

Criteria for assessing core standards in 2008/09

Acute trusts

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Use of “we” (Overview section)

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 2008/2009 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.

Overview

These are the 2008/09 criteria for assessing core standards between 1 April 2008 and 31 March 2009 for trusts that provide acute and specialist services. 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 primary care trusts (PCTs). As set out in the Healthcare Commission 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 two sets of criteria for assessing PCTs; one for their role as providers and one set for their role as commissioners of services. A single PCT document containing both 2008/09 sets of criteria has been produced and is available to PCT trusts.

What else has changed?

This year, we have expanded 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 some documents have, in turn, become longer, trusts should find the criteria and the rationales more explicit, clearer and hence helpful when assuring themselves of their compliance against core standards.

As set out in our 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 trusts' 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 procedures¹ guidance **in accordance with** *The Interventional Procedures Programme* (Health Service Circular 2003/011). (C03) (NICE interventional procedures are required by the standard itself).

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).

- 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.** (C04d)

Where references are recognised as useful for trusts but are not directly the subject of 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 trusts' 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 – i.e, 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.

The NHS Litigation Authority's Risk Management Standards have now been rolled out to all 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.

Please see Appendix 1 for more details about this and other changes, in particular a change in the way we use patient environment action team findings.

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.

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
<p>Element one</p> <p>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.</p>	<p>Elements one and two</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p>Element two</p> <p>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 reoccurrence of incidents in the future.</p>	
<p>Element three</p> <p>Reported incidents are aggregated and analysed to seek to identify common patterns, relevant trends, likelihood of repetition and actions required to prevent</p>	<p>Element three</p> <p>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</p>

the reoccurrence of similar incidents in the future, for the benefit of patients / service users as a whole.

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 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.

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.

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
<p>Element one</p> <p>The healthcare organisations have made arrangements to safeguard children under Section 11 of the Children Act 2004 having regard to statutory guidance entitled <i>Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004</i>.</p>	<p>Element one</p> <p>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.</p> <p>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.</p>
<p>Element two</p> <p>The healthcare organisation works with partners to protect children and participate in reviews as set out in <i>Working together to safeguard children</i> (HM Government, 2006).</p>	<p>Element two</p> <p>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.</p>
<p>Element three</p> <p>The healthcare organisation 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 <i>Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004</i>.</p>	<p>Element three</p> <p>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.</p>

Core standard C3

Healthcare organisations protect patients by following NICE Interventional Procedures guidance.

Elements

Element one

The healthcare organisation follows NICE interventional procedures² guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011). Arrangements for compliance are communicated to all relevant staff.

Rationale

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 procedures³ 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

Element one

The healthcare organisation 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).

To note: the measurement of the MRSA target is undertaken through the 'national priorities' component of the annual health checks.

Rationale

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

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.

- Hygiene Code 4f.

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.

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

Element one

The healthcare organisation 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.

Rationale

Element one

No change to this element from 2007/08

Element two

The healthcare organisation 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

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).

Rationale

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

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.

Rationale

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

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 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).

Rationale

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

Element one

The healthcare organisation 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.

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.

Rationale

Elements one and 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.

Core standard C5b

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

Elements

Element one

The healthcare organisation 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 is monitored and reviewed on a regular basis and action is taken accordingly.

Element two

The healthcare organisation ensures that it provides opportunities for clinicians⁵ to develop their clinical leadership skills and experience.

Rationale

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

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

Element one

The healthcare organisation ensures that clinicians from all disciplines participate

Rationale

Element one

The wording of the elements has been amended to better reflect the standard and to clarify that 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)

in activities to update the skills and techniques that are 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.

responsibility being assessed is that of the 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

Element one

The healthcare organisation ensures that clinicians⁶ are involved in prioritising, conducting, reporting and acting on regular clinical audits⁷.

Element two

The healthcare organisation ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research.

