the whole year. As standard contracts are applied more widely within the NHS, in future assessment years the requirements of these contacts may be used to underpin the criteria.

Commissioned services and independent contractors

As in previous years, the 2008/09 assessment of PCTs' assurance of compliance with core standards includes reference to the PCT commissioner's role in relation to the quality of its commissioned services and the arrangements it makes with its independent contractors. To underline the importance of this role, we have explicitly included reference to this for every standard (for commissioned services) and for relevant aspects of each element (for independent contractors). The generic nature of the tests applied remains. When considering how to complete their declaration, we ask PCTs to consider the services provided by commissioned services and independent contractors in the following ways[2]:

[2] Please note, PCTs are asked to declare at the (more detailed) element level when thinking about independent contractors, but at the level of the whole standard, for commissioned services.

The commissioned services test

PCTs are expected to have appropriate mechanisms in place for identifying and responding to significant concerns regarding the providers' services that they commission. A PCT commissioner should consider whether it has appropriate mechanisms through which it can identify and where appropriate respond to any significant concerns with regard to those commissioned services being consistent with the overall standard.

The Healthcare Commission recognises that PCTs will differ in the mechanisms used in relation to quality and safety in their commissioned services. PCTs will be formalising their requirements and monitoring arrangements more through detailed contractual clauses and service level agreements and, increasingly, the new standard contracts.

For PCTs (whether in their capacity as co-ordinating PCTs or associate PCTs) that are in contractual agreements using the NHS standard contract for acute trusts, "mechanism" means complying with the obligations contained in that contract (which include requirements relating to the *Standards for Better Health*). Specific examples are:

- Clause 33 of the standard NHS contract for acute services sets down specific duties on PCTs and acute providers in relation to Clinical Quality Reviews which could be applicable when considering whether appropriate mechanisms are in place in relation to core standards which relate to the quality of clinical care – for example C 5a.
- Clause 15 of the standard NHS contract for acute services sets down specific duties on PCTs and acute providers in relation to reporting and learning from incidents which could be applicable when considering whether appropriate mechanisms are place in relation to core standard C1a.

PCTs will also be taking part in the world class commissioning assurance process which includes an assessment of PCT performance against a set of indicators, competencies and governance arrangements. In relation to competency 10 (which expects PCTs to "effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes for value for money") the guidance says that:

> "Commissioners will need to manage their relationships and contracts with providers in order to ensure that they deliver the highest possible quality of service and value for money. This will involve working closely with providers to sustain and improve provision, engaging in constructive performance discussions to ensure continuous improvement. Commissioners will need to ensure that their providers understand and promote the values of the NHS."

The assurance framework looks to PCTs to:
- Use performer information.
- Implement regular provider performance discussions.
- Have mechanisms for resolving ongoing contractual issues.

The level at which PCTs are performing against this competency will vary, but at level 2, criteria include:

- Data is accessible and used to monitor provider performance.
- Regular reports (at least monthly) addressing performance of major providers, acute care, primary and community care and social care for internal and external use.
- Contracts indicate when intervention is required. etc[3].

Relationship with world class commissioning assurance – general guidance

In a number of cases there are similarities between some components of the world class commissioning competencies and aspects of the Healthcare Commission's core standards assessment (see table below). The Healthcare Commission is working closely with the Department of Health (DH) to ensure that the annual health check's core standards assessment and DH's world class commissioning assurance systems are complementary and some additional information on this is given below.

The Healthcare Commission will use the outputs from the world class commissioning assurance process as one of the large number of items in its screening process, which aims to verify the declarations that PCTs make in relation to core standards. However, the Healthcare Commission will **not** be using the outputs of the world class commissioning assurance programme to provide assurance in relation to any standard, and PCTs must still make a declaration of compliance for the whole year of assessment, in the usual way. This is because world class commissioning assurance cannot provide assurance for the whole of the 2008/09 assessment year. In addition, the standards and competencies, largely, are not directly comparable. We will be undertaking some work with DH in the coming year to examine the correlation between the two systems, and to explore how this might help streamline the assessments in future.

However, for the number of standards where there are similarities, our intention is that the gathering of evidence by PCTs will enable them to minimise duplication of effort in collecting and collating evidence. The areas of similarity are described more fully in the table below.

[3] *World class commissioning: Commissioning assurance handbook* (Department of Health, Dec 2007)

Table A – Similarities between core standards assessment and world class commissioning competencies

Core standard (commissioner)	World class commissioning competency
C14 c) Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery. **Element one** The PCT acts on, and responds to, complaints appropriately and in a timely manner and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the PCT. **Element two** Demonstrable improvements are made to the delivery of a PCT's functions as a commissioning body as a result of concerns and complaints from patients/ service users, relatives and carers.	**3)** Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health.
C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services. **Element one** The PCT seeks and collects the views and experiences of patients/service users, carers and the local community, particularly those people who are seldom listened to, on an ongoing basis when commissioning, designing, planning, and improving healthcare services, as required by Section 242 of the National Health Services Act 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the PCT acts in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender along with impact assessments) under the following "public body duties" * statutes: ▪ *the Race Relations (Amendment) Act 2000,* ▪ *the Disability Discrimination Act 2005, and* ▪ *the Equality Act 2006*;	**3)** Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health.

and where appropriate, having due regard to the associated codes of practice. • The phrase *"public body duties"* is defined in C7e. **Element two** The PCT demonstrates to patients/ service users, carers and the local community, particularly those people who are seldom listened to, how it has taken their views and experiences into account in commissioning, designing, planning, and improving healthcare services in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. The PCT should act in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under: the following "*public body duties*"* statutes: ▪ *the Race Relations (Amendment) Act 2000,* ▪ *the Disability Discrimination Act 2005, and* ▪ *the Equality Act 2006.* and where appropriate, having due regard to the associated codes of practice. * The phrase *"public body duties"* is defined in C7e.	
C22 Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by: a) co-operating with each other and with local authorities and other organisations; and c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships. **Element one** The PCT actively works with other healthcare organisations, local government and other local partners to promote, protect and demonstrably improve the health of the community served and narrow health inequalities through the Local Strategic Partnership(s), children's partnership arrangements, Crime and Disorder Reduction Partnerships, and other recognised partnerships, such as Youth Offending Teams.	**1)** Are recognised as the local leader of the NHS. **2)** Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities. **3)** Proactively seek and build continuous and meaningful engagement with the public and

Element two The PCT works closely with partners in coordinating health equity audits, conducting a comprehensive Joint Strategic Needs Assessment (JSNA), and contributing to developing the health and health-related Local Area Agreements, which are reflected in their strategic or operational planning. **Element three** Commissioning decisions are taken based on the JSNA and in line with the LAA, and taken in consultation with clinicians, local authorities and other partners, including patients, the public and their representatives. **Element four** The PCT monitors and reviews its contribution to public health partnership arrangements and takes action as required.	patients, to shape services and improve health **5)** Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements. **6)** Prioritise investment according to local needs, service requirements and the values of the NHS.
C23 Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections. **Element one** The PCT coordinates health equity audit, equality impact assessments and assesses the health needs of its local population, including analysis of its demography, health status and health inequalities, health and social care use, and patient and public views and contributes this to the joint strategic needs assessment (JSNA). **Element two** The PCT's commissioning decisions and local target setting are informed by intelligence from its assessment of health needs, the JSNA, the Director of Public Health's Annual Public Health Report (APHR), information from health equity audits, equality impact assessments, evidence of effectiveness and national priorities.	**2)** Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities. **3)** Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health **5)** Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and

Element three The PCT commissions good-quality, evidence-based programmes and services to improve health and well-being, and narrow health inequalities, based on the needs of the population served. **Element four** The PCT monitors and reviews its commissioning decisions in relation to improving health and tackling health inequalities and, where appropriate, makes changes. **Element five** The PCT implements policies and practices to improve the health and wellbeing of its workforce.	requirements. **6)** Prioritise investment according to local needs, service requirements and the values of the NHS. **7)** Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes.

The Department of Health will also be relying on some key aspects of current regulatory activities (including the Core Standards Assessment from 2007/08) to support world class commissioning assurance (particularly in relation to the Board section of the governance assessment, financial performance via the Audit Commission's Use of Resources assessment, some indicators (eg national cancer waiting time targets), and by drawing on the Commission's patient survey programme where relevant. DH will include this information in its contextual information for WCC analysts. The DH will also send SHAs details of core standards for which the PCT is not assured of compliance. All core standards for which the PCT is not assured of compliance and the competency to which they are relevant will be included in the briefing for panel members undertaking world class commissioning reviews.

The independent contractor test

PCTs should consider whether they have taken **reasonable steps** to assure themselves that the services provided by independent contractors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the elements set out in the criteria document. In doing so, they will need to have regard to the published **provider** criteria, rather than those that relate to the corporate and commissioning functions.

We recognise that PCTs have different ways of taking reasonable steps to engage and communicate with independent contractors. For example, they could do this through the work of the executive committee (or PEC), by reviewing information from the quality outcomes framework (QOF) or by engaging with local networks (for example the local dental practice board, local pharmacy committee, local optometry committee.)

Our discussions with PCTs regarding current practice in holding independent contractors to account indicates that systematic rather than ad hoc arrangements are in place in many PCTs. Some examples are given below, but this list is intended to be neither prescriptive nor exhaustive.

Their overall approach

- The PCT has established arrangements with independent contractors, setting out: the approach to monitoring, the performance information to be collected, and how unsatisfactory performance will be dealt with, for example through the administration of their performers' lists.

The structures and processes in place in relation to independent contractors

- The PCT has clearly identified staff responsible for addressing primary care commissioning.

The nature of engagement with independent contractors

- The PCT promotes awareness of the need for services to be consistent with the relevant aspects of criteria among independent contractors and has systematic processes for engaging with the full range of independent contractors.

The nature of the mechanisms in place to understand performance in relation to independent contractors

- The PCT is using the mechanisms already in place for the performance management of independent contractors, to seek assurance on core standards, for example contract monitoring[4].

[4] For example, part 22 of the Standard GMS contract states that the Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by the PCT, SHA or SoS.

Whether there are mechanisms to support improvement where necessary

- The PCT has in place a range of support and incentives to address issues of non-compliance and poor performance.

The PCT may wish to consider the above when considering whether it has taken reasonable steps to ensure that the services provided by independent contractors are consistent with the relevant aspects of the elements set out in the criteria document.

Reasonable assurance

Reasonable assurance, by definition, is not absolute assurance. Conversely, reasonable assurance cannot be based on assumption. Reasonable assurance is based on documentary evidence that can stand up to internal and external challenge. In determining what level of assurance is reasonable, trusts must reflect that the core standards are not optional and describe a level of service which is acceptable and which must be universal. Our expectation is that each PCT's objectives will include compliance with the core standards. This will be managed through the trust's routine processes for assurance.

Significant lapse

Trust boards should decide whether a given lapse is significant or not. In making this decision, we expect that boards will consider the extent of risk of harm this lapse posed to patients, staff and the public, or indeed the harm actually done as a result of the lapse. The type of harm could be any sort of detriment caused by lapse or lapses in compliance with a standard, such as loss of privacy, compromised personal data, or injury, etc. Clearly this decision will need to include consideration of a lapse's duration, its potential harmful impact and the likelihood of that harmful impact occurring. There is no simple formula to determine what constitutes a 'significant lapse'. This is, in part, because our assessment of compliance with core standards is based on a process of self-declaration through which a trust's board states that it has received 'reasonable assurance' of compliance. A simple quantification of the actual or potential impact of a lapse, such as the loss of more than £1 million or the death of a patient for example, cannot provide a complete answer.