Rationale

Elements one and 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

Element one

The healthcare organisation 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

Rationale

Elements one and 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

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)

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 transfer⁸) 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

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.

organisational level. Element two focuses on the 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 Healthcare 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

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 healthcare organisation has effective clinical governance⁹ 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 healthcare organisation has effective corporate governance¹⁰ 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 *NHS trust model standing orders, reservation and delegation of powers and standing financial instructions March 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 healthcare organisation systematically assesses¹¹ and manages¹² 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.

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).

Core standard C7b

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

Elements

Element one

The healthcare organisation 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.

Rationale

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

This standard will be measured through the use of resources assessment.

Rationale

Not applicable

Core standard C7e

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

Elements

Element one

The healthcare organisation 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

Rationale

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

(including, among other things, equality schemes for race, disability and gender, along with impact 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, 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.
- 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)

for Racial Equality published May 2002)

- ‘The Duty to Promote Disability Equality. Statutory Code of Practice’ (England and Wales) (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.

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

Element two

The healthcare organisation 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.

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

This standard will be measured through the existing national targets assessment

Rationale

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

Element one

Staff are supported, and know how, to

Rationale

Element one

No change to the element. The HSC 1999/198 has

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).

been 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

Element one

The healthcare organisation 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

Rationale

Elements one and 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 for example, 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 organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Elements

Element one

The healthcare organisation 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 healthcare organisation 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.

Rationale

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 employment¹³ 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"

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.

The new standards were launched on 18 March 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 2008¹⁴.

Core standard C10b

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

Elements

Element one

The healthcare organisation explicitly requires all employed healthcare professionals¹⁵ 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.

Rationale

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

Element one

The healthcare organisation 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,

Rationale

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.

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).

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.

Element two

The healthcare organisation 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.

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 C07e

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

Element one

Staff participate in relevant mandatory training programmes as defined by the relevant sector-specific NHSLA Risk Management Standards

Element two

Staff and students participate in relevant induction programmes.

Element three

The healthcare organisation 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-attendance, action is taken to rectify this.

Rationale

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 all types of trusts for the year 2008/09. The criterion/criteria have been updated to reflect this.

Element two

No change to this element from 2007/08.

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 – ie, probity, clinical quality and patient safety (including risk management training referred 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

Element one

The healthcare organisation 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”*. This includes 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

Rationale

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 C07e and information about the codes of practice is given in the rationale to C07e.

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

Element one

The healthcare organisation 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).

Rationale

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

Element one

The healthcare organisation 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 two

The healthcare organisation 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, 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
- 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

Rationale

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, for example, 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

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 codes. The 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, among other things.

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.

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

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*.

Rationale

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.

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. Bournemouth 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 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 healthcare organisation 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

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 healthcare organisation 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.

Rationale

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

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 healthcare organisation acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.

Element two

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

Rationale

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

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

Element one

The healthcare organisation has systems in place to ensure that patients / service users, carers and relatives are not treated adversely as a result of having complained.

Rationale

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

Element one

The healthcare organisation 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.

Rationale

Element one

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

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.

Rationale

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 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

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 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 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.

Rationale

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 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

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

Element one

Rationale

Element one

The healthcare organisation 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, 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
- 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 healthcare organisation 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).

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 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 healthcare organisation 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, 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
- 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 healthcare organisation 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, 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
- 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

Element one

The healthcare organisation 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, among other things, equality schemes for race, disability and gender, along with impact assessments)

Rationale

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 ensuring access to services.

The phrase “public body duties” is defined in C7e and information about the codes of practice is given

under the following “public body duties”*statutes:

in the rationale to C7e.

- 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.

* The phrases “public body duties” is defined in C7e.

Element two

The healthcare organisation 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 appropriate 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 existing national targets and new national targets 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 organisation.

Elements

Element one

The healthcare organisation effectively manages the health, safety and environmental risks to patients/service users, staff and visitors, in accordance with all relevant¹⁶ 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.