Determining what constitutes a significant lapse depends on the standard that is under consideration, the circumstances in which a trust operates (such as the services they commission, their functions and the population they serve), and the extent of the lapse that has been identified (for example, the duration of the lapse and the range of services affected, the numbers exposed to the increased risk of harm, the likely severity of harm to those exposed to the risk (taking account their vulnerability to the potential harm), etc. Note that where a number of issues have been identified, these issues should be considered together in order to determine whether they constitute a significant lapse.

PCTs' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the published criteria. When PCTs provide services directly, they have primary responsibility for ensuring they meet the core standards. In this respect, PCTs will be making a separate declaration in respect of any services that they directly provide, either alone or in partnership.

For PCT commissioners, boards will need to make a declaration that relates to their responsibilities as corporate bodies and commissioners of services. In addition, they

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Examples of aspects of the NGMS contract that relate to core standards include: requirements on premises, information for patients, complaints, use of personal information, access to practice lists and discrimination, medicines management, safeguarding children, infection control and decontamination, appropriate professional registration, indemnity, appraisal, confidentiality of data, data protection, employment rights, clinical governance, and consent.

should consider whether they have assurance of compliance for commissioned services and independent contractors, as described above.

Equality, diversity and human rights

One of the Healthcare Commission's strategic goals continues to be to encourage respect within services for people's human rights and for their diversity, and to promote action to reduce inequalities in people's health and experiences of healthcare. In line with the intention of *Standards for Better Health*, we expect that healthcare organisations will interpret and implement the standards in ways which challenge discrimination, promote equity of access and quality of services, reduce inequalities in health, and which respect and protect human rights.

More specifically, core standard C7e asks trusts to challenge discrimination, promote equality and respect human rights. The proposed criteria for C7e include a focus on how the trust is promoting equality, including by publishing information specified by statute in relation to race, disability and gender. Note that we have run three audits of trusts' websites, looking for this information, and we remain concerned that many trusts are still not compliant with legislation, particularly in relation to race equality.

Using the findings of others

Please see Appendix 3 for information regarding using the findings of others for commissioning criteria.

In-year revisions to legislation, codes of practice and guidance

All legislation, codes of practice and guidance referred to in the core standard criteria are up to date at time of publishing. During the assessment year trusts are expected to ensure they comply with any replacements, revisions, amendments or supplements to the said legislation, codes of practice or guidance and will be assessed on this basis.

Part Two – 2008/09 Criteria for assessing core standards for PCTs as commissioner of services

In the following pages you will find the criteria for the assessment of core standards in 2008/09 for PCT commissioners. This section cross-refers to the provider criteria, along with rationales for any changes. They are laid out in order of the core standards and grouped by domain, and the domain outcomes and standards themselves are quoted.

Part Two – 2008/09 PCT commissioning criteria

First domain: Safety

Domain outcome: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard C1a

Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Commissioning decisions are informed by information arising from the analysis of incidents reported to it by the providers of commissioned services (in accordance with the PCT's own requirements set down for incidents to be reported to it by its commissioned services) and the national analysis of incidents.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C1a rationale (element one)

- PCTs' systems to ensure that providers are reporting SUIs to them, as the commissioning body may be set down in the PCT's own policies, in policies agreed with SHAs, and / or in contractual arrangements. This element reflects that PCTs should be using information about reported incidents to inform commissioning decisions. It also recognises that for Foundation Trusts, these systems may not be in place, since the transfer of SUI performance management responsibility to commissioning PCTs is ongoing during 2008/09.

- National analysis of incidents may come from a range of organisations including the National Patient Safety Agency (NPSA), Health and Safety Executive, Medicines and Healthcare products Regulatory Agency (MHRA), Health Protection Agency, and the Counter Fraud and Security

Management Service.

- The provider elements related to incident reporting and analysis have not been replicated for commissioners, as the nature of reportable incidents for PCT commissioners do not directly concern patient safety, and therefore would go beyond the domain outcome.

Core standard C1b

Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one PCTs have in place policies for the timely management of all communications concerning patient safety issued from the National Patient Safety Agency (NPSA) and the Medicines Healthcare Products Regulatory Agency (MHRA) via national distribution systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) the UK Public Health Link System (UKPHLS). Such policies are operated effectively.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C1b rationale (element one)

- As per provider criteria. Element amended to reflect commissioning PCTs' responsibilities to manage patient safety communications as appropriate, rather than direct implementation.

Core standard C2

Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has made arrangements to safeguard children under Section 11 of the Children Act 2004 having regard to statutory guidance entitled *"Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004".*	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two The PCT works with partners to protect children and participate in reviews as set out in *Working together to safeguard children* (HM Government, 2006).	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element three The PCT should have agreed systems, standards and protocols about sharing information about a child and their family both within the organisation and with outside agencies having regard to "Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004".	

C2 rationale (elements one, two and three)

- In March 2007 statutory guidance was published, updating previous guidance, which is based on the Children Act 2004. Compliance with this was required by October 2005 and all elements should now be in place. The guidance issued under section 11(4) of the Children Act 2004 which requires each person or body to which the Section 11 Duty applies to have regard to any guidance given to them by the Secretary of State. This means that they must take this guidance into account and, if they decide to depart from it have clear reasons for doing so.
- PCTs have specific duties in this area to safeguard children. Section 11 of the Children Act 2004 places a duty on PCTs to ensure that in discharging their functions they have regard to the need to safeguard children and they must co-operate with the Local Authority in the establishment and operation of the Local Safeguarding Childrens Board (LSCB) and, as partners must share responsibility for the effective discharge of its function in safeguarding children. PCT Chief Executives have responsibility for ensuring that the health contribution to safeguarding children is discharged effectively across the whole local health economy through the PCT's commissioning arrangements. Where practice based commissioners undertake commissioning services, this should be done in partnership with PCTs who need to ensure their safeguarding duties are fulfilled. The PCT must also ensure that all health organisations, including the independent healthcare sector with whom they have commissioning arrangements, have links with a specific LSCB, and that health agencies work in partnership in accordance with their agreed LSCB plan.

Statutory guidance (Section 5) states that PCTs should be "ensuring that their staff are trained and competent to be alert to potential indicators of abuse or neglect in children, know how to act on their concerns and fulfil their responsibilities in line with LSCB procedures".

Core standard C3

Healthcare organisations protect patients following NICE Interventional Procedures guidance.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**Not applicable**

C3 rationale (element one)

- Not applicable – These procedures are not directly undertaken by a commissioning body.

Core standard C4a

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin-resistant Staphylococcus aureus (MRSA).

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4a rationale (element one)

- Not applicable to this standard, as the Hygiene Code is targeting NHS providers who are commissioning services relevant to this standard (not PCT commissioning).

Core standard C4b

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4b rationale (elements one and two)

- Not applicable as concerns the provision of clinical care

Core standard C4c

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs

will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4c rationale (element one)

- Not applicable as the Hygiene Code is targeting NHS providers who are commissioning services relevant to this standard (not PCT commissioning).

Core standard C4d

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4d rationale (elements one and two)

- Not applicable as more relevant to commissioned services and independent contractors than the commissioning process.

Core standard C4e

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4e rationale (element one)

- Not applicable to commissioning bodies.

Second domain: Clinical and cost effectiveness

Domain outcome: Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

Core standard C5a

Healthcare organisations ensure that they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT funds the implementation of relevant NICE technology appraisals within its commissioned services for patients whose clinicians recommend treatments in line with NICE technology appraisals. Mechanisms are in place to: identify relevant technology appraisals; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for relevant technology appraisals.

Element two

The PCT can demonstrate how it takes into account nationally agreed guidance where it is available as defined in National Service Frameworks (NSFs), NICE clinical guidelines, national plans and nationally agreed guidance, when commissioning and when planning services, care and treatment. The PCT has mechanisms in place to identify guidance that is relevant to the services it commissions and meet the needs of its local population. The PCT has mechanisms in place to: take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for guidelines.

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C5a rationale (elements one and two)

- As for provider rationale. Wording adjusted to make it relevant to PCTs' commissioning and planning functions.

- The Secretary of State's directions to the service relate to the funding of technology appraisal guidance The National Health Service Act 1977, Directions to Primary Care Trusts and NHS Trusts for the Funding of Technology Appraisal Guidance from the National Institute for Clinical Excellence (NICE). July 2003, and all subsequent amendments and further directions.

Core standard C5b

Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For provider element one only** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element two Not applicable	**Element two** Not applicable

C5b rationale (elements one and two)

- Not applicable – This concerns the delivery of clinical care.

Core standard C5c

Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C5c rationale (element one)

- Not applicable – as concerns the provision of clinical care

Core standard C5d

Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C5d rationale (elements one and two)

- Not applicable.

Core standard C6

Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT works in partnership with other health and social care organisations to commission services (including joint commissioning) to ensure that the individual needs of patients / service users are properly managed and met:

- where responsibility for the care of a patient is shared between the organisation and one or more other health and/or social care organisations;

and/or

- where the major responsibility for a patient's care is moved (due to admission, referral, discharge or transfer) across organisational boundaries.

Where appropriate, these arrangements are in accordance with:

- Section 75 partnership arrangements of the National Health Service Act 2006 (previously section 31 of the Health Act 1999);
- the Community Care (Delayed Discharges etc.) Act 2003 and Discharge from hospital pathway, process and practice (DH, 2003).

Where appropriate, these arrangements are in accordance with the relevant aspects of the following guidance or equally effective alternatives:

- *Guidance on the Health Act Section 31* partnership agreements (DH, 1999);
- guidance on partnership working contained within relevant National Service Frameworks and national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National Service Framework for Older People (DH, 2001) and the Cancer Reform Strategy (DH, December 2007);
- the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH, 2007).

Element two

Not applicable

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C6 rationale (element one)

- Element one - As per provider rationale. Wording has been amended to reflect PCTs' commissioning functions.

- The structure and wording of the elements have been amended to better reflect the standard and to clarify that the partnership responsibilities being assessed include those of the organisation. Element one has been made more explicit to indicate that we would expect organisations to be assured that they using partnerships to ensure that patients' needs are met when they move between organisations and when more than one organisation is contributing to patients' care. Various guidance and legislative documents are relevant to this standard. Organisations are legally obliged to comply with arrangements laid out in Section 75 of the National Health Service Act 2006 and the Community Care (Delayed Discharges etc.) Act 2003. The additional documents listed in element one are all good practice guidance or strategic frameworks which organisations are not mandated to follow. The Commission would, however, expect an organisation to have good reason and clear rationale for following a different course of action from that set out in these documents.

- Principles and Rules of Cooperation and Competition (principle 2) states that "Providers and commissioners must co-operate to ensure that the patient experience is of a seamless health services regardless of organisational boundaries, and to ensure service continuity and sustainability"(DH, 13/12/07 Gateway ref. 9244).

C6 rationale (element two)

- Not applicable as this concerns the delivery of care

Third domain: Governance

Domain outcome: Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Core standard C7a&c

Healthcare organisations:

a) apply the principles of sound clinical and corporate governance; and

c) undertake systematic risk assessment and risk management.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one
The PCT has effective clinical governance arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients/ service users.

Element two
The PCT has effective corporate governance arrangements in place that where appropriate are in accordance with *Governing the NHS: A guide for NHS boards* (Department of Health and NHS Appointments Commission, 2003), and the *Primary care trusts model standing orders, reservation and delegation of powers and standing financial instructions* August 2006 (DH, 2006).

Element three
The PCT systematically assesses and manages its risks, both corporate and clinical, in order to ensure probity, clinical quality and patient safety.

Independent contractors test

For each relevant provider element
For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C7a&c rationale (elements one, two and three)

- As per provider criteria.

Core standard C7b

Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS managers* (Department of Health, 2002), *NHS Counter fraud & corruption manual third edition* (NHS Counter Fraud Service, 2006), and having regard to guidance or advice issued by the CFSMS.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C7b rationale (element one)

- As per provider criteria.