Rationale

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 been updated and published as *The NHS Healthy*

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

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 healthcare organisation 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

Element one

The healthcare organisation 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 transfers¹⁷.

Rationale

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

Healthcare organisations 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

Element one

The healthcare organisation 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).

Rationale

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 relevant¹⁸

Element two

The hygiene code was updated in January 2008.

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

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

The overarching duty 4 is to provide and maintain a 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 healthcare organisation 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 JSNA and health equity audits to identify population health needs.

Element one

Adding Joint Strategic Needs Assessments (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 healthcare organisation contributes appropriately and effectively to nationally recognised and/or statutory partnerships, such as the Local Strategic Partnership, 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 healthcare organisation 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**Element one**

The healthcare organisation'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.

Rationale**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**Element one**

The healthcare organisation 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.

Rationale**Element one**

This better reflects the standard for Acute and Specialist services.

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 for all providers.

Element three

The healthcare organisation implements policies and practices to improve the health and wellbeing 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**Element one**

The healthcare organisation protects the public by having a planned, prepared and, where possible, practised response

Rationale**Element one**

The sentence has been amended by adding 'protects the public' in order to ensure outcome, as well as process, is assessed.

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).

Guidance on all counts has been updated. NHS 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)*

Interim guidance has been released for business continuity (This is guidance for all NHS organisations on Business Continuity Management (BCM). It will be further developed, refined and revised by the NHS Resilience Project Team who will issue final BCM guidance). NHS organisations are expected to follow this interim guidance and emerging supplements starting from the publication date of June 2008.

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 healthcare organisation 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*

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.

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).

Appendix one: Healthcare Commission's use of the findings of others in the Core standards assessment 2008/09

Working with others

The Healthcare Commission has a statutory responsibility to promote the effective coordination of reviews or assessments relating to 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. While existing inspection methodologies have been developed as the best ways 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.

Other recent, as well as 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 and 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 Standards
- NHSLA Risk Management Standards for Ambulance Standards
- NHSLA Risk Management Standards for Primary Care Trusts Standards

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 the 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 recent 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 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, 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.

We expect that evidence collected by trusts to provide assurance for the **Audit Commission Auditors' Local Evaluation (ALE)** 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 **ALE** data is used within our screening process when we select trusts for inspections in the summer.

We also use the ALE findings directly as part of our inspections. For particular standards which have been selected for inspection, where positive assurance is provided from ALE this information is used as evidence and substitutes the need for additional local work 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 ALE would not be used alone to determine a lack of assurance of compliance but will inform questions that assessors will ask during inspection

We are working with the Audit Commission to apply the same methodology when considering the findings of their **use of resources** assessment for primary care trusts.

ALE List: C6, C7ac, C7b, C8a, C14a, C17, C21

Patient Environment Action Teams (PEAT)

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 two – reference documents

For the 2005/06, 2006/07 and 2008/09 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
C01a	<i>Building a safer NHS for patients: implementing an organisation with a memory</i> (Department of Health, 2001)
C02	<p><i>Safeguarding Children and Young People: Roles and Competencies for Health Care Staff</i> (Royal College of Paediatrics and Child Health April 2006)</p> <p><i>Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities</i> (DCSF 2008)</p> <p><i>Sharing personal information: How governance supports good practice</i> (DCSF August 2008)</p>
C04a	<p><i>Essential steps to safe, clean care: introduction and guidance</i> (Department of Health, 2006)</p> <p><i>National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services</i> (Ambulance Service Association, 2004)</p> <p>Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12</p> <p><i>Infection control practices for ambulance services</i> (Infection Control Nurses Association, April 2001)</p>
C04d	<i>Building a safer NHS: improving medication safety</i> (Department of Health 2004)
C05a	<i>How to put NICE guidance into practice</i> (NICE, December 2005)
C07ac	<p><i>Clinical governance in the new NHS</i> (HSC 1999/065)</p> <p><i>Assurance: the board agenda</i> (Department of Health 2002)</p> <p><i>Building the assurance framework: a practical guide for NHS boards</i> (Department of Health 2003)</p>
C7b	<i>Directions to NHS Bodies on counter fraud measures</i> (Department of Health, 2004)
C08b	<i>Leadership and Race Equality in the NHS Action Plan</i> (Department of Health 2004)
C10a	The set of six documents that make up the NHS Employment Standards: 1. <i>Verification of identity checks</i>