Core standard C7d

Healthcare organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources.

PCT commissioned service test (for whole standard)

Not applicable

Elements	Independent contractors test
Element one Not applicable	Not applicable

C7d rationale

- Not applicable – This standard will be measured under the use of resources quality of financial management assessment

Core standard C7e

Healthcare organisations challenge discrimination, promote equality and respect human rights.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT should challenge discrimination and respect human rights in accordance with:

- *the Human Rights Act 1998,*
- *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health, 2000),*
- The general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the *"public body duties"*,* and
- *"employment and equalities legislation"*** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time.

*"Acting in accordance with '*public body duties*"' means: Acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following statutes:

- Race Relations (Amendment) Act 2000
- Disability Discrimination Act 2005
- Equality Act 2006

and, where appropriate, having due regard to the associated codes of practice.

**"Acting in accordance with '*employment and equalities legislation*"' means: Acting in accordance with relevant legislation including:

- Equal Pay Act 1970 (as amended),
- Sex Discrimination Act 1975 (as amended)
- Race Relations Act 1976 (as amended)
- Disability Discrimination Act 1995

Independent contractors test

For provider element one only

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

- Employment Equality (Religion or Belief) Regulations 2003
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Age) regulations 2006
- Part Time workers (Protection from Less Favourable Treatment) Regulations 2000
- Fixed Term Employees (Protection from Less Favourable Treatment Regulations 2002)
- Employment Rights Act section 80F-I (relating to the right to request flexible working)
- Working Time Regulations 1998 (as amended).

and, where appropriate, having due regard to the associated codes of practice equalities and employment legislation regarding age, disability, gender, race, religion and belief and sexual orientation, including discrimination legislation; and where appropriate, having due regard to the associated codes of practice.

Element two

The PCT promotes equality, including by publishing information specified by statute, in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under:

- *The Race Relations (Amendment) Act 2000*
- *The Disability Discrimination Act 2005*
- *The Equality Act 2006*

and where appropriate, having due regard to the associated codes of practice. ; and in accordance with *Delivering Race Equality in Mental Health Care (Department of Health, 2005).*

C7e rationale (elements one and two)

- As per provider criteria.
- The PCT should ensure that all documents such as service specifications, invitations to tender and service contracts, fully reflect their policy for the protection of vulnerable adults and specify how they expect providers to meet the requirements of the policy. They should require that any allegation or complaint about abuse that may have occurred within a service subject to contract specifications be brought to the attention of the contracts officer of any purchasing authority. Monitoring arrangements should include adult protection issues.
- PCTs are obliged to undertake equality impact assessments of relevant functions and policies.

Such assessments should consider the impact on the promotion of race, disability and gender equality as a minimum. Commissioning of goods facilities and services by a PCT carries with it the potential for adverse impact (for example on disabled people or on Black and Minority ethnic groups) if these services facilities or goods are not delivered equitably or are not accessible to all. PCTs should use their Commissioning function to promote equality by ensuring for example that the services it contracts out meet the needs of different groups.

Core standard C7f

Healthcare organisations meet the existing performance requirements

PCT commissioned service test (for whole standard)

Not applicable

Elements	Independent contractors test
Element one Not applicable	Not applicable

C7f rationale

- Not applicable – This standard will be measured under the indicators-based assessment

Core standard C8a

Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one PCT staff are supported, and know how, to raise concerns about services confidentially and without prejudicing their position, including in accordance with The Public Disclosure Act 1998: Whistle Blowing in the NHS (HSC 1999/198)	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with

the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C8a rationale (element one)

- No changes proposed

Core standard C8b

Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT supports and involves its staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level and in accordance with *"employment and equalities legislation"**; and where appropriate, having regard to the associated codes of practice. including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element two PCT staff from minority groups are offered opportunities for personal development to address under-representation in the workforce compared to the local population in accordance with *"employment and equalities legislation"** including legislation regarding age, disability, gender, race, religion and belief, sexual	

orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender.

* The phrases *"public body duties"* and "employment and equalities legislation" are defined in C7e.

C8b rationale (elements one and two)

- As per provider criteria.

Core standard C9

Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has effective systems for managing records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007). The PCT should comply with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and demonstrate they are complying with supplemental mandates and guidance if they are introduced during the assessment period.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element two Not applicable	

C9 rationale (elements one and two)

- As per provider criteria

Core standard C10a

Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and staff in ongoing NHS employment in accordance with the NHS Employment Standards (NHS Employers) 2008 **Element two (new)** PCTs meet their specific duties in relation to ensuring that those who join their performers list as GPs medical practitioners and, dentists and ophthalmic practitioners have the appropriate checks.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C10a rationale (elements one and two)

As per provider criteria. Element 2 added to reflect PCTs' specific duties regarding independent contractors.

Core standard C10b

Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT explicitly requires all employed healthcare professionals to abide by relevant codes of professional conduct. Mechanisms are in place to identify, report and take appropriate	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community

action when codes of conduct are breached.	pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C10b rationale (element one)

- As per provider criteria

Core standard C11a

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT recruits staff in accordance with relevant *"employment and equalities legislation"** and with particular regard to employment and equalities regulations including legislation regarding age, disability, gender, race, religion and belief, and sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender. and discrimination legislation; and where appropriate, having due regard to the associated codes of practice . * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e. **Element two** The PCT aligns workforce requirements to its service needs by undertaking workforce planning, and by ensuring that its staff are appropriately trained and qualified for the work they undertake as a commissioning organisation.	**For provider element one only** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C11a rationale (elements one and two)

As per provider criteria. Wording adjusted to reflect PCTs' commissioning functions.

Core standard C11b

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Staff participate in relevant mandatory training programmes **Element two** Staff and students participate in relevant induction programmes **Element three** The PCT verifies that staff participate in mandatory training programmes (including those referred to in Element 1). Where trusts identify non-attendance, action is taken to rectify this.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C11b rationale (elements one, two and three)

- Rationale as per provider criteria.
- Element three has been amended to cover PCT verification of staff participation in all mandatory training programmes. This would include training necessary to ensure probilty (as per provider criteria), but given the commissioner role, would be less likely to concern clinical quality and patient safety.

Core standard C11c

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT ensures that all staff concerned with all aspects of the commissioning of healthcare have	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that

opportunities to participate in professional and occupational development at all points in their career in accordance with "*employment and equalities legislation"** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice; and in accordance with the relevant aspects of *Working together – learning together: a framework for lifelong learning for the NHS* (Department of Health 2001) or an equally effective alternative.

* The phrases "public body duties" and "employment and equalities legislation" are defined in C7e

the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C11c rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function.

Core standard C12

Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirement of the research governance framework are consistently applied.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has effective research governance in place, which complies with the principles and requirements of the Research governance framework for health and social care, second edition (Department of Health 2005).	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C12 rationale (element one)

- As per provider criteria.

Fourth domain: Patient focus

Domain outcome: Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Core standard C13a

Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT ensures that staff treat patients/ service users, carers and relatives with dignity and respect and, where relevant, identify, and take preventive and corrective actions where there are issues and risks with dignity and respect

Element two

In commissioning healthcare services, the PCT seeks to meet the needs and rights of different patient groups with regard to dignity including by meeting the relevant requirements in accordance with *the Human Rights Act 1998* and the general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "*public body duties*"* statutes:

- *the Race Relations (Amendment) Act 2000*
- *the Disability Discrimination Act 2005, and*
- *the Equality Act 2006.*

and where appropriate, having due regard to the associated codes of practice.

The healthcare organisation should act in accordance with the requirements in the National Service Framework for older people (Health Service circular 2001/007), to ensure that older people are not unfairly discriminated against in accessing NHS or social care services as a result of their age.

* The phrase *"public body duties"* is defined in C7e.

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C13a rationale (element ones and two)

- As per provider criteria. PCTs may have contact with patients, carers, and relatives within its commissioning function, so this element will apply.
- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function.

Core standard C13b

Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two The PCT provides patients/service users, including those with language and/or communication support needs, with appropriate and sufficient information suitable to their needs, on the use and disclosure of confidential information held about them in accordance with Confidentiality: NHS code of practice (Department of Health 2003)	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element three The PCT monitors and reviews current practices to ensure effective consent processes relating to element 2 (on the use and disclosure of confidential information held about them).	

C13b rationale (elements one, two and three)

- Not applicable – as concerns the delivery of clinical care.
- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function. Element three refers to element two.

Core standard C13c

Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, excpepct where authorised by legislation to the contrary.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one When using and disclosing patients'/ service users personal information, PCT staff act in accordance with the Data Protection Act 1998, the Human Rights Act 1998, the Freedom of Information Act 2000 and Confidentiality: NHS code of practice (Department of Health 2003), Caldicott Guardian Manual 2006 (Department of Health 2006) PCTs should comply with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and demonstrate they are complying with supplemental mandates and guidance if they are introduced during the assessment period.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C13c rationale (element one)

- As per provider criteria.

Core standard C14a

Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one PCTs ensure that patients/ service users,	**For each relevant provider element** For independent contractors, the PCT should

relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system relating to the PCT's functions as a commissioning body, including information about how to escalate their concerns; and the PCT acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to them.

Element two
Patients/ service users, relatives and carers are provided with opportunities to give feedback to the PCT on the quality of services it commissions.

have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C14a rationale (elements one and two)

As per provider criteria. Wording amended to reflect that this element relates to PCTs' commissioning functions.

Core standard C14b

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has systems in place to ensure that patients/ service users, carers and relatives are not treated adversely as a result of having complained.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C14b rationale (element one)

- No change.

Core standard C14c

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT acts on, and responds to, complaints appropriately and in a timely manner and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the PCT.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Demonstrable improvements are made to the delivery of a PCT's functions as a commissioning body as a result of concerns and complaints from patients/ service users, relatives and carers.	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C14c rationale (elements one and two)

- As per provider criteria. Wording amended to reflect PCT commissioning functions.

Core standard C15a

Where food is provided healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	Not applicable
Element two Not applicable	

C15a rationale (elements one and two)

- Not applicable as standard concerns provision of food to patients/ service users.

Core standard C15b

Where food is provided healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	Not applicable
Element two Not applicable	
Element three Not applicable	

C15b rationale (elements one, two and three)

- Not applicable as standard concerns provision of food to patients/ service users.

Core standard C16

Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has identified the information needs of its service population, and provides suitable and accessible information on the services it commissions in response to these needs. This includes the provision of information in relevant languages and formats in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "*public body duties*"* statutes:	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

- *the Race Relations (Amendment) Act (2000),*
- *the Disability Discrimination Act (2005), and*
- *the Equality Act (2006)*;

and where appropriate, having due regard to the associated codes of practice.

* The phrase *"public body duties"* is defined in C7e.

Element two

The PCT provides patients/ service users and, where appropriate, carers with sufficient and accessible information on the services it commissions, including those patients/ service users and carers with communication or language support needs. In doing so PCTs must have regard, where appropriate, to the *Code of Practice to the Mental Capacity Act 2005* (Department of Constitutional Affairs 2007) and the Code of Practice to the Mental Health Act (Department of Constitutional Affairs 1983).

C16 rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' functions.

Fifth domain: Accessible and responsive care

Domain outcome: Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Core standard C17

The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT seeks and collects the views and experiences of patients/service users, carers and the local community, particularly those people who are seldom listened to, on an ongoing basis when commissioning, designing, planning, and improving healthcare services, as required by Section 242 of the National Health Services Act 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the PCT acts in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender along with impact assessments) under the following "public body duties" * statutes:

- *the Race Relations Amendment Act 2000,*
- *the Disability Discrimination Act 2005, and*
- *the Equality Act 2006*;

and where appropriate, having due regard to the associated codes of practice.