	<p>2. <i>Right to work checks</i> 3. <i>Registration and qualification checks</i> 4. <i>Employment history and reference checks</i> 5. <i>Criminal record checks</i> 6. <i>Occupational health checks</i></p> <p>These are downloadable from www.nhsemployers.org/primary/primary-3524.cfm</p> <p>The Criminal Record Bureau website provides additional information on Criminal record checks. See www.crb.gov.uk</p> <p>The UK Border Agency website provides information on their checking service for employers. See http://www.bia.homeoffice.gov.uk/employers/employerssupport/ecs</p>
C11a	<i>Code of practice for the international recruitment of healthcare professionals</i> (Department of Health 2004)
C11c	<i>Continuing professional development: quality in the new NHS</i> (HSC 1999/154) <i>Continuing professional development: quality in the new NHS</i> (DH, 1999)
C13a	<i>NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff</i> (Department of Health, 2003).
C13b	<i>Good practice in consent: achieving the NHS plan commitment to patient centred consent practice</i> (HSC 2001/023) <i>Seeking Consent: working with children</i> (Department of Health 2001)
C16	<i>Toolkit for producing patient information</i> (Department of Health 2003) <i>Information for patients</i> (NICE) <i>Guidance On Developing Local Communication Support Services And Strategies</i> (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) <i>Community Engagement in Health</i> (NICE public health guidance Feb 2008)
C18	<i>Building on the best: Choice, responsiveness and equity in the NHS</i> (Department of Health 2003).
C20a	<i>A professional approach to managing security in the NHS</i> (Counter Fraud and Security Management Service 2003) and other relevant national guidance <i>Design for patient safety: Towards future ambulances</i> (National Patient Safety Agency and The Helen Hamblin Trust, 2007) for ambulance trusts only BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C21	<i>Developing an estate's strategy</i> (1999) <i>Developing an estates strategy</i> (Department of Health, 2008), updated

	<p>version of previous document, but was not published until August 2008 <i>A risk based methodology for establishing and managing backlog</i> (NHS Estates, 2004)</p> <p>Add <i>BS EN 1789: 2007 Medical vehicles and their equipment</i> for ambulance trusts only</p> <p><i>Design for patient safety: Towards future ambulances</i> (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only</p> <p><i>National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services</i> (Ambulance Service Association, 2004) for ambulance trusts only</p> <p>BS EN 1789:2000 Medical vehicles and their equipment – road ambulances</p>
C22ac	<p><i>Choosing health: making healthier choices easier</i> (Department of Health 2004)</p> <p><i>Tackling health inequalities: a programme for action</i> (Department of Health 2003)</p> <p><i>Making partnerships work for patients, carers and service users</i> (Department of Health 2004)</p> <p><i>Guidance on Joint Strategic Needs Assessment</i> (Department of Health, 2007)</p>
C23	<p><i>Choosing health: making healthy choices easier</i> (Department of Health 2004)</p> <p><i>Delivering Choosing health: making healthier choices easier</i> (Department of Health 2005)</p> <p><i>Tackling Health Inequalities: A programme for action</i> (Department of Health 2003)</p> <p><i>Guidance on Joint Strategic Needs Assessment</i> (Department of Health, 2007)</p>
C24	<p><i>Getting Ahead of the Curve</i> (Department of Health, 2002)</p> <p><i>Beyond a major incident</i> (Department of Health, 2004)</p>