* The phrase *"public body duties"* is defined in C7e.

Element two

The PCT demonstrates to patients/ service users, carers and the local community, particularly those people who are seldom listened to, how it has taken their views and experiences into account in

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

commissioning, designing, planning, and improving healthcare services in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. The PCT should act in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under: the following "*public body duties*"* statutes:

- *the Race Relations (Amendment) Act 2000,*
- *the Disability Discrimination Act 2005, and*
- *the Equality Act 2006* ;

and where appropriate, having due regard to the associated codes of practice.

* The phrase *"public body duties"* is defined in C7e.

C17 rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function. Reference to PCTs "commissioning, designing, planning, and improving healthcare services" relate to their commissioning function.

Core standard C18

Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one When commissioning services, the PCT takes steps to enable all members of the population it serves to access them equally, including acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "*public body duties*"*statutes: • *the Race Relations (Amendment) Act 2000,* • *the Disability Discrimination Act 2005, and* • *the Equality Act 2006* ;	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

and where appropriate, having due regard to the associated codes of practice.

* The phrases *"public body duties"* is defined in C7e.

Element two
In commissioning services, the PCT takes steps to ensure that patients/ service users are offered choice in access to services and treatment, and those choices in access to services and treatment are offered on a fair, just and reasonable basis, including to disadvantaged groups and including acting in accordance with the general and specific duties imposed on public bodies as in Element one and including, where appropriate, having due regard to the associated codes of practice.

C18 rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function, which is one step removed from direct service provision.
- In addition, PCTs are obliged to undertake equality impact assessments of relevant functions and policies (originally proposed within the Race Relations Amendment Act 2000, and subsequently other equality legislation). Such assessments should consider the impact on the promotion of race, disability and gender equality as a minimum. Commissioning of goods facilities and services by a PCT carries with it the potential for adverse impact (for example on disabled people or on Black and Minority ethnic groups) if these services facilities or goods are not delivered equitably or are not accessible to all. PCTs should use their Commissioning function to promote equality by ensuring for example that the services it contracts out meet the needs of different groups.

Core standard C19

Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

PCT commissioned service test (for whole standard)

Not applicable

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** Not applicable

C19 rationale (elements one)

- Not applicable – This standard will be measured under the indicators-based assessment

Sixth domain: Care environments and amenities

Domain outcome: Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standard C20a

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The healthcare organisation effectively manages the health, safety and environmental risks to staff and visitors, in accordance with all relevant health and safety legislation, fire safety legislation, the *Disability Discrimination Act 1995*, and the *Disability Discrimination Act 2005*; and by having regard to *The* d*uty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005). It also acts in accordance with the mandatory requirements set out in *Firecode – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety* (Department of Health, 2006), in so far as the requirements are relevant to the PCT, and follows the guidance contained therein, or equally effective alternative means to achieve the same objectives. It also considers, and where appropriate follows, the good practice guidance referred to in *The NHS Healthy Workplaces Handbook* (NHS Employers 2007) or equally effective alternative means to achieve the same objectives.

Element two

The PCT provides a secure environment which protects, staff, visitors and their property, and the physical assets of the organisation, including in accordance with *Secretary of State directions on measures to tackle violence against staff and professionals who work in or provide services to the NHS* (Department of Health 2003, as

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

amended 2006) and *Secretary of State directions on NHS security management measures* (Department of Health 2004, as amended 2006)

C20a rationale (elements one and two)

- As per provider criteria. Wording amended to reflect PCTs role in commissioning services, and focus on staff and visitors, rather than patients, as clinical care is not provided by PCT commissioners.

Core standard C20b

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C20b rationale (elements one and two)

- Not applicable as this standard relates to provision of healthcare. The confidential handling of patient records will be assessed under C9.

Core standard C21

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For provider element one only** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C21 rationale (elements one and two)

- Not applicable as concerns provision of clinical care

Seventh domain: Public health

Domain Outcome: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standard C22a&c

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by
a) co-operating with each other and with local authorities and other organisations; and

c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT actively works with other healthcare organisations, local government and other local partners to promote, protect and demonstrably improve the health of the community served and narrow health inequalities through the Local Strategic Partnership(s), children's partnership arrangements, Crime and Disorder Reduction Partnerships, and other recognised partnerships, such as Youth Offending Teams.	Not applicable
Element two The PCT works closely with partners in coordinating health equity audits, conducting a comprehensive Joint Strategic Needs Assessment (JSNA), and contributing to developing the health and health-related Local Area Agreements, which are reflected in their strategic or operational planning.	
Element three Commissioning decisions are taken based on the JSNA and in line with the LAA, and taken in consultation with clinicians, local authorities and other partners, including patients, the public and their representatives.	
Element four The PCT monitors and reviews its contribution to public health partnership arrangements and takes action as required.	

C22a&c rationale (elements one, two three and four)

- As per provider criteria. Updated to reflect current guidance.
- Element one – "Promote and protect" more closely reflects the stands. Children's partnership arrangements are of increasing importance at a local level.
- Element two – The JSNA came into effect in April 2008 as a statutory requirement in relation to needs assessment and feeds into the local joint plan, the Local Area Agreement (LAA).
- Element three – See element 2.
- Element four – This reflects the standard and contributes to its outcome focus.

Core standard C22b

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT's policies and practice to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report (APHR).	Not applicable

C22b rationale (element one)

- No change needed. The APHR continues to be seen as a key document to influence PCT policies and practice for commissioning.

Core standard C23

Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT coordinates health equity audit, equality	**For each relevant provider element** For independent contractors, the PCT should

impact assessments and assesses the health needs of its local population, including analysis of its demography, health status and health inequalities, health and social care use, and patient and public views and contributes this to the joint strategic needs assessment (JSNA).

Element two
The PCT's commissioning decisions and local target setting are informed by intelligence from its assessment of health needs, the JSNA, the Director of Public Health's Annual Public Health Report (APHR), information from health equity audits, equality impact assessments, evidence of effectiveness and national priorities

Element three
The PCT commissions good-quality, evidence-based programmes and services to improve health and well-being, and narrow health inequalities, based on the needs of the population served.

Element four
The PCT monitors and reviews its commissioning decisions in relation to improving health and tackling health inequalities and, where appropriate, makes changes

Element five
The PCT implements policies and practices to improve the health and wellbeing of its workforce.

have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C23 rationale (elements one, two, three, four and five))

- Element one – The JSNA reflects current developments and updates the element. The inclusion of health inequalities better reflects the standard and contributes to domain outcomes.
- Element two – See rationale for element one above. The range of intelligence better reflects the standard.
- Element three – This focuses on the outcome of commissioning, and more closely reflects the standard.
- Element four – This adequately addresses the standard.
- Element five – This adequately addresses the standard.

Core standard C24

Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one In commissioning services, the PCT is satisfied that the provider will protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with the Civil Contingencies Act (2004), the NHS Emergency Planning Guidance 2005, and associated supplements (Department of Health, 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document) *N/A for general dental practitioners and community optometrists
Element two The PCT protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the Civil Contingencies Act 2004, The NHS Emergency Planning Guidance 2005 and associated annexes (Department of Health 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	

C24 rationale (elements one and two)

As per provider criteria. Updated to reflect current guidance. Commissioning resilience is fundamental to ensure that all organisations are able to achieve robust arrangements for dealing with incidents. PCTs provide the local management function for the NHS and operate as both providers and commissioners of services for their locality. PCTs must ensure that for all functions for which they are responsible, the highest level of service to patients is maintained regardless of what might happen to clinical/non clinical procedures or the infrastructure of facilities. The Civil Contingencies Act 2004 identifies PCTs as a 'Category 1 Responder', and imposes a statutory requirement on the PCT to have robust Business Continuity Management (BCM) arrangements in place to manage disruptions to the delivery of services, ensuring that all commissioned service providers are capable of providing services at an appropriate level. The PCT BCM requirements should be explicitly described and covered by commissioning, procurement and contract management processes.

Appendix 3 – Healthcare Commission's use of the findings of others in the Core standards assessment 2008/09 of PCTs as Commissioners

Use of the findings of others

We will continue to make use of the findings of others and have reviewed how we do this in order to increase this where possible, and to ensure that it is effective, both in reducing burden on trusts and also in targeting our inspections. Note that, as in 2007/08, we will make use of others' **in-year findings** – i.e. findings based on observance of compliance during the assessment year (i.e. 31 March 2008 to 1 April 2009), as evidence of assurance of compliance during the year 2008/2009. Findings of others relating to recent years will be used to help target inspections.

Mandatory assessment of the NHS Litigation Authority's Risk Management Standards has been suspended for PCTs for the 2008/09 assessment year. However, we will still make in-year use of their findings for PCTs who undergo volunteer assessment or have achieved **in-year** (i.e. 31 March 2008 to 1 April 2009) level 2 (or 3) in 2008/09 where this provides a level of assurance of compliance.

In year findings of others will also be used in our screening process to help target inspections; so that for example where there are positive findings in relation to a trust, this will reduce the chances of that trust being selected for inspection.

As well as the Healthcare Commission's use of the findings of others in this way, trusts also have the option of using findings of others that relate to matters within the assessment year as part of their assurance processes, but it is not a requirement and it is always open to trusts to assure themselves of compliance with the core standards in other ways.

Appendix 4 – Standards and elements applicable to independent contractors

When making its declaration, each PCT should consider whether it has taken reasonable steps to ensure that its independent contractors are meeting the standards. The Healthcare Commission recognises that each PCT will have different arrangements in place through which they do this, and that the arrangements will be different for the each of the independent contractor groups.

In the table below we have set out the relevant standards that the Healthcare Commission will apply the 'reasonable steps' assessment in the 2008/09 assessment. For the standards where we will not apply the reasonable steps, for a particular independent contractor group, this is marked with an N/A. The standards identified as N/A, are generally where the assessment focuses on the role of the PCT (such as C22a&c – public health partnerships), or where the standards are not relevant to the services provided by the contractor (such as C15 – food).

Standard	General Practitioner	General dental practitioners	Community pharmacists	Community optometrists
C1a	√	√	√	√
C1b	√	√	√	√
C2	√	√	√	√
C3	N/A	N/A	N/A	N/A
C4a	√	√	N/A	√
C4b	√	√	√	√
C4c	√	√	√	√
C4d	√	√	√	√
C4e	√	√	√	X
C5a	√	√	√	√
C5b	√ (element one for GP registrars and medical students)	N/A	N/A	N/A
C5c	√	√	√	√
C5d	√	√	√	√
C6	√	√	√	√
C7ac	√	√	√	√
C7b	√	√	√	√
C7e	√ (element one)	√ (element one)	√ (element one))	√ (element one)
C8a	√	√	√	√
C8b	√	√	√	√
C9	√	√	√	√
C10a	√	√	√	√
C10b	√	√	√	√
C11a	√ (element one)	√ (element one)	√ (element one)	√ (element one)
C11b	√	√	√	√
C11c	√	√	√	√
C12	√	√	√	√
C13a	√	√	√	√

Standard	General Practitioner	General dental practitioners	Community pharmacists	Community optometrists
C13b	√	√	√	√
C13c	√	√	√	√
C14a	√	√	√	√
C14b	√	√	√	√
C14c	√	√	√	√
C15a	N/A	N/A	N/A	N/A
C15b	N/A	N/A	N/A	N/A
C16	√	√	√	√
C17	√	√	√	√
C18	√	√	√	√
C20a	√	√	√	√
C20b	√	√	√	√
C21	√	√	√ (element one)	√ (element one)
C22ac	N/A	N/A	N/A	N/A
C22b	N/A	N/A	N/A	N/A
C23	√	√	√	√
C24	√ (communicable disease control)	N/A	√ (communicable disease control)	N/